Report on an unannounced short follow-up inspection of

HMP Shrewsbury

2–4 February 2010

by HM Chief Inspector of Prisons

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Introduction

HMP Shrewsbury has acted as a local prison serving local courts since the nineteenth century. In January 2010, with little fanfare – and without notice to the Inspectorate – it was re-roled to become a category C training prison for vulnerable prisoners, while retaining a small local prison function serving the courts of mid-Wales. Inspectors therefore arrived for this short unannounced follow-up inspection in February unaware of the prison's new designation. Our confusion was evidently still shared by many prisoners and staff, but of more concern were the severe regime limitations, which appear to make Shrewsbury a singularly poor choice as a training prison.

With the influx of large numbers of vulnerable prisoners, considerable efforts had been made to ensure a safe environment. Some separation was enforced but most prisoners were managed on normal location, apparently without serious incident. However, security procedures were still being revised and did not yet adequately address the issues posed by the new population. There was a sound approach to anti-bullying, but the quality of suicide prevention measures was variable, which was unacceptable given the tragic series of self-inflicted deaths since our last visit. There were few adjudications, little use of force, and segregation was only used for short periods. Drug use was low and the integrated drug treatment system had been introduced, although it was unclear how relevant the system was to the prison's changed population.

There had been some refurbishment since our previous inspection, and the establishment was clean and well furnished. Staff-prisoner relations were generally positive, but were not supported by a functioning personal officer scheme, and the incentives and earned privilege scheme was in disarray. Provision around race equality was well developed, and there was good support for foreign nationals. However, other aspects of diversity were less well developed. Health care was much improved.

Even as a local prison, we had previously assessed Shrewsbury as not providing sufficient purposeful activity. There had been some improvement in the amount and range of work available, and education was well managed, but provision fell well short of what we would expect in a training prison. Prisoners spent too long locked in their cells, and the time out of cell monitoring data grossly exaggerated their actual experience.

Resettlement and offender management staff were struggling to manage the array of new risks and needs posed by the massively expanded vulnerable prisoner population. Analysis of these risks and needs was inadequate, although a range of basic provision was in place along most of the resettlement pathways. However, many prisoners, particularly sex offenders, had sentence planning targets to attend offending behaviour programmes when no such programmes existed at Shrewsbury. Other sex offenders were in denial of their offending, but again there was no specialist motivational work to address this. It was, therefore, difficult to see how these prisoners were going to address their offending behaviour effectively while at Shrewsbury.

At the last inspection, Shrewsbury was a busy and effective – if overcrowded and antiquated – local prison dealing with short-sentenced prisoners. With minimal planning it has re-roled to a specialist training prison, largely housing vulnerable prisoners. However, it is poorly equipped for this new role. Though it retains a number of its previous strengths, it is unclear how – with limited activities and interventions and a restricted regime – it can realistically achieve its new

role as a specialist, twenty-first century training prison for longer-term prisoners.

Anne Owers April 2010
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Shrewsbury is a category C prison holding vulnerable prisoners, with a category B facility on C wing which will serve the courts of Mid-Wales.

Area organisation
West Midlands

Number held
271

Certified normal accommodation
182

Operational capacity
340

Last inspection
June 2006

Brief history
The prison is situated in the town of Shrewsbury in Shropshire. The present prison was built in 1877, but there has been a prison on the site since 1793. Much of the original building has long since disappeared and the present establishment dates largely from the 1880s.

Description of residential units
HMP Shrewsbury consists of two residential wings (A wing and C wing).
A wing has a certified normal accommodation (CNA) of 160, with an operational capacity of 297. C wing has a CNA of 22, with an operational capacity of 43. Although the establishment has an operational capacity of 340, this will fluctuate depending on the number of single cell prisoners located on the wings.

A wing cells are located on four Victorian galleried landings, which have recently been refurbished. It has three safer cells, two constant supervision cells and the safer custody intervention suite. It also houses a number of integrated drug treatment system (IDTS) cells with hatches for unrestricted observation for those prisoners on stabilisation. The majority of these cells are located on the A2 landing, with a small number located on the A1 landing. Within A wing is a small separation care and control unit comprising three cells and one special cell. A wing is used to accommodate vulnerable prisoners; however, at the time of the inspection, a small number of mainstream prisoners were still located here due to the current re-role.

C wing is used to accommodate the remand and mainstream population. It also holds vulnerable prisoners. It has a safer cell within its accommodation and also houses a small number of IDTS cells with hatches for unrestricted observation for those prisoners on stabilisation. It is a self-contained wing with its own servery (with direct access to the kitchen), workshops and a classroom.

Section 1: Healthy prison assessment

Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2006 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

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

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

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

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

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

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

Safety

HP4 At our inspection in 2006, we found that in Shrewsbury, outcomes for prisoners were reasonably good against this healthy prison test. We made 29 recommendations in this area, of which 17 had been achieved, six partially achieved, five not achieved and one was no longer applicable. We have made a further 31 recommendations.

HP5 Prisoners reported a reasonable experience of transfers to the prison. Issues with the high level of transfers due to the re-role were being handled proactively. The reception area was small but adequate. The procedures in reception were thorough and respectful but prisoners experienced long waits there.

HP6 Prisoners were not all able to make telephone calls on their first night. There was no designated first night accommodation and night staff did not know the location of newly arrived prisoners. Thorough first night interviews were carried out in private in reception and new arrivals were made welcome. Prisoners felt safe on their first night.

HP7 Induction was comprehensive and immediate. Prisoners were prioritised depending on previous prison experience but all received basic information about the prison and met relevant staff and peer supporters.

HP8 Insufficient attention was given to self-harm and suicide prevention measures. Safer custody meetings were inconsistently attended and there was ineffective follow-up of significant issues, such as progress against Prisons and Probation Ombudsman recommendations following deaths in custody. The quality of assessment, care in custody and teamwork (ACCT) documentation was variable, with some evidence of good quality planning and follow-up, but some poor delivery of relevant support and attendance at case reviews. Care map planning was limited. There was a recruitment drive for Listeners, as the team of five was heavily utilised.

HP9 Staff were aware of indications of bullying and referred a wide range of incidents to the bullying liaison officer for further investigation. Exit interviews were carried out and indicated that prisoners felt safe. A recent safety survey had been conducted but not yet analysed.

HP10 The establishment had not yet made the shift to operate as a category C prison and the security department was reviewing procedures to support the necessary change. There was reliable security information, which had seen priorities change from drugs and mobile telephones to public protection issues. The series of changes meant that staff and prisoners were unclear about some rules and routines.

HP11 Segregation was used for relatively short periods, with about half of the prisoners located there returning to their wing at Shrewsbury and half transferring out. Basic

entitlements were met but files showed poor interaction and staff were not specifically trained for their role.

HP12 There was a low level of adjudications. Adjudicating governors met to look collectively at tariffs and quashed adjudications but had yet to develop more local quality assurance and trend analysis.

HP13 There was little use of force, and the incidents for which we saw video recordings showed some well handled removals, although some of the paperwork and video footage indicated areas for improvement. Special accommodation had been used for self-harm-related incidents and also whenever strip-searching was carried out in connection with use of force.

HP14 The integrated drug treatment system (IDTS) was developing well and there was multidisciplinary case management. A range of treatments was available and a harm reduction programme for all prisoners on induction.

HP15 The mandatory drug testing positive rate was below target. Suspicion testing was carried out efficiently. There was not a clear separation between mandatory and voluntary drug testing arrangements.

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

Respect

HP17 At our previous inspection, we found that in Shrewsbury, outcomes for prisoners were reasonably good against this healthy prison test. We made 63 recommendations in this area, of which 36 had been achieved, five partially achieved and 22 not achieved. We have made a further 30 recommendations.

HP18 The outside areas were clean and the internal environment was much improved. Communal areas were clean and pleasantly furnished. Prisoners were unnecessarily restricted from wearing their own clothes.

HP19 The incentives and earned privileges scheme was in disarray. The differentials between levels did not act as an incentive for improving behaviour. Information about incentive levels was not transferred with prisoners and they were placed on standard as the default position. The facility list was not appropriate for category C prisoners.

HP20 Prisoners were generally positive about staff and we saw some good staff–prisoner interactions. On association, some staff were confident and relaxed but others were less engaged. Staff used surnames rather than titles or first names but were responsive to prisoner requests.

HP21 The personal officer scheme was not functioning properly. Although cell cards listed the individual's personal officer, the relationship was mostly in name only. There were few personal officer entries under the recently introduced P-Nomis system and staff saw their role as dealing with queries rather than supporting reintegration into the community.

HP22 Catering was good, but meals were served too early and breakfast packs were distributed on the day before consumption. The three-week menu cycle met dietary requirements and there was a good level of consultation with prisoners. National Vocational Qualifications (NVQs) were not available to prisoners working in the kitchen.

HP23 The shop list under the new contractor offered more items than previously and there was evidence of responsiveness to consultation at the quarterly changes.

HP24 The overarching diversity strategy did not include information about delivery. Although there was effective work on race equality and disability, there were gaps around religion, sexuality and gender dysphoria. The focus of the diversity, race and equality action team was on race and foreign nationals. A disability liaison officer saw those identifying themselves as having a disability but this did not result in any formal care planning, although relevant referrals were made. There were no adapted cells.

HP25 Provision around race equality was well developed. The full-time race equality officer (REO) was proactive but stretched, as he also covered foreign nationals and older prisoners. All racist incidents were investigated thoroughly and 10% of racist incident report forms (RIRFs) were scrutinised by an independent body. There were peer equality representatives, who met the REO regularly.

HP26 There was a good foreign national policy. Professional translation services were used, and also staff and prisoner interpreters where appropriate, to help to those who could not understand English. There was good liaison with the UK Border Agency, which held monthly surgeries at the establishment, but no links with specialist independent advice and voluntary sector organisations.

HP27 Faith provision was good and there was easy access to corporate worship and other activities. The chaplaincy team played a key role in resettlement.

HP28 Most complaints were responded to comprehensively and within timescales. Good statistical data were collected but there was little evidence of any analysis of trends.

HP29 Remand prisoners were seen on reception to identify any bail issues and support prisoners in securing legal representation. Any subsequent legal advice was provided by application, and the names of the legal services officers were listed on cell cards.

HP30 There had been significant improvements in healthcare. The staffing skills mix was good. Prisoners' access to a GP was good; routine waiting times were less than five days and emergency cases were seen immediately. Health screening in reception was good. Dental services were good and the waiting times for appointments short. Mental health provision was of a high quality (including primary care), a range of services was provided and in-reach support was good. Mental health awareness training was provided.

HP31 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still reasonably good against this healthy prison test.

Purposeful activity

HP32 At our previous inspection, we found that in Shrewsbury, outcomes for prisoners were not sufficiently good against this healthy prison test. We made 21 recommendations in this area, of which 13 had been achieved, two partially achieved and six not achieved. We have made a further eight recommendations.

HP33 There were concerns about the accuracy of the time out of cell data, as local monitoring recorded 10 hours unlocked each weekday and 6.5 hours at weekend, every week, regardless of changes in the population. This did not reflect prisoners' experience. No prisoner received more than three hours out of their cells at weekends unless they attended the gym or visits, or were wing orderlies. Association was reliably offered but exercise was not available to those working full time, and the Astro-turf facility, which comprised the exercise area, was unusable in wet weather.

HP34 The number of work activities and the range available had improved, although most were part time and low skilled. Levels of vocational training were low. Promptness of arrival at work and engagement there was good.

HP35 The role of head of learning and skills was combined with resettlement. Learning and skills, the education department and the careers information and advice service were well managed. There was an adequate range of education courses available. There was a clear sense of direction but there had been no needs analysis to identify what work and learning opportunities were required with the changing population. The establishment of the activity allocation board had resulted in an improvement on the previous systems. Waiting lists were short and well managed. There were approximately 138 full-time equivalent work places and around 55 full-time equivalent education places. The quality of education and facilities was good, with comfortable classrooms which were well equipped and resourced.

HP36 The library facility had improved but was underused. The two prison officers responsible for moving prisoners to the library were often redeployed to other duties. The system for reducing book losses was undermined by the lack of computer tracking and knowledge of the book return boxes on the wings. Records of access were not kept but the librarian estimated that only around 30% of the population used the library.

HP37 There was a good new gym facility which was well managed. Four sessions were available each week and most prisoners could go at least twice a week, including sessions for those working full time. The range of activities available was reasonable, with good general health promotion. Staff believed that around 60% of the population accessed the facilities but there were no accurate figures available. No courses were offered in PE at the time of the inspection.

HP38 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still not sufficiently good against this healthy prison test.

Resettlement

HP39 At our previous inspection, we found that in Shrewsbury, outcomes for prisoners were reasonably good against this healthy prison test. We made 24 recommendations in

this area, of which 12 had been achieved, six partially achieved, four not achieved and two were no longer applicable. We have made a further 16 recommendations.

HP40 There was a plan to use induction and offender management information to understand the needs of the changed prisoner profile and to prepare a relevant strategy concentrating on education, training and employment, and resettlement, but this had not yet been developed. Each resettlement pathway had a lead and there was good engagement with the West Midlands area arrangements. There were structures to assess and meet immediate resettlement needs but poor monitoring arrangements to ensure that needs identified on arrival were responded to before discharge. The pre-discharge board did not always take place and there was insufficient engagement with those who did not attend boards. Analysis of need was inadequate and there were gaps in resettlement provision. No offending behaviour programmes were available and there were prisoners with enhanced thinking skills and sex offender treatment programme needs outstanding.

HP41 The offender management team was not sufficiently resourced to cope with the requirements of the changed population and the uniformed staff were too often used for other duties. Most of the prisoners in scope of offender management had no offender supervisor. Staff prioritised public protection and multi-agency public protection arrangements (MAPPA) issues. Over half of the low-risk offenders coming under offender assessment system (OASys) arrangements did not have assessments. The OASys clerk identified targets and referred prisoners to the range of reintegration services where appropriate but there was no monitoring of how successful these referrals had been.

HP42 Observation, classification and allocation work was also in a state of flux with the large numbers of prisoners transferring in and out. The usual arrangement to see new prisoners on induction was temporarily on hold, but the team was working hard to identify and transfer out prisoners who could not meet outstanding targets at Shrewsbury.

HP43 Prisoners received front-end information about what services were available and knew who to go to, but reported difficulty in gaining access to relevant staff towards the end of their sentence. Housing needs were identified on induction and most prisoners were aware of the available Nacro services. Most prisoners were reported as going out to settled accommodation.

HP44 Citizens Advice Bureau staff attended weekly to give a range of financial and debt advice. Resettlement staff were trained in money management to offer support to prisoners.

HP45 The education department ran a variety of business and finance courses but they were not prioritised for prisoners close to release. JHP Ltd offered advice and guidance through the careers information and advice service (CIAS). Jobcentre Plus also offered advice on induction and about jobs on release. Matching employment opportunities offered in the prison to the job market was problematic under the change of role, as prisoners came from, and were discharged to, locations all over the country. An employment fair had resulted in some prisoners gaining employment in the community.

HP46 Healthcare discharge planning was adequate, with links maintained with the local community. There was no healthcare involvement with release planning boards The

care programme approach was used effectively. Palliative care arrangements were in place.

HP47 Management of the drug strategy was now more coordinated. All prisoners were screened for alcohol problems but services for alcohol-only users were limited. There were established links with community-based services, including drug intervention programme teams.

HP48 The pathway for family and friends was well developed and there were good initiatives to support positive contact, including family days and parenting courses. Visits did not start on time because of the small gate and searching area but prisoners and visitors reported good relationships with visits staff.

HP49 The lack of accredited offending behaviour programmes and a needs analysis meant that there was an unmet need and significant gaps in provision. There was no motivational work available for those denying their offence.

HP50 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were not sufficiently good against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 The area manager should urgently raise concerns regarding failures in information sharing about prisoner suicide and self-harm risk with relevant criminal justice agencies. (HP38)

Achieved. The area manager had informed the prisoner escort and court services forum of these concerns. There was evidence in the files of the prison being notified by the police and by court services about the vulnerability of prisoners.

2.2 All areas of the residential units should be made safe. Showering facilities should be serviceable and the shower area on A1 landing should close immediately until it is safe to use. (HP39)

Achieved. There had been extensive structural work carried out on A wing, which had addressed our previous concerns around physical safety in this area. Showers had been refurbished to a good standard, with appropriate levels of screening and sealed, non-slip flooring, but there was some rusting of the metalwork in these areas. C wing showers were of a lower standard.

Further recommendation

2.3 The shower area on C wing should be refurbished.

2.4 The personal officer scheme should be re-launched and details of how it supports the offender management model clarified. Staff should be provided with appropriate guidance and training to enable them to take on the new responsibilities. (HP40)

Not achieved. The most recent personal officer scheme policy was dated September 2009 and, although it incorporated all the key elements in terms of responsibilities and links with available interventions, it did not explain the personal officer's role in relation to offender management. There had been no specific training or coaching for staff and they were unaware of their specific role under the scheme.
We repeat the recommendation.

2.5 The vulnerable prisoners' exercise yard should be improved as a matter of urgency. (HP41)

Achieved. The yard had been resurfaced in 2007, with benches and plants installed. Despite this, it remained unsuitable to be used for time in the fresh air. Although it was used for exercise for mainstream and remand prisoners, it was dark, shaded and unpleasant.

Further recommendation

2.6 Only the main yard should be used for exercise.

2.7 There should be sufficient work available to enable all prisoners to be fully occupied throughout the working day. This work should be purposeful and provide opportunities for prisoners to gain industry-recognised vocational qualifications to prepare them for release. (HP42)

Not achieved. The number of work and activity places had increased, although most work places were part time. Two additional workshops had been opened following the previous inspection. However, some of the work undertaken was low skilled and did not engage all prisoners fully. A small proportion of prisoners had worked for long periods in these workshops. Low skilled in-cell work was carried out by a small proportion of prisoners. Only a small number of prisoners were on vocational courses (see further recommendation 2.217).

2.8 The management and strategic direction of the drug strategy should be prioritised by the prison's senior management team with a clearly defined lead and management reporting line. (HP43)

Achieved. The drug strategy was prioritised by the senior management team, and the deputy governor had the clearly defined lead as the drug strategy coordinator. Counselling, assessment, referral, advice and throughcare (CARAT) and supply reduction teams had implemented a protocol to achieve more coordinated working and the drug strategy coordinator held meetings to ensure that both strands worked together for the benefit of prisoners.

Other recommendations

Courts, escorts and transfers

2.9 More use should be made of the video-link suite. (1.6)

Achieved. The prison had two private video link interview rooms and a video link court room. Diaries from 2008 and 2009 were not available, but in 2007 there had been extensive use of video link facilities for consultation with solicitors, probation interviews and remand hearings in the court room. With the recent change in the prison population, the use of the video link facilities had started to reduce, and they were now being used for legal interviews and offender manager contact rather than the needs of a remand population. The level of use was still being maintained at an average of 20 occasions a week.

Additional information

2.10 The contractor for prisoner transfers was G4S. Vans were clean and prisoners told us that they had been provided with food and drink during their journey to the establishment.

2.11 Relationships between escort and reception staff were good, with effective communication and information sharing. Prisoners told us that they were treated respectfully, which was consistent with treatment we observed at reception.

2.12 At the time of the inspection, the level of prisoner transfers was high, with transfers from the establishment to other local prisons, and category C prisoners being received. There were no new remand prisoners during the inspection.

2.13 Because of the busy nature of the transition period for the establishment's change of function (see recommendation 2.61), we observed vans arriving at the same time, which led to delays in disembarking prisoners. Reception staff managed this situation as well as they could, by disembarking prisoners sooner than they would normally, searching them and holding them in a room to wait for identification. Prisoners experienced long waits in reception.

Further recommendation

2.14 Prisoners should be moved to residential units promptly.

First days in custody

2.15 Prisoners identified as a high risk to other prisoners on the cell-sharing risk assessment should not be placed in shared accommodation. (1.20)

Achieved. Prisoners assessed as high risk were located in cells alone. In some cases, this took up space in double cells, which caused problems for the prison in finding space for new arrivals.

2.16 Prisoners should be able to make a free telephone call on their first night. (1.21)

Not achieved. Not all prisoners were offered a telephone call on their first night. The first night officer told newly arrived vulnerable prisoners that, for public protection purposes, they could not make a telephone call until the following evening, when the numbers on their PIN accounts had been activated. Some staff told us that they offered to ring numbers on prisoners' behalf to check that the call would be accepted and then would allow the prisoner to make a two-minute call. This did not happen in all cases. In our groups, only a small number of prisoners said that they had been able to make a call.
We repeat the recommendation.

2.17 The design of reception should be reviewed to ensure that it provides an appropriate environment where staff can effectively undertake procedures and that respects the privacy and confidentiality of prisoners. (1.22)

Achieved. Reception had been redesigned so that routine interviews identifying new arrivals and checking their property could be held in discrete areas. A private interview with health services staff was conducted in a designated room at one end of reception, and an interview with the first night officer was held in a separate room. The first night interview covered the cell sharing risk assessment and prisoners were encouraged to share any fears or concerns that they had in private.

2.18 Prisoners should be fully occupied during induction. (1.23)

Achieved. On the first morning of induction, prisoners attended a formal presentation and were interviewed by staff from a range of resettlement and activities departments. During the inspection, observation, classification and allocation staff had started participating in identifying prisoners with outstanding sentence planning targets who would require transfer to another

training establishment. During the afternoons, new prisoners undertook gym induction and education assessments, and visited the chaplaincy. They could also attend the library and, once their induction was complete, the gym.

2.19 Basic skills assessments should be completed in good time for the prisoner to access any necessary courses. (1.24)

Achieved. Assessment of prisoners' literacy and numeracy needs were now completed by Manchester College during induction and this information was used to inform planning.

2.20 Prisoners should not have to repeat basic skills tests simply to allow the prison to meet its performance targets. (1.25)

Achieved. Prisoners who had evidence of the results of recent basic skills assessments were no longer required to repeat tests.

2.21 The content and length of induction should reflect the needs of the various prisoner groups held at Shrewsbury. (1.27)

Achieved. Most prisoners arriving at Shrewsbury had been transferred from other prisons, and the induction had been modified to avoid repetition of material with which they would already be familiar. A small number of remand and newly sentenced prisoners from Welsh courts received a fuller induction. Different versions of the induction booklet were available for these groups. Prisoners who required further help with any issues could return to the induction department to meet specialist providers.

Additional information

2.22 The reception area was adequate for the number of prisoners passing through it, although it was particularly busy during the inspection. Incoming prisoners were provided with a shower before changing into prison clothing, and with a meal if held through a meal time.

2.23 The process of receiving prisoners was long, especially because a thorough cell sharing risk assessment and first night interview was held before they were taken to their accommodation. Typically, the process took two hours, but on one particularly busy day during the inspection, prisoners who had arrived at 2pm did not get to their accommodation until 7.15pm.

2.24 Reception staff were efficient and respectful throughout the process. The level of care they provided was demonstrated when we observed a prisoner who had arrived with a cut on his head. The reception officer asked him how it had come about and investigated it with the escort staff before being satisfied that it had been caused accidentally by the prisoner himself.

2.25 Insiders were present in the first night centre to help new arrivals, and Listeners were available for those who requested them. New arrivals were offered a smoker's pack and/or a grocery pack, which were deducted from their prison shop account.

2.26 There were four cells designated as first night accommodation on A wing. This was not sufficient for the number arriving, and they were spread around the wing in whichever cells were available. Night staff did not know the location of newly arrived prisoners, as no record was kept in the wing office.

2.27 The cells were prepared by Insiders, who greeted new arrivals and spent time answering their questions. We observed prisoners being asked their preferences for a cell mate, and their

wishes being heeded. Prisoners in our groups and new arrivals we met said that they had felt safe on their first night and had been provided with the information they required.

2.28 Induction ran every weekday, so prisoners usually attended on their first day in the prison. There was a designated induction room, with private offices for confidential interviews. Insiders provided informal information and answered questions during this period.

Further recommendation

2.29 Newly arrived prisoners should be readily identifiable to first night staff.

Residential units

2.30 Cells designated as single should not routinely be used to hold two prisoners. (2.14)

Not achieved. There had been no discernible change in cell allocation.
We repeat the recommendation.

2.31 Effective toilet screening should be installed. (2.15)

Achieved. All the cells we visited had full-length screening surrounding the toilet.

2.32 Facilities for prisoners to eat out of cell should be provided. (2.16)

Not achieved. There were some fold-down tables but these had not been used for some time and would only seat a small amount of prisoners when used. Staff and prisoners we spoke to said that they were not used.
We repeat the recommendation.

2.33 Prisoners' full names should be displayed on cell cards. (2.17)

Achieved. Cell cards displayed preferred names and individual photographs, and also highlighted who the personal officer was.

2.34 Notice boards should offer relevant information in a range of languages. (2.18)

Not achieved. All the notices that we saw throughout the prison were in English only.
We repeat the recommendation.

2.35 The offensive displays policy should be widely published and adhered to. (2.19)

Achieved. Prisoners and staff were aware of the policy and there was no offensive material on display in any of the cells we inspected.

2.36 Prisoners should have daily access to showers. (2.20)

Achieved. Access to showers was good at the time of the inspection, with prisoners reporting a daily opportunity to shower, in addition to taking showers at the gym.

2.37 Colour-coding of cleaning equipment should be adhered to across the establishment. (2.21)

Partially achieved. Although the visible equipment on the wings was clearly marked, cleaning equipment in the more remote areas was incorrectly marked.
We repeat the recommendation.

2.38 A laundry facility should be installed on A wing. (2.22)

Partly achieved. Laundry equipment had been ordered and delivery was imminent.

2.39 Prisoners should be given the opportunity to wear their own clothes. (2.23)

Not achieved. The only prisoners allowed to wear their own clothes at the time of the inspection were remand prisoners, and this was on the proviso that they were in possession of three sets of appropriate clothing.
We repeat the recommendation.

2.40 Additional telephones should be installed on both units to meet the expectation ratio of 1:20. Prisoners should be able to make telephone calls in private. (3.67).

Achieved. Each landing now had four telephones, so there was a ratio of at least one to every 20 prisoners.

Additional information

2.41 The outside areas were clean and the internal environment was much improved. Communal areas were clean and pleasantly furnished, and new association areas and equipment had been introduced on the landings. Cells were well painted and clean, but cold. The availability of curtains was limited, and prisoners often used towels as curtains.

2.42 The recent decoration of A wing had had a positive impact, and the wing looked clean and well maintained.

Further recommendation

2.43 All cells should be fitted with curtains.

Staff-prisoner relationships

2.44 Staff should address prisoners by their chosen name. (2.29)

Not achieved. Staff routinely called prisoners by their surnames, although there were some instances where prisoners were clearly well known and called by their first or nicknames.
We repeat the recommendation.

2.45 Managers should routinely encourage staff to challenge prisoners about their offending behaviour. (2.30)

Not achieved. Managers had not refocused staff on the need to challenge offending behaviour, and residential staff did not consider this as their role.
We repeat the recommendation.

Additional information

2.46 The atmosphere was positive on the wings and interactions between staff and prisoners were good. Prisoners were generally positive about staff, and felt that they were treated respectfully by most. There had been a significant change in the prisoner population, with many prisoners coming from outside the area who were not previously known to staff. This change may have contributed to a lack of knowledge of names but had not diminished the generally positive way that staff engaged with prisoners.

2.47 All staff were responsive to prisoner requests and prisoners said that there were staff they could go to for help. While many staff were confident in challenging poor behaviour, there was little awareness of supporting behaviour likely to reduce the risk of reoffending. Staff we spoke to saw their role wholly in terms of dealing with queries and ensuring the well-being of those in their care rather than supporting reintegration into the community.

2.48 There was evidence of responsive consultation with prisoners, albeit predominantly through wing and peer representatives. There was wider consultation around faith but there was no mechanism for the views of the wider prison population to be gathered by those representing them. Issues raised at wing-based consultative meetings had been followed up, although these meetings seemed to have stalled at the time of the inspection. The use of peer supporters was reasonable, given the recent transfers in and out of the prison.

Further recommendation

2.49 Prisoner consultative events should be held regularly and be representative of the wider population.

Personal officers

2.50 There should be focussed management attention to ensure implementation of the personal officer scheme and staff should have appropriate training and support. (2.35)

Not achieved. The personal officer scheme was not widely understood or implemented. While prisoners knew who their personal officer was, because they were allocated on a cell location basis and their names were on the cell cards, there were no structured meetings and personal officers rarely completed reports for prisoners on their caseload (see recommendation 2.4).

2.51 Staff should wear name badges. (2.36)

Not achieved. We saw few managers and no discipline or civilian staff wearing name badges. Uniformed staff were identifiable by their epaulettes, and we heard prisoners referring to staff by their numbers.

Further recommendation

2.52 Photographs identifying personal officers by name should be published on each wing.

Additional information

2.53 Residential staff said that they were personal officers to all prisoners, which mitigated the ineffectiveness of the personal officer scheme but limited the possibility of forming a specialised one-to-one relationship with a smaller number of prisoners and following through sentence planning and resettlement issues. This gap was likely to be even more significant, given the change of role to take longer-term, category C prisoners.

2.54 Few prisoners had been introduced to their personal officer or had dedicated meetings. All electronic files had the name of a personal officer recorded but some were incorrect.

2.55 Record keeping was poor. Paper files had been archived, so any information on prisoners dated back only to the advent of P-Nomis or the prisoner's more recent arrival. Of the 15 personal history files we sampled on P-Nomis, few comments showed evidence of interaction. Some personal officers did not have a password for the computer system, or confidence in using it, and some had not made any entries since the system had been introduced in November 2009. Even where personal officers were able to access the system, entries were irregular. None of the files we sampled had any reference to sentence plans or behaviour-related objectives, and only one mentioned family contact. Management checks noted on the files made no comment on the quality or quantity of entries.

2.56 Few officers could give personal details about prisoners for whom they were responsible. There had been a significant influx of new prisoners, and this knowledge would take time to build. Prisoners who had remained at Shrewsbury after the change of role were better known.

Further recommendations

2.57 Staff should take up their designated responsibilities in the personal officer role, including report writing for those on their caseload.

2.58 All personal officers should introduce themselves to those on their caseload and meet them regularly to discuss and make a note of progress.

2.59 All personal officers should have access to the P-Nomis system and make weekly entries for prisoners for whom they are responsible.

2.60 Management checks should establish the quality and quantity of personal officer entries and follow up issues with the individuals involved.

Bullying and violence reduction

2.61 An area strategy should be drawn up to assist the prison to implement a non-collusive approach to accommodate all prisoners on standard location. (3.13)

Achieved. Shrewsbury had changed its function in January 2010 from a local prison to primarily a category C training prison for vulnerable prisoners. During the transition period, a differentiated regime had been run for prisoners who did not wish to associate with vulnerable prisoners. During the inspection, the differentiation was terminated and there was no routine separation of prisoners.

2.62 Where possible, the safer prisons meeting should be chaired by the same senior manager to ensure consistency. (3.12)

Not achieved. Following the sudden and sad death of the deputy governor, the meetings should have been chaired by someone of his seniority, but this did not consistently happen. We repeat the recommendation.

Additional information

2.63 Prisoners told us that they felt safe and they rarely saw any bullying.

2.64 Staff were aware of indications of bullying and had submitted 119 bullying alert forms in the previous five months (the only period for which data were available). The reasons for the submissions ranged from prisoners requesting separation and reporting bullying, to observations of misuse of prescribed drugs and theft of milk from the chaplaincy. Most of these had not resulted in anti-bullying interventions. The prisoners concerned had been interviewed by safer custody managers and an assessment made of the need for an intervention. Records of the interviews showed that assessments were thorough, action taken where necessary and that appropriate advice was provided to prisoners. The reports were discussed at the safer custody meeting but there was no evidence of any analysis or learning being implemented.

2.65 The prison operated a three-stage anti-bullying intervention. Only two such interventions had been opened in the period recorded. The prisoners concerned had been transferred with the change of the prison's role, and records of the intervention were not available.

2.66 An 'at risk' helpline was publicised through the internal prisoners' magazine and on telephones as a means of reporting victimisation or suicide risk. This was available to prisoners to call through their PIN telephone allocation.

2.67 The prison undertook an exit survey with discharged and transferred prisoners and recorded positive results. The results were reported to the safer custody meeting but did not lead to further action. However, observation in reception of the exit survey being conducted with a prisoner demonstrated its limitations; it was not conducted in private and the context of imminent release was not conducive to full consideration by the respondent. A safety survey had recently been conducted.

Further recommendations

2.68 The findings from bullying alert information should be used by the safer custody committee to inform continuous improvement.

2.69 Prisoners should be able to call the 'at risk' helpline free of charge.

Housekeeping point

2.70 The prison should ensure that the safer custody survey covers all aspects of safer custody.

Self-harm and suicide

2.71 The suicide prevention coordinator should be provided with sufficient, predictable and regular facility time to carry out these duties. (3.25)

Not achieved. Safer custody had been managed by a principal officer, but he had recently been appointed to the post of head of residential and had not been replaced. Two senior officers currently shared the job, providing the service for half a day a week. They had to prioritise the safer custody work which was undertaken but did not have enough time to carry out the full range of tasks adequately.
We repeat the recommendation.

2.72 The case manager allocated to a prisoner at risk should remain the same for the duration of the ACCT document so that the prisoner at risk receives consistent support from familiar staff. (3.26)

Partially achieved. Three senior officers had been trained as case managers for assessment, care in custody and teamwork (ACCT) cases, and the same officer remained for the duration of the document. They were not able to attend reviews consistently and the extent of their involvement with the prisoner varied.

Further recommendation

2.73 The case manager allocated to a prisoner at risk should contribute to each review and record regular personal contact with the prisoner when on duty.

2.74 Prisoners subject to the constant watch level of supervision should be reviewed in line with local and national instructions. Belongings should not routinely be removed unless exceptional risk has been highlighted and a formal risk assessment undertaken. (3.27)

Partially achieved. Constant watch was rarely used and there was just one record available. This showed that the initial review of constant watch had not been carried out until day three. Subsequent reviews had been carried out at 24-hour intervals. The prisoner who had been on constant watch told us that he had been allowed to retain his belongings.

Further recommendation

2.75 Prisoners subject to the constant watch level of supervision should be reviewed in line with local and national instructions.

2.76 The 'at risk' helpline should be regularly checked for faults. (3.28)

Not achieved. The 'at risk' helpline was not available when we called it on three occasions from an external line. It was available when called from an internal prison telephone.

Further recommendation

2.77 The 'at risk' helpline should be available to external callers.

2.78 The intervention suite on A wing should be more comfortably furnished and made more homely and welcoming. (3.29)

Achieved. Two cells had been combined on the ground floor of A wing to provide the Listener intervention suite. The room created had been freshly painted and furnished with bunk beds, soft chairs and a coffee table. It was decorated with curtains, paintings and an aquarium.

2.79 Night entries should not be made at predictable intervals. (3.30)

Not achieved. In most ACCT documents, a checklist sheet was used for night observations and these were recorded at predictable intervals. There were two examples of observations being carried out at random times through the night.
We repeat the recommendation.

Additional information

2.80 Insufficient attention was given to self-harm and suicide prevention. This area was managed through the safer custody meeting. Attendance at the meeting was not consistent, especially by health services staff, who were not able to provide representatives to morning meetings. Prisoners and representatives of the Samaritans attended regularly.

2.81 There had been five deaths in custody since the previous inspection, four of which had been self-inflicted. The Prisons and Probation Ombudsman (PPO) had prepared four reports on the deaths, and was investigating the fourth self-inflicted death at the time of the inspection. Separate action plans arising from the recommendations had been drawn up by the prison and by the healthcare department. The prison could not provide copies of all the action plans, and those we saw did not include a full record of progress. There was no evidence that the substance of the action plans was considered at the safer custody meeting and there was no continuous improvement plan developed from the findings of the investigations. The healthcare action plans were considered by prison clinical governance meetings and at the prison partnership board.

2.82 In 2009 there had been 237 ACCT documents opened, which reflected the establishment's role as a busy local prison. However, the number appeared to be falling, with a more settled population, and there were three open at the time of the inspection.

2.83 The ACCT documents we examined varied in quality. The main criticisms were that immediate action plans had not been fully completed, the content of care maps was limited and ACCT documents had been closed without the care map being fully addressed. Review meetings were often limited in scope and did not have multidisciplinary representation. Observation intervals were not adhered to and there were gaps without entries in the records. Quality checks were recorded but in a number of cases did not pick up deficiencies. Prisoners we spoke to reported variable levels of care and some that they received better support from the chaplaincy than from residential staff.

2.84 Communication with receiving establishments about prisoners being transferred on open ACCT documents was thorough and the prisoner was kept informed of developments. During the inspection, a prisoner who was on an open ACCT document was received without prior notification. The sending prison was contacted to ensure that there was a full exchange of information.

2.85 The prison had undertaken a training programme of foundation ACCT training, which had been delivered to 47% of staff.

2.86 There were five Listener-trained prisoners and the prison was undertaking a recruitment programme to increase the number to the level recommended by the Samaritans. Prisoners arriving from other prisons who were already trained were not used until their suitability had been confirmed by the sending establishment. Listeners were well supported by the local Samaritan group, which provided weekly group meetings.

Further recommendations

2.87 The full range of departments designated in the safer custody policy should be represented at every safer custody meeting.

2.88 Death in custody action plans should be reviewed at the safer custody meeting.

2.89 A continuous improvement plan should be developed from the findings of the Prisons and Probation Ombudsman reports and managed through the safer custody meeting.

2.90 The quality of assessment, care in custody and teamwork (ACCT) practice and recording should be checked daily by the safer custody manager and deficiencies addressed.

2.91 The prison should ensure that all staff receive foundation ACCT training and that a programme of refresher training is in place.

Applications and complaints

2.92 Replies to healthcare complaints should not be unnecessarily defensive. (3.81)

Achieved. The healthcare complaints we reviewed were appropriately responded to. Prisoners were addressed by their full name and title and a full response was provided, alongside an apology where necessary.

Additional information

2.93 On average, 44 complaints were submitted each month. The nature of the complaints varied greatly but recently there had been a large number about prisoners' property having not arrived with them or not being able to access items from the property store. Prisoners were aware of how to make complaints and some had had a reasonable experience of submitting a complaint and having it responded to in a timely manner.

2.94 The complaints clerk collected the complaints each weekday morning and they were scanned into the computer. A copy was then sent to the appropriate department or staff, with a timescale for a response. The establishment discouraged interim replies, as this did not constitute dealing with the complaint and could not be included in their key performance targets. The prison reported that 99% of complaints were responded to within the appropriate timescale.

2.95 A record of the prisoner's ethnicity and location and the nature of the complaint was maintained but, although we were told by the head of the business management unit that it was discussed at the senior management meeting, we saw no evidence of this in the minutes provided. A small sample (10%) of complaints was quality checked by the deputy governor. Five per cent of prisoners were asked to complete a survey to rate how they felt their complaint

had been dealt with and to comment on the effectiveness of the complaints system. Generally, prisoners fed back positive comments.

2.96 The complaints we looked at were dealt with promptly; those that needed to be referred to other establishments were actioned appropriately, and complaints with the racist or bullying box ticked were referred to the race equality officer (REO) or safer custody coordinator.

Legal rights

2.97 Unsentenced prisoners should have ready access to an effective bail information scheme. (3.87)

Achieved. There were three legal services and bail information officers, two of whom had received recent training. The re-role of the establishment meant that, although they had sufficient profiled time to undertake legal services and bail information work, the demand for these services had reduced in conjunction with the remand population. A legal services/bail information officer was available each day to meet new receptions and to inform them of the services available. The names of these staff were printed on the cell cards. Both the legal services/bail information officer and ClearSprings worked to secure bail accommodation for prisoners. Referrals were made to hostel accommodation but the last three bail referrals made to hostel accommodation had been refused because of prisoners not meeting their criteria. It was not clear what type of legal services provision would be available once the population of the establishment had completely changed, but we were told that remand prisoners would continue to be received from the designated Welsh courts, so a bail service would continue to be provided.

2.98 Legal services officers should have the facility to offer prisoners telephone calls in pursuance of their legal rights. (3.88)

Partially achieved. There was no formal arrangement for prisoners to be offered telephone calls in pursuance of their legal rights. One legal services officer told us that she would informally facilitate prisoners making a supervised call to their legal representative using her PIN account or make a call on the prisoner's behalf.
We repeat the recommendation.

2.99 Arrangements should be made to provide legal advice about immigration and deportation to all those requiring it. (3.89)

Not achieved. Legal services officers were unaware of legal issues for foreign national prisoners and this group was expected to receive specialist help from the foreign national's coordinator. Legal services officers limited themselves to giving prisoners a list of immigration solicitors (see section on foreign national prisoners).
We repeat the recommendation.

Additional information

2.100 Legal visits were available on Wednesday to Friday mornings and three spaces were available in the afternoons. The meetings were mainly conducted in the social visits room but private interview space was available.

2.101 The legal services officers were responsible for issuing recall packs to prisoners. There were 64 recalled prisoners at the time of the inspection. They assisted prisoners with sending out information to legal representatives or making contact with them.

Faith and religious activity

2.102 The multi-faith room should be extended to offer prisoners a suitable area to practice their faith. (5.46)

Achieved. The multi-faith room, with a capacity of 30, was large enough for the population of non-Christian prisoners. The largest group was Muslims, of whom there were 29, with around 19 attending prayers regularly. The Muslim chaplain was satisfied with the room. He had also arranged with his colleague chaplains for curtains to be put in place to cover Christian artefacts in the chapel if more room was required.

2.103 Clarification on the procedure for prisoners attending Friday prayers should be provided to both staff and prisoners. (5.47)

Achieved. Procedures for prisoners attending Friday prayers had been clarified and published. Friday was a working day, and those who wished to attend prayers were brought back to their wings an hour before lunch, so that they could wash in time for afternoon prayers.

Additional information

2.104 The chaplaincy provided religious leaders for all faiths represented in the prison through a combination of employed and sessional chaplains.

2.105 A wide range of religious classes was provided, covering Christian, Muslim, Sikh and Buddhist religions, which were run during the week.

2.106 The chaplaincy provided important resettlement support for prisoners through courses and community links.

2.107 The supporting offenders through restoration inside (SORI) restorative justice course was provided for non-sex offenders four times a year. It was run by a multidisciplinary staff group and involved community and victim representatives.

2.108 The chaplaincy ran the Fresh Start New Beginnings charity, which provided counsellors and mentors for prisoners. Those engaged in the programme were provided with advice and planning for release, backed by community support after release from custody. Practical support, such as loans for accommodation deposits and help with applications for employment, was also provided. There had been 150 referrals to the charity in the previous 12 months and it was working with 10 released prisoners at the time of the inspection.

2.109 The prison Toe by Toe scheme was managed by the chaplaincy. Peer mentors and volunteers were recruited to help prisoners with literacy problems. Other services provided by the chaplaincy included family liaison, daily visits to prisoners on ACCT documents, a volunteer-led art class and a church choir.

Good practice

2.110 *The charity, Fresh Start New Beginnings, was a valuable and comprehensive mentoring service for prisoners.*

Substance use

2.111 Clinical services should be extended to offer a more flexible regime incorporating stabilisation, detoxification and maintenance provision including methadone. (8.44)

Achieved. The integrated drug treatment system (IDTS) had recently been established and new staff had been employed. A new regime of stabilisation, detoxification and maintenance, including the use of methadone, was ready to take patients from March 2010.

2.112 The role of the CARAT team in relation to prisoners subject to detoxification should be clearly defined and implemented. (8.45)

Achieved. The role of the counselling, assessment, referral, advice and throughcare (CARAT) team in relation to prisoners subject to detoxification was clearly defined in a written protocol. The protocol was monitored by the head of primary care and head of crime reduction. The CARAT team role was a standing agenda item at the drug strategy meeting.

2.113 Shrewsbury should introduce voluntary testing and clearly differentiate it from the current compliance testing. (8.50)

Not achieved. The programme of voluntary drug testing continued as at our previous inspection and was still linked to the incentives and earned privileges (IEP) scheme, rendering the process compliance testing.
We repeat the recommendation.

2.114 Voluntary or compliance testing for prisoners on C wing should be undertaken on C wing using mobile testing facilities. (8.51)

No longer relevant. The changing role of the prison integrated all prisoners, negating the need for mobile testing facilities.

2.115 Any negative sanction for positive drugs tests relating to health and safety should be subject to risk assessments rather than a blanket ban. (8.52)

Achieved. Prisoners testing positive for illicit non-prescribed drugs were risk assessed before engaging in work or the gym and before any sanctions were imposed if deemed necessary.

Additional information

2.116 Substance use and alcohol services were commissioned by Shropshire County Council and provided privately by Criminal Reduction Incentive (CRI).

2.117 Multidisciplinary case management took place weekly. It was envisaged that there would be a lower demand for services with the changed role of the prison, allowing greater emphasis on programme delivery. The drug strategy had been developed and was reviewed twice a year, including clear developmental targets.

2.118 The voluntary drug testing positive rate fluctuated monthly between 1% and 5%, with an average of 110 compacts, and the mandatory drug testing positive rate in the year to date was 9.8%, against a target of 12%. In the six months between August 2009 and January 2010 an average of 8.3 tests had been carried out per month and the positive rate was reasonable at 53%. Positive findings included benzodiazepines, buprenorphine and opiates.

Diversity

2.119 Training in diversity should be extended to all staff and those members of the diversity management team who have not yet received it. (3.37)

Partially achieved. Most members of the diversity management team had been trained. Only 29% of other staff had received recent training in diversity matters.

Further recommendation

2.120 All staff should undertake diversity training that covers all strands of the diversity agenda.

Additional information

2.121 Diversity came under the management of a senior manager, who also had responsibility for community engagement. She was supported by the race equality officer (REO) (full time) and the disability liaison officer (DLO) (eight hours a week). Photographs of the membership of the diversity, race and equality action team (DREAT) were displayed prominently around the prison.

2.122 The overarching diversity policy was brief, with no information about how it would be delivered. The prisoner policy had been separated out to make it easier for prisoners to understand how it related to them. There was more underpinning work, and there were separate policies for race equality, foreign nationals, older prisoners and disability but little in place for religion, sexuality and gender.

2.123 There was a monthly DREAT meeting. This was described as being co-chaired by the diversity manager and the governor, although the previous three meetings had not been attended by the governor. Attendance was consistent from appropriate departments and members of Shrewsbury Action Against Racism, although the focus was on race and foreign nationals, as work under the other diversity strands was not fully developed. There had been a quarterly diversity management team meeting which focused on staff issues and the strategic development of diversity. This had not met since March 2009 but was due to be revitalised following the creation of a regional equalities management team. The diversity action plan had been managed under this meeting. There was little monitoring or analysis of diversity apart from SMART (Systematic Monitoring and Analysing of Race equality Template) monitoring.

2.124 There were three prisoner diversity representatives for equality and two more had been identified to cover matters relating to older prisoners and disability. They regularly attended and contributed to the monthly diversity meetings and had received some training from the REO to assist them in their role.

Further recommendations

2.125 The diversity policy should be developed to include all aspects of diversity and details of how the policy will be delivered in practice.

2.126 All aspects of diversity should be discussed at the diversity, race and equality action team (DREAT) meeting, which should be attended and chaired by the governor or deputy governor.

2.127 The quarterly diversity management team meeting should be reinstated.

2.128 Monitoring and analysis of equality of treatment should be carried out for all the different diversity strands.

Race equality

2.129 Assistant race relations liaison officers should be given sufficient profiled time to be effective in this role. (3.38)

Not achieved. The identified assistant race relations officer was rarely given profiled time to undertake the role.
We repeat the recommendation.

2.130 Prisoners making racist incident complaints should be informed of the outcome in writing. (3.39)

Achieved. Prisoners were informed of the outcome in writing promptly and in sufficient detail to address all the issues raised. Prisoners were also informed of their right to appeal against any decisions made.

Additional information

2.131 Black and minority ethnic prisoners accounted for 18.4% of the prison population. Race equality was the most developed strand of diversity, with a comprehensive policy in place and active and effective management through the DREAT meeting. The diversity team was under-resourced, resulting in the dedicated REO also taking on work relating to foreign national and older prisoners. He was proactive in his role and known to staff and prisoners. There was effective monitoring of treatment of prisoners by ethnicity, which was carried out at the monthly meeting. There had been some problems identified with under-representation of black and minority ethnic prisoners in certain work areas, and as a result the REO attended the weekly labour allocation boards to ensure equity of access for all prisoners.

2.132 The REO actively supported staff in challenging prisoners around race issues. When staff submitted racist incident report forms (RIRFs) stating that prisoners had called them racist, he encouraged them to go back to the prisoners to ascertain the reasons why. In most cases, the issues were resolved at this stage.

2.133 There had been 43 RIRFs submitted in 2009, a reduction on the previous year, and three in 2010 to date. There were no identified patterns or trends and the reduction was thought to be due to the increased profile of the REO.

2.134 All racist incidents were investigated thoroughly by the REO. The investigations were detailed and addressed all the matters raised by prisoners and staff. RIRFs were signed off by the diversity manager, and all were discussed at the monthly DREAT meeting. Ten per cent were independently scrutinised by a member of staff from Shrewsbury Action Against Racism. A written report was submitted after the independent scrutiny, identifying areas for improvement or attention, and action was taken to address these. One of the main issues that had been identified was that staff submitting RIRFs had not completed section three of the report, which detailed any action they had taken to deal with the incident. This suggested that some staff were relying on the REO to challenge racist behaviour. There were no formal interventions for challenging racism, although a log was kept of victims and some support was offered to them by the REO.

2.135 Impact assessments had been undertaken for the statutory 10 policy areas and these were under review due to the need to include all aspects of equality in the assessment. The schedule for completing these had fallen behind, although this had been recognised at the DREAT meeting and action was being taken to address the matter.

2.136 There was an effective system to identify prisoners whose current or previous convictions were of a racist nature. Referrals were made to the REO by reception, induction and security staff, and offender managers and supervisors, depending on when the information came to light. All such prisoners were seen individually by the REO, who discussed with them the expected standards of behaviour at the establishment and gave them written information to support the discussion.

2.137 There were regular meetings between the REO and the equality representatives but little consultation with black and minority ethnic prisoners beyond these meetings.

2.138 Regular events took place to celebrate diversity, and recent events included Holocaust Memorial Day, Black History Month and Kick Racism out of Football. External organisations were involved and these events were supported by displays throughout the establishment.

Further recommendations

2.139 All racist incident report forms (RIRFs) should be signed off by the governor.

2.140 All RIRFs should be completed in full by the person submitting the report.

2.141 Interventions to challenge racism and to protect victims should be introduced.

Good practice

2.142 *The interviewing of all prisoners with current or previous convictions for racist offences was an indicator of the positive action taken by the race equality officer to combat racism.*

Foreign national prisoners

2.143 The foreign nationals liaison officer should be given sufficient time and senior management support to put the policy into practice. (3.48)

Not achieved. Foreign national work was carried out by the REO alongside his other work, which resulted in his time being stretched. Identified foreign nationals liaison officers on the

wings did not have profiled time to carry out their work, although they did have job descriptions.

Further recommendation

2.144 The race equality officer and foreign nationals liaison officers on the wings should be given sufficient time to carry out their work.

2.145 The foreign nationals induction pack and other key information should be available in translation. (3.49)

Partially achieved. The foreign national coordinator told us information would be translated on an individual basis but that little local information, including the induction pack, had been translated into other languages. Some information was however available in 26 other languages (see 2.212).
We repeat the recommendation.

Further recommendation

2.146 Staff should be made aware of the translated material available and give relevant information to prisoners in their own language.

2.147 Prisoners held solely on immigration matters should be released, deported or removed to an immigration removal centre. (3.50)

Not achieved. Prisoners waiting to be deported were often transferred to immigration removal centres in the days before their deportation. There were seven prisoners waiting for deportation at the time of the inspection, one of whom had been waiting two months beyond the end of his sentence.
We repeat the recommendation.

2.148 The prison should develop links with IND to establish regular casework surgeries for prisoners recommended for deportation. (3.51)

Achieved. Links had been established and developed with the UK Border Agency (formerly the Immigration and Nationality Directorate (IND)), which held monthly surgeries in the prison and also attended on an ad hoc basis, as required.

Additional information

2.149 Foreign nationals accounted for 5% of the prisoner population. There was a detailed foreign national prisoner policy, which gave sufficient information to staff and prisoners about how this group would be managed at Shrewsbury. There was no separate foreign nationals committee, but matters relating to nationality were dealt with sufficiently well at the DREAT meeting.

2.150 Professional translation services were used by some staff to provide information and help to those who could not understand English sufficiently well. Some prisoners also helped to translate, for non-confidential matters. There was a foreign national orderly, who assisted prisoners in completing forms. There was no independent advice service available for immigration purposes.

2.151 Twice-weekly meetings were held to offer support to foreign national prisoners and these ran as a drop-in service, with no formal minutes taken. Any issues raised were fed back through the DREAT and senior management team meetings.

2.152 The prison provided a generous amount of free PIN telephone credit to foreign national prisoners, who could also receive one visit a month. This was between £10 and £30 a month, depending on privilege level on the IEP scheme.

Further recommendation

2.153 Independent immigration advice and support should be made available to foreign national prisoners.

Disability

This area was not inspected at the previous inspection.

2.154 There was a part-time untrained DLO, who was detailed for eight hours a week to work with prisoners with disabilities. She saw all prisoners who had self-identified a disability on reception or later during their time at the establishment. She discussed their needs with them and referred them to departments which could provide assistance, such as education and healthcare. There was no formal screening or assessment tool used and no formal care planning in place. There were no central records or log kept of prisoners with disabilities. We were told there were about 20 in the prison at the time of the inspection. The DLO told us that the re-role of the prison had resulted in an increase in prisoners with restricted mobility.

2.155 Three prisoners had been identified as needing assistance in leaving their cells or wing in emergencies, and they all had personal emergency evacuation plans. There was no carer or mentoring system and there were no regular forums for prisoners with disabilities to air their views or receive support. One shower on each wing had been adapted for use by prisoners with disabilities but there were no fully adapted cells.

Further recommendations

2.156 The disability liaison officer should receive appropriate training to undertake the role.

2.157 There should be a formal assessment screening tool to complete for prisoners with disabilities.

2.158 All prisoners with disabilities should have a care plan identifying their needs and how they will be met.

2.159 A central log should be kept of all prisoners with disabilities.

2.160 There should be a carer or mentor scheme in place for prisoners with disabilities requiring additional assistance.

2.161 There should be at least one adapted cell on each wing for use by prisoners with disabilities.

2.162 Regular consultation meetings should take place with prisoners with disabilities.

Older prisoners

This area was not inspected at the previous inspection

2.163 There was a policy for older prisoners which detailed the limited resources available. The needs of older prisoners were looked after by the REO. The recent re-role of the establishment had resulted in an increase in the age range, and there were 50 prisoners over 50 at the time of the inspection.

2.164 Services for older prisoners were not fully developed. A nurse had been identified as having responsibility for older prisoners, and these prisoners could attend a support group on Tuesday mornings. This was designed to give them quiet time away from the wing and enable them to raise any problems with the REO and nurse.

2.165 There were no formal links with external agencies to provide additional support and information.

Further recommendations

2.166 The needs of older prisoners should be fully assessed and a comprehensive action plan drawn up to identify how those needs will be met and what services will be provided.

2.167 There should be a dedicated officer to carry out the role of providing support to older prisoners.

Gender and sexual orientation

This area was not inspected at the previous inspection

2.168 Policies for neither of these aspects of diversity had been developed and there were no identified services or resources for either (see further recommendation 2.126). The diversity manager said that any prisoner reporting issues concerning sexual orientation or gender would be dealt with on a case-by-case basis.

Religion

2.169 There was no policy to address prisoners' access to religious services and support, and no formal monitoring or analysis relating to religion (see further recommendation 2.126).

Health services

2.170 The primary care trust and the prison should formulate a longer-term strategic plan to guide development of services to prisoners. (4.51)

Achieved. A strategic plan had been developed with the partnership board in addition to the prison health delivery plan. These had been used in the further development of services for prisoners.

2.171 Health promotion material, including oral health, should be displayed at strategic points throughout the prison and written material should be available for prisoners to take away. (4.52)

Achieved. There were good displays of health promotion material, including oral health, and leaflets were available for prisoners. We were told that note was made of national health promotion campaign days.

2.172 Arrangements should be made to enable prisoners to take or have their medicines dispensed in privacy including making alternative arrangements for prisoners unable to attend either of the two pharmacy hatches. (4.53)

Not achieved. Medicines administration was carried out predominantly on the A2 landing and the facilities provided were sufficient to meet the needs of prisoners. Alternative facilities on the A1 landing were inadequate and did not provide sufficient privacy for patients.
We repeat the recommendation.

2.173 The transport of medication around the prison by nursing staff should be subject to a security review. (4.54)

Achieved. A security review had been carried out, as a result of which the transport of medication around the prison had been reduced, and secure containers were provided as required. The establishment of the new IDTS facility would avoid further the movement of medication around the prison.

2.174 Access to healthcare should be audited to provide assurance of equality especially for ethnic minorities and foreign nationals. (4.55)

Achieved. The healthcare audit and health needs assessment had identified the requirement for equity of access, taking account of ethnic minorities and foreign nationals.

2.175 Dental treatment records (form FP25) should be retained in the dental surgery and a summary of treatment written by the dentist in the main clinical record. (4.56)

Not achieved. Dental treatment records were still recorded in the main clinical record for prisoners. The SystmOne electronic record system was in the process of being installed, and this would help to resolve the issue.

2.176 All documentation relating to the dentist and dental surgery should be available within the prison healthcare department. (4.57)

Achieved. All dental documentation was now retained on site and made available within the healthcare centre.

2.177 A skill mix review should be undertaken to ensure that qualified nurses' skills are used appropriately. (4.58)

Achieved. A skill mix review had been completed following the health needs assessment, which was reviewed annually. A new staff profile ensured that the department had the correct staffing levels and skill mix.

2.178 A learning and development plan for the health centre team should be undertaken so that the available training budget is directed strategically according to the primary care needs of prisoners. (4.59)

Achieved. Training was directed appropriately to meeting the needs of the prison population.

The training needs assessment formed part of the prison health development plan and clinical governance action plan.

2.179 The prison, the primary care trust and the dental service should clarify and agree the role of dental health staff in relation to administrative and other tasks including escorting patients. (4.60)

Achieved. The role of dental staff had been clarified and no dental staff were involved in general administrative and other tasks, including the escorting of patients.

2.180 Prisoners with a healthcare appointment should continue their daily routine and be escorted from education or work to attend the health centre rather than waiting in their cell. (4.61)

Partially achieved. Prisoners with a healthcare appointment were allowed to continue with their daily routine, including attendance at work. There were still issues around the inappropriate role of nurses escorting patients.

Further recommendation

2.181 Dedicated discipline staff should be allocated to the healthcare centre to facilitate the more flexible movement of prisoners requiring healthcare appointments and thereby releasing nursing staff from inappropriate duties.

2.182 Triage algorithms should be used to ensure consistency in treatment and care provided. (4.62)

Achieved. Nursing staff had access to a comprehensive range of triage algorithms, which were used to ensure consistency of treatment. The effectiveness of the algorithms had also been assessed by the primary care trust (PCT), which was satisfied with the practice.

2.183 The medicines and therapeutic committee should revise the special sick policy to ensure appropriate medicines that can be supplied under the authority of a nurse are available for supply. (4.63)

Achieved. A new special sick procedure had been established, ensuring that appropriate medicines could be administered under the authority of a nurse.

2.184 The issue of co-codamol by nurses under special sick arrangements should stop. (4.64)

Achieved. The issue of co-codamol under special arrangements had stopped.

2.185 Patient group directions should be introduced to enable a greater range of appropriate medicines to be administered under special sick circumstances. (4.65)

Achieved. A good range of patient group directions had been created and continued to be developed. This enabled prisoners to be given a greater range of appropriate medicines, as required under special sick circumstances.

2.186 Pharmacy arrangements should ensure same or next working day delivery of prescribed medicines. (4.66)

Achieved. All prescribed medicines were made available on the same day or within 24 hours. We were told that health services staff were satisfied with the current pharmacy contract.

2.187 Prisoners should be able to consult a pharmacist. (4.67)

Achieved. The pharmacy contract included the requirement for prisoners to be given the opportunity for consultation with a pharmacist. The pharmacist visited the prison as required to see prisoners on request.

2.188 Named-patient dispensed medicines should be issued whenever possible in preference to general stock. The circumstances under which general stock medication is used should be agreed by all relevant parties and set out in a policy. (4.68)

Achieved. Named-patient dispensed medicines were used as much as possible in preference to general stock. The medicines and therapeutics committee had agreed the circumstances under which general stock medications were to be used and this was set out in policy.

2.189 The prison should take active steps to increase the number of prisoners able to have their medication in-possession and develop a policy signed up to by all relevant parties. The effectiveness of the policy including the approach to risk assessment should be audited regularly. (4.69)

Not achieved. Prisoners continue to have limited in-possession medications. Despite the development of an in-possession protocol, the risk assessment of prisoners was over-weighted to avoid having medication in possession. The changing role of the prison would make this even more inappropriate.
We repeat the recommendation.

2.190 The prescribing of benzodiazepines and opiate analgesia should be the subject of audit. (4.70)

Achieved. Audits were carried out quarterly, as a result of which there had been a significant reduction in the prescribing of benzodiazepines and opiate analgesia. There had also been a recent significant decrease in prison population requirements for these medications.

2.191 The dental waiting list should be actively managed and audited by the dental team to ensure patients are seen in order of priority, to bring waiting times down to more reasonable levels and to assess if further sessions are needed. (4.71)

Achieved. The dental team prioritised waiting times and these had been reduced to an acceptable level. A dental triage system had been introduced and the dental list was managed by the dentist. Routine cases were seen within two weeks and urgent cases at the next clinic within the week. A programme of audit for the system had been established.

2.192 The mental health needs of prisoners should be reviewed so that strategies and plans for the future of mental healthcare to prisoners are appropriate, including access to the full range of services appropriate to the management of severe mental illness. (4.72)

Achieved. The mental health needs of prisoners were reviewed as part of the annual health needs assessment. Planning was subsequently carried out to inform the prison health development plan appropriately to the needs of the prison population. A full range of services to care for prisoners with severe mental illness was available through the mental health in-reach team.

2.193 A wider range of mental health primary care therapies including options for group work should be available for prisoners with mild to moderate mental health problems. (4.73)

Achieved. The primary mental health services were supported by four mental health nurses, offering a range of primary care therapies. One of the nurses had recently introduced the option of cognitive behavioural therapy for appropriate patients.

2.194 The position within mental health in-reach as to care programme approach responsibilities should be resolved without delay. (4.74)

Achieved. The care programme approach (CPA) complied with national guidelines and the PCT policy. There were clear lines of responsibility with the mental health in-reach team. Documentation was requested for prisoners already on the CPA and produced locally if they became subject to the CPA during their time in the prison.

2.195 Alternative facilities to the staff toilet should be made available for prisoners to provide urine samples. (4.75)

Not achieved. Despite managers having considered alternative arrangements, prisoners and staff continued to share the same toilet.
We repeat the recommendation.

Additional information

2.196 Health services were commissioned and provided by Shropshire County NHS PCT. The healthcare centre was a small facility, which was clean and well maintained. Prisoners had access to good primary care facilities and specialist clinics.

2.197 Prisoners' access to a GP was good, with clinics available daily (apart from Sunday), and routine waiting times were less than five days. Staffing levels were good and 24-hour healthcare cover was satisfactory. There was only one nurse vacancy at the time of the inspection.

2.198 A range of nurse-led and specialist clinics was provided, with most treatments carried out in the healthcare centre. Clinical records were well managed and regularly audited.

2.199 The mental health in-reach team was well staffed, with each nurse taking a caseload of about 12 patients. Mental health awareness training was provided on a rolling programme for all prison staff, and counselling services were provided by two visiting psycho-social counsellors.

Learning and skills and work activities

2.200 A formal labour board should be established with representation from security, residential, education and workshop staff. This board should take into account the needs and wishes of the prisoners. Formal links with the sentence and custody planning process should be established. (5.28)

Achieved. A labour board had been established soon after the previous inspection, and was now called the activity allocation board. There were clear terms of reference and minutes were kept of the weekly meetings. Meetings were well attended and there was a good representation of staff from key areas such as industries, catering, education and careers information advice and guidance. The board also included a member of staff from security and

the REO, who helped to ensure equality of access. There were links to sentence plans and waiting lists were appropriately managed. Most work and activity places were fully allocated and waiting lists were short.

2.201 The current risk assessment process linked to job allocation should be reviewed to ensure fairness and consistency. (5.29)

Achieved. Prisoners' needs were discussed at the activity allocation board and appropriate risk assessments were undertaken by security staff. These were highlighted for activity allocation board members by colour coding the identified risks.

2.202 Pay rates should be reviewed so that lower pay is not a disincentive to attend education (5.30).

Achieved. New pay rates had recently been introduced in January 2010 after consultation with prisoner groups. The new pay structure was fair and equitable, and no prisoner groups were disadvantaged. Prisoners were encouraged into education or vocational training courses and given a small increase in their basic pay for the successful completion of qualifications.

2.203 Target setting on part-time courses should be reviewed to enable more learners to achieve qualifications. (5.13)

Achieved. More realistic target setting was now undertaken with prisoners, to ensure that they had a better opportunity to succeed. Most learners who stayed on their course succeeded. Achievement rates were high across most courses and averaged between 80% and 100%.

2.204 Procedures for movement from accommodation and exercise should be reviewed to ensure more learners arrive at classes on time. (5.14)

Achieved. Improvements had been made to the movement of prisoners following the previous inspection. Most prisoners now attended work and education classes on time.

2.205 The availability of literacy, numeracy and language learning should be extended to those not attending formal education classes. (5.15)

Achieved. Support was given to prisoners identified through the initial assessment at induction as having literacy and numeracy needs. Prisoners in workshops and prisoner orderlies in the gym who were not undertaking courses were well supported in their work place by staff from the education department. Some prisoners were given individual support on the wings if needed.

2.206 The book stock should be increased to reflect the capacity of the new library facility. (5.16)

Achieved. The library facility had been improved with the addition of more computers, new display cases and comfortable chairs and seating areas. The book stock had increased and the range of learning materials for those on education and vocational courses had improved and was now satisfactory.

2.207 Methods to reduce the level of stock loss should be introduced. (5.17)

Not achieved. Book loss remained high, at 152 books lost in the six months up to December 2009. However, not all prisoners were aware that there was a provision for returning books on

the wings, and the process for accounting for book loss was inadequately managed. The computer system for recording book loss had not worked since September 2009 and books were not deemed lost until six months after their due return date.
We repeat the recommendation.

2.208 The library officer should not be routinely redeployed to other tasks. (5.18)

Not achieved. Two part-time library officers were now employed. They were often taken off this duty or redeployed elsewhere, and prisoners did not get regular access to the library (see additional information).
We repeat the recommendation.

2.209 Formal links with the education department should be further developed so that the library can become a learning resource centre for those prisoners undergoing educational courses. (5.19)

Achieved. Links between the library and education staff had been developed. The writer in residence worked well to engage prisoners in writing articles, poetry and short stories for publication in the quarterly prisoner magazine.

Additional information

2.210 The education facility had improved since the previous inspection. Education classrooms were well equipped with computers and interactive whiteboards and were comfortable and conducive learning environments.

2.211 The role of head of learning and skills was combined with resettlement. Learning and skills were well managed, as were the education department and the careers information and advice service (CIAS). There was an adequate range of education courses available, such as information and communications technology, art and design, literacy and numeracy. Some courses had good progression routes from level one to three. However, there were no prisoners on distance learning or Open University courses. The head of learning and skills had been proactive in ensuring a more cohesive approach to education and training across the prison, and had encouraged active and full participation at the quality improvement group, with support from all key departments. There was a clear sense of direction and realisation of the need to develop a range of appropriate work and learning opportunities for the new prison population, although the prison had yet to undertake a needs analysis to identify what was required.

2.212 JHP Ltd offered advice and guidance through the CIAS, as well as information for prisoners at induction. Staff from the education contractor, Manchester College, carried out initial assessments of prisoners' literacy and numeracy needs where required. Three prisoner orderlies supported the advice and guidance service. Prisoners underwent a thorough induction to all key areas of learning and skills and work opportunities. Information was available to prisoners through induction leaflets available in Braille and 26 languages. A signer was available for prisoners with impaired hearing.

2.213 Most prisoners were able to undertake work and/or education classes. There were approximately 138 full-time equivalent work places and around 55 full-time equivalent education places. Most education and work was part time. This was particularly concerning in the light of the prison's new role as a training prison. A small number of prisoners were unemployed. A satisfactory range of training courses was offered, although only 30 prisoners were undertaking vocational qualifications. These included courses in industrial cleaning,

carpentry at level one, painting and decorating, and National Vocational Qualifications (NVQs) in warehousing and performing manufacturing operations (PMO), although no prisoners were taking vocational qualification in the kitchen. Stoke on-Trent College was responsible for assessments in the workshops for level two PMO. Training was satisfactory, and in some areas, such as the kitchen, carpentry and desk-top publishing, prisoners learnt good skills. However, in some workshops, vocational work was low skilled – for example, basic sewing and packaging. Some prisoners in these workshops were not fully occupied and many had worked there for a long time.

2.214 The library was run by a part-time senior and deputy librarian, supported by one prison orderly. The orderly did not have the opportunity to gain qualifications. The library facility had been improved and was spacious, well laid out and had good seating areas for reading. Four computers were available but only for those on education courses. Prisoners had suitable access to Prison Service Orders and other appropriate legal references. There was a good library stock, with an adequate range of foreign language and easy-read books.

2.215 The library was underused, except by prisoners on education courses, who had open access to the facility when in classes. Other prisoners had to rely on being escorted by the two allocated prison officers, who were redeployed (see recommendation 2.207). Records of access were not kept but the librarian estimated that only around 30% of the population currently used the library.

Further recommendations

2.216 More skilled work should be made available. This work should be purposeful and provide opportunities for more prisoners to gain a wider range of industry-recognised vocational qualifications.

2.217 Access to the library should be improved.

Physical education and health promotion

2.218 New physical education facilities should be provided as a matter of urgency. (5.39)

Achieved. The new gym and sports hall facilities, which had been built two years earlier, were well used by prisoners. They included a well-equipped and adequately sized sports hall, a cardiovascular (CV) suite, a weights room and a suitably equipped classroom. Resources for courses were good and most CV equipment was in good working order.

2.219 A wider range of short accredited courses should be made available to prisoners. (5.40)

Not achieved. No courses were being offered in PE at the time of the inspection because of the changing role of the prison. Courses had been stopped in November 2009, although there were plans to offer a more suitable range of courses once the re-roled population was more settled.
We repeat the recommendation.

2.220 The management of the new Astro turf facility should be reviewed as a matter of urgency. (5.41)

Achieved. The Astro-turf facility was kept suitably tidy, although it was only used for PE during

dry weather, as it was unusable after rain. This had implications for prisoners' time in the fresh air, as it was also the main exercise area.

Further recommendation

2.221 The Astro turf should be upgraded to offer all-weather provision.

Additional information

2.222 The PE provision was good and had improved significantly. Prisoners had access to at least two sessions of PE a week, and in most cases four, including sessions for those working full time. Although there were no figures available, staff believed that around 60% of the population accessed the facilities regularly. A good programme of PE was offered on weekdays, at weekends and in the evenings. The senior officer and the three full-time PE staff were well qualified and enthusiastic. They made good use of the space available and offered a range of provision, including training sessions aimed at the over-40s.

2.223 The sports equipment was well maintained and clean gym kit was available to all prisoners, although trainers were limited to small or large sizes. Towels were available from the wings. The showers in the PE department were kept clean and in good condition, and offered good supervision.

2.224 There were links with the health services and CARAT teams to provide a programme of remedial sport for prisoners who needed it. Healthy living was generally well promoted to prisoners who accessed PE, and three trained prison orderlies helped prisoners with weight management and health-related issues.

Further recommendations

2.225 Data regarding the use of the gym should be collected and analysed to improve attendance.

2.226 Training shoes should be available in a range of sizes.

Time out of cell

2.227 All prisoners should be offered at least ten hours a day out of their cells. (5.56)

Not achieved. There was no evidence that prisoners at Shrewsbury were offered at least 10 hours a day out of their cells. There was confusion about how the hours were measured (see recommendation 2.233). The governor's weekly regime monitoring recorded 10 hours unlocked each weekday and 6.5 hours at the weekend. This was recorded every week, regardless of changes in the population. A generous estimate of the time out of cell for a fully employed prisoner would be 7.75 hours during the week. The figure reported centrally for January was nine hours, which was not achieved by any prisoner. No prisoner received more than three hours out of their cells at weekends unless they attended gym or visits, or were wing orderlies.
We repeat the recommendation.

Further recommendation

2.228 A review of the monitoring system for time out of cell should be carried out in order clearly to ensure accurate recording and representing of data.

2.229 Association activities should be made available to all prisoners. (5.57)

Achieved. All landings had association equipment, and a new set of board games became available on A wing during the inspection. Evening association on A wing was still split, with prisoners unlocked for approximately one hour, which restricted the amount of time available to access facilities (see further recommendation 2.238).

2.230 Staff supervising exercise should do so within the security fence and should use this time to interact with prisoners in their care. (5.58)

Partially achieved. Staff observed exercise from inside the exercise yard. On the day we observed exercise, staff from the offender management unit (OMU) supervised the session, but they did not necessarily know the prisoners and there was no interaction.

Further recommendation

2.231 Staff supervisory exercise should use this time to interact and get to know prisoners in their care.

2.232 Prisoners not leaving their cell during association periods should be monitored and questioned as to why they are not participating. (5.59)

Not achieved. There was no formal monitoring process but staff indicated that when there were repeated refusals to participate in association, they would enquire why.
We repeat the recommendation.

2.233 The establishment should liaise closely with Prison Service headquarters to ensure time out of cell is recorded properly. (5.60)

Not achieved. The head of inmate activities told us that the time out of cell figures had been set at the beginning of the year, based on the regime available. There had been no alteration to these figures throughout the year. They were collated on a spreadsheet by a clerk who, along with her manager, was not sure how they reflected any changes to the regime (such as cancellation of exercise or work) or population. The spreadsheet showed that the calculation was based on the number of prisoners on each level of the IEP scheme, set against the projected hours available. This did not reflect prisoners' experiences (see recommendation 2.227), the views of wing staff or the observations we made during the inspection.

Additional information

2.234 Association was reliably offered but remained split along the lines of the previous remand function. Exercise was not available to those working full time, or part time if their exercise period coincided with their working hours. Prisoners expressed dissatisfaction over the lack of exercise and access to the open air.

2.235 On association, some staff were confident and relaxed but others were less engaged and based themselves in offices.

2.236 Prisoners on C wing were allocated exercise time immediately after unlock, during a 45-minute period when they were also expected to clean their cells, make applications, shower and use the telephone. The Astro-turf which comprised the exercise area contained no benches or activities (see recommendation 2.218).

2.237 There was more equipment on the wings than at the time of the previous inspection, but prisoners' access to it was unnecessarily restricted, as was access to the telephones.

Further recommendations

2.238 All prisoners should be unlocked to associate at the same time.

2.239 Managers should encourage staff to be proactive in their contact with and management of prisoners, and to interact with prisoners on the residential wings rather than stay in the wing offices during association.

2.240 Prisoners on C wing should be allocated an exercise period which does not conflict with other regime and personal activities.

2.241 Access to recreational equipment should not be restricted during periods of association.

Security and rules

2.242 The staffing and workload of the security department should be reviewed to enable matters to be dealt with consistently and thoroughly. (6.10)

Achieved. Staffing in the security department was more consistent, enabling matters to be dealt with appropriately and within the required timescales.

2.243 Attendance at the security committee should be improved to enable departments to make a full contribution and to facilitate the cascading of information across the prison. (6.11)

Achieved. Staff from a large range of departments attended the meeting and provided detailed reports for discussion.

2.244 Security objectives should be more specific. (6.12)

Achieved. Detailed security objectives had been set to reflect the identified risks and issues for the establishment.

2.245 Residential staff should be able to account for the prisoners on their wing. (6.13)

Achieved. During our roll checks, staff were able to account for prisoners on their wing.

2.246 Visitors should be subject to closed visits only when an indication from a drug dog is corroborated with at least one other piece of security intelligence. (8.49)

Achieved. All intelligence was based on at least two forms of evidence, and closed visits were imposed only if there was corroborating intelligence following indication by the drug dog.

Additional information

2.247 At the time of the inspection, staff in the security department were in the process of reviewing a number of security systems and procedures following the re-role to category C. This included physical security matters, the processes for risk assessing and allocating prisoners to activity places, and procedures for managing harassment and child protection.

2.248 An average of 150 security information reports (SIRs) were received monthly and there had been a shift in the subject matter being reported. Previously, the main subjects had been related to drugs and mobile telephones. At the time of the inspection, the main concerns were child protection, harassment and PIN telephone monitoring.

2.249 The SIRs were analysed and a monthly security assessment report compiled, which covered detailed information on a range of subjects, including incidents, use of force, mandatory drug testing (MDT) rates and closed visits. This was discussed at the monthly security committee meeting and objectives set for the following month. There were reasonable links and information sharing with other departments, ensuring that staff were aware of the current issues and risks faced by the prison. The department had a good working relationship with the local police, who provided support when there was illicit activity during visits.

2.250 Target searching and suspicion drug testing were up to date. The positive rate for suspicion MDTs was between 65% and 70%, suggesting that intelligence was of a good quality.

2.251 At the time of the inspection, there were two prisoners and one visitor subject to closed visits, and 10 banned visitors (including a number banned from visiting all prisons). Some prisoners had been placed on closed visits as a result of illicit activity unrelated to visits. The administrative procedures were good, with reviews taking place monthly.

2.252 Prisoners and visitors could submit their views in writing and were informed of the outcome of the reviews. Closed visits procedures were lifted when there was no indication of further illicit activity.

2.253 Local rules and routines were displayed on both wings, and prisoners were given information during induction regarding expected behaviour.

Further recommendation

2.254 Prisoners should only be placed on closed visits when there is intelligence to suggest that illicit activity is related to visits.

Discipline

2.255 The adjudications room should be relocated to an area where adjudications can take place uninterrupted and free from noise. (6.26)

Achieved. The adjudications room had been relocated off the wing and provided a much more suitable environment in which to conduct adjudications.

2.256 Algorithms should be completed correctly and quality checked by the governor in charge of the separation, care and control unit. (6.27)

Achieved. All the algorithms we sampled had been completed correctly and signed off by the duty governor.

2.257 Control and restraint equipment should be stored inside the establishment. (6.28)

Achieved. The control and restraint equipment had been relocated inside the prison and made more easily accessible.

2.258 Prisoners should be given their award in writing and made aware of the appeals procedure. (6.29)

Partially achieved. In the adjudications we observed, the prisoners left the adjudication room without the paper explaining the punishment they had been given. The expectation was that the staff would hand the sheet to them later. They were also told that staff would explain the appeals procedure to them, rather than the adjudicating governor doing so.

Further recommendation

2.259 Prisoners should be given their punishment in writing at the time of the adjudication, and the appeals procedure should be explained by the adjudicating governor.

2.260 Use of force forms should be discussed at the quarterly control and restraint coordinator's meeting. These forms should be quality checked by the deputy governor. (6.30)

Partially achieved. The use of force forms were discussed at the use of force review meeting and quality checked by the deputy governor. We were able to see the minutes for only two of these meetings (for August and December 2009) and it was not possible from the minutes to tell whether any qualitative analysis had been undertaken, as they showed only the collection of data. From our analysis it was clear that, while there were incidents which had been dealt with well, there were some which required more enquiry into why force had been used and a discussion with staff about future practice.

Further recommendation

2.261 The use of force forms and recordings of planned uses of force should be scrutinised at the use of force review meetings, to examine procedure and develop good practice.

2.262 All planned removals should be video recorded. Staff involved in incidents should be given a cool down period before being requested to get involved in another potential incident. All injuries should be recorded and F213s completed. (6.31)

Partially achieved. All but one of the last nine planned removals had been video-recorded. All incidents included the correct paperwork, including F213s. The same staff were used to strip prisoners as had conducted the removal.

Further recommendations

2.263 All planned removals should be recorded and immediately quality assured to ensure that correct practice is followed.

2.264 Staff used for planned removals should not be used to strip-search the prisoner.

Additional information

2.265 There were fewer adjudications than at the time of the previous inspection, with an average of 46 per month for the previous six months, compared with 53. The adjudications we observed were conducted respectfully and allowed prisoners the opportunity to present their case, but from these and paperwork sampled, there was not always evidence that all relevant witnesses were called before hearings were concluded. There were no procedures to ensure that prisoners were reissued with their paperwork when an adjudication was reconvened. Prisoners were given time to prepare for adjudications and offered assistance.

2.266 Adjudicating governors met to look collectively at tariffs and quashed adjudications but had yet to develop more local quality assurance and trend analysis. There was no local procedure for reviewing adjudications and rectifying errors.

2.267 The levels of force were low, at 3.6 per 100 of the prison population. Some of the video recordings we observed showed well-handled removals. There were, however, also some instances where paperwork and video footage indicated that force, including handcuffs, was used when prisoners were compliant. Video-recording continued during strip-searching. The quality assurance processes did not involve an in-depth analysis of incidents, action on emerging patterns or result in issues being followed up with staff to improve future practice.

2.268 The special cell had been used nine times between January and December 2009 but was also used whenever strip-searching was carried out in connection with use of force. On five occasions this was for the same prisoner. Paperwork and video footage showed this cell had occasionally been used when the individual was compliant. Prisoners were not held there for long periods. A body belt had been used on one occasion to prevent a prisoner harming himself repeatedly. Force and the special cell had been used on two occasions to manage self-harming behaviour.

2.269 Prisoners continued to be segregated at the end of the A1 landing, although the barriers separating this area from the rest of the wing had now been removed. There were three segregation cells, a safer cell and a strip cell. Conditions were reasonable but the cells were extremely cold.

2.270 Most stays in segregation were for relatively short periods, the longest being for 14 days' cellular confinement. During the previous six months, 19 had been held in cellular confinement under Rule 55 (cellular confinement), 12 under Rule 45 (good order or discipline) and nine under Rule 53 (pending adjudication). Use of these cells had increased, with an average of six prisoners located there in the previous six months compared with four at the time of the previous inspection. Two prisoners were located in the cells during the inspection. Prisoners refusing to transfer out were located there before their adjudication, and in January 2010 half of the prisoners segregated returned to their wing at Shrewsbury and half transferred out. Data had started to be gathered about the use of segregation and special accommodation, but there was no regular forum for trends monitoring and quality assurance.

2.271 All prisoners located in the separation, care and control unit (SCCU) were strip-searched. Basic entitlements were met but files showed poor interaction and, although staff were selected for their role in the SCCU, they were not specifically trained.

Further recommendations

2.272 Adjudicating governors should allow all potentially relevant information to be heard before concluding the hearing.

2.273 Prisoners should be issued with the paperwork for all reconvened adjudications.

2.274 Local adjudication standardisation meetings should analyse trends in adjudications and develop a method for quality assurance of practice. This should include mitigating or quashing locally any adjudications which have not been conducted properly.

2.275 Force should not be used when prisoners are compliant.

2.276 Prisoners should not be video-recorded during strip-searches.

2.277 A multidisciplinary staff group should quality-assure video footage of planned removals, following up by discussions with staff involved, and monitor trends in the use of force and use of special accommodation and mechanical restraints.

2.278 Special accommodation should not be used when prisoners are compliant.

2.279 Special accommodation should not be used for prisoners who are self-harming.

2.280 Segregation cells should be kept at an appropriate temperature.

2.281 A multidisciplinary staff group should monitor trends in the use of segregation and ensure that procedures are adhered to.

2.282 Segregated prisoners should be strip-searched only where need has been identified through risk assessment.

2.283 Personal files should have meaningful entries from all staff who have contact with segregated individuals.

2.284 Staff selected to work in the separation, care and control unit should receive specific and relevant training in de-escalation, race equality, suicide prevention, mental health, personality disorder and motivational interviewing.

Incentives and earned privileges

2.285 The incentives and earned privileges scheme should operate consistently and fairly across the prison. (6.39)

Achieved. There was a single IEP policy in use across both residential units.

2.286 The availability of accommodation or association should not restrict a prisoner's progress or access to privileges under the incentives and earned privileges scheme. (6.40)

Achieved. Levels of IEP were not dependent on location or the number of prisoners already on a particular level.

Additional information

2.287 The IEP scheme was in disarray. The differentials between levels did not act as an incentive for improving behaviour. There was much confusion in relation to what items were allowed in possession. Prisoners arriving from other category C establishments routinely had items removed that they had had in possession for long periods. Many prisoners we spoke to expressed dissatisfaction about having these possessions removed, having previously earned the privilege to hold them (mainly at other establishments) and spent their limited amounts of money on them. The facilities list had not been updated and was not appropriate for category C prisoners. Reception staff also reported difficulties in trying to store all of the 'excess kit' that new prisoners brought from other category C prisons.

2.288 Prisoners transferring in were assumed to be on the standard level of the IEP scheme unless there was evidence of enhanced status. Wing staff told us that they had had to telephone sending establishments to confirm IEP status because of issues surrounding the P-Nomis computer system. Prisoners were frustrated that information about their IEP level was not transferred with them.

2.289 There was one prisoner on the basic level of the scheme at the time of the inspection. He was due for a review after 28 days on basic, although the entries on P-Nomis were vague and failed to record attitude, targets or behaviour. Staff reported difficulties in accessing the system, and a number of staff were unable to access the system at all.

Catering

2.290 Lunch should be served between noon and 1.30pm and tea between 5pm and 6.30pm. (7.8)

Not achieved. Lunch was served at 11.30am and tea at 4.30pm (4.15pm at weekends).
We repeat the recommendation.

2.291 National vocational qualifications should be expanded to all prisoners working in the kitchen environment. (7.9)

Not achieved. Only one prisoner had undertaken an NVQ in the kitchen in the previous year, and funding had since been withdrawn by the Learning and Skills Council.
We repeat the recommendation.

2.292 The kitchen floor should be re-surfaced. (7.10)

Not achieved. The kitchen floor had been repaired in places but required full resurfacing.
We repeat the recommendation.

2.293 The kitchen should be deep cleaned. (7.11)

Achieved. The kitchen was deep cleaned every six months, most recently in September 2009.

Additional information

2.294 All food was prepared in a central kitchen, which was linked by short corridors to both wings, minimising the distance that food had to travel to the point of service. Catering staff attended the wings at every meal.

2.295 Food storage, preparation and serving areas were clean and staff and prisoners working in these areas had received appropriate training. There were 11 prisoners working in the kitchen, which was one of the few areas where work was full time.

2.296 Prisoners in our groups spoke positively about the food provided, apart from the breakfast packs, which were distributed on the day before consumption. The food we sampled was of reasonable quality and quantity. There was a three-week menu cycle which was varied and included halal, vegetarian and healthy options. The menu was easy to understand and included pictures to simplify decision-making. Specialist diets were catered for. Serving implements for halal food were kept in the main kitchen and sent to the wings with the food. We observed servery workers using them to serve halal options.

2.297 Food comments books were available on both wings and were checked weekly, with responses by catering staff. Further consultation took place through a twice-yearly food survey, attendance by catering staff at prisoner committee meetings and through the DREAT meeting. Some changes had been made to the menu as a result of this consultation.

Good practice

2.298 *The picture menu was easy to understand and assisted prisoners in making informed choices about their meals.*

Prison shop

2.299 Distribution of shop orders should not absorb so much time. (7.18)

Achieved. The distribution system had been changed to speed up the delivery of shop orders and ensure that prisoners were not unnecessarily taken away from purposeful activity on a Thursday morning.

Additional information

2.300 The contract for the shop had been transferred to DHL/Booker in November 2009. In our groups, prisoners said that shop choices met their needs, although there had been some price rises following the change of contract.

2.301 Prisoners could place a full order within a week of arrival at the establishment. Shop orders were packed at HMP Drake Hall, which served most of the West Midlands area, and distributed on Thursdays. Distribution was well supervised and a prisoner orderly assisted prisoners in dealing with queries with DHL staff.

2.302 DHL staff were given a list of all prisoners who were either absent or due for transfer on the day of delivery. Any prisoners who had left had their monies refunded. Those who were in reception received their shop order there and those who were at court or appointments had their orders checked by wing staff and held on the wing for their return.

2.303 Prisoners who had not received goods because of errors made by DHL staff did not have the errors rectified at the point of distribution, despite an information notice to prisoners stating that this would be the case. Price lists were out of date, as they did not reflect the recent increase in VAT, and prisoners were required to work out the extra amount that they would be charged. Consultation with prisoners about the shop took place through prisoner meetings, and changes could be made to the shop list quarterly.

Further recommendations

2.304 The prison shop guidance should be adhered to, with prisoners' orders being rectified at the point of delivery, as stated.

2.305 The shop price list should be updated to reflect recent rises in VAT.

Good practice

2.306 *The system for dealing with shop orders for prisoners who were absent on the day of distribution showed consideration for prisoners' needs.*

Strategic management of resettlement

No recommendations were made under this heading at the previous inspection.

Additional information

2.307 The re-roling of the establishment had had a large impact on the overall management of resettlement, as the profile of the population and the function of the establishment had changed significantly. However, the strategic management of resettlement had not yet responded to these changes. Plans were being made in terms of analysing the needs of the population once the transition had been completed, as well as reviewing the resources of the offender management unit (OMU).

2.308 The current resettlement policy and the reducing reoffending strategy (2010) were not based on a comprehensive needs analysis. Some historical data had been collected from the induction process. While this was used to monitor the resettlement provision, it was not sufficient for this new cohort of prisoners. The majority of them were sex offenders, some of whom required substantial interventions to address their offending behaviour, others were in denial about their offending and many were from outside the West Midlands. The prisoner population was much older than at the time of the previous inspection.

2.309 The head of reducing reoffending planned to use the induction information and offender management data to understand fully the changed prisoner profile and prepare a relevant strategy concentrating on education, training and employment, and resettlement, but this had not yet been developed.

2.310 The range of resettlement services at the establishment was reasonably comprehensive and the chaplaincy team played a pivotal role in supporting prisoners' reintegration needs (see section on faith and religious activity). Each of the resettlement pathways had a lead and there was good engagement with regional reducing reoffending arrangements. A bi-monthly resettlement meeting – chaired by the head of reducing reoffending and, in her absence, the resettlement manager, a principal officer – was well attended by the pathway providers and a range of departments from across the establishment. The meeting focused too heavily on pathway provision and operational issues, and insufficient attention was given to whether this provision was needed and what the outcomes were from providing it. This could only be effectively achieved once the needs analysis was completed.

2.311 The pre-discharge board did not cover all prisoners who were due to be released in sufficient time to address their needs, and there was evidence that some prisoners were being seen shortly before discharge. There was insufficient monitoring of the reasons why some prisoners did not attend boards and analysis of need or possible gaps in resettlement provision. No offending behaviour programmes were available and there were prisoners with outstanding needs for enhanced thinking skills and the sex offender treatment programme (see section on offender management and planning).

Further recommendations

2.312 A needs analysis of the population should be completed and used to update the resettlement policy.

2.313 Pre-discharge boards should be convened at least four weeks before discharge.

2.314 Resettlement meetings should strategically plan and manage resettlement services to ensure that it meets the needs of the population.

Offender management and planning

2.315 Senior managers should allocate sufficient OASys trained staff to clear the backlog of cases and to keep new assessments up to date. (8.7)

Not achieved. At the time of the inspection, the OMU was undergoing a significant transition. There were four offender supervisors (two probation officers, two Prison Service officers). There were a further four members of staff who were trained in the offender assessment system (OASys), making a total of eight staff who were able to complete the assessments. Despite the rapid intake of prisoners since the re-roling, there were systems to ensure that prisoners who were in scope of offender management were identified. Most of the prisoners had been transferred from other establishments, and 127 (although this number increased during the inspection) were in scope of offender management; and the offender manager was responsible for preparing and reviewing the OASys assessments.

2.316 The offender supervisors/trained assessors were responsible for reviewing the assessments of the 62 prisoners who were assessed as low risk. Of this group, only 29 had arrived with an up-to-date assessment; during the inspection, dates were identified for reviewing the assessments of the remaining 33 prisoners. Although the offender supervisors were tasked with some of this work, the two uniformed staff were redeployed to other duties.

2.317 During the inspection, the number of prisoners fluctuated but on one day there were 22 prisoners on remand and a further 23 who were serving sentences of less than 12 months. While needs were identified on arrival, and for some prisoners were followed up and addressed before release, there was no formal custody planning for this group of prisoners. We repeat the recommendation.

Further recommendation

2.318 Remand and short-sentenced prisoners should have a custody plan that records their offending behaviour and resettlement needs.

2.319 Observation, classification and allocation staff should not be redeployed when there is a backlog of prisoners requiring classification and allocation. (6.14)

Partially achieved. Before the start of the re-roling process, staff had been regularly redeployed to other duties. Staffing had been mainly consistent ever since, but there were still some times when the department was unstaffed.
We repeat the recommendation.

2.320 Acceptance criteria from other establishments in the area should not exclude prisoners on unwarranted medical grounds. (6.15)

No longer relevant. The prisons that would not accept prisoners on transfer on medical grounds would no longer be accepting prisoners from the establishment following the re-role.

2.321 Indeterminate-sentenced prisoners should be transferred to first stage prisons at least within one month of receiving their sentence. (8.16)

Not achieved. At the time of the inspection, there were eight indeterminate-sentenced prisoners at the establishment, five serving indeterminate sentences for public protection (IPP) and three life-sentenced prisoners who had had their licence revoked. All three licence recalls had been at the establishment for some time, waiting for their cases to be heard by the parole board. All indeterminate-sentenced prisoners were managed by two offender supervisors. Four of the five IPP prisoners were waiting for transfers to other establishments in order to start their sentence plans, and had been at the establishment between two weeks and seven months. One IPP prisoner who was on a medical hold had been at the establishment since December 2007 and had not yet started any of his sentence plan targets because of his ongoing ill health and treatment. We spoke to some of these prisoners, who confirmed that they had contact with staff from the OMU and were aware of their sentence plan targets.
We repeat the recommendation.

2.322 Confidential summary dossiers for indeterminate-sentenced prisoners should be sourced and maintained. (8.17)

Achieved. Confidential summary dossiers and confidential documents in general were appropriately sourced and locked away securely, with only a small number of staff able to access them. Sensitive information was not held in indeterminate-sentenced prisoners' general document folders.

2.323 Confidential documents such as witness statements should be held securely with restricted access and should not be held together with life sentence plans. (8.18)

Achieved. See recommendation 2.325.

2.324 All wing staff and other relevant departments should have updated information on prisoners subject to public protection measures and staff should ensure that these prisoners are properly monitored. (8.29)

Partially achieved. Staff and relevant departments were informed of prisoners subject to public protection measures by email, and the risk management meeting minutes recorded those prisoners whom staff needed to be made aware of. P-Nomis also had an alert system which highlighted prisoners who were being monitored, or when there were significant risk indicators. Due to the change in population, the manager of the OMU was keen to deliver training to staff to increase their awareness of the types of public protection measures and their responsibilities in ensuring that prisoners were not breaching them. During the inspection, we were told by the manager of the OMU that approximately 120 prisoners should have been subject to telephone monitoring but that it was not possible regularly to monitor this number of prisoners (see additional information).
We repeat the recommendation.

2.325 A protocol should be developed with West Mercia police force covering the exchange of information and action to be taken when prisoners breach harassment orders or other public protection restrictions. (8.30)

Partially achieved. There was no protocol with West Mercia police force but there were good working relationships with them through the part-time police liaison officer (PLO), who attended the risk management meetings. Any incidents of prisoners breaching public protection restrictions were referred to him, and he would notify the necessary police force, as it was not just restricted to prisoners from the West Midlands area. This arrangement worked well and there were clear routes to report breaches of restrictions and other intelligence.

Additional information

2.326 The existing offender management team was not sufficiently resourced to cope with the requirements of the changed population and we were told by the manager of the unit that he hoped to secure more staff once the re-profiling was complete in the coming months.

2.327 Seventy of the 127 prisoners who were subject to offender management arrangements had not been allocated an offender supervisor. During the inspection, OMU staff started to try to meet all the new receptions to gain basic information and an overview of their needs. Other than this, they saw prisoners only on application and responded to correspondence from offender managers. This was an interim measure until the population settled. In our prisoner groups, few were aware of who their offender supervisor was and had no contact with him or her.

2.328 The OASys clerk identified low-risk prisoners, checked their sentence plan targets and referred prisoners to the range of reintegration services where appropriate, but there was no mechanism for reviewing or monitoring how successful these referrals had been.

2.329 Staff in the observation, classification and allocation (OCA) department were in the process of reviewing their procedures to manage a different category prisoner population. A database was under construction to record review dates for newly received prisoners, and staff were

familiarising themselves with the criteria for transferring prisoners to category D (open) conditions.

2.330 Due to the number of prisoners received daily, OCA staff could not always meet new receptions on induction to discuss their category and sentence and when they might expect to be reviewed. However, they prioritised applications from prisoners for whom a review was due and tried to meet all new receptions as soon as possible. Prisoners could attend review boards and were given the chance to appeal any decisions made.

2.331 There had been approximately 20 applications a week from newly received prisoners either wanting to move to a prison closer to home or who needed to under take offending behaviour programmes (mainly sex offender treatment programmes) which were not available at Shrewsbury. Some prisoners had already been transferred out to undertake programmes as places became available at HMPs Risley and Stafford.

2.332 The two lifer offender supervisors had not received lifer training, and during the inspection a senior officer was receiving managing indeterminate sentences and risk (MISaR) training for his new role as lifer manager. There were no specific forums for this group of prisoners but they were able to access the family days available to the rest of the population.

2.333 There was no public protection policy specific to the establishment. Two probation officers were responsible for managing prisoners' public protection and multi-agency public protection arrangements (MAPPA), supported by a part-time senior probation officer. During the inspection, there were 27 MAPPA level two cases, eight MAPPA level three and 167 identified as falling under public protection measures. Ten prisoners were subject to harassment orders and there were 124 child restriction cases.

2.334 Although the expectation was that prisoners would arrive with their public protection paperwork completed, we were told by the manager of the OMU that many prisoners arrived with insufficient, or no, paperwork. These prisoners were therefore placed on restrictions and the public protection paperwork was started at Shrewsbury. This meant that some prisoners who had previously had their telephone numbers cleared, or were able to have contact with specific individuals, were no longer permitted contact with these individuals until all the necessary checks had been completed. Many prisoners complained about this during the inspection, as for some of them it was taking a number of weeks before restrictions were removed. A six-week review of all these cases was built in, to assess the information that had been gathered from relevant departments, in particular children's services, and appropriate action was taken to reduce monitoring arrangements or remove restrictions.

2.335 A monthly risk management meeting was chaired by the head of resettlement and attended by appropriate staff. Intelligence was shared, individual cases were discussed and action points were followed up. Breaches of restrictions were discussed and responded to and there was an exchange of information with the security department and the PLO.

Further recommendations

2.336 There should be sufficient staff allocated to the offender management unit to manage the increase in high-risk prisoners and keep assessments up to date.

2.337 Prisoners required to undertake specific offending behaviour programmes not available at Shrewsbury should not be transferred to the prison.

2.338 Lifer staff should receive appropriate training in order to manage the casework of indeterminate-sentenced prisoners.

2.339 There should be specific forums and events for indeterminate-sentenced prisoners.

2.340 There should be a public protection policy specific to the establishment, outlining how public protection cases are managed and staff's responsibilities.

2.341 Prisoners should arrive at the establishment with all the necessary public protection paperwork.

Resettlement pathways

2.342 Psycho-social provision should be developed specifically for prisoners subject to clinical detoxification programmes. (8.46)

Achieved. The detoxification programme was in line with the national provision and included psycho-social provision. All participants were subject to joint review with the CARAT and IDTS teams.

2.343 The CARAT team should deliver group work to support the current one-to-one provision available. (8.47)

Achieved. The CARAT team provided group work, in addition to the one-to-one provision, using facilities in the education department and the gym. A new facility was due to be opened in March 2010.

2.344 The CARAT team should develop and implement a harm reduction checklist to be used with all CARAT clients. (8.48)

Achieved. A harm reduction checklist had been developed and was used with all CARAT clients. In addition, all prisoners received a harm reduction programme on induction.

2.345 A survey of visitors and prisoners should be carried out to explore how the current visiting service and environment can be improved. (3.68)

Achieved. A visitors' survey had been completed in 2007 and the responses used to improve the visits environment. Some of the main issues that were raised by visitors were the lack of car parking, poor child play area and the distance between the gate and the visits room. Some of the feedback from visitors could not be acted on, such as the availability of car parking, given the location of the establishment, and the distance between the gate and the visits room. The child play area had been improved and was a pleasant environment, staffed during the weekend by the Pre-school Learning Alliance.

2.346 Prisoners should receive a reception visit within 48 hours of arrival. (3.69)

Achieved. Remand prisoners were permitted reception visits within 24 hours of arrival. Prisoners who had been transferred from other establishments were permitted to use visiting orders from their previous establishment to facilitate a visit in the week of their arrival, if they so wished.

2.347 Visitors should not be called forward to the gate until they are allowed to enter the prison. The visitors' search area should be extended and visitors should be offered sufficient privacy during the searching process. (3.70)

Partially achieved. We observed visitors being called over in small groups of no more than seven visitors at a time because of the small gate and searching area. Visitors were required to queue at the entrance to the gate until their identification had been checked, so most were exposed to the elements. Once checked, they had the opportunity to use the lockers and were called through into a small search area, which had not been extended since the previous inspection. This area was screened by a curtain, which offered privacy, but the space remained inadequate. Despite the poor environment, searching staff conducted rub-down searches in a friendly and respectful manner.
We repeat the recommendation.

2.348 Letters to banned visitors should include instructions on how to appeal against the decision. (3.71)

Achieved. The letters sent to visitors banned from visiting the establishment clearly outlined that they could appeal against the decision by writing to the prison and that they would receive a written reply.

2.349 The area used to hold visitors before going to the visits hall should be made more user-friendly (this information should be gained through the visitors' survey). It should not be referred to as 'the cage'. (3.72)

Partially achieved. The area used to hold visitors before being escorted to the visits hall had not changed. It was a Perspex construction with a few seats. We observed visitors waiting in the area for no more than five minutes, but it was cold, in full view of staff and visitors moving around the establishment, and unpleasant. Staff referred to it as the waiting area or shelter.

Further recommendation

2.350 The area used to hold visitors before going to the visits hall should be an appropriate environment for groups of visitors to wait, with sufficient seating.

2.351 The visits hall should be refurbished to remove the fixed furniture, introduce a canteen facility and establish a crèche. The children's area should be supervised and more relevant facilities provided. (3.73)

Partially achieved. The visits hall was light and airy and contained 15 tables, where most social visits were conducted. The seating was fixed and there was no canteen, but three vending machines sold a range of cold drinks and snacks and were in working order during the visit session we observed. We were told that there were plans for a space next to the vending machines to be converted into a canteen facility. The crèche area was a large and pleasant environment. It was not supervised during the week but children were able to use the space and we observed children accessing the area and bringing toys and books to the visits table.
We repeat the recommendation.

2.352 More discreet security arrangements should be introduced to replace the need for prisoners to wear bibs. (3.74)

Not achieved. Prisoners were required to wear orange bibs on entry to the visits hall. This was

despite the fact that all male visitors were required to have their hands stamped with an ultraviolet pen which was checked before leaving the establishment.
We repeat the recommendation.

2.353 Arrangements for the management of vulnerable prisoners (VP) within the visits hall should be reviewed and more sensitive arrangements than identifiable VP seating introduced. (3.75)

No longer relevant. Most prisoners were now vulnerable prisoners. We observed one visits session where 13 visits were taking place, all involving vulnerable prisoners. We were told by the visits senior officer that there was no need to separate vulnerable prisoners from the remaining minority of prisoners and that all visits sessions were integrated.

2.354 Prisoners should be able to receive a visit within one week of admission. (1.26)

Achieved. See recommendation 2.345.

2.355 A needs assessment should be conducted to ascertain whether suitable offending behaviour programmes could be delivered. (8.10)

Not achieved. A needs assessment had not been completed and no accredited offending behaviour programmes were delivered. The chaplaincy team delivered the SORI course (see section on faith and religious activity). There were plans to complete a needs assessment of the population once the re-role was complete but there were some prisoners at the establishment who had substantial sentence planning targets and needed to be transferred to other establishments where these programmes were delivered. While the OCA and the OMU worked hard to identify and subsequently transfer prisoners who needed specific interventions, some prisoners would remain at the establishment waiting for transfer with no programmes to participate in. Furthermore, we were told that a significant number of prisoners were denying their offence, but there was no motivational work available at the time of the inspection.
We repeat the recommendation.

Additional information

2.356 In our groups, most prisoners told us that they had been seen by a range of reintegration services during induction, even those who had been eligible for the fast-track induction (see section on first days in custody). Prisoners in our groups who were due to be discharged in the next four to six weeks were less clear about how their specific needs would be met. We were provided with a list of the next 50 prisoners to be discharged. We spoke to 10 prisoners who were due to be discharged in the next two weeks and only two of them said that they had discussed their resettlement needs, one with the CARAT team and the other with an offender supervisor, as he was a prolific or priority offender. None of this group of prisoners had been invited to a pre-discharge board.

2.357 The resettlement minutes highlighted that prisoners were supposed to be invited to attend a meeting a week before their discharge to check on accommodation needs and for job searches to be completed. However, this left insufficient time for any significant needs to be discussed, and the passport system, which at the time of the previous inspection tracked each need, was not running effectively. The manager of the OMU told us that the passport system was not up to date and was reliant on pathway providers giving them information about prisoners' needs and subsequent action taken, and that they were not proactive in gathering these important data. It was unclear whether the passport system would be needed with the introduction of P-Nomis and the imminent arrival of layered offender management.

2.358 Housing needs were identified on induction and most prisoners were aware of the Nacro service, although one prisoner about to be discharged had accommodation needs and was likely to be released with no fixed abode. The Nacro worker was co-located with the Fresh Start New Beginnings worker, so there was sharing of information and mutual working to secure accommodation. Ninety-three per cent of prisoners were reported as going out to settled accommodation. There were insufficient links with accommodation agencies outside the West Midlands. We were told that the Nacro worker maintained a database of all prisoners seen but she was not available during the inspection.

2.359 Although there was no resettlement course available, the education department offered prisoners the opportunity to undertake a variety of modules of business and finance courses. Most of those who stayed on the courses passed their qualifications. However, these were not suitably prioritised for prisoners who were near release. Matching employment opportunities offered in the prison to the job market was problematic under the change of role, as prisoners came from and were discharged to, locations all over the country. An employment fair had resulted in some prisoners gaining employment in the community.

2.360 A member of staff from Jobcentre Plus attended the prison every day to offer advice about jobs on release, along with a member of staff from JHP Ltd (see section on learning and skills and work activities)

2.361 Healthcare discharge planning was adequate, with links maintained with the local community. There was no healthcare involvement with release planning boards. There were satisfactory procedures for the management of the terminally ill, and the care programme approach was used effectively for prisoners with severe and enduring mental health problems.

2.362 Substance use and alcohol services were commissioned by Shropshire County Council and provided by CRI. The drug strategy was now more coordinated; it was reviewed twice a year and included clear developmental targets.

2.363 All prisoners were screened for alcohol problems but services for alcohol-only users were limited. There were established links with community-based services, including drug intervention programme teams.

2.364 A Citizens Advice (CA) worker attended the establishment weekly and provided a range of financial and debt advice. He was able to see only a maximum of four prisoners each week, so some prisoners who had been referred to him were discharged without seeing him. There was no facility to help prisoners open a bank account. Resettlement staff had been trained in money management and delivered sessions to some prisoners with identified needs.

2.365 Remand and unconvicted prisoners could expect to receive a maximum of three visits a week (excluding privileged visits) and convicted prisoners a maximum of two visits every 28 days, with an additional two privileged visits if they were enhanced prisoners. Visiting times were Wednesday to Saturday, with two sessions: 1.45–2.30pm, previously for visitors for remand prisoners, and 2.45– 3.45pm for those visiting convicted prisoners; however, with the re-role all prisoners were able to access both sessions.

2.366 Visits could only be booked through the visits booking line, which was open from Monday to Friday, from 8.45–11.45am and 1–3.30pm. The visits booking staff were located in the visitors centre outside the gate, which was open from 1pm until after the last visits session had finished. The visitors centre was a bright environment, with ample seating and a range of information available. Two members of staff worked there, and interacted well with visitors and

responded to any questions they had. There was a small hot and cold drinks machine but no snacks were available and there were insufficient toys and books for children.

2.367 The visits hall contained three interview rooms; we observed one being used by a member of the prison visitors scheme and a vulnerable prisoner. There were two closed visits booths and a non-contact table, which we were told was offered to visitors when a drug dog had indicated but there was no further intelligence about the visitor.

2.368 The visits session we observed did not start on time for all visitors because of the small gate and search area and the staggered arrangements of getting visitors through the process to the visits hall. Despite this, the visits session was relaxed and staff supervised the session well, without being overbearing or punitive about physical contact. Prisoners were able to hand out property in visits. Some families had to travel long distances from the West Midlands, and extended visits were facilitated where appropriate. Visitors we spoke to were mainly positive about their experience of visiting the establishment.

2.369 Family days were run regularly and supported by family services, which encouraged prisoners and their children to spend time together. The day involved a range of departments and activities. Prisoners who had completed the parent craft course were eligible for the family day, subject to risk assessment, and enhanced prisoners and those referred by wing staff were considered. The email a prisoner scheme was also available at the establishment.

Further recommendations

2.370 A resettlement course should be developed which is clearly prioritised for prisoners near their release date.

2.371 The prison should establish links with accommodation providers across the country, given the wide catchment area from which prisoners now come.

2.372 The prison should continue to establish strong links with employers to help prisoners into employment when they leave custody.

2.373 Support services for alcohol-only users should be introduced.

2.374 Visitors should be able to book a visit at the visitors centre.

Housekeeping point

2.375 A range of children's toys and books should be available in the visitors centre.

Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Main recommendation (from the previous report) To the governor

3.1 The personal officer scheme should be re-launched and details of how it supports the offender management model clarified. Staff should be provided with appropriate guidance and training to enable them to take on the new responsibilities. (2.4)

Recommendations To the Chief Executive of NOMS

3.2 Cells designated as single should not routinely be used to hold two prisoners. (2.30)

3.3 Indeterminate-sentenced prisoners should be transferred to first stage prisons at least within one month of receiving their sentence. (2.321)

3.4 Prisoners required to undertake specific offending behaviour programmes not available at Shrewsbury should not be transferred to the prison. (2.337)

3.5 Prisoners should arrive at the establishment with all the necessary public protection paperwork. (2.341)

Recommendations To the governor

Courts, escorts and transfers

3.6 Prisoners should be moved to residential units promptly. (2.14)

First days in custody

3.7 Prisoners should be able to make a free telephone call on their first night. (2.16)

3.8 Newly arrived prisoners should be readily identifiable to first night staff. (2.29)

Residential units

3.9 The shower area on C wing should be refurbished. (2.3)

3.10 Facilities for prisoners to eat out of cell should be provided. (2.32)

3.11 Notice boards should offer relevant information in a range of languages. (2.34)

3.12 Colour-coding of cleaning equipment should be adhered to across the establishment. (2.37)

3.13 Prisoners should be given the opportunity to wear their own clothes. (2.39)

3.14 All cells should be fitted with curtains. (2.43)

Staff–prisoner relationships

3.15 Staff should address prisoners by their chosen name. (2.44)

3.16 Managers should routinely encourage staff to challenge prisoners about their offending behaviour. (2.45)

3.17 Prisoner consultative events should be held regularly and be representative of the wider population. (2.49)

Personal officers

3.18 The personal officer scheme should be re-launched and details of how it supports the offender management model clarified. Staff should be provided with appropriate guidance and training to enable them to take on the new responsibilities. (2.4)

3.19 Photographs identifying personal officers by name should be published on each wing. (2.52)

3.20 Staff should take up their designated responsibilities in the personal officer role, including report writing for those on their caseload. (2.57)

3.21 All personal officers should introduce themselves to those on their caseload and meet them regularly to discuss and make a note of progress. (2.58)

3.22 All personal officers should have access to the P-Nomis system and make weekly entries for prisoners for whom they are responsible. (2.59)

3.23 Management checks should establish the quality and quantity of personal officer entries and follow up issues with the individuals involved. (2.60)

Bullying and violence reduction

3.24 Where possible, the safer prisons meeting should be chaired by the same senior manager to ensure consistency. (2.62)

3.25 The findings from bullying alert information should be used by the safer custody committee to inform continuous improvement. (2.68)

3.26 Prisoners should be able to call the 'at risk' helpline free of charge. (2.69)

Self-harm and suicide

3.27 The suicide prevention coordinator should be provided with sufficient, predictable and regular facility time to carry out these duties. (2.71)

3.28 The case manager allocated to a prisoner at risk should contribute to each review and record regular personal contact with the prisoner when on duty. (2.73)

3.29 Prisoners subject to the constant watch level of supervision should be reviewed in line with local and national instructions. (2.75)

3.30 The 'at risk' helpline should be available to external callers. (2.77)

3.31 Night entries should not be made at predictable intervals. (2.79)

3.32 The full range of departments designated in the safer custody policy should be represented at every safer custody meeting. (2.87)

3.33 Death in custody action plans should be reviewed at the safer custody meeting. (2.88)

3.34 A continuous improvement plan should be developed from the findings of the Prisons and Probation Ombudsman reports and managed through the safer custody meeting. (2.89)

3.35 The quality of assessment, care in custody and teamwork (ACCT) practice and recording should be checked daily by the safer custody manager and deficiencies addressed. (2.90)

3.36 The prison should ensure that all staff receive foundation ACCT training and that a programme of refresher training is in place. (2.91)

Legal rights

3.37 Legal services officers should have the facility to offer prisoners telephone calls in pursuance of their legal rights. (2.98)

3.38 Arrangements should be made to provide legal advice about immigration and deportation to all those requiring it. (2.99)

Substance use

3.39 Shrewsbury should introduce voluntary testing and clearly differentiate it from the current compliance testing. (2.113)

Diversity

3.40 All staff should undertake diversity training that covers all strands of the diversity agenda. (2.120)

3.41 The diversity policy should be developed to include all aspects of diversity and details of how the policy will be delivered in practice. (2.125)

3.42 All aspects of diversity should be discussed at the diversity, race and equality action team (DREAT) meeting, which should be attended and chaired by the governor or deputy governor. (2.126)

3.43 The quarterly diversity management team meeting should be reinstated. (2.127)

3.44 Monitoring and analysis of equality of treatment should be carried out for all the different diversity strands. (2.128)

Diversity: Race equality

3.45 Assistant race relations liaison officers should be given sufficient profiled time to be effective in this role. (2.129)

3.46 All racist incident report forms (RIRFs) should be signed off by the governor. (2.139)

3.47 All RIRFs should be completed in full by the person submitting the report. (2.140)

3.48 Interventions to challenge racism and to protect victims should be introduced. (2.141)

Diversity: Foreign national prisoners

3.49 The race equality officer and foreign nationals liaison officers on the wings should be given sufficient time to carry out their work. (2.144)

3.50 Staff should be made aware of the translated material available and give relevant information to prisoners in their own language. (2.146)

3.51 Prisoners held solely on immigration matters should be released, deported or removed to an immigration removal centre. (2.147)

3.52 Independent immigration advice and support should be made available to foreign national prisoners. (2.153)

Diversity: Disability

3.53 The disability liaison officer should receive appropriate training to undertake the role. (2.154)

3.54 There should be a formal assessment screening tool to complete for prisoners with disabilities. (2.157)

3.55 All prisoners with disabilities should have a care plan identifying their needs and how they will be met. (2.158)

3.56 A central log should be kept of all prisoners with disabilities. (2.159)

3.57 There should be a carer or mentor scheme in place for prisoners with disabilities requiring additional assistance. (2.160)

3.58 There should be at least one adapted cell on each wing for use by prisoners with disabilities. (2.161)

3.59 Regular consultation meetings should take place with prisoners with disabilities. (2.162)

Diversity: Older prisoners

3.60 The needs of older prisoners should be fully assessed and a comprehensive action plan drawn up to identify how those needs will be met and what services will be provided. (2.166)

3.61 There should be a dedicated officer to carry out the role of providing support to older prisoners. (2.167)

Health services

3.62 Arrangements should be made to enable prisoners to take or have their medicines dispensed in privacy including making alternative arrangements for prisoners unable to attend either of the two pharmacy hatches. (2.172)

3.63 Dental treatment records (form FP25) should be retained in the dental surgery and a summary of treatment written by the dentist in the main clinical record. (2.175)

3.64 Dedicated discipline staff should be allocated to the healthcare centre to facilitate the more flexible movement of prisoners requiring healthcare appointments and thereby releasing nursing staff from inappropriate duties. (2.181)

3.65 The prison should take active steps to increase the number of prisoners able to have their medication in-possession and develop a policy signed up to by all relevant parties. The effectiveness of the policy including the approach to risk assessment should be audited regularly. (2.189)

3.66 Alternative facilities to the staff toilet should be made available for prisoners to provide urine samples. (2.195)

Learning and skills and work activities

3.67 Methods to reduce the level of stock loss should be introduced. (2.207)

3.68 The library officer should not be routinely redeployed to other tasks. (2.208)

3.69 More skilled work should be made available. This work should be purposeful and provide opportunities for more prisoners to gain a wider range of industry-recognised vocational qualifications. (2.216)

3.70 Access to the library should be improved. (2.217)

Physical education and health promotion

3.71 A wider range of short accredited courses should be made available to prisoners. (2.219)

3.72 The Astro turf should be upgraded to offer all-weather provision. (2.221)

3.73 Data regarding the use of the gym should be collected and analysed to improve attendance. (2.225)

3.74 Training shoes should be available in a range of sizes. (2.226)

Time out of cell

3.75 Only the main yard should be used for exercise. (2.6)

3.76 All prisoners should be offered at least ten hours a day out of their cells. (2.227)

3.77 A review of the monitoring system for time out of cell should be carried out in order clearly to ensure accurate recording and representing of data. (2.228)

3.78 Staff supervisory exercise should use this time to interact and get to know prisoners in their care. (2.231)

3.79 Prisoners not leaving their cell during association periods should be monitored and questioned as to why they are not participating. (2.232)

3.80 The establishment should liaise closely with Prison Service headquarters to ensure time out of cell is recorded properly. (2.233)

3.81 All prisoners should be unlocked to associate at the same time. (2.238)

3.82 Managers should encourage staff to be proactive in their contact with and management of prisoners, and to interact with prisoners on the residential wings rather than stay in the wing offices during association. (2.239)

3.83 Prisoners on C wing should be allocated an exercise period which does not conflict with other regime and personal activities. (2.240)

3.84 Access to recreational equipment should not be restricted during periods of association. (2.241)

Security and rules

3.85 Prisoners should only be placed on closed visits when there is intelligence to suggest that illicit activity is related to visits. (2.254)

Discipline

3.86 Prisoners should be given their punishment in writing at the time of the adjudication, and the appeals procedure should be explained by the adjudicating governor. (2.259)

3.87 The use of force forms and recordings of planned uses of force should be scrutinised at the use of force review meetings, to examine procedure and develop good practice. (2.261)

3.88 All planned removals should be recorded and immediately quality assured to ensure that correct practice is followed. (2.263)

3.89 Staff used for planned removals should not be used to strip-search the prisoner. (2.264)

3.90 Adjudicating governors should allow all potentially relevant information to be heard before concluding the hearing. (2.272)

3.91 Prisoners should be issued with the paperwork for all reconvened adjudications. (2.273)

3.92 Local adjudication standardisation meetings should analyse trends in adjudications and develop a method for quality assurance of practice. This should include mitigating or quashing locally any adjudications which have not been conducted properly. (2.274)

3.93 Force should not be used when prisoners are compliant. (2.275)

3.94 Prisoners should not be video-recorded during strip-searches. (2.276)

3.95 A multidisciplinary staff group should quality-assure video footage of planned removals, following up by discussions with staff involved, and monitor trends in the use of force and use of special accommodation and mechanical restraints. (2.277)

3.96 Special accommodation should not be used when prisoners are compliant. (2.278)

3.97 Special accommodation should not be used for prisoners who are self-harming. (2.279)

3.98 Segregation cells should be kept at an appropriate temperature. (2.280)

3.99 A multidisciplinary staff group should monitor trends in the use of segregation and ensure that procedures are adhered to. (2.281)

3.100 Segregated prisoners should be strip-searched only where need has been identified through risk assessment. (2.282)

3.101 Personal files should have meaningful entries from all staff who have contact with segregated individuals. (2.283)

3.102 Staff selected to work in the separation, care and control unit should receive specific and relevant training in de-escalation, race equality, suicide prevention, mental health, personality disorder and motivational interviewing. (2.284)

Catering

3.103 Lunch should be served between noon and 1.30pm and tea between 5pm and 6.30pm. (2.290)

3.104 National vocational qualifications should be expanded to all prisoners working in the kitchen environment. (2.291)

3.105 The kitchen floor should be re-surfaced. (2.292)

Prison shop

3.106 The prison shop guidance should be adhered to, with prisoners' orders being rectified at the point of delivery, as stated. (2.304)

3.107 The shop price list should be updated to reflect recent rises in VAT. (2.305)

Strategic management of resettlement

3.108 A needs analysis of the population should be completed and used to update the resettlement policy. (2.312)

3.109 Pre-discharge boards should be convened at least four weeks before discharge. (2.313)

3.110 Resettlement meetings should strategically plan and manage resettlement services to ensure that it meets the needs of the population. (2.314)

Offender management and planning

3.111 Senior managers should allocate sufficient OASys trained staff to clear the backlog of cases and to keep new assessments up to date. (2.315)

3.112 Remand and short-sentenced prisoners should have a custody plan that records their offending behaviour and resettlement needs. (2.318)

3.113 Observation, classification and allocation staff should not be redeployed when there is a backlog of prisoners requiring classification and allocation. (2.319)

3.114 All wing staff and other relevant departments should have updated information on prisoners subject to public protection measures and staff should ensure that these prisoners are properly monitored. (2.324)

3.115 There should be sufficient staff allocated to the offender management unit to manage the increase in high-risk prisoners and keep assessments up to date. (2.336)

3.116 Lifer staff should receive appropriate training in order to manage the casework of indeterminate-sentenced prisoners. (2.338)

3.117 There should be specific forums and events for indeterminate-sentenced prisoners. (2.339)

3.118 There should be a public protection policy specific to the establishment, outlining how public protection cases are managed and staff's responsibilities. (2.340)

Resettlement pathways

3.119 Visitors should not be called forward to the gate until they are allowed to enter the prison. The visitors' search area should be extended and visitors should be offered sufficient privacy during the searching process. (2.347)

3.120 The area used to hold visitors before going to the visits hall should be an appropriate environment for groups of visitors to wait, with sufficient seating. (2.350)

3.121 The visits hall should be refurbished to remove the fixed furniture, introduce a canteen facility and establish a crèche. The children's area should be supervised and more relevant facilities provided. (2.351)

3.122 More discreet security arrangements should be introduced to replace the need for prisoners to wear bibs. (2.352)

3.123 A needs assessment should be conducted to ascertain whether suitable offending behaviour programmes could be delivered. (2.355)

3.124 A resettlement course should be developed which is clearly prioritised for prisoners near their release date. (2.370)

3.125 The prison should establish links with accommodation providers across the country, given the wide catchment area from which prisoners now come. (2.371)

3.126 The prison should continue to establish strong links with employers to help prisoners into employment when they leave custody. (2.372)

3.127 Support services for alcohol-only users should be introduced. (3.373)

3.128 Visitors should be able to book a visit at the visitors centre. (3.374)

Housekeeping points

Bullying and violence reduction

3.129 The prison should ensure that the safer custody survey covers all aspects of safer custody. (2.70)

Resettlement pathways

3.130 A range of children's toys and books should be available in the visitors centre. (2.375)

Examples of good practice

Faith and religious activity

3.131 The charity, Fresh Start New Beginnings, was a valuable and comprehensive mentoring service for prisoners. (2.110)

Diversity: Race equality

3.132 The interviewing of all prisoners with current or previous convictions for racist offences was an indicator of the positive action taken by the race equality officer to combat racism. (2.142)

Catering

3.133 The picture menu was easy to understand and assisted prisoners in making informed choices about their meals. (2.298)

Prison shop

3.134 The system for dealing with shop orders for prisoners who were absent on the day of distribution showed consideration for prisoners' needs. (2.306)

Appendix I: Inspection team

Sara Snell	Team leader
Vinnett Pearcy	Inspector
Andrew Rooke	Inspector
Karen Dillon	Inspector
Paul Rowland	Inspector
Kellie Reeve	Inspector
Michael Bowen	Healthcare inspector
Neil Edwards	Ofsted inspector

Appendix II: Prison population profile

Status	18–20-year-olds	21 and over	%
Sentenced		188	70.1
Recall		62	23.1
Convicted unsentenced		12	4.5
Remand		3	1.1
Civil prisoners		1	0.4
Detainees		2	0.7
Total		268	100

Sentence	18–20-year-olds	21 and over	%
Unsentenced		15	5.6
Less than 6 months		7	2.6
6 months to less than 12 months		13	4.9
12 months to less than 2 years		60	22.4
2 years to less than 4 years		71	26.5
4 years to less than 10 years		83	31.0
10 years and over (not life)		11	4.1
ISPP		5	1.9
Life		3	1.1
Total		268	100

Age	Number of prisoners	%
Please state minimum age	21	
Under 21 years	0	0.0
21 years to 29 years	73	27.2
30 years to 39 years	74	27.6
40 years to 49 years	71	26.5
50 years to 59 years	19	7.1
60 years to 69 years	24	9.0
70 plus years	7	2.6
Please state maximum age	77	
Total	268	100

Nationality	18–20-year-olds	21 and over	%
British		255	95.1
Foreign nationals		13	4.9
Total		268	100

Security category	18–20-year-olds	21 and over	%
Uncategorised unsentenced		15	5.6
Uncategorised sentenced		1	0.4
Cat A		0	0.0
Cat B		2	0.7
Cat C		250	93.3
Cat D		0	0.0
Other		0	0.0
Total		268	100

Ethnicity	18–20-year-olds	21 and over	%
White			
British		218	81.3
Irish		1	0.4
Other White		5	1.9
Mixed			
White and Black Caribbean		1	0.4
White and Black African		1	0.4
White and Asian		1	0.4
Other Mixed		1	0.4
Asian or Asian British			
Indian		5	1.9
Pakistani		13	4.9
Bangladeshi		2	0.7
Other Asian		3	1.1
Black or Black British			
Caribbean		3	1.1
African		4	1.5
Other Black		1	0.4
Chinese or other ethnic group			
Chinese		0	0.0
Other ethnic group		2	0.7
Not stated		7	2.6
Total		268	100

Religion	18–20-year-olds	21 and over	%
Baptist		2	0.7
Church of England		74	27.6
Roman Catholic		24	9.0
Other Christian denominations		8	3.0
Muslim		31	11.6
Sikh		1	0.4
Hindu		0	0.0
Buddhist		6	2.2
Jewish		0	0.0
Other		27	10.1
No religion		95	35.4
Total		268	100

Sentenced prisoners only

Length of stay	18–20-year-olds		21 and over	
	Number	%	Number	%
Less than 1 month			187	73.9
1 month to 3 months			58	22.9
3 months to 6 months			2	0.8
6 months to 1 year			3	1.2
1 year to 2 years			2	0.8
2 years to 4 years			1	0.4
4 years or more			0	0.0
Total			253	100

Unsentenced prisoners only

Length of stay	18–20-year-olds		21 and over	
	Number	%	Number	%
Less than 1 month			2	13.3
1 month to 3 months			11	73.3
3 months to 6 months			2	13.3
6 months to 1 year			0	0.0
1 year to 2 years			0	0.0
2 years to 4 years			0	0.0
4 years or more			0	0.0
Total			15	100

Main offence	18–20-year-olds	21 and over	%
Violence against the person		44	16.4
Sexual offences		160	59.7
Burglary		19	7.1
Robbery		15	5.6
Theft and handling		5	1.9
Fraud and forgery		2	0.7
Drugs offences		20	7.5
Other offences		2	0.7
Civil offences		1	0.4
Offence not recorded/holding warrant		0	0.0
Total		268	100