Report on an unannounced short follow-up inspection of

HMP Wayland

6 – 8 April 2009

by HM Chief Inspector of Prisons

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1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

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Introduction

HMP Wayland, in Norfolk, is a much expanded category C training prison. On our last visit, we described it as an impressive establishment, but identified some emerging strains arising from its population growth. This unannounced short follow-up inspection found that these pressures had had a negative impact but that, overall, the prison continued to perform commendably well in many areas.

Wayland remained a safe place, despite having had to open five new residential units, holding an additional 300 prisoners. Early days were well managed, although reception was now too small for the number of prisoners that passed through. Violence reduction and suicide prevention arrangements were reasonable and made good use of prisoner representatives, but more support was needed for victims of bullying. There had been a significant increase in the use of force, coinciding with the population increase, but this had now begun to reduce. There was commendably little illicit drug use, and an effective integrated drug treatment system had been introduced.

Environmental conditions had deteriorated in some parts of the prison, which were now litter strewn and dirty. Staff–prisoner relationships were also less positive and we saw less engagement than on our last visit. Work to promote diversity was generally good, but many black and minority ethnic prisoners still reported negatively about staff. Healthcare was not sufficiently resourced to meet the needs of the expanded population.

Prisoners had a good amount of time out of cell, but there were insufficient activity places to keep them all purposefully occupied. The education, work and vocational training that was available was generally of good quality, and provision had improved in a number of areas. Library access had increased and there were adequate PE facilities.

Resettlement was well managed and the establishment took an imaginative and thoughtful approach to offender management. The increased numbers of indeterminate-sentenced prisoners were frustrated by the limited provision available to them. There were reasonable services available along most of the resettlement pathways, although support on release for those with ongoing health issues was weak.

Wayland had nearly doubled its population since our last inspection and this had placed considerable pressure on the prison. Some areas, particularly reception and healthcare, were now struggling to cope with the numbers of prisoners that needed to be dealt with, while relationships between staff and prisoners appeared to have deteriorated. Nevertheless, while worrying, these visible strains should not obscure much other good work that had been sustained. Managers and staff deserve credit for managing the expansion in a way that ensured that Wayland remained a largely safe and purposeful prison, with a sound focus on resettlement.

Anne Owers — September 2009
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Wayland is a category C adult male training prison for convicted prisoners.

Area organisation
Eastern

Number held
1009

Certified normal accommodation
955

Operational capacity
1,017

Last inspection
June 2006

Brief history
HMP Wayland opened in 1985. The site buildings have been added to on four occasions, with the last major development of five new house blocks, kitchen, education, healthcare and segregation units going into operation from June 2008.

Description of residential units

A wing	Convicted adults, including induction unit	144
B wing	Convicted adults	120
C wing	Convicted adults	120
D wing	Convicted adults	120
E wing	Vulnerable and sex offenders	97
F Wing	Vulnerable and sex offenders (enhanced)	40
G wing	Convicted adults (enhanced)	36
H wing	Convicted adults (enhanced)	40
J wing	Convicted adults (shared double cells)	60
K wing	Convicted adults (shared double cells)	60
L wing	Convicted adults (shared double cells)	60
M wing	Convicted adults (shared double cells)	60
N wing	Convicted adults (shared double cells)	60

Section 1: Healthy prison assessment

Introduction

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

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

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

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

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

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

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

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

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

Safety

HP4 In 2006, the prison was performing well against this healthy prison test. Of the 22 recommendations in this area, 16 were assessed as achieved, two were partially achieved, three were not achieved and one was no longer relevant. We have made 16 further recommendations.

HP5 G4S was the escort provider and had a good relationship with prison staff. Prisoners were reasonably positive about their journeys to the establishment and said that they were treated well by escort staff. The Independent Monitoring Board reported many complaints about property not arriving with prisoners from other establishments.

HP6 The reception had not increased in size since the expansion but was able to cope with the demand and prisoners were received courteously. The four holding rooms had recently been fitted with closed-circuit television. Two had been redecorated, while two remained in need of some attention, and only one displayed information on the walls. A prisoner orderly was used in reception, but his presence during the booking-in process, including the cell sharing risk assessment, was inappropriate.

HP7 All prisoners were moved swiftly to either A wing or, for vulnerable prisoners, E wing first night accommodation, and staff were welcoming. Prisoners were not routinely seen on an initial one-to-one basis to allow anxieties to be discussed. Cells on A wing were prepared for new arrivals but were unsatisfactory, with torn blankets over windows and graffiti.

HP8 There was good interaction between staff and prisoners on the A wing first night and induction unit. The induction process started on the next working day after arrival, was efficient and comprehensive, and ensured that prisoners spent time with all key players and peer supporters. The process on E wing was less well structured and took up to two weeks to complete.

HP9 Most prisoners reported that they felt safe at the establishment. Vulnerable prisoners said that they felt intimidated at particular times, such as going to and from work and visits. Violence reduction procedures were managed reasonably, despite the long-term absence of a coordinator. A team of prisoner representatives was fully engaged in supporting the work. There were no formal interventions for bullies or victims, and insufficient steps were taken to reintegrate victims who ended up in the segregation unit back onto normal location, although bullies were.

HP10 Suicide and self-harm procedures were well managed, and support for prisoners at risk was good. Written information was given to all prisoners for whom assessment, care in custody and teamwork (ACCT) documentation was opened, offering information and suggestions for helpful activity and, with consent, families were informed. Information was collected, analysed and acted on. The Listener scheme was well supported, with 14 Listeners and 14 undergoing training. The co-location of the safer custody team with the first night and induction unit led to good communication and support of those deemed vulnerable.

HP11 Security department priorities were appropriately concentrated around mobile telephones and drugs, particularly the selling of medication. Security seemed commensurate with the risks identified. There had been a spike in the submission of security information reports in mid-2008 as the population expanded.

HP12 The segregation unit accommodation was in good order. All prisoners held there had access to a basic regime and were allocated a personal officer. Segregation files did not demonstrate meaningful interactions between staff and prisoners there. Trends were analysed at the quarterly segregation and adjudication meetings and a sample of adjudications and all upheld appeals were discussed for lessons learned.

HP13 There had been a significant increase in the level of force used between 2007 and 2008, but the trend appeared to be reducing in 2009 to date. Statistics showed that more use of force had been used against prisoners from black and minority ethnic backgrounds and this had also been tracked. The special accommodation had been used three times in 2009; the paperwork indicated good interaction between staff and prisoners and that they were moved from the accommodation as soon as possible.

HP14 The integrated drug treatment system had been introduced and was led by a proactive and multidisciplinary team, the Community Alcohol and Drug Service (CADS), and included sessions from a specialist GP. Support practitioners were being trained as pharmacy technicians, so that they could support the delivery of medication. Methadone and buprenorphine were offered. Secondary detoxification was not available. Patients were either maintained or placed on a reducing regime, according to motivation. The service was well managed, with a dedicated waiting room with closed-circuit television cover, but there were concerns around the diversion of medication which had led to changes in the time of treatment delivery. There was no single residential unit for those participating in the service.

HP15 The random mandatory drug testing random positive rate quoted at the time of the inspection was low, at 4.6% in the year to date, against a target of 6%. Even with buprenorphine positive tests included, the figure stood at 4.8%.

HP16 On the basis of this short follow-up inspection, we considered that the prison was still performing well against this healthy prison test.

Respect

HP17 In 2006, the prison was performing well against this healthy prison test. Of the 35 recommendations in this area, eight were assessed as achieved, 10 were partially achieved and 17 were not achieved. We have made 33 further recommendations.

HP18 The external areas around A to D wings were dirty, with litter on the ground, items hanging out of windows and bird excrement on the walls, despite the work of a regular cleaning party. Other external areas were more pleasant. The internal areas were in a reasonable state of decoration and clean, with the exception of the first night cells on A wing, which were grimy and in a poor state of decoration. Cells designed for one were still being shared, despite being unsuitable.

HP19 There was an average of one telephone for 30 prisoners across the wings but there were few complaints about access. Visitors were able to book visits online and

prisoners could book visits for them through an application system. Family and children visits were run every Monday.

HP20 The incentives and earned privileges (IEP) scheme was not location based, but enhanced prisoners on G, H and F wings received longer association, had better facilities and could make snacks for themselves. Otherwise, the main differentials between levels were access to duvets, visits and games consoles. The scheme was more related to behaviour than compliance with sentence planning, although some attention was paid to achievement of targets. Black and minority ethnic prisoners were under-represented on the enhanced level of the scheme and the reasons for this had not been sufficiently explored.

HP21 Staff–prisoner relationships had deteriorated. Although staff were responsive to approaches by prisoners, few were seen engaging actively on association, exercise or visits. Relationships between prisoners were mainly positive and the atmosphere was good humoured. Prisoners, with the exception of vulnerable prisoners, were negative about staff. There was a particularly negative perception from black and minority prisoners and race representatives.

HP22 Prisoners knew who their personal officer was but most had little one-to-one contact with them. Entries in wing files varied. Prisoners' surnames were most commonly used. Management checks in files comprised just a stamp and a signature. Although most personal officers contributed towards categorisation and IEP reviews, there was no involvement in sentence planning or resettlement.

HP23 Food was of a good standard and met a variety of dietary, religious and cultural needs. Prisoners working in the kitchen were able to take vocational qualifications. Opportunities for dining in association were still being missed.

HP24 The disability liaison officer did not have time to carry out his role. There was a discrepancy between the number of people identifying themselves as having a disability and the number recorded on the local inmate database system (LIDS). The new accommodation had no facilities for those with mobility problems, and there were no facilities for older prisoners. There was good promotion of race equality and diversity.

HP25 The perceptions of prisoners from a black and minority ethnic background were poor. The full-time race equality officer and deputy were well regarded, despite receiving no training, but were left to address issues that staff should have dealt with. Prisoner race representatives had confidence in the racist incident report forms (RIRF) system and encouraged prisoners to use it. Despite this, there had been a decrease in submissions since the previous year. RIRFs indicated that staff did not challenge racist behaviour. Black and minority ethnic prisoners identified a lack of cultural awareness.

HP26 The legal services officer also acted as the foreign nationals coordinator. He saw everyone on reception and completed a questionnaire regarding need. His work was not sufficiently well advertised and not covered in his absence. Despite having no formal training, he had developed provision well. UK Border Agency involvement had increased. The Immigration Advisory Service visited weekly and the Refugee Council had started to attend the establishment. These services were not sufficiently well advertised.

HP27 Although a triplicate application system had been introduced, it was not monitored or tracked, and replies sometimes did not engage with the request made. The complaint process was better, and trends were monitored and analysed by ethnicity, location and subject, and action taken in response. Quality assurance was good.

HP28 All religious groups were represented at the prison. The chaplaincy offered a variety of activities and programmes. The new mutli-faith room provided good facilities.

HP29 All healthcare areas were clean and tidy. Staffing levels were greatly under-resourced. There were too few GP sessions, although nurse practitioners offered a comprehensive service. There were some delays in access but the quality of what was available was reasonable. Lack of administrative support meant that nurses undertook clerical duties, taking them away from clinical work. The dental waiting list had become unmanageable and there was no-out-of-hours service. The medication administration system was poor. Mental health services were inadequate, and prisoners with acute needs were transferred to HMP Norwich.

HP30 On the basis of this short follow-up inspection, we considered that the prison was now performing reasonably well against this healthy prison test.

Purposeful activity

HP31 In 2006, the prison was performing reasonably well against this healthy prison test. Of the 12 recommendations in this area, six were assessed as achieved, five were partially achieved and one was not achieved. We have made eight further recommendations.

HP32 There were insufficient activity places for the population to be employed full time. Only 80% of the population had access to some form of work or education, and during our roll checks 30% of prisoners were not engaged in any purposeful activity. Timeliness in education and training sessions had improved. The new education facilities were good and well resourced. Education was better linked with sentence planning and IT was being developed to sequence better the completion of identified targets. Access to education for vulnerable prisoners had improved but was still limited. Access to qualifications within work had improved, although there was still unaccredited work and vulnerable prisoners could not undergo any accredited training. The vocational workshops were well resourced. The quality of work and vocational training was good and relevant to the labour market.

HP33 Time out of cell was around 10 hours a day for most prisoners, when core day times were adhered to, and a theoretical 18 hours for enhanced prisoners on H, F and G wings. Association was reliable and offered every day, although prisoners were sometimes unlocked late for the evening meal. Time in the fresh air was curtailed for those leaving work late.

HP34 Library provision had increased, with three libraries now available. The stock was reasonable with a good range of foreign language dictionaries and audio books. We estimated that under 50% of prisoners accessed the libraries each week.

HP35 Physical education was mainly recreational, although a limited number of accredited courses, including health promotion, had been introduced. Full-time employed

prisoners could access the gym five times a week and everyone else four times a week. The facilities were adequate, with the exception of the outside pitches.

HP36 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Resettlement

HP37 In 2006, the prison was performing reasonably well against this healthy prison test. Of the 19 recommendations in this area, 14 were assessed as achieved, three were partially achieved, one was not achieved and one was no longer relevant. We have made seven further recommendations.

HP38 The resettlement strategy was clear and action needed as a consequence of the recent needs assessment had been agreed. Aims were linked with resettlement pathways. Resettlement needs were assessed at induction, relevant referrals made and a meeting held six weeks before release. Release on temporary licence was not used to assist resettlement.

HP39 The prison treated all prisoners serving over 12 months as in scope of offender management. The basic resettlement needs of prisoners serving less than 12 months were dealt with through the induction assessment. There were gaps in provision for life-sentenced prisoners and those serving an indeterminate sentence for public protection. Offender assessment system (OASys) assessments were up to date, with only 15 awaited from community offender managers, and the quality was good, with targets closely aligned with risk assessments.

HP40 There was still only one lifer manager and he was unable meet the demands of the increased indeterminate-sentenced population. The prison was only able to deliver a third of the parole reports required in the year. Too few staff were lifer trained or dedicated and there was insufficient focus on this population.

HP41 A range of offending behaviour programmes were eventually accessible to those identified as needing them. The programmes offered were responsive to identified need and the majority of referrals to programmes were based on recommended targets.

HP42 Categorisation procedures were up to date and reviews were picked up automatically at the six- or 12-month stage or by application. Prisoners waited an average of six weeks for transfer.

HP43 Provision around the resettlement pathways was reasonable. Housing needs were identified as part of the induction process and relevant referrals made. Citizens Advice provided monthly surgeries and Jobcentre Plus provided benefit advice and arranged community grants.

HP44 The Foundation Training Company ran pre-release courses for around 200 prisoners a year, but not for vulnerable prisoners. The recently established Action for Employment (A4E) 'work out' supported people into work.

HP45 The procedures for those released with ongoing mental and physical healthcare issues were underdeveloped. There were no pre-release clinics and discharge

services were basic. Drug and alcohol support was better. The counselling, assessment, referral, advice and throughcare (CARAT) team was well established, although significantly burdened by administrative work. There was a good relationship with drug intervention programme teams in the community.

HP46 Public protection arrangements had improved. All new receptions were assessed for public protection issues and referred to the integrated risk management group where appropriate. This group then conducted reviews and oversaw multi-agency public protection arrangements (MAPPA) arrangements.

HP47 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from the previous report) To the area manager

2.1 Prisoners who need 24-hour care should be transferred without delay to an in-patient unit. (HP38)

Achieved. There had been some progress with the care of mentally ill patients, but difficulties remained in individual cases. These related mainly to professional disagreements in diagnosis, which had led to delays in the transfer of patients to secure units. When this occurred, negotiations took place with HMP Norwich, which had an inpatient facility, to ensure that the best interests of the patient were met by transferring the patient there until the mental health professionals agreed ongoing treatment (see paragraph 2.140).

Main recommendations To the governor

2.2 There should be more educational and vocational training opportunities for vulnerable prisoners. (HP39)

Partially achieved. Extra education classes for the 200 vulnerable prisoners had been introduced. These took place on the wings and in the new education building on Thursday evening and Friday afternoon, at times when this was closed to main prisoners. However, vulnerable prisoners still had less choice than mainstream prisoners. They had access to only three unaccredited work areas (wing work, tailors' workshop and market gardens). A large workshop was available, but plans to make this available to vulnerable prisoners were on hold pending a decision as to whether vulnerable prisoners remained at Wayland.
We repeat the recommendation.

2.3 Education, training and work spaces should be fully utilised and the number of prisoners who are unoccupied or engaged in domestic work reduced. (HP40)

Partially achieved. Education, training and work were fully utilised, although most education places were part time. Even the full-time provision could for some prisoners be only six sessions a week. Domestic work continued to occupy 13% of prisoners, although most cleaners took British Institute of Cleaning Sciences qualifications and some kitchen workers took catering awards. Despite having almost enough places for the population, too many prisoners were still not fully occupied.
We repeat the recommendation.

2.4 Nationally recognised skills accreditation should be available to prisoners in all work areas. (HP41)

Partially achieved. In conjunction with Action for Employment (A4E), accreditation had been introduced in cleaning, kitchen work areas and for library and education orderlies and peer support workers. In waste management, staff were trained and equipment bought ready to introduce fork-lift truck driving awards. No accreditation was offered in bicycle repair and contract workshops, clothing and main stores, canteen, waste management and recycling, or

for most orderlies.
We repeat the recommendation.

2.5 There should be a strategy for the control and protection unit (CPU) that sets out what it aims to provide and achieve for the different groups of prisoners held there. (HP42)

Not achieved. The unit had reverted back to being called a segregation unit and had been relocated to a purpose-built unit on the far side of the establishment, alongside the newly built accommodation. The unit had no strategy setting out what it aimed to achieve for the different groups of prisoners held there, but the operating procedures outlined the regime, most of which could be accessed subject to a risk assessment. Prisoners were located on the unit under good order, discipline procedures or under Rule 45 for their own protection. A phased return to normal location form was available, and its use had been discussed at the September 2008 adjudication and segregation meeting, but there was no evidence that it was used to reintegrate prisoners back to normal location. The three prisoners located in the segregation unit for their own protection at the time of the inspection were to be transferred out to other establishments, but it was unclear from their individual history sheets what steps had been taken to return them to one of the 13 accommodation units at the establishment. Prisoners told us that the easiest way to get a transfer was to be located in the segregation unit.
We repeat the recommendation.

Further recommendation

2.6 After segregation, prisoners should be encouraged to return to normal location and their return should be appropriately planned and implemented.

2.7 The resettlement strategy should be revised to include targets to measure progress, take account of the National Offender Management Service resettlement pathways, and make links with relevant area resettlement strategies. (HP43)

Partially achieved. The resettlement strategy had been revised, with clear targets for each resettlement pathway. Each target was supported by the specification of detailed actions, which set out how the targets would be achieved. This included action that was to be taken both in the prison and the area. Resettlement management was more driven by the monitoring of the nationally driven key performance targets for accommodation, education and employment than by their local goals. There was no strategic use of internal performance management information.

Further recommendation

2.8 The targets set locally for community reintegration should be measurable and monitored at the strategic resettlement meetings. They should also be updated annually, based on the needs of the population.

Other recommendations

To the Chief Executive of NOMS

2.9 Cells designed for one prisoner should not be used to hold two. (2.9)

Not achieved. The vast majority of the cells found at our last inspection to be occupied by two prisoners, although designed for one, continued to be occupied by two prisoners. There were

26 cells doubled on A wing and seven on B, C and D wings. One of the cells which was doubled on A wing was now used as a Listeners suite. The accommodation remained inappropriate for sharing.
We repeat the recommendation.

2.10 Life-sentenced prisoners who have been recommended for open conditions should be able to progress as soon as possible. (8.18)

Achieved. The prison proactively facilitated transfers. Most life-sentenced prisoners moved to open conditions within three months of being recategorised. There had been resistance from open prisons to accepting transfers in the previous year, and two cases had been referred to area office, with the result that the receiving establishment had been directed to accept the transfers. Two prisoners were waiting for transfer to open conditions at the time of the inspection. One was due to move later in April 2009, having been recommended for a move in January, and the other had been retained to complete a sex offender programme. There were further difficulties in moving him because his brother was in the establishment to which he would normally have been sent.

Other recommendation

To the area manager

2.11 The mandatory drug testing waiting area should be refurbished. (8.49)

Achieved. The mandatory drug testing suite had been relocated to a purpose-built room in the new building, which housed J, K, L, M and N wings, the segregation unit and a new healthcare facility.

Other recommendations

To the governor

Arrival in custody

Courts, escorts and transfers

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

Additional information

2.12 The transport of prisoners was undertaken by G4S. Staff reported good relationships with the escorting contractors, and prisoners in our groups told us that both G4S and reception staff had treated them well. A number of prisoners in our groups reported that they had been given out-of-date food for their journeys. Most moves were to and from other prisons, with approximately 30 new arrivals every week.

2.13 The independent monitoring board (IMB) reported that the largest number of complaints they received involved property and, in many cases, the complaint was that property had not come with the prisoner on transfer, nor subsequently been forwarded.

Further recommendations

2.14 All food offered to prisoners during journeys to and from the establishment should be in date.

2.15 The escort contractor should bring prisoners' property with them on transfer.

First days in custody

2.16 The prisoner orderly working in reception should also be a Listener. (1.20)

Partially achieved. The current prisoner orderly was not a Listener, but a fully trained Listener was due to take over this position when the Listener training was completed (see paragraph 2.59). Listeners were called to reception if required.

2.17 A Listener should be based on the induction spur. (1.21)

Achieved. A Listener was now located permanently on the induction spur and would be replaced on his release or transfer. There were also two Listeners working in the drop-in centre on the wing.

2.18 Prisoners on induction should have alternative out of cell activities during the working day when they are not attending induction modules. (1.22)

Achieved. The induction programme was now a rolling programme and prisoners did not have to wait to join it. It was completed in three and a half days and prisoners then moved on quickly to work or education activities.

2.19 Induction staff should participate in the delivery of the race relations and self-harm induction modules. (1.23)

Achieved. Induction staff were involved in induction presentations and provided support to prisoners giving information to new arrivals.

Additional information

2.20 The reception area had not increased in size with the increased population at Wayland. It remained adequate for the number of prisoner movements only because of careful management of transfers in and out of the establishment. Closed-circuit television (CCTV) had recently been installed in the holding rooms, but only one out of the four had any information displayed on the wall. Two holding rooms had been redecorated but two remained in need of attention.

2.21 Reception staff remained on duty during the lunch period to process new arrivals, but they could not move prisoners to the induction wing during this time, so there were some delays for prisoners who arrived at this time. At other times, prisoners were moved reasonably quickly to the wings. Basic procedures were carried out, including a cell sharing risk assessment, property check and the issue of canteen packs.

2.22 We observed the prisoner orderly handling prisoners' property and assisting in checking items to be issued to new arrivals. He was also present while initial processes, including the cell sharing risk assessment, were carried out, enabling him to overhear confidential information given to and by new arrivals.

2.23 On leaving reception, most prisoners were taken to the A wing induction spur. Vulnerable prisoners were located on E wing. On arrival on the wing, prisoners were greeted by staff and

two prisoner induction orderlies. There were also two prisoner cleaners who were available to assist new prisoners. New arrivals were given help in completing documentation and information to ensure that they knew what would happen on their first night. They were able to participate in association if they arrived before the end of the core day. Access to telephones was difficult, as there was one telephone for 56 prisoners on this wing. Several prisoners in our groups reported that they had been unable to make a telephone call on their first night because of this.

2.24 Although prisoners were given the opportunity to speak to staff on a one-to-one basis, many refused this chance, and no formal first night assessment was carried out for any new arrival.

2.25 Cells were prepared for new arrivals. However, the one we checked was grubby, with graffiti and toothpaste over the walls and a torn blanket up at the window. Staff told us that they did not expect the cleaners to remove the toothpaste and that they considered the cell to be adequately clean.

2.26 We observed good interaction between staff and prisoners and between prisoners and the prisoner orderlies on the induction unit. Prisoners would start the induction programme on the next working day after arrival, unless they arrived on Thursday to Saturday, as the programme operated on Monday to Thursday. It was completed in three and a half days, and prisoners then moved on quickly to work or education activities. The programme included input from induction staff and various agencies, including the counselling, assessment, referral, advice and throughcare (CARAT) team, Ormiston Trust and prisoner representatives for race relations and safer custody. Although prisoners were out of their cells during their time on induction, even when not undertaking modules, there was little to occupy them. Prisoners we spoke to who were due to leave the unit were positive about the induction programme and all had been allocated to work within two weeks of arrival at the establishment.

2.27 The induction process for those allocated directly to E wing (the wing for vulnerable prisoners and sex offenders) from reception was in a different format. It contained the same elements, although prisoners on this unit told us that they had spent little time with the agencies that came to see them. They did not have a specific induction timetable and elements of the programme were delivered as and when staff were available. It took up to two weeks to complete, during which time prisoners undertook educational assessments before being allocated to work.

Further recommendations

2.28 The prisoner orderly in reception should not have access to confidential information about other prisoners.

2.29 At least two more telephones should be installed on the induction spur.

2.30 Cells on the induction spur should be refurbished and properly cleaned for new arrivals.

2.31 Prisoners should be seen by first night staff on a one-to-one basis on arrival, so that they have the opportunity to raise any anxieties in private at the earliest opportunity.

2.32 When not participating in the induction programme, prisoners should be offered alternative activities to occupy their time.

2.33 Prisoners allocated to E wing should receive the same induction programme as those on A wing.

Housekeeping points

2.34 Up-to-date information should be provided in all the holding rooms in reception.

2.35 The two holding rooms in reception which are in need of attention should be redecorated.

Environment and relationships

Residential units

2.36 All prisoners should have access to laundry facilities for their own clothes. (2.10)

Partially achieved. All the new accommodation had laundry facilities. The wings which had not had laundry facilities at the previous inspection remained in the same situation. Prisoners continued to wash clothing by hand and dry it on the pipes in their cells.
We repeat the recommendation.

2.37 Prisoners should be able to shower in private. (2.11)

Partially achieved. All the new accommodation had private showering facilities and prisoners on H, G and F wings were also able to shower in private.
We repeat the recommendation.

2.38 Prisoners should have access to telephones on every weekday evening. (3.67)

Achieved. Prisoners had reliable access to telephones during association, which took place on Monday to Thursday evenings, Friday afternoon and Saturday and Sunday mornings and afternoons. They could also access the telephones during the weekday if they were not at work. This meant that most prisoners were able to use the telephone, despite there being only one telephone for 30 prisoners on most wings, rather than our expectation of one for 20.

Further recommendation

2.39 Further telephones should be installed on the wings, to allow one for every 20 prisoners.

Additional information

2.40 The external areas around A, B, C and D wings were dirty. There was litter on the ground, items hanging out of windows and bird excrement on the walls, despite the work of a regular cleaning party. There was some graffiti on posts leading to these wings. Other external areas were better kept and more pleasant.

2.41 The internal areas were in a reasonable state of decoration, and communal areas and cells were clean, with the exception of the first night cells on A wing, which were grimy and poorly maintained. Prisoners in our groups, other than vulnerable prisoners, reported difficulties in accessing cleaning materials.

2.42 The state of showers varied; those on A, B, C and D wings, but not on E wing, had been refurbished. There were no problems with access, even on H wing, where only three showers

were in working order, for 40 men. Prisoners were positive about the in-cell shower facilities on F, G and J to M wings. There were complaints about the environment and the temperature of the older showers.

Staff-prisoner relationships

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

Additional information

2.43 Staff–prisoner relationships had deteriorated. The large influx of prisoners and new staff may have contributed to the change in the dynamic. Staff did not go out on the landings, but stayed in the offices. Although responsive to approaches by prisoners, few were seen engaging actively on association, exercise or visits. Prisoners told us that whenever they tried to talk to staff about issues that they were dissatisfied about, staff would tell them to put in a complaint, rather than engaging in a conversation with them, and we also observed this happening. Relationships between prisoners were mainly positive and the atmosphere was good humoured. Prisoners, with the exception of vulnerable prisoners, both in groups and on a one-to-one basis, were negative about staff. There was a particularly negative perception from black and minority prisoners and race representatives (see paragraph 2.85).

Further recommendations

2.44 Managers should ensure that they, and the staff for whom they are responsible, have a high profile in the residential areas.

2.45 Staff should be encouraged to engage with prisoners and discuss the reasons for decisions.

Personal officers

2.46 There should be clear management checks on the quality of staff entries in wing history sheets, and action should follow when entries are inadequate. (2.18)

Partially achieved. Prisoners' files showed evidence of management checks but these comprised simply a stamp and a signature. Only one out of the files sampled commented on the quality of the entries or flagged up any concerns where action needed to be taken.

Further recommendation

2.47 The management checks on staff entries in wing history sheets should include a comment on the quality of those entries and action taken where the quality or number of entries is inadequate.

Additional information

2.48 Prisoners knew who their personal officer was, based on cell allocation, but most had little one-to-one contact with them. There was little evidence that personal officers introduced themselves to the prisoners in their care.

2.49 Entries in wing files varied but in some cases showed a good knowledge of the individual concerned. There was evidence that prisoners' requests were dealt with appropriately by some officers. The tone of the comments was appropriate but prisoners' surnames were most commonly used in the files.

2.50 Although most personal officers contributed towards categorisation and incentives and earned privileges (IEP) reviews, there was no involvement in sentence planning or resettlement.

Further recommendations

2.51 Personal officers should introduce themselves to the prisoners in their care and meet them regularly thereafter.

2.52 Personal officers should play a key role in supporting prisoners to progress through their sentence, including following up targets around resettlement and sentence planning.

Housekeeping point

2.53 Prisoners should be referred to by their preferred name or title, both on a one-to-one basis and in wing files.

Duty of care

Bullying and violence reduction

2.54 The role of prisoner representatives in the implementation of the violence reduction strategy should be clarified. (3.9)

Achieved. The prisoner representatives had an appropriate job description. They attended the monthly safer custody meetings, were involved in the induction process and were readily identifiable. They had free movement around the prison to carry out their tasks.

2.55 The central anti-bullying record should be kept up to date. (3.10)

Achieved. The central anti-bullying record was up to date, and contained adequate information.

2.56 Intervention plans for bullies and victims should accompany the prisoner when he moves residential units. (3.11)

Achieved. Intervention plans accompanied prisoners if they were transferred to another unit, and changes of location were recorded in the documents.

2.57 There should be regular surveys of prisoners' views and experience of bullying and the results used to develop policy. (3.12)

Achieved. An annual survey of prisoners had been undertaken and the results used to inform the policy. Exit surveys were carried out daily and the results collated and analysed regularly.

2.58 There should be formal structured interventions or programmes to address bullying and reduce the risk of victimisation. (3.13)

Not achieved. There were no formal interventions or programmes to address bullying, or to prevent victimisation.
We repeat the recommendation.

Self-harm and suicide

2.59 The number of trained Listeners in the main prison should be increased. (3.23)

Achieved. There were 11 Listeners available for the main prison and three on the vulnerable prisoner units. A further 14 were undergoing training, due to finish at the end of April 2009.

2.60 The doctor should see all prisoners on an open F2052SH (self-harm monitoring form). (3.24)

No longer relevant. The assessment, care in custody and teamwork (ACCT) process, which has superseded the F2052SH documentation, provided adequate support and access to medical care when required.

2.61 The mental health in-reach team (MHIRT) and the chaplaincy should have greater involvement in the management of self-harmers. (3.25)

Partially achieved. Chaplaincy staff were regularly involved in the care of those at risk of self-harm. The mental health in-reach team was inadequately resourced for the size of the prison and was not able to become fully involved in providing support to self-harmers.

Further recommendation

2.62 The mental health in-reach team should be increased to enable adequate support to be given to those at risk of self-harm.

2.63 There should be a formal system to follow up prisoners when an F2052SH has been closed. (3.26)

Achieved. A follow-up interview was included as part of the ACCT process. Prisoners were able to give feedback on their experience of being managed under this process.

2.64 The F2052SH register should be completed fully and trends identified. (3.27)

Achieved. An electronic database, accessible to all staff, was fully maintained. A weekly report was prepared for the operational meeting, and a monthly report for the safer custody meeting. Information was analysed, discussed at the latter meeting, and trends were identified. Actions were not always identified or results of actions recorded.

2.65 Outside agencies should be consulted and involved in the ongoing care of those at risk of suicide and self-harm. (3.28)

Achieved. Various agencies were included in the care of those at risk, including CARAT, integrated drug treatment system (IDTS) and offender management unit (OMU) staff and the Samaritans. Police were informed of the release of prisoners who had self-harmed, and OMU staff contacted external probation officers.

2.66 Night staff should be issued with individual anti-ligature equipment. (3.29)

Achieved. All night staff had been issued with anti-ligature knives, and emergency response kits containing additional equipment were available on all units.

Additional information

2.67 The overall management of bullying, violence reduction and suicide and self-harm came under the remit of a member of the senior management team, supported by the safer custody team. At the time of the inspection, the safer custody team consisted of a principal officer with managerial oversight, and two part-time senior officers. The team was due to change, to comprise a full-time senior officer with full-time administrative support, with the principal officer continuing in her role.

2.68 Systems for managing those at risk were well developed. All prisoners managed through the ACCT process were given written information to explain the process, and ideas for how to cope with their feelings of self-harm. They were also offered activity packs. Staff routinely asked every such prisoner if they wished their next of kin to be informed, and contact was made with family or friends if requested. There were five open ACCT documents at the time of the inspection. These were generally of a satisfactory standard, with evidence of good observations and interactions between staff and prisoners and appropriate implementation and monitoring of care maps. All ACCT documents were quality checked by managers, and any issues raised at the safer custody meeting, with actions resulting. The co-location of the safer custody team with the first night and induction unit led to good communication and support to those deemed vulnerable.

2.69 Violence reduction procedures were managed reasonably, despite the long-term absence of a coordinator. Investigations were carried out for all identified acts of violence, and prisoners identified as bullies were managed through a four-stage system. These prisoners were monitored by staff and daily observations recorded. When evidence of further bullying was found or suspected bullying was confirmed, appropriate challenges were made and action taken.

2.70 Victims of bullying were offered support and daily observations were recorded. Some victims of bullying had been located on the segregation unit after getting themselves into serious debt and all other avenues of support had been exhausted. However, they were rarely reintegrated back onto normal location, although the bullies were. Their usual option for leaving the segregation unit was transfer to another prison. Prisoners in our groups reported feeling safe at the establishment, with the exception of vulnerable prisoners, who said that they felt unsafe on their way to and from work and visits.

Further recommendations

2.71 Victims of bullying who are located in the segregation unit should be managed back to normal location where possible.

2.72 The reasons behind vulnerable prisoners feeling unsafe on their way to work and visits should be explored and action taken to improve arrangements.

Housekeeping point

2.73 Actions to address identified trends in safer custody should be recorded in the safer custody meeting minutes.

Good practice

2.74 *All prisoners managed through the assessment, care in custody and teamwork (ACCT) process were given written information to explain the process and ideas for how to cope with their feelings of self-harm. They were also offered activity packs.*

2.75 *Staff routinely asked every prisoner subject to the ACCT process if they wished their next of kin to be informed, and contact was made with family or friends if requested.*

Diversity

2.76 The diversity policy should be rewritten to take account of the specific needs of all prisoners, and cover age, disability and sexual orientation. (3.43)

Not achieved. The diversity policy was aimed at staff, prisoners and visitors, but mainly focused on race equality and did not cover age or sexual orientation. There was a separate disability policy, which outlined the role of the disability liaison officer (DLO) and the process of assessment. The deputy governor told us that a single diversity strategy was being developed which would incorporate all the strands of diversity. A diversity committee meeting, which discussed staff and prisoner issues and monitored the implementation of the diversity action plan, was chaired by the deputy governor.
We repeat the recommendation.

2.77 The in-cell facilities available to wheelchair users should be redesigned to ensure they meet prisoners' needs. (3.44)

Not achieved. The accommodation was not compliant with the Disability Discrimination Act, and the newer accommodation was not accessible to wheelchairs. We met one prisoner using a wheelchair who told us of the difficulties he experienced at the establishment because of his disability. He was unable to use the wheelchair in his cell, as it did not fit through the door, but a reasonable adjustment had been made to the wheelchair to help him to get out of it, and rails had been fitted in his cell to assist him to get about within the cell. Other prisoners we spoke to with disabilities confirmed that they had not met with or spoken to anyone specifically about their disability, and cited accessing the exercise yard on E wing as difficult, as, although a ramp had recently been installed there, there were no hand rails for prisoners who used walking sticks.
We repeat the recommendation.

Additional information

2.78 The DLO, who was also a full-time PE instructor, did not have sufficient time to carry out his role. Newly arrived prisoners were required to complete a disability questionnaire as part of the health screening. Where appropriate, this information was sent to the DLO, the fire officer and the education department. Prisoners who required assistance during an emergency situation

were identified on a discrete board in the wing office and staff had a sound knowledge of the prisoners and their disabilities.

2.79 There was a discrepancy between the number of people identifying themselves as having a disability through the locally distributed questionnaire (65) and the number on the local inmate database (LIDS) (145). Assistant DLOs had recently been appointed on every wing. There were no facilities for older prisoners. Good promotion of race equality and diversity had taken place, including a celebration of Black History Month and Lesbian, Gay, Bisexual and Transgender Month.

Further recommendations

2.80 The disability liaison officer and assistant disability liaison officers should have sufficient time to complete their duties.

2.81 Services and facilities for older prisoners should be developed.

Race equality

2.82 Ethnic monitoring should be collated and analysed separately for the main prison and the vulnerable prisoner unit. (3.41)

Not achieved. Ethnic monitoring was recorded separately for main location prisoners and vulnerable prisoners. The ethnic breakdown of all prisoners on the two vulnerable prisoner units was clearly recorded. Ethnic monitoring data which identified possible inequalities was analysed across the whole population, but the vulnerable prisoner unit was not analysed separately.
We repeat the recommendation.

2.83 The establishment should investigate the reasons for the poor responses to our survey by black and minority ethnic prisoners. (3.42).

Not achieved. This recommendation was previously rejected by the establishment and consequently little progress had been made to address some of the poor perceptions held by black and minority ethnic prisoners. Poor perceptions continued to be expressed by these prisoners in our prisoner groups and during the course of the inspection. Black and minority ethnic prisoners said that they felt discriminated against, particularly in relation to moving on from the establishment, achieving category D status and being approved for release on temporary licence (ROTL) and home detention curfew. These prisoners considered the lack of black and minority ethnic staff to be a significant issue, further compounded by their perception that most staff lacked cultural awareness. Ninety-eight per cent of staff had completed diversity training and 75 had so far completed the 'challenge it and change it' training.
We repeat the recommendation.

Additional information

2.84 Thirty-one per cent of the prison population were from black and minority ethnic backgrounds. The full-time race equality officer (REO) and deputy were well regarded, in particular by the prisoner race representatives, but neither had received any training.

2.85 Some of the poor perceptions of black and minority ethnic prisoners were valid. There were examples in racist incident report forms (RIRFs) of staff witnessing overt racist behaviour and submitting a RIRF, rather than challenging it. Additionally, ethnic monitoring data which highlighted that action needed to be taken were either not appropriately investigated or the outcome of the investigation was not communicated to prisoners, so that they could be confident that race equality was a priority for the establishment.

2.86 A total of 175 RIRFs had been submitted in 2007/08 and 38 in the year to date. Prisoners expressed a lack of confidence in the system and felt that the outcome usually favoured the alleged perpetrator. The deputy REO told us that there had been a 49% decrease in the number of RIRFs submitted in the same period in the previous year. Although, anecdotally, this decrease was linked to serial complainants having left the establishment, this was yet to be explored and had been placed on the agenda for the next race equality action team (REAT) meeting.

2.87 Although the RIRF investigations were thorough, the letter sent to the complainant was poor, did not provide detailed feedback about the efforts made to investigate the complaint and did not reassure the complainant. In addition, actions taken against prisoners who were found to have been racist were inadequate. The forms stated that perpetrators of racist behaviour 'would be given advice and information', but no detail of what this entailed was given, nor was there any record of action subsequently taken. Similarly, when staff had failed to act on a racist incident, the forms said that they too would be given advice and information but, again, there was no detail of what this entailed or any record of it taking place.

2.88 We met 10 of the 11 prisoner race representatives, who included two traveller representatives. They all had confidence in the RIRF system and encouraged prisoners to use it. However, they too had poor perceptions about the treatment of black and minority ethnic prisoners. All of the race representatives had been trained by a member of Norwich and Norfolk Race Equality Council (NNREC) and were in the process of being trained on ethnic monitoring data. The NNREC also independently quality assured a random sample of RIRFs and assisted with impact assessments.

2.89 Ethnic monitoring data were analysed at the REAT meeting. In the minutes of successive REAT meetings between July and December 2008, it was highlighted that the number of black and minority ethnic prisoners on the enhanced level of the IEP scheme and approved for ROTL was below the expected range, and that the number submitting complaints and subject to use of force was above the expected range. Although some of these findings were investigated by appropriate senior managers, it was not always clear what the explanation was or what subsequent action was taken, if any (see sections on use of force and incentives and earned privileges).

Further recommendations

2.90 Any instances of staff reporting racist incidents but not taking action at the time should be followed up with the individuals concerned, to identify any issues and to increase their confidence in dealing with future racist incidents.

2.91 The decrease in the number of racist incident report forms (RiRFs) being submitted should be investigated.

2.92 The response to complainants following submission of RIRFs should be more detailed and give an overview of the investigation and any action taken, as well as outlining the establishment's commitment to race equality.

2.93 The race equality officer (REO) and deputy REO should receive appropriate training.

2.94 All ethnic monitoring data highlighting the need for action should be enquired into and relevant action taken. The outcome of this should be discussed at the race equality action team meeting and communicated to prisoners.

Foreign national prisoners

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

Additional information

2.95 Although the number of foreign national prisoners recorded at the establishment was 183, there were, in fact, only 146 (15%). The UK Border Agency (UKBA) took an interest in these prisoners with regard to their immigration status. The legal services officer (LSO) undertook the role of foreign nationals coordinator, with some support from the REO and deputy. Despite no formal training, he had developed provision well. UKBA involvement had increased; they visited the establishment once a month and had held a two-day conference in the month before the inspection. The Immigration Advisory Service visited every Tuesday and the Refugee Council had started to attend the establishment. These services were not sufficiently well advertised, and some foreign national prisoners were unaware of them.

2.96 A group of foreign national prisoner representatives met the LSO and the REO every two months. It was unclear who was responsible for distributing the minutes to foreign national prisoners so that they were kept up to date.

2.97 The foreign national prisoners we spoke to were aware of the role of the LSO but were concerned that notices to deport were issued very late. Those we spoke to were also concerned that the £3 PIN credit that they were given each month was not sufficient to make international telephone calls.

2.98 During the inspection, there were 11 foreign nationals held solely on immigration warrants, all of whose sentences had expired in 2009. The immigration clerk made weekly contact with the population management unit in order to keep them updated of these prisoners, so that they could be moved to immigration removal centres at the earliest opportunity.

Further recommendation

2.99 The full range of immigration services attending the prison should be advertised across the establishment, particularly on residential wings, and staff should be aware of these services.

Housekeeping point

2.100 The minutes of the bi-monthly meeting held between the foreign national representatives and the REO should be made available to all foreign national prisoners.

Applications and complaints

2.101 There should be a quality audit of responses to prisoner complaints. (3.77)

Achieved. The secretariat manager quality audited a random sample of 10% of the complaints. The checklist was thorough and included commenting on whether the complaint had been handled at the appropriate level and sufficiently thoroughly investigated, and also on the tone, timeliness and appropriateness of the response. This information was recorded and analysed at the senor management meeting. The main trend that had been highlighted was that some staff did not address prisoners by their preferred name, or address them at all, but, overall, the responses were good. Trends were monitored and analysed by ethnicity, location, subject and action taken in response. Quality assurance was good. Prisoners were asked for feedback but nothing had yet been done to analyse the results.

Additional information

2.102 Although a triplicate application system had been introduced, it was not monitored or tracked, and replies sometimes did not engage with the request being made, which caused frustration to prisoners.

Further recommendation

2.103 The application system should be monitored to ensure that staff respond to prisoners' applications and that this is done in a timely manner.

Legal services

2.104 The legal services officer should receive suitable training as soon as possible. (3.81)

Not achieved. The full-time LSO had not received training. We were told that a training course would be available in July 2009, but the LSO did not know if he would be required to attend.
We repeat the recommendation.

2.105 Suitably trained staff should be available to cover for the absence of the legal services officer. (3.82)

Not achieved. There was no cover for the LSO. As a consequence, in his absence new receptions were not seen by anyone in this regard and had no one with whom to discuss legal services provision at the establishment. The LSO was unable to see new prisoners retrospectively because of his heavy workload.
We repeat the recommendation.

Additional information

2.106 The LSO attempted to see all new receptions, either during the reception process or once located on the induction wing. Prisoners who did not have legal representation were given a list of solicitors if required. They were also asked if they planned to appeal their sentence, and details of their legal representatives were recorded where appropriate.

2.107 The library contained up-to-date copies of Prison Service Orders and the LSO could be accessed by application if necessary. We saw examples of applications being sent to the LSO which should have been dealt with by wing staff. The LSO told us that this was a regular occurrence.

Substance use

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

Additional information

2.108 The introduction of the integrated drug treatment system (IDTS) had gone well and this aspect of reducing the demand for illicit drugs and treating those in need was well integrated with the overall drug strategy (see paragraph 2.249).

2.109 Service delivery to those on the IDTS was well managed. There was a dedicated waiting room for those waiting for medication, which had CCTV cover. There had been concerns about the diversion of medication once prisoners had left the area. Treatments times had been changed to try to avoid immediate contact between those on medication and those returning to the wings from work. The problem of immediate diversion was exacerbated by the fact that prisoners on IDTS could be located anywhere in the prison.

2.110 The random mandatory drug testing positive rate quoted at the time of the inspection was low, at 4.6% in the year to date, against a target of 6%. There had been a spike in July 2008 with the increase in the prison population, but this had settled back to the pre-increase average. Even with buprenorphine-positive tests included, the figure stood at 4.8%.

Further recommendation

2.111 Support for those on the integrated drug treatment system should be concentrated in specific residential areas.

Health services

2.112 Sufficient numbers of healthcare staff should be available in the evening to ensure proper patient care. (4.47)

Partially achieved. .Although there had been an increase in staffing levels, the significant increase in prisoner numbers, their increasingly diverse medical needs and the additional healthcare locations meant that current levels did not meet the needs of prisoners. Currently, there were two trained nurses and a healthcare assistant (HCA) on duty each evening (see further recommendation 2.145).

2.113 Emergency equipment should be checked weekly and after use, and these checks should be recorded. (4.48)

Achieved. Emergency equipment was checked daily and after use, and records maintained.

2.114 The reception medical room should be refurbished urgently to ensure that infection control guidelines are met and that security systems are in place. Alternatively, the reception health screening should be moved to the main healthcare department. (4.49)

Partially achieved. The medical room in reception had been relocated to an area nearer the reception desk. The room was suitable for its use, although it did not have an alarm bell.

Further recommendation

2.115 The reception medical room should have an alarm bell installed.

2.116 There should be additional dental sessions to reduce the waiting list. (4.50)

Not achieved. There had been no increase in dental sessions, and the dental waiting list had become unmanageable (see further recommendation 2.148).

2.117 The dispensary area on E wing should be appropriately furnished and clinically clean. The stable door should be lowered to facilitate prisoners in wheelchairs, and the gated door adjusted so that it can be locked back. (4.51)

Partially achieved. The healthcare room had been completely refurbished and was suitable for its use. However, no alterations had been made to the stable door, which meant that prisoners using a wheelchair were disadvantaged when attending the hatch. We were told that the alterations had not been made because nurses were concerned about the safety issues associated with the door being lowered. However, these issues should not arise with officers supervising medication. A small reduction in the height of the stable door would allow prisoners using wheelchairs to talk to health services staff more easily and receive their medication appropriately.

Further recommendation

2.118 The stable door should be lowered to facilitate prisoners in wheelchairs, and the gated door adjusted so that it can be locked back

2.119 Generic counselling services should be available to prisoners. (4.52)

Not achieved. Mental health services were limited and unable to meet the needs of most prisoners. The Norfolk and Waveney Mental Health Partnership Trust (NWMHPT) employed one full-time registered mental health nurse (RMN) primary link mental health worker, and a part-time RMN healthcare officer (HCO) provided limited support. A psychiatrist (mainstream) held one session a week, and every two weeks a forensic psychiatrist held a session at the prison. A new mental health worker (RMN) had been recruited to deal with the more severe and enduring mental health needs of prisoners but had not yet taken up the post. Because of the high workload, the RMNs had to limit one-to-one work in order to assess as many new referrals as possible. There were no structured counselling services and there was no access to clinical psychologists. A comprehensive mental health needs assessment, which involved prisoner consultation, had been completed in March 2008 and had recognised that there should be sufficient resources in primary care teams to meet the high levels of primary mental health needs among prisoners. The findings and recommendations of this assessment had not yet been acted on.

Further recommendation

2.120 The prison should work with the PCT to ensure the introduction of a structured and appropriately resourced mental health service, including psychological and dual diagnosis support. Prisoners should have access to appropriately qualified medical and nursing staff, who should be supported by administrative staff.

2.121 Visiting consultants should have access to their patients. (4.53)

Achieved. The problem of visiting consultants having access to their patients had largely been resolved. The system for taking prisoners to the healthcare department worked well and there were no reports of significant delays in health services workers accessing their patients because of failures in the prison system.

2.122 Day care facilities should be introduced and accessible to all prisoners. (4.54)

Not achieved. There were no day care facilities for prisoners who needed such support. The change in the prison population profile had brought new challenges in managing prisoners with mental health concerns and poor coping strategies. The introduction of a well structured and resourced day care service would provide prisoners with support and guidance, as well as providing a degree of respite for residential staff.
We repeat the recommendation.

2.123 Dedicated administrative staff should be employed to carry out all administrative functions. 4.55)

Partially achieved. A full-time administrative support officer was in post. There was also funding to provide a full-time personal assistant to the head of healthcare, and a 'bank' administrator provided part-time support. However, with over 1,000 prisoners now held at the prison, additional organisational resources were needed to meet the huge burden and remove from nursing staff all general administrative functions such as filing and making healthcare appointments, so that they would be able to undertake more clinical duties, including nurse-led clinics such as smoking cessation.

Further recommendation

2.124 The requirement for administrative support should be reviewed to ensure that clinical staff only undertake necessary tasks. Their administrative duties should not detract from their primary function of providing clinical care to prisoners.

2.125 Clinical supervision should be available to all staff, including specialist nurses. (4.56)

Achieved. There was a contemporaneous clinical policy, and the head of healthcare was a qualified clinical supervisor. There were systems to support those staff wishing to participate in clinical supervision, but uptake by staff was poor.

2.126 Secondary dispensing should cease. (4.57)

Achieved. There was no evidence of secondary dispensing taking place. Some medications, particularly those provided daily in-possession, were received from the pharmacy in Henley bags, and these were properly labelled with the prisoner's name and number, and the quantity and name of the drug was clear.

2.127 Medication should be supplied from a legally valid prescription, and the in-possession policy should be reviewed. (4.58)

Partially achieved. Prescriptions were correctly written on a computer-generated prescription chart, which was signed by the GP. However, nurses transcribed the prescribed medication onto a standard prison prescription and administration chart, which was then used to record

the administration of the drug. Therefore, two charts were in use at any time and only one was legally valid. We had access to the latest draft copy of the in-possession policy, which included a patient risk assessment. Once the draft was approved by the medicines management committee, the new policy would be implemented.

Further recommendation

2.128 Only one prescription and administration chart should be in use at any time, and records of administration should be on the same chart as the prescription. The head of healthcare should ensure that nursing staff adhere to the Nursing and Midwifery Council guidelines regarding standards for medicines management.

2.129 There should be regular pharmacist input with dedicated support for the pharmacy technician. (4.59)

Partially achieved. There was no on-site pharmacist but telephone support from the senior pharmacist at HMP Norwich was available to the full-time pharmacy technician and pharmacy assistant. There were few visits by the pharmacist.

Further recommendation

2.130 The pharmacist should offer on-site support at least once a week.

2.131 The pharmacist should have professional control of the stock, and a dual labelling system should be introduced. (4.60)

Partially achieved. The pharmacist at HMP Norwich had overall professional control of stock but delegated day-to-day control of stock at Wayland to the technician. There was no dual labelling system.

Further recommendation

2.132 A dual labelling system should be introduced.

2.133 Mental health case reviews should include representatives from relevant departments, such as wing officers, where appropriate. (4.61)

Not achieved. The single-handed mental health worker was unable to carry out specific case reviews owing to the heavy caseload. However, she had established good working relationships with all other prison staff and, where appropriate, shared information about the prisoners in her care with prison staff. Mental health staff and the head of healthcare were resolute in their approach to patient confidentiality, but also recognised the need to advise other prison staff, including wing staff, about the management of individual prisoners. .
We repeat the recommendation.

2.134 The system of ensuring prisoners receive their healthcare appointment should be reviewed. (4.62)

Not achieved. The system for making healthcare appointments had not changed, and prisoners continued to complain that they waited too long to see various health professionals,

including doctors. Application forms were held on the wings, and prisoners gave completed forms to nursing staff in wing treatment rooms, placed them in a healthcare secure post box outside the main healthcare department or gave them to wing staff to send through the internal mail. The relevant appointments were made by nursing staff in the healthcare department using the computerised clinical information system, SystmOne, and the appointment list was then returned to wing offices by health services staff. It was impossible to determine where the failings were in the system, but prisoners felt that there was a fault in the whole system. The head of healthcare was currently working to establish a more auditable system which would provide wing staff with an electronic list of which prisoners needed to attend the healthcare department on any particular day.
We repeat the recommendation.

2.135 A programme of mental health awareness training for staff should be introduced. (4.63)

Not achieved. There was no formal mental health awareness training for any prison staff.
We repeat the recommendation.

Additional information

2.136 The Norfolk PCT had responsibility for commissioning health services at HMPs Wayland, Norwich and Blundeston, and a health needs assessment was currently under way. An offender health partnership board was in place and chaired by the prison governors on a rotational basis. All three prisons were undergoing a tendering process, with no clear indication yet of future providers.

2.137 Staffing levels were greatly under-resourced. Current staffing levels comprised a band 8 registered general nurse (RGN) head of healthcare, two band 7 RGNs, eight band 6 RGNs, two HCAs and an HCO RMN. All were full time, except the HCO RMN. Nursing staff had a range of experience and qualifications, including nurse prescribers and those specialised in sexual health, diabetes and asthma. The services provided were of a reasonable quality and range. The expansion of the prison, which had included an additional healthcare facility, meant that health services staff were spread across three discrete healthcare areas, which were some distance from each other.

2.138 A housekeeper was employed to manage all healthcare areas, which were all clean and tidy. The GP provision of five sessions a week from a local GP practice was inadequate for the number of prisoners held, and there was a two- to three-week wait to see a GP. The same surgery was on call until 6pm Monday to Friday, and the PCT out-of-hours service was on call at night and weekends. Nurse practitioners, who were also independent prescribers, had taken up post, but prisoners had a poor perception of their role and it was insufficiently promoted across the prison. The nurse practitioners held seven sessions each week and dealt with many conditions, although some prisoners felt uncomfortable at not always seeing a doctor. A significant number of prisoners failed to attend nurse practitioner appointments, and this was currently being monitored to determine the cause.

2.139 The healthcare department was open from 8am until 8.30pm Monday to Thursday, and from 8am until 5.30pm from Friday to Sunday, inclusive. There was a good selection of nurse-led clinics and visiting health professionals, but the nurse-led clinics were not run regularly because of staff shortages. Specialist clinics, including podiatry, physiotherapy, optician and visits from a specialist hepatitis nurse, were run regularly.

2.140 The heads of healthcare for HMPs Norwich and Wayland were working closely to develop a protocol to ensure that any prisoner needing 24-hour mental health care was transferred to

HMP Norwich without undue delay. They had a weekly on-call rota, so that decisions were made at the highest level, ensuring that patient care took priority.

2.141 Equipment was held in the main healthcare department and in the new block. However, it was extremely heavy and bulky to carry, and the logistics of the prison meant that, in an emergency, health services staff had to carry it long distances, negotiating doors, stairs and corridors, all of which was time-consuming, as well as representing a possible health and safety issue for many nurses in transporting equipment across the prison.

2.142 The Norwich Community Health and Care Trust (NCHCT) provided dental services to the prison, but no additional sessions had been introduced following the increase in prisoner numbers, and the waiting list was out of control, with prisoners waiting up to 11 months for routine treatment. Treatment was provided by one dentist and a dental nurse, and the four sessions a week made little impact on the considerable waiting list. Prisoners complaining of severe pain were seen at the next dental session, but this arrangement was manipulated by prisoners who were not in pain but had been waiting for months for routine treatment. In addition, some dental time was lost because of significant numbers of prisoners failing to attend appointments, notably from the newly built wings. It was suggested that this was due to a lack of officer escorts from these wings. Prisoners from the main wings attended during free-flow movements. There was no-out-of-hours service, although in an emergency the prisoner would be taken out to the local dental access centre.

2.143 The dental surgery had no decontamination area, even though the movement of equipment across the surgery presented a contamination risk. There was limited oral health promotion. We were told that a business case for the refurbishment of the dental surgery had been presented to the prison partnership board for its consideration. This had addressed the requirement for a new dental surgery and additional dental sessions and staff.

2.144 The pharmacy was based in the main healthcare department and open on Monday to Friday. Prisoners from A, B, C, D, G and H wings collected their medication from a hatch in the pharmacy which led out onto the main corridor. This was not always a satisfactory arrangement, as prisoners were often dissatisfied with certain aspects of their medication and behaved inappropriately towards the technician. Discipline staff were normally available to supervise the waiting queues, but prisoners remained unruly and disrespectful at times. We met the chief pharmacist and were told that there were plans to introduce a dedicated pharmacist post at Wayland. A candidate had been identified and been offered the post. The medicines management committee met monthly to discuss pharmacy provisions across all three prisons for which they were responsible. The committee were currently developing a 'pain ladder', as well as reviewing prescribing habits. Pharmacy stocks appeared appropriate and well managed, and the items we checked were in date. Medicine cabinets appeared to be in good order.

Further recommendations

2.145 A full staff skill mix review should be undertaken by the primary care trust to ensure that there are sufficient qualified and unqualified healthcare workers to deliver a health service equal to that found in the community. This should include administrative staff.

2.146 The role of nurse practitioners in the prison should be advertised to prisoners and the service they offer promoted.

2.147 The head of healthcare should request the expertise of professional emergency paramedics in determining the essential equipment needed and where it should be located, to ensure that

health services staff reach the emergency area quickly and are able to respond effectively to any medical emergency.

2.148 Healthcare managers should work with the Norwich Community Health and Care Trust to ensure that prisoners have access to dental treatment within NHS guidelines.

2.149 Healthcare managers should work with the Norwich Community Health and Care Trust to ensure that dental treatment is carried out in a surgery that is suitable for its use.

2.150 An out-of-hours dental protocol should be formalised.

2.151 The head of healthcare, cluster pharmacist and head of security should review the overall medication administration system, to ensure that prisoners receive their medication in a safe and confidential manner. Sufficient discipline staff should always supervise medication administration.

2.152 Prisoners should have the opportunity to discuss confidential matters with pharmacy staff.

Activities

Learning and skills and work activities

2.153 Individual learning plans and reviews should be used to plan and review prisoners' learning. (5.20)

Achieved. Individual learning plans were used to plan and review prisoners' learning in education and vocational training, although they varied in quality.

Further recommendation

2.154 The quality of individual learning plans should be improved.

2.155 Prisoners working in the kitchen and library should have the opportunity to gain qualifications. (5.21)

Achieved. Kitchen workers could take hospitality and catering awards, and library orderlies customer service awards.

2.156 Education and training sessions should start and finish on time. (5.22)

Partially achieved. There had been a focus on better timeliness, supported by a governor's order to reduce movement time by 50% to 15 minutes. Senior prison managers now received weekly monitoring reports. Lateness reports could lead to prisoners' IEP level being affected, although vocational staff did not always reinforce this by reporting prisoners. There were delays in the arrival and collection of prisoners, but most sessions during the inspection had prompt start and finish times.

Further recommendation

2.157 The improvements in timeliness should be built on and delays reduced further, so that activity sessions start and finish as scheduled.

2.158 The computing rooms should have sufficient space and be suitably equipped. (5.23)

Achieved. The original computing rooms in the old education block had had class numbers reduced to provide more space, and new desks and equipment, including air conditioning, had been provided. The computing rooms in the new education building were spacious, with well-resourced facilities.

2.159 There should be routine monitoring of areas of equality and diversity, in addition to race, for prisoner participation in education and training. (5.24)

Achieved. Data were collected by A4E to monitor prisoners participating in education and vocational training by race, age, disability and residential wing, using a comprehensive computerised management information system. However, the data were insufficiently analysed and used.

Further recommendation

2.160 The data collected on equality and diversity should be analysed routinely and used to inform provision and target any areas requiring action.

2.161 The library should carry additional copies of foreign language dictionaries to meet prisoner demand. (5.25)

Achieved. The library carried dictionaries in around 33 different languages, and there were good arrangements to move these between the three libraries at Wayland and obtain dictionaries in additional languages from Norfolk County Library Services to meet population needs. Librarians were aware of the changing needs of non-English-speaking prisoners.

Additional information

2.162 The role of head of learning and skills had been extended to head of regimes. The post holder was now responsible for all the prison workshops, work areas and PE, and for liaising with the education and vocational training contractor and library provider. The head of regimes chaired the learning and skills quality improvement group and was responsible for collating the prison-wide self-assessment report (SAR). The most recent SAR available was for April 2007 to March 2008 and many of its related action plan points had been completed.

2.163 The education and vocational training contract had been awarded to A4E, and was currently under review for a new four-year contract. The A4E education manager had been in post for 18 weeks and her deputy manager was responsible for managing the A4E vocational training provision.

2.164 In addition to information, advice and guidance at the prison induction given by Tribal staff, A4E staff provided a week's vocational induction programme when prisoners were allocated by the prison's allocations staff from waiting lists to training workshops. Allocations to education classes were efficiently carried out by A4E guidance staff. Further diagnostic assessments

were appropriately carried out for prisoners with literacy and numeracy needs to identify more accurately ability level for class allocation.

2.165 There were insufficient places for the population to be employed full time. Excluding those on induction, offending behaviour programmes and recreational PE, there were 770 activity places for up to 1,017 prisoners. During our roll checks, 30% of prisoners were not engaged in any purposeful activity. There were 40 full-time places in education, although full time for some was as few as six sessions a week. There were 210 part-time places in education. Including those who left work to attend two sessions a week, 521 prisoners were engaged in some form of education, the equivalent of 52% of the population taking part in education. This was a considerable improvement from the previous inspection, when only 22% of the population had been engaged in education. Education was also better linked with sentence planning, and IT was being developed to sequence better the completion of identified targets.

2.166 There were 161 full-time equivalent places in vocational training workshops and around 20% of the population could undertake some form of vocational qualification in their place of work. There were 489 work places, some of which included vocational training (the library, kitchen, cleaning party and horticulture). The vocational workshops were well resourced and accessed by around 16% of the population at any one time. Vocational training staff and peer supporters were undertaking accredited qualifications. The quality of work and vocational training was good and relevant to the labour market, but vulnerable prisoners could not access any accredited training. Literacy and numeracy, IT and English for speakers of other languages provision was good and embedded in the workshops.

2.167 There was a new multi-purpose activity building, providing an extra 115 education and 36 vocational training places. It included well-resourced, spacious classrooms, three vocational training areas, a cardiovascular gym, library and multi-faith area. Access was good, with a large lift suitable for wheelchairs. Prisoners from the main and new wings used both the original and new facilities.

2.168 Library provision had increased and three libraries were now available. The orderlies in the main libraries had access to customer service qualifications. The stock was reasonable, with a good range of audio books. Despite the good provision, we estimated that fewer than 50% of prisoners accessed the libraries each week. No spare time activities took place which might increase the relevance of the library for prisoners.

Further recommendations

2.169 The number of full-time equivalent activity places should be increased to meet the needs of the population.

2.170 There should be diagnostic assessment and learning support for prisoners who display specific learning needs, such as dyslexia.

2.171 The library services should be better promoted and the number of prisoners accessing the facilities increased.

2.172 Extracurricular activities should be introduced in the library.

Physical education and health promotion

2.173 There should be more vocational training opportunities for prisoners in physical education (PE). (5.45)

Partially achieved. Some vocational qualifications had been introduced. In 2008/09, around 10% of the population took part, and one level two gym instructors' course, seven first-aid at work courses and three diet and nutrition courses were offered. All had high pass rates. The number of courses offered was limited owing to under-staffing, as the team was short of two instructors and focused on recreational sessions which reached a larger number of prisoners. We repeat the recommendation.

Additional information

2.174 Full-time employed prisoners could access the gym five times a week and everyone else four times a week. Sixty-five per cent of prisoners accessed the gym against a target of 55%. The facilities were adequate, with the exception of the outdoor pitches. A range of remedial gym equipment was available in the new education block but prisoners complained about lack of access to toilets and showers.

2.175 An additional gym had been built by construction prisoners in the workshop area to provide more access to gym facilities for the 300 extra prisoners.

Faith and religious activity

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

Additional information

2.176 The chaplaincy coordinator was a Baptist pastor. In his team, as well as Mormon, Orthodox Christian and Jehovah's Witness faiths, the main Christian denominations were catered for. There were also chaplains available to cater for the needs of Muslim, Sikh, Jewish and Hindu prisoners. The coordinator had contacted the Pagan Society to try to ensure that a Pagan chaplain could be made available when required.

2.177 A new multi-faith facility had been established in the new development to cater for the increasing number of non-Christian prisoners. The room could accommodate up to 120 people and had purpose-built washing facilities in an adjoining room, with storage for footwear.

2.178 As well as religious services, the chaplaincy provided a range of courses, including victim awareness (the Sycamore programme), Bible and Qur'an study, living with loss, Arabic and meditation.

Time out of cell

2.179 Evening association should be extended to every weekday. (5.59)

Not achieved. For the majority of prisoners evening association took place on Monday to Thursday evenings. This meant that prisoners did not have association in the evenings on Friday, Saturday or Sunday. Enhanced prisoners on F, G and H wings received evening association seven days a week, as they had done at our previous inspection.

2.180 Sufficient staff should be deployed to outside exercise to maintain appropriate levels of supervision and control. (5.60)

Achieved. The levels of supervision for exercise were sufficient for the main exercise period before lunch, and PE staff walked around the circuit in the old accommodation with prisoners, to improve supervision. Summer evening association had not yet begun and it was this particular period which had given rise to the recommendation. We were unable to assess the levels of supervision, although we were told that staffing was always flexible, depending on the number choosing to go outside.

Additional information

2.181 Access to time out of cell was good across the prison and very good for those on F, G and H wings. It was around 10 hours a day for most prisoners, when core day times were adhered to, and a theoretical 18 hours for enhanced prisoners on F, G and H wings. Association was reliable and offered every day, although prisoners were sometimes unlocked late for the evening meal. Time in the fresh air was sometimes not available for those coming in from work if they were released late.

Housekeeping point

2.182 Prisoners should be released from work in time to access exercise during the week.

Good order

Security and rules

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

Additional information

2.183 Security department priorities were appropriately concentrated on mobile telephones and drugs, particularly the selling of medication. Security seemed commensurate with the risks identified. There had been a spike in the submission of security information reports in mid-2008, which we were told was because of a combination of new staff and increased roll.

2.184 We were also told by the security department that there was room for improvement around dynamic security and the enforcing of rules on wings. They said that there was an over-reliance on the security department to make decisions that wing staff and other disciplines could make. They also said that prisoners perceived that the prison was run by the security department because it was easier to blame unpopular decisions on the security team than to take personal responsibility.

Discipline

2.185 The adjudications meeting should sample records of adjudications to ensure that charges are adequately investigated, and to share good practice. (6.24)

Achieved. Quarterly segregation and adjudication meetings analysed trends. A sample of adjudications and all upheld appeals were also discussed at this meeting, to improve practice. One of the issues that had been identified concerned inconsistencies in punishments given within the tariff range, and examples of punishments that might have an impact on prisoners'

health, such as loss of gym, were highlighted. It was also highlighted that between September and November 2008, 85 out of 415 adjudications had been dismissed because they had taken over six weeks to complete.

Further recommendation

2.186 Adjudications should be completed expeditiously.

2.187 Prisoners should always be released from special accommodation as soon as its use is no longer justified. (6.25)

Achieved. The special accommodation had been used three times in 2009. The paperwork indicated good interaction between staff and prisoners, and that prisoners were moved from the accommodation as soon as possible.

2.188 The violence reduction and safer custody strategies should identify ways to encourage prisoners to remain on or return to normal location as an alternative to transfer out of the prison. (6.26)

Not achieved. There was no information contained in either of the strategy documents outlining that the focus should be on encouraging prisoners to remain at the establishment and return to normal location. Prisoners continued to be transferred out of the prison, particularly if they were located in the segregation unit for their own protection (see recommendation 2.5). We repeat the recommendation.

Additional information

2.189 There were 668 adjudications between December 2007 and May 2008, and this more than doubled to 1,430 between June 2008 and November 2008, following the opening of the new accommodation. This may have been because of some of the initial difficulties arising when the roll was increased and prisoners were settling into the new accommodation. The main charges concerned use of threatening, abusive and insulting words, being in possession of drugs or other contraband, and disobeying a lawful order.

2.190 There had been a significant increase in the level of force used between 2007 and 2008 (87 compared with 172). The establishment was aware of the trend following the opening of the new accommodation and influx of new staff. The 31 uses of force in 2009 to date indicated that the trend was reducing. Statistics showed that more use of force had been used against prisoners from black and minority ethnic backgrounds, and this had also been tracked (see paragraph 2.85)

2.191 The segregation unit contained 14 cells, including one for special accommodation. The unit was light and clean. All prisoners located on the unit were strip searched. During the inspection, there were nine prisoners located on the unit: five under good order or discipline, three under Rule 45 in their own interest (due to being victims of bullying) and one under Rule 53, pending an adjudication hearing. One of the prisoners had been located there since 28 February 2009, as he was the victim of bullying. Staff told us that, because he was serving an indeterminate sentence for public protection (IPP), there were difficulties in organising a transfer to another establishment.

2.192 All prisoners were allocated a personal officer once located on the unit, but wing history sheets did not demonstrate any meaningful interactions between personal officers and prisoners there. The regime included daily access to showers (although when full, this was reduced to three times a week), access to the telephone and exercise. All cells had an electricity supply and prisoners were permitted a radio and television, subject to a risk assessment and their IEP level.

2.193 The regime was particularly sparse for prisoners located on the unit for their own protection, although they could associate during exercise periods, following a risk assessment. Improving the regime for this group of prisoners had been discussed at adjudications and segregation unit meetings, but staffing implications had been highlighted as a disincentive to implement this, as was the possibility of an increase in the number of prisoners wanting to be located on the unit.

2.194 The special accommodation had some fire damage.

Further recommendations

2.195 Prisoners who are located on the segregation unit should be strip searched only if indicated by a risk assessment.

2.196 Prisoners located on the segregation unit for their own protection should have access the same regime as on main location.

Incentives and earned privileges

2.197 There should be more incentives for foreign national prisoners on enhanced status who do not receive visits. (6.33)

Not achieved. We were told by one of the residential governors, who also had the policy lead for the IEP scheme, that foreign national prisoners could send home recordings of themselves on DVDs to family members, subject to a risk assessment. However, the deputy REO, prisoner race representatives and the LSO were unaware of this arrangement, and it was not included in the foreign national prisoners policy strategy document. In addition, it did not achieve the outcome of better incentives for foreign national prisoners on enhanced.
We repeat the recommendation.

2.198 Prisoners should not be moved from enhanced to standard status without a warning. (6.34)

Achieved. The files we reviewed showed that prisoners were issued with written warnings, including the reason. These were also retained in prisoners' wing history sheets.

Additional information

2.199 The percentage of prisoners on basic, standard and enhanced levels of the IEP scheme stood at 1%, 53% and 46%, respectively. The scheme was not location based, but enhanced prisoners on G, H and F wings received longer association, had better facilities and could make snacks for themselves. Otherwise, the main differentials between levels were access to duvets, visits and games consoles.

2.200 The scheme was related more to behaviour than compliance with sentence planning targets, although some attention was paid to the achievement of targets. Black and minority ethnic prisoners were under-represented on the enhanced level of the scheme, and the reasons for this had not been sufficiently explored. During the inspection, prisoners said that they thought it was difficult to achieve enhanced status.

2.201 The policy lead for the IEP scheme had reported to the REAT in response to concerns about the under-representation of black and minority ethnic prisoners on the enhanced level of the scheme. He was unable to provide information about the number of prisoners who had arrived at the establishment with enhanced status, or identify the issues that black and minority ethnic prisoners were presenting that might have precluded them from reaching enhanced status. He cited the lack of complaints about the IEP scheme as evidence that there were no 'real' concerns.

2.202 At the time of the inspection, there were six prisoners on the basic regime. Reviews were appropriately held after seven days, and every seven days thereafter. However, the targets that prisoners were expected to achieve were not recorded or given to the prisoners in writing, so it was unclear what each of the prisoners had to do to progress, or how this was measured. There was, however, evidence that prisoners were removed from the basic regime at these reviews.

Further recommendations

2.203 The under-representation of black and minority ethnic prisoners on the enhanced level of the incentives and earned privileges (IEP) scheme should be investigated and reported back to the race equality action team, with evidence to support findings and recommendations for action.

2.204 Targets should be set for prisoners placed on the basic regime.

Services

Catering

2.205 All prisoners should be able to dine communally. (7.8)

Not achieved. All meals were served in a wing servery and prisoners ate in their cells, with the exception of a few prisoners on the enhanced wings. On the wings, there was room for prisoners to eat communally, close to the servery in most cases.
We repeat the recommendation.

2.206 Breakfast packs should be issued on the morning they are to be eaten. (7.9)

Not achieved. Breakfast packs were sent to the wings with the evening meals for distribution. The cereal was issued separately from the other contents of the pack, so that prisoners could choose not to take it. This had been introduced to reduce the amount of cereal that was discarded and had caused a problem with vermin around the residential blocks.
We repeat the recommendation.

2.207 Prisoners on F wing should be served meals on their wing. (7.10)

Not achieved. Prisoners on F wing continued to collect their meals from E wing and carry their

food back to their cells. This applied in all weathers.
We repeat the recommendation.

Additional information

2.208 The menu was on a four-week cycle and provided the opportunity for prisoners to eat a balanced and nutritious diet. The provision for cultural, religious and dietary preferences was good. The food we tasted was hot and of good quality.

2.209 Food was stored, prepared and served with utensils and equipment that were appropriate to cultural and religious sensitivities.

2.210 During the inspection, a new menu was introduced on a trial basis, replacing the option of a hot lunch with a sandwich or salad, contrary to the stated preference of prisoners in a consultation exercise. Many prisoners complained about this change. They felt that the cold meal was not sufficient and wanted the option of a hot meal at midday.

2.211 Prisoners working in the kitchens and on serveries had received appropriate training and were health checked. There were six prisoners undertaking National Vocational Qualification training in the kitchen.

Prison shop

2.212 The establishment should conclude negotiation on a contract with reliable suppliers who can cater for the needs of all prisoners. (7.18)

Achieved. The prison shop supplier was due to be changed to DHL and Booker, and the transition was scheduled for 25 May 2009, having previously been arranged for the beginning of 2009. Prisoners were consulted about the timeline of the new provider taking over and product selection. The establishment had not received a copy of the final product list with prices, so a price comparison could not be made. However, the new product list had over 370 items, compared with the existing list of fewer than 300 items. Prisoners were most negative about delays in receiving catalogue orders.

Further recommendation

2.213 Catalogue orders should be delivered within two weeks of items being ordered and paid for.

Resettlement

Strategic management of resettlement

2.214 There should be an analysis of the resettlement needs of prisoners and its results used to inform the resettlement strategy. (8.5)

Achieved. An audit of prisoner resettlement needs had been conducted in August/September 2008 and analysed to produce a report in January 2009. The report was based on a representative sample of 280 prisoners, extrapolated to the general population. It addressed the provision of programmes and services to meet the criminogenic and resettlement needs of the population. It found that the provision of thinking skills, education and accommodation

interventions was appropriate and made recommendations about redirecting substance misuse and resources for violent offenders.

2.215 The resettlement committee should have formal arrangements for partner agencies to meet each other. (8.6)

Achieved. Resettlement was managed through the reducing reoffending committee, which met bi-monthly. It was chaired by the head of reducing reoffending and included the partner agencies that provided services to the prison. These included Nacro, the Ormiston Trust, Tribal, A4E and Jobcentre Plus. Minutes of recent meetings showed that partner agencies made good use of the opportunity to meet formally. Issues for prisoners, such as linking accommodation to employment opportunities and sharing information about benefit changes, were discussed at these meetings.

Offender management and planning

2.216 The backlog of offender assessment system (OASys) assessments should be reduced as soon as possible, and the staff group involved should continue to be protected from redeployment until the backlog is cleared. (8.11)

Achieved. OASys assessments were up to date for all relevant prisoners, except for some IPP prisoners with an offender manager in the community. At the time of the inspection, there were 15 such assessments outstanding, out of a population of 91. The prison requested these assessments in a timely fashion and followed up requests effectively through the offender management unit (OMU) and the probation department. Eight officers were allocated to the OMU and they were redirected to other departments according to operational need. This varied from month to month, but the figures we saw showed that this was between 3% and 40% of their time. The fact that there was no backlog of OASys assessments demonstrated that this was acceptable.

2.217 A lifer forum should be established and life-sentenced prisoners should be given an opportunity to air their concerns. (8.19)

Achieved. The lifer forum met quarterly and was chaired by the lifer manager. The lifer clerks and probation officer offender supervisors also attended. All life-sentenced prisoners were invited, and about 30 attended. The minutes of meetings we saw showed that issues important to lifers, such as parole board delays, the backlog of lifer plans and lifer privileges, were discussed. A similar forum was established at the beginning of 2009 for IPP prisoners. Prisoners were frustrated by the lack of progress on important issues and wanted to see more positive outcomes from the meetings.

2.218 The lifer team meeting should be held quarterly. (8.20)

Achieved. Lifer team meetings were held monthly, having increased in frequency from quarterly. The meetings were chaired by the reducing reoffending governor and attended by the lifer manager, probation officer offender supervisors, psychology staff and lifer clerks. Minutes of the meetings showed that the issues raised at lifer forums were discussed, and the organisation of service delivery was prominent in the agenda.

2.219 Records relating to public protection should be objective and based on evidence. (8.72)

Achieved. When a case was allocated, the offender supervisor double checked to identify any public protection issues. Such cases were referred to the public protection manager (a senior

probation officer), who identified the critical few (those at very high risk who required regular monitoring and tracking by the committee) who needed to be referred to the inter-departmental risk management committee (IDRM). Minutes of the IDRM showed that they were identifying the crucial few cases, based on evidence.

Additional information

2.220 The OMU was organised in 'pods', corresponding to prisoners' home areas. There were four pods, each with two officers and a clerk working in them.

2.221 All prisoners serving more than 12 months (97% of the population) had an OASys sentence plan and were allocated to an offender supervisor. The files we inspected showed that these set appropriate targets and were reviewed at the specified times. Plans were prepared by OMU staff on the basis of documentary information and an interview with the prisoner. Records showed that these interviews gave prisoners the opportunity to question information and state their own views of the suitability of sentence planning targets. The quality of sentence plans for this group of prisoners was rigorously checked by offender supervisors and a further sample was checked by the head of offender management. The basic resettlement needs of the 29 prisoners serving less than 12 months were dealt with through the induction assessment.

2.222 Since the previous inspection, the lifer population at the establishment had increased from 30 to more than 90, and there were also 94 IPP prisoners. This had created greater demands on the establishment, which it struggled to meet. The main responsibility for the lifer and IPP population resided with a dedicated lifer manager at senior officer grade, line managed by the governor with responsibility for reducing reoffending. The lifer manager had been in post since October 2007 and had received no specialist training for the work. His caseload was too large.

2.223 In response to the increase in the lifer and IPP population, the lifer team had moved into the OMU and was assisted by the staff there in preparing lifer plans and IPP sentence plans. Offender supervision was provided by seconded probation officers, and support for lifer days was allocated to the resettlement manager. In spite of this extra support, there was still a backlog of lifer plans which was only now being addressed. There were 56 lifer plans which were not up to date, and the plan for completion would not be achieved until November 2009. Psychology staff now contributed to lifer plans but there was poor provision for individual work with lifers.

2.224 The lifer and IPP prisoners we met were dissatisfied with the services they received. They felt that their time at the establishment was 'dead time' because of a lack of specialist provision and a fear that progression through their sentence was being delayed. They were distributed throughout the prison, rather than in dedicated lifer and IPP wings, which they felt illustrated the absence of a dedicated approach to their needs. They were aware that staff were not specially trained, and this compounded these feelings.

2.225 One of the most pressing concerns was the delay in parole board reviews. While there was some delay in preparing dossiers, the main cause of the delay was the failure of the parole board to provide review dates. The prison was only able to service a third of the parole boards required in the year. The governor had written to the parole board, but the number of hearings for lifer and IPP prisoners was inadequate. IPP prisoners often had fairly short tariffs and many we met were without a review several months past the due date.

2.226 Public protection arrangements had improved. All new receptions were assessed for public protection issues and referred to the integrated risk management group where appropriate.

This group then conducted reviews and oversaw multi-agency public protection arrangements (MAPPA) arrangements. The inter-departmental risk management group met monthly and was chaired by the public protection manager. Membership included the OMU manager, resettlement manager, police liaison officer, and staff from the Ormiston Trust, Probation Service, counselling, assessment, referral, advice and throughcare (CARAT) team and healthcare department. The consideration of cases was relevant and focused on the action to be taken, with clear allocation of tasks.

2.227 This group also managed safeguarding children procedures. A review of files to identify previous convictions had resulted in offenders being more accurately identified on the population database and for telephone monitoring to be more carefully targeted.

2.228 Categorisation procedures were up to date and reviews were picked up automatically at the six- or 12-month stage or by application. Out of 427 reviews since 1 January 2009, only 33 had been approved for category D (8%). Prisoners waited for transfer for an average of six weeks.

Further recommendations

2.229 Staff working with lifers and prisoners serving indeterminate sentences for public protection should receive specialist training.

2.230 The prison should undertake a review which sets clear targets for the strategy, management and resourcing of services for indeterminate-sentenced prisoners in consultation with them and learning from best practice elsewhere.

Resettlement pathways

2.231 Formal discharge plans should be extended to all prisoners. (8.62)

Achieved. All prisoners were interviewed on induction by resettlement orderlies, who completed a needs analysis with them. This was collected by a resettlement officer, who made relevant referrals based on this information and passed to the OMU those who came under sentence planning arrangements. Six weeks before discharge, prisoners were interviewed to ensure that there had not been a change in circumstances or needs identified which had not been addressed.

2.232 There should be systems to ensure that prisoners suitable for resettlement release on temporary licence (ROTL) are considered and encouraged to apply. (8.63)

Partially achieved. The system for considering ROTL applications ensured that prisoners' entitlement was checked and their application considered by a monthly ROTL board. It was a reactive system, which did not seek out suitable opportunities to use ROTL as a means of enhancing resettlement, except in the case of prisoners being considered for a move to a working-out unit at Norwich. There were usually 10 to 15 applications a month, of which around four would be granted. There were opportunities to use ROTL in resettlement which were not being taken. One example was of a local employer who had visited the prison on an open day and asked to test out potential employees before release.
We repeat the recommendation.

2.233 The primary care trust (PCT), in partnership with the prison, should establish the type and level of additional resources and clinical support needed to prepare for accepting

prisoners on methadone maintenance programmes. (8.46)

Achieved. The integrated drug treatment system (IDTS) programme had been implemented approximately a year before the inspection. The Community Alcohol and Drugs Service (CADS) was responsible for the delivery of the programme, which was under regular review. The service also provided drug and alcohol support in the local community. The team comprised a band 8 CADS manager, who was an RGN, a band 7 RGN clinical lead, one band 6 RGN and one band 6 RMN. Supporting the clinical team were two non-nurse practitioners, who were undertaking pharmacy technician courses which would allow them to assist with medications; one of the practitioners was also a trained counsellor. All staff were full time, except for the RMN. A GP with a special interest in substance use supported the team. The team had integrated well into the prison and established good relationships with all departments.

2.234 The drug strategy should include a detailed local action plan and performance measures. (8.45)

Achieved. A comprehensive drug strategy document had been published in August 2008 and was due for renewal in 2009. The document contained a local action plan which included performance measures and target dates. Performance measures included mandatory drug testing (MDT) of 6% of the prison population, weekend testing and random MDT. The local action plan included monthly reviews of the drug strategy, supply reduction, voluntary drug testing (VDT), harm minimisation, resettlement and community links.

2.235 Counselling, assessment, referral, advice and throughcare service (CARATs) resources should be increased to enable the team to provide ongoing casework and reviews, and to introduce group work modules. (8.47)

Partially achieved. CARAT resources had increased significantly but it appeared that the benefits had been largely eroded because of the significant increase in the number and types of prisoners now housed at the establishment. There were no group work modules.

Further recommendation

2.236 Substance use group work modules should be introduced.

2.237 There should be a separate compliance testing compact for enhanced-status prisoners. (8.48)

Not achieved. There was no separate compliance testing compact for enhanced prisoners, despite remaining drug free being a condition for retaining enhanced status.
We repeat the recommendation.

2.238 There should be a formal analysis of prisoner need for offending behaviour programmes, and the results used to direct the number and type of programmes the prison can offer prisoners. (8.27)

Achieved. An analysis of prisoner need for offending behaviour programmes had been undertaken in 2008 and reported in early 2009. The analysis identified the programmes which were appropriate for the prison population and recommended more appropriate programmes for substance misusers and those with drink-related violence convictions. These

recommendations had been accepted by the senior management team for implementation during 2009.

2.239 Allocation to enhanced thinking skills (ETS) courses should reflect targets and objectives set in sentence plans. (8.28)

Achieved. Referrals to programmes came through OASys or CARAT plans, which had set targets according to prisoner risk and need. Prisoners who made individual applications to undertake ETS were advised that their place on a programme would be determined by whether it had been identified as a need in their sentence plan and prioritised according to their date of release. Prisoners sometimes had to wait for considerable periods before attending a programme, and often prisoners arriving more recently, but with closer release dates, would take priority and then be seen as jumping the queue.

2.240 Prisoners should be allowed to apply for family visits, whatever their incentives and earned privileges (IEP) status, and clear criteria about eligibility for family visits should be published. (3.68)

Achieved. All prisoners, irrespective of their IEP status, were allowed to apply for children and family visits. The visits were advertised and application forms made clear the route for prisoners to apply. Applications had to be supported by personal officers and security staff.

2.241 The number of visits that can take place for vulnerable prisoners should not be restricted below the capacity of the main visits room. (3.69)

No longer relevant. The visiting arrangements had changed, and vulnerable prisoners now had their visits in the main visits hall. While the move from wing-based visits had been unpopular with vulnerable prisoners, it offered better confidence with regard to public protection arrangements and gave visitors full access to the services offered by the Ormiston Trust and the independent caterer.

2.242 The governor should give written authority before any visitor is strip searched. (3.70)

Achieved. The procedures for strip searching visitors clearly stated that it could only be done with the authorisation of the duty governor. Although we were told that there had been one strip search of a visitor since the previous inspection, it was not possible to track down the paperwork for this during the inspection, so we were unable to confirm that the laid-down procedures had been used. We were not alerted to any concerns about this, either by visitors or prisoners.

Additional information

2.243 The resettlement unit was managed by a senior officer, supported by a prison officer and administrator. The team ensured that assessments of all new prisoners led to referral to appropriate services, and was also responsible for a resettlement drop-in centre based on the induction wing, which was staffed by trained prisoner orderlies. This facility offered induction interviews and provided prisoners with specific information about resettlement opportunities. It was also the location for advice clinics provided by specialist services such as Citizens Advice and accommodation providers who visited the prison. A new database to support staff to plan for resettlement had just been introduced which gave all users access to information about the involvement of individual prisoners in resettlement services.

2.244 Accommodation issues were dealt with by Nacro staff, who saw prisoners 12 weeks before release. Performance was impressive in this area, with more than 90% of prisoners being released to accommodation each month.

2.245 The Foundation Training Company provided pre-release courses for around 200 prisoners a year. This did not include vulnerable prisoners. A recently established A4E 'work-out team' also supported prisoners in preparing for and finding further training and/or employment on release. The establishment outcomes were higher in delivering prisoners into education or training against the target (32% against 10%) but lower in delivering them into employment (31.2% against 49%).

2.246 Prisoners' problems with finance and debt were addressed by the Citizens Advice service, which visited the prison monthly. Prisoners could also get advice on benefits and grants from Jobcentre Plus staff based at the prison.

2.247 Healthcare release procedures were weak and underdeveloped. There were no structured pre-release clinics but prisoners received medication before being released into the community, if needed.

2.248 The IDTS team was in the prison from 8am until 4pm every day. The team saw all new receptions during the induction course. There were 40 prisoners in the team's care at the time of the inspection, all of whom were on either methadone or buprenorphine. Methadone maintenance programmes were available, as well as help for those wishing to reduce their dependence. There was no facility for prisoners requesting secondary detoxification. Those needing such support were transferred to HMP Norwich. Methadone administration took place twice daily and there were strict measures to reduce the potential 'trading' of medication. Discipline staff searched all prisoners before administration of medicines and stayed throughout the administration period. Security measures were good, with a pupil recognition system in place, although this did not always work properly. Security measures were regularly reviewed and upgraded as necessary. Where possible, all prisoners under the care of the IDTS team were seen before release.

2.249 Phoenix Fixtures provided the CARAT service and the team comprised a team leader and 5.5 whole-time equivalent CARAT workers. An additional part-time worker was due to be employed imminently. There was one full-time administrative support worker. The limited administrative support meant that CARAT workers had to complete onerous but necessary paperwork, which reduced the time they could spend with prisoners or undertaking group work. A high number of prisoners arrived from other prisons without their CARAT paperwork, and it took considerable time to follow up missing notes. The CARAT team accepted referrals from anywhere in the prison and had a current caseload of 634 (272 active and 362 suspended). New clients were normally seen within five days and transfers in within 15 days; there were between 80 and 90 prisoners waiting to have a first assessment completed at the time of the inspection. A key performance target of 200 drug intervention records had been exceeded in December 2008. The team had failed to complete its monthly target of four group work modules owing to the burden of work, and had been financially penalised as a result. Most work with prisoners was done on a one-to-one basis, including work with alcohol users. Alcoholics Anonymous and Narcotics Anonymous held regular group meetings in the prison, but we were told by one vulnerable prisoner that Alcoholics Anonymous did not extend its support to prisoners on E and F wings. The CARAT team had excellent relationships with other prison departments, including healthcare, IDTS and accommodation agencies. Release plans were discussed with other departments, and local drug intervention programme (DIP) teams were frequent visitors to the prison. Where possible, DIP teams were encouraged to meet their clients at the prison gates on release into the community.

2.250 There was little evidence of illegal drug use at the prison, and the main concern was in relation to the 'trading' of prescribed medication. This was frequently reviewed with health services staff in an effort to maintain maximum supervision during medicine administration. The IDTS team was particularly conscientious in its efforts to prevent the passing of medication and constantly reviewed its methods of administration to ensure that this did not happen. Prisoners housed on G, H and F wings were subject to VDT as a condition of residing on these wings.

2.251 Contact with families was supported, in spite of the distance many had to travel for visits. Visits could be booked online and prisoners could book visits through the application system. Children and family visits were run every Monday. The visits room was functional but hot. Refreshments were available through an independent caterer. Work on the children and families resettlement pathway included a parenting course run by the Ormiston Trust, which also ran the visits area crèche and supervised the family days. The chaplaincy provided volunteer visitors for prisoners without contacts in the community.

2.252 There was a large programmes team in the prison, consisting of prison officers, psychology assistants and psychology trainees. Among the accredited programmes offered was anger replacement treatment, which had been run by the local Probation Service, but the arrangement was currently under review. There had been 36 commencements in the previous year. Control of violence for angry impulsive drinkers (COVAID) had had 50 commencements in the previous year but was being reviewed as a result of the needs analysis. ETS had had 140 commencements in the previous year, but there was always a waiting list; this was managed to ensure that all prisoners requiring the programme had the opportunity to complete it before release. Eight programmes of prisoners addressing substance-related offending (P-ASRO), each comprising 12 participants, had been planned. Two types of sex offender treatment programmes (SOTPs) had been run, but these were being reviewed, alongside the provision at other establishments in the area. The prison would shortly be adopting the rolling SOTP.

Further recommendations

2.253 Pre-release courses should be available for vulnerable prisoners.

2.254 The prison should provide additional administrative support to the counselling, assessment, referral, advice and throughcare (CARAT) team.

2.255 Prisoners on E and F wings should have access to Alcoholics Anonymous support.

Section 3: Summary of recommendations

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

Main recommendations

To the governor

3.1 There should be more educational and vocational training opportunities for vulnerable prisoners. (2.2)

3.2 Education, training and work spaces should be fully utilised and the number of prisoners who are unoccupied or engaged in domestic work reduced. (2.3)

3.3 Nationally recognised skills accreditation should be available to prisoners in all work areas. (2.4)

3.4 There should be a strategy for the control and protection unit (CPU) that sets out what it aims to provide and achieve for the different groups of prisoners held there. (2.5)

Recommendation

To Director General of NOMS

3.5 Cells designed for one prisoner should not be used to hold two. (2.9)

Recommendations

To the governor

Courts, escorts and transfers

3.6 All food offered to prisoners during journeys to and from the establishment should be in date. (2.14)

3.7 The escort contractor should bring prisoners' property with them on transfer. (2.15)

First days in custody

3.8 The prisoner orderly in reception should not have access to confidential information about other prisoners. (2.28)

3.9 At least two more telephones should be installed on the induction spur. (2.29)

3.10 Cells on the induction spur should be refurbished and properly cleaned for new arrivals. (2.30)

3.11 Prisoners should be seen by first night staff on a one-to-one basis on arrival, so that they have the opportunity to raise any anxieties in private at the earliest opportunity. (2.31)

3.12 When not participating in the induction programme, prisoners should be offered alternative activities to occupy their time. (2.32)

3.13 Prisoners allocated to E wing should receive the same induction programme as those on A wing. (2.33)

Residential units

3.14 All prisoners should have access to laundry facilities for their own clothes. (2.36)

3.15 Prisoners should be able to shower in private. (2.37)

3.16 Further telephones should be installed on the wings, to allow one for every 20 prisoners. (2.39)

Staff–prisoner relationships

3.17 Managers should ensure that they, and the staff for whom they are responsible, have a high profile in the residential areas. (2.44)

3.18 Staff should be encouraged to engage with prisoners and discuss the reasons for decisions. (2.45)

Personal officers

3.19 The management checks on staff entries in wing history sheets should include a comment on the quality of those entries and action taken where the quality or number of entries is inadequate. (2.47)

3.20 Personal officers should introduce themselves to those for whom they have responsibility and meet them regularly thereafter. (2.51)

3.21 Personal officers should play a key role in supporting prisoners to progress through their sentence, including following up targets around resettlement and sentence planning. (2.52)

Bullying and violence reduction

3.22 There should be formal structured interventions or programmes to address bullying and reduce the risk of victimisation. (2.58)

Self-harm and suicide

3.23 The mental health in-reach team should be increased to enable adequate support to be given to those at risk of self-harm. (2.62)

3.24 Victims of bullying who are located in the segregation unit should be managed back to normal location where possible. (2.71)

3.25 The reasons behind vulnerable prisoners feeling unsafe on their way to work and visits should be explored and action taken to improve arrangements. (2.72)

Diversity

3.26 The diversity policy should be rewritten to take account of the specific needs of all prisoners, and cover age, disability and sexual orientation. (2.76)

3.27 The in-cell facilities available to wheelchair users should be redesigned to ensure they meet prisoners' needs. (2.77)

3.28 The disability liaison officer and assistant disability liaison officers should have sufficient time to complete their duties.(2.80)

3.29 Services and facilities for older prisoners should be developed. (2.81)

Race equality

3.30 Ethnic monitoring should be collated and analysed separately for the main prison and the vulnerable prisoner unit. (2.82)

3.31 The establishment should investigate the reasons for the poor responses to our survey by black and minority ethnic prisoners. (2.83)

3.32 Any instances of staff reporting racist incidents but not taking action at the time should be followed up with the individuals concerned, to identify any issues and to increase their confidence in dealing with future racist incidents. (2.90)

3.33 The decrease in the number of racist incident report forms (RiRFs) being submitted should be investigated. (2.91)

3.34 The response to complainants following submission of RIRFs should be more detailed and give an overview of the investigation and any action taken, as well as outlining the establishment's commitment to race equality. (2.92)

3.35 The race equality officer (REO) and deputy REO should receive appropriate training. (2.93)

3.36 All ethnic monitoring data highlighting the need for action should be enquired into and relevant action taken. The outcome of this should be discussed at the race equality action team meeting and communicated to prisoners. (2.94)

Foreign national prisoners

3.37 The full range of immigration services attending the prison should be advertised across the establishment, particularly on residential wings, and staff should be aware of these services. (2.99)

Applications and complaints

3.38 The application system should be monitored to ensure that staff respond to prisoners' applications and that this is done in a timely manner. (2.103)

Legal rights

3.39 The legal services officer should receive suitable training as soon as possible. (2.104)

3.40 Suitably trained staff should be available to cover for the absence of the legal services officer. (2.105)

Substance use

3.41 Support for those on the integrated drug treatment system should be concentrated in specific residential areas. (2.111)

Health services

3.42 The reception medical room should have an alarm bell installed. (2.115)

3.43 The stable door should be lowered to facilitate prisoners in wheelchairs, and the gated door adjusted so that it can be locked back. (2.118)

3.44 The prison should work with the PCT to ensure the introduction of a structured and appropriately resourced mental health service, including psychological and dual diagnosis support. Prisoners should have access to appropriately qualified medical and nursing staff, who should be supported by administrative staff. (2.120)

3.45 Day care facilities should be introduced and accessible to all prisoners. (2.122)

3.46 The requirement for administrative support should be reviewed to ensure that clinical staff only undertake necessary tasks. Their administrative duties should not detract from their primary function of providing clinical care to prisoners. (2.124)

3.47 Only one prescription and administration chart should be in use at any time, and records of administration should be on the same chart as the prescription. The head of healthcare should ensure that nursing staff adhere to the Nursing and Midwifery Council guidelines regarding standards for medicines management. (2.128)

3.48 The pharmacist should offer on-site support at least once a week. (2.130)

3.49 A dual labelling system should be introduced. (2.132)

3.50 Mental health case reviews should include representatives from relevant departments, such as wing officers, where appropriate. (2.133)

3.51 The system of ensuring prisoners receive their healthcare appointment should be reviewed. (2.134)

3.52 A programme of mental health awareness training for staff should be introduced. (2.135)

3.53 A full staff skill mix review should be undertaken by the primary care trust to ensure that there are sufficient qualified and unqualified healthcare workers to deliver a health service equal to that found in the community. This should include administrative staff. (2.145)

3.54 The role of nurse practitioners in the prison should be advertised to prisoners and the service they offer promoted. (2.146)

3.55 The head of healthcare should request the expertise of professional emergency paramedics in determining the essential equipment needed and where it should be located, to ensure that health services staff reach the emergency area quickly and are able to respond effectively to any medical emergency. (2.147)

3.56 Healthcare managers should work with the Norwich Community Health and Care Trust to ensure that prisoners have access to dental treatment within NHS guidelines. (2.148)

3.57 Healthcare managers should work with the Norwich Community Health and Care Trust to ensure that dental treatment is carried out in a surgery that is suitable for its use. (2.149)

3.58 An out-of-hours dental protocol should be formalised. (2.150)

3.59 The head of healthcare, cluster pharmacist and head of security should review the overall medication administration system, to ensure that prisoners receive their medication in a safe and confidential manner. Sufficient discipline staff should always supervise medication administration. (2.151)

3.60 Prisoners should have the opportunity to discuss confidential matters with pharmacy staff. (2.152)

Learning and skills and work activities

3.61 The quality of individual learning plans should be improved. (2.154)

3.62 The improvements in timeliness should be built on and delays reduced further, so that activity sessions start and finish as scheduled. (2.157)

3.63 The data collected on equality and diversity should be analysed routinely and used to inform provision and target any areas requiring action. (2.160)

3.64 The number of full-time equivalent activity places should be increased to meet the needs of the population. (2.169)

3.65 There should be diagnostic assessment and learning support for prisoners who display specific learning needs, such as dyslexia. (2.170)

3.66 The library services should be better promoted and the number of prisoners accessing the facilities increased. (2.171)

3.67 Extracurricular activities should be introduced in the library. (2.172)

Physical education and health promotion

3.68 There should be more vocational training opportunities for prisoners in physical education (PE). (2.173)

Discipline

3.69 After segregation, prisoners should be encouraged to return to normal location and their return should be appropriately planned and implemented. (2.6)

3.70 Adjudications should be completed expeditiously. (2.186)

3.71 The violence reduction and safer custody strategies should identify ways to encourage prisoners to remain on or return to normal location as an alternative to transfer out of the prison. (2.188)

3.72 Prisoners who are located on the segregation unit should be strip searched only if indicated by a risk assessment. (2.195)

3.73 Prisoners located on the segregation unit for their own protection should have access the same regime as on main location. (2.196)

Incentives and earned privileges

3.74 There should be more incentives for foreign national prisoners on enhanced status who do not receive visits. (2.197)

3.75 The under-representation of black and minority ethnic prisoners on the enhanced level of the incentives and earned privileges (IEP) scheme should be investigated and reported back to the race equality action team, with evidence to support findings and recommendations for action. (2.203)

3.76 Targets should be set for prisoners placed on the basic regime. (2.204)

Catering

3.77 All prisoners should be able to dine communally. (2.205)

3.78 Breakfast packs should be issued on the morning they are to be eaten. (2.206)

3.79 Prisoners on F wing should be served meals on their wing. (2.207)

Prison shop

3.80 Catalogue orders should be delivered within two weeks of items being ordered and paid for. (2.213)

Strategic management of resettlement

3.81 The targets set locally for community reintegration should be measurable and monitored at the strategic resettlement meetings. They should also be updated annually, based on the needs of the population. (2.8)

Offender management and planning

3.82 Staff working with lifers and prisoners serving indeterminate sentences for public protection should receive specialist training. (2.229)

3.83 The prison should undertake a review which sets clear targets for the strategy, management and resourcing of services for indeterminate-sentenced prisoners in consultation with them and learning from best practice elsewhere. (2.230)

Resettlement pathways

3.84 There should be systems to ensure that prisoners suitable for resettlement release on temporary licence (ROTL) are considered and encouraged to apply. (2.232)

3.85 Substance use group work modules should be introduced. (2.236)

3.86 There should be a separate compliance testing compact for enhanced-status prisoners. (2.237)

3.87 Pre-release courses should be available for vulnerable prisoners. (2.253)

3.88 The prison should provide additional administrative support to the counselling, assessment, referral, advice and throughcare (CARAT) team. (2.254)

3.89 Prisoners on E and F wings should have access to Alcoholics Anonymous support. (2.255)

Housekeeping points

First days in custody

3.90 Up-to-date information should be provided in all the holding rooms in reception. (2.34)

3.91 The two holding rooms in reception which are in need of attention should be redecorated. (2.35)

Personal officers

3.92 Prisoners should be referred to by their preferred name or title, both on a one-to-one basis and in wing files. (2.53)

Self-harm and suicide

3.93 Actions to address identified trends in safer custody should be recorded in the safer custody meeting minutes. (2.73)

Foreign national prisoners

3.94 The minutes of the bi-monthly meeting held between the foreign national representatives and the REO should be made available to all foreign national prisoners. (2.100)

Time out of cell

3.95 Prisoners should be released from work in time to access exercise during the week. (2.182)

Good practice

Self-harm and suicide

3.96 All prisoners managed through the assessment, care in custody and teamwork (ACCT) process were given written information to explain the process and ideas for how to cope with their feelings of self-harm. They were also offered activity packs. (2.74)

3.97 Staff routinely asked every prisoner subject to the ACCT process if they wished their next of kin to be informed, and contact was made with family or friends if requested. (2.75)

Appendix I: Inspection team

Sara Snell	Team leader
Andrew Rooke	Inspector
Vinnett Pearcy	Inspector
Karen Dillon	Inspector
Bridget McEvilly	Healthcare and substance misuse inspector
Nicola Rabjohns	Healthcare and substance misuse inspector
Julia Horsman	Ofsted inspector

Appendix II: Prison population profile

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

Status	18–20 year olds	21 and over	%
Sentenced	1	904	90.4
Recall		85	8.5
Convicted unsentenced			
Remand			
Civil prisoners			
Detainees		11	1.1
Total	1	1000	100

Sentence	18–20 year olds	21 and over	%
Unsentenced			
Less than 6 months		5	0.5
6 months to less than 12 months		19	1.9
12 months to less than 2 years		76	7.6
2 years to less than 4 years	1	314	31.4
4 years to less than 10 years		370	37.0
10 years and over (not life)		30	2.0
ISPP		96	9.6
Life		90	9.0
Total	1	1000	100

Age	Number of prisoners	%
Please state minimum age	20	
Under 21 years	1	0.1
21 years to 29 years	435	43.5
30 years to 39 years	269	26.9
40 years to 49 years	201	20.1
50 years to 59 years	73	73.0
60 years to 69 years	19	1.9
70 plus years	3	0.3
Please state maximum age	76	
Total	1001	100

Nationality	18–20 year olds	21 and over	%
British	1	817	81.7
Foreign nationals		183	18.3
Total	1	1000	100

Security category	18–20 year olds	21 and over	%
Uncategorised unsentenced			
Uncategorised sentenced			
Cat A			
Cat B			
Cat C	1	979	97.9

Cat D		21	2.1
Other			
Total	1	1000	100

Ethnicity	18–20 year olds	21 and over	%
White			
British	1	628	62.8
Irish		11	1.1
Other White		50	5.0
Mixed			
White and Black Caribbean		20	2.0
White and Black African		1	0.1
White and Asian		2	0.2
Other Mixed		13	1.3
Asian or Asian British			
Indian		12	1.2
Pakistani		11	1.1
Bangladeshi		7	0.7
Other Asian		22	2.2
Black or Black British			
Caribbean		105	10.5
African		53	5.3
Other Black		35	3.5
Chinese or other ethnic group			
Chinese		7	0.7
Other ethnic group		19	1.9
Not stated		4	0.4
Total	1	1000	100

Religion	18–20 year olds	21 and over	%
Baptist		3	0.3
Church of England		288	28.8
Roman Catholic	1	164	16.4
Other Christian denominations		44	4.4
Muslim		146	14/.6
Sikh		11	1.1
Hindu		3	0.3
Buddhist		42	4.2
Jewish		5	0.5
Other		64	6.4
No religion		230	23.0
Total	1	1000	100

Sentenced prisoners only

Length of stay	18–20 year olds		21 and over	
	Number	%	Number	%
Less than 1 month			86	8.6
1 month to 3 months	1		198	19.8
3 months to 6 months			212	21.2
6 months to 1 year			269	26.9
1 year to 2 years			171	17.1
2 years to 4 years			44	4.4
4 years or more			20	2.0
Total	1		1000	100

Unsentenced prisoners only

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

Main offence	18–20 year olds	21 and over	%
Violence against the person	1	243	24.3
Sexual offences		125	12.5
Burglary		113	11.3
Robbery		118	11.8
Theft and handling		18	1.8
Fraud and forgery		20	2.0
Drugs offences		206	20.6
Other offences		129	12.9
Civil offences			
Offence not recorded / holding warrant		28	2.8
Total	1	1000	100