Report on an unannounced short follow-up inspection of

HMYOI Aylesbury

3 – 6 May 2011

by HM Chief Inspector of Prisons

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Introduction

Our last full inspection of HMYOI Aylesbury in March 2009 found that on the whole, the prison was achieving reasonably good outcomes for prisoners in most areas. Our most significant concern was prisoners' lack of opportunity to engage in purposeful activity. This short follow-up inspection found that the prison had failed to make sufficient progress in implementing our recommendations and achieving improved outcomes in any area other than resettlement. Indeed, in some areas, particularly purposeful activity, the outcomes appeared to have significantly declined.

At the time of the inspection, Aylesbury housed 437 young men aged between 18 and 21, most of whom had been convicted of serious offences and were serving long sentences. No doubt they were a challenging population to manage.

Recording of violent incidents and assaults had improved but painted a troubling picture. There had been 249 of these incidents in 2010. Figures for the first quarter of 2011 were lower but these incidents often involved the use of weapons. There had been 373 incidents where staff had used force in 2010 but again, the number of incidents had declined sharply in the first few months of 2011. The records indicated that control and restraint had been used nearly 300 times in 2010 and we were told that special accommodation had been used on a significant number of occasions although this was later disputed. Similarly batons had been drawn by staff on nearly 40 occasions over the last two years, and although used on only a few of those occasions, this was much more than we have seen elsewhere.

Arrangements to support prisoners at risk of self-harm or suicide had much improved but overall, staff relationships appeared distant. There was not a clear policy for safeguarding vulnerable prisoners. Security arrangements were generally proportionate but some rules, such as the complete prohibition on property being posted or handed in were very restrictive and rigidly enforced. Others, such as the offensive display policy, appeared to be ignored. There was no drug therapy (IDTS) system in places and we were told that four out of five suspicion drug tests were not carried out.

Accommodation standards were poor. Many cells were dirty and there was insufficient encouragement to prisoners to keep them clean. Cells designed for one were used for two and in many of these, the toilet was insufficiently screened. In single cells, the unscreened toilet was next to the bed head.

There had been reasonable progress on diversity issues. There was a monthly forum for the just under 20% of the population who were foreign nationals, many of whom had lived in the UK for a long time. The UK Border Agency held a regular forum. The prison benefitted from an active and engaged chaplaincy. Health care was reasonable but cleanliness in some areas was not of the required standards and some pharmacy practices needed to be tightened up.

There was far too little for the young men to do. Prisoners who were fully engaged with the regime could get seven or eight hours out of their cell each day but some had as little as 45 minutes to an hour. We found 44% of prisoners locked behind their cell doors during the working part of the day. A breakfast pack was served in the evening, lunch was served at the cell door and prisoners complained of being hungry. Association was not reliable and frequently cancelled. Prisoners could not have a shower every day, after work or before visits. The quantity and range of work, training and education had decreased since our last inspection. Workshop places operated well below capacity and many prison jobs did not keep prisoners fully occupied. There was no literacy, numeracy or ESOL support in vocational training or work. Gym provision was reasonable but opportunities for exercise were limited to 30 minutes a day. A new management team had been put in place by the education and vocational training contractor in January 2011 and some improvement was beginning to become evident. Some staff vacancies had been filled and some new workshop activity was planned.

Resettlement was a better picture. The reducing reoffending strategy was comprehensive but needed updating. Offender management was improving and was generally on schedule but quality assurance required improvement. Work with indeterminate sentenced prisoners was generally good. Accommodation provision was reasonable and few prisoners left the prison without somewhere settled to live. The poor levels of education, training and employment overall did not adequately prepare prisoners for getting and keeping work on release. Arrangement for visits needed improvement.

A short follow-up inspection is necessarily limited and does not provide a sufficiently comprehensive picture of a prison for us to make the firm judgements that we would in a full inspection. Nevertheless, what we saw in this inspection was a prison in which young men serving long sentences spent most of the day locked in their cells and, when they were out on the wings, too little attempt to engage them or help them develop the skills and experience they needed to get and hold down a job on release.

However, there were some signs of improvement. Levels of violence were falling and a new management team was beginning to make an improvement in learning and skills. The prison now needs some assistance to build on this and its improving resettlement work, so that young men leave the prison having received the support and direction which might help reduce the risk that they offend again.

Nick Hardwick **July 2011**
HM Chief Inspector of Prisons

Fact page

Task of the establishment
Aylesbury holds long-term sentenced young adult males aged between 18 and 21 serving from two years to life imprisonment.

Prison status (public or private, with name of contractor if private)
Public

Region/Department
South East

Number held
427

Certified normal accommodation
437

Operational capacity
444

Date of last full inspection
9-13 March 2009

Brief history
The current site opened as a county gaol in 1847 and became a women's prison in 1890. Two additional wings built in 1902 served initially as an 'inebriates' centre' and, from the mid-1930s, as a borstal for girls. In 1959, the prison was converted to accommodate adult male prisoners and its role was changed in 1961 to accommodate young men aged between 17 and 21. From 1969, Aylesbury was designated a young prisoner prison for long-term male offenders aged 17 to 21 serving sentences up to life. Since October 1989, Aylesbury has been designated a long-term young offender institution.

Description of residential units

A, B and C wings	Victorian-style radial design general wings holding 68, 68 and 63 prisoners. C wing is the induction wing as well as holding general prisoners
D wing (built 1997)	holding up to 55 general prisoners
E wing (built 1997)	long-term prisoner wing holding up to 72 general prisoners
F wing (built 1902)	'poor copers' wing and also prisoners completing the sex offender treatment programme, holding up to 48 prisoners
G wing (built 1902)	general wing, holding up to 48 general prisoners
H wing	enhanced wing, holding up to 22 prisoners

Escort contractor
Area 2

Health service commissioner and providers
HMYOI Aylesbury is the commissioner for Care UK

Learning and skills providers
The Manchester College

Section 1: Summary

Introduction

1.1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2009 and assess the progress achieved. All full inspection reports include a summary of outcomes for prisoners 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.

1.2 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. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected and giving an overall assessment against the following definitions:

Making insufficient progress
Overall progress against our recommendations has been slow or negligible and/or there is little evidence of improvements in outcomes for prisoners.

Making sufficient progress
Overall there is evidence that efforts have been made to respond to our recommendations in a way that is having a discernible positive impact on outcomes for prisoners.

Safety

1.3 At our last full inspection in 2009, we found that outcomes for prisoners against this healthy prison test were reasonably good but made 31 recommendations. At this unannounced short follow up inspection, we found that eight of the recommendations had been achieved, six partially achieved and 17 were not achieved.

1.4 Arrangements for young adults during their early days in Aylesbury had failed to improve. Too many prisoners still spent too long in reception, often in holding rooms that were of a poor standard, and many did not get their property processed on the day of their arrival. Governance arrangements around induction were underdeveloped and we were still not assured that all aspects of the induction programme were completed. Prisoners spent long periods locked up between induction sessions.

1.5 At the last inspection, we had concerns about the accurate recording of violent incidents. The prison had made good progress in this area and we were assured that incidents of violence were now captured from a variety of useful sources. The prison had carried out an anti-bullying survey but the return rate had been particularly poor. This required more effort and innovation on the part of the safer custody team. Levels of violence were high, with an increase in the use of weapons.

1.6 Progress with self-harm prevention was good, with only two recommendations not achieved. Case reviews were more meaningful, with good attendance and written contributions. Assessment, care in custody and teamwork (ACCT) documents were better managed and indicated meaningful interactions by staff with prisoners. A Listener was deployed on the first night centre to help settle new arrivals and access to a Listener at night had improved. The prison did not have any cells that met the required specification of a safer or reduced risk cell. There were plans for three cells to be converted. Prisoners requesting the dedicated Samaritans telephone were not routinely monitored by staff.

1.7 We were concerned at the last inspection by the lack of a clear policy that specified safeguards for vulnerable prisoners. Although this work was in progress, a policy had still not been implemented. Reintegration plans had been introduced for all vulnerable prisoners residing on F wing and progress had been made in allowing prisoners to move back to mainstream wings without compromising their safety.

1.8 Security arrangements appeared broadly proportionate but there remained an almost complete ban on property being handed or posted in, which was excessive. Closed visits were enforced sparingly but could still be used following a single drug dog indication in the absence of any other intelligence.

1.9 There has been limited progress towards recommendations previously made across the spectrum of issues relating to discipline. Despite some quality assurance, adjudication paperwork too often suggested insufficient exploration of circumstances and evidence before a finding of guilt.

1.10 There had been some reduction in the use of force in recent months but overall use remained high and governance arrangements required improvement. The level of baton drawing/usage was the highest we have seen and was not subject to consistent scrutiny to assure us that this was justified. Use of force documentation was not subject to any quality assurance and much was incomplete. Records did not clearly indicate how staff de-escalated incidents.

1.11 The new segregation unit was a decent living space but the exercise yards were stark. Throughput of prisoners on the unit was high and documentation authorising location was too often of a poor standard. It was unacceptable that residents could not shower daily and disappointing that the engaging staff/prisoner relationships observed were not reflected in case notes.

1.12 The integrated drug treatment system (IDTS) had been due to start in April 2011 but the IDTS nurses had still not started their duties. Prisoners with detoxification needs were diverted elsewhere. The mandatory drug testing (MDT) suite was small but reasonable, although holding rooms were small and sometimes dirty. The target MDT rate was 5% and the year-to-date figure was 4.53%. We were told that up to 80% of suspicion tests were not done due to staffing issues.

1.13 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient progress against our recommendations.

Respect

1.14 At the last inspection, we determined that outcomes for prisoners against this test were reasonably good. We made 68 recommendations. At this short follow up inspection, we found that 18 recommendations had been achieved, 13 were partially achieved and 33 had not been achieved. Three recommendations were now no longer relevant.

1.15 Although some aspects of the environment were reasonable, little improvement had been made since the last inspection, with over three-quarters of relevant recommendations not achieved. Most cells we inspected were dirty, with graffiti often evident. The offensive display policy was not effectively enforced. Access to stored property was poor, with some applications taking months to be processed. Prisoners did not routinely get a daily shower and too many limitations applied to the own clothes policy. Cells designed for one prisoner continued to hold two but adequate furniture was supplied in these cells. Toilets remained insufficiently screened.

1.16 There had been limited progress regarding the incentives and earned privileges (IEP) scheme. The differences between the standard and enhanced privilege levels remained small and those available to enhanced prisoners, such as extra time unlocked and access to own clothing, were not delivered consistently. The IEP scheme appeared broadly fair and there was evidence of progression to the enhanced level but too many staff warnings appeared petty. There was limited discretion and single incidents could lead to regression to basic. Targets, reviews and constructive engagement with those on basic were often poor.

1.17 Our observations and discussions with prisoners suggested the quality of relationships with staff remained distant. Use of preferred names or titles in addressing prisoners was not well embedded and the quality of staff entries in P-Nomis files did not suggest fully effective engagement.

1.18 Many prisoners could name their personal officer and many seemed to know a member of staff they could turn to if they required help. Regular entries in P-Nomis files were required from personal officers and a new personal officer assessment template had recently been introduced, although it was not well embedded. The quality and sophistication of personal officer work needed to develop further.

1.19 Prisoners appeared reasonably content with catering arrangements and there had been some improvement against recommendations but breakfast was still inappropriately served the evening before it was meant to be eaten. There remained no opportunities to dine in association. This was compounded further when baguette lunch meals were often served at the door to cells, which was inappropriate. The prison now operated a DHL shop service. More items were on offer, although the list still did not include fresh fruit. Arrangements for cash advances and subsequent repayment concerning those prisoners transferring to Aylesbury had improved.

1.20 Provision under diversity strands remained reasonable, with seven out of eight recommendations achieved or partially achieved. There were policies addressing all strands, although some were being updated. The diversity and race equality action team (DREAT) met bi-monthly with good attendance across the establishment. Although the proportion of staff trained in 'challenge it, change it' had increased, it was still only 65%.

1.21 There has been reasonable progress within the area of race equality. Meetings with black and minority ethnic prisoners alternated with the DREAT bi-monthly and the three recommendations in this area had been achieved or partially achieved. SMART analysis was reasonable, although further interrogation was still required. The number of racist incident report forms (RIRFs) received was still quite low and they were generally well managed. RIRF forums had been run with prisoners reviewing anonymised actual cases to help build confidence in the system.

1.22 The foreign national population had risen slightly since 2009, although there were relatively few who had not been in Britain for a number of years. The prison was now providing a monthly forum and UK Border Agency surgery for foreign nationals, although there was still no independent immigration advice available.

1.23 Prisoners displayed little confidence in either applications or complaints, stating that both processes were not expeditious. Legal visits were still available on only two mornings a week but the legal services officer was now fully trained.

1.24 The chaplaincy appeared active and engaged and access to Muslim prayers had improved.

1.25 Health care was reasonable and had made some progress with recommendations but, disappointingly, approximately two-thirds remained unachieved. The inpatient unit had been closed and young men with acute health needs were diverted elsewhere. Primary care met basic needs and nursing staff were respectful and proactive. GP services were provided by one GP. The reception health care room was dirty and untidy and there was no access to SystmOne. Dental services were improved but pharmacy services were limited to supply and basic clinical input. There was no primary mental health service, which was a significant gap for this long-term population. There was a good secondary mental health service but it could meet the needs of only a small subset of young men with some complex mental and behavioural needs.

1.26 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient progress against our recommendations.

Activity

1.27 In 2009, we concluded that outcomes for prisoners against this healthy prison test were not sufficiently good and made 22 recommendations. The findings of this short follow up inspection were that one recommendation had been achieved, five had been partially achieved and 16 had not been achieved.

1.28 In learning and skills, progress against our recommendations had been slow and negligible. Despite some recent improvements in the contracted education and vocational training provision, provided by The Manchester College (TMC), the offender learning and skills service (OLASS) contractor, the prison acknowledged that progress to remedy weaknesses had been slow and many remained. Of 17 recommendations, only one had been fully achieved. The education and vocational training offered had deteriorated greatly during 2010, with many long-term closures of activities. Some 70 vocational training places as well as education classes had been lost. Some improvement had been evident since January 2011, led by a new management team. This included some increase in the delivery of contracted education hours to 55%, from 28% of its capacity in August 2010. The college's quality assurance arrangements had been re-started but overall those across learning and skills had not been adequately reviewed since 2009.

1.29 Unemployed numbers had increased to 27% from 20% in 2009. On a roll check during the inspection, 44% (179) of the population were locked in their cells compared to 37% in 2009.

We were told that 49% of the population were in paid activities, although TMC education and vocational training provision was operating at only 55% of its capacity. Many jobs did not fully occupy prisoners during the core day, especially the 63 wing-based jobs. Work was mostly unaccredited and menial. We were told that 27% of the population participated part-time in education, training and/or work. However, less than 20 vocational training places were offered. Information for prisoners about the range of activities offered was insufficiently well coordinated and promoted.

1.30 PE staffing numbers had dropped by 38% and accredited provision had been greatly reduced since late 2010. Only 50% of the population attended weekly, similar to at the 2009 inspection, and in 2011 predominately doing recreational activities.

1.31 The library provision remained good and had greatly increased borrowing rates from around 600 items a month in 2009 to around 1300 in the same period of 2011.

1.32 Time out of cell, association and exercise were significant concerns at our last inspection and as a consequence we made seven recommendations, including two main recommendations. None had been fully implemented. Unlocked time remained limited and very poor for some. Association was limited and frequently cancelled and exercise was offered for only 30 minutes a day first thing in the morning. Slippage in the regime appeared routine. Exercise yards were bleak, some were small and none had any equipment. The evidence suggested take up of exercise by prisoners was poor. Engagement between staff and prisoners on exercise and association was usually limited.

1.33 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient progress against our recommendations.

Resettlement

1.34 At our last inspection, we reported that outcomes were reasonably good against this test. We made 38 recommendations. This short follow up inspection found that 14 recommendations had been achieved, seven had been partially achieved and 17 were not achieved.

1.35 Strategically, there has been some progress in relation to resettlement but greater integration was required. The reducing reoffending strategy document was now comprehensive and covered all aspects of provision, although it required updating with greater emphasis on development objectives. Pathway leads attended bi-monthly meetings but objectives were not routinely reviewed and some developments remained compartmentalised.

1.36 The staffing complement of offender management had been reduced but this did not appear to have had a negative impact on levels of work. Most prisoners now had an up-to-date OASys, although there was a backlog among some. Levels of contact with prisoners had generally improved but the quality of interventions varied and there was no effective quality assurance mechanism to manage this. Pre-release assessments were reasonable and links between resettlement staff and offender supervisors had improved but were still not integrated with all departments.

1.37 The number of indeterminate sentenced prisoners had reduced in the last two years and work with this population remained reasonably good. Arrangements for public protection had improved, with good inter-departmental involvement and greater responsibility taken by offender supervisors.

1.38 Accommodation provision was reasonable. Some 92% of prisoners returned to settled accommodation with virtually no one released to no fixed address. Depleted activity provision and no pre-release course were not assisting in the preparation of prisoners for release. Prisoners were seen and checked by health care during the week before release and given information about accessing health services. Prisoners subject to the care programme approach were also linked with community mental health teams. Although a money management programme was provided through education and some debt advice through resettlement staff, there was no specialist debt provision.

1.39 Access to the counselling, assessment, referral, advice and throughcare service had improved and all young men were seen during induction for an initial consultation. Building skills for recovery was being piloted and appeared to be popular and successful. Weekly Alcoholics Anonymous meetings were available for young men with alcohol problems.

1.40 There has been little development under the children and families pathway, although parenting and family learning accredited courses were offered through education and the library. There remained significant delays in processing visitors and the environment remained quite austere, with fixed, regimented seating and no children’s play area.

1.41 A good range of programmes were still provided and allocation of places was generally well managed. Developments had appropriately been based on a comprehensive needs analysis undertaken in 2010.

1.42 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 **All incidents of violence and assault should be accurately recorded through the incident reporting system. (HP47)**
Achieved. The safer custody team gathered evidence from the incident reporting system, the orderly officer daily log, alarm bell records and records of adjudications. A total of 249 violent incidents had been recorded in 2010 and 49 in the first quarter of 2011. A cross-reference of the data sources showed that all incidents were accurately recorded. This included proven adjudications for fights and assaults, which had not always been accurately recorded at the time of our last inspection.

2.2 **There should be a clear policy that specifies safeguards for vulnerable prisoners. (HP48)**
Not achieved. A specific vulnerable prisoner policy was being developed but had not yet been implemented.

2.3 **The quantity, range and quality of work, education and vocational training should be increased. (HP49)**
Not achieved. The quantity and range of work, education and vocational training had actually decreased and there were now 20 fewer places in brickwork, eight fewer in painting and decorating, 18 fewer in industrial cleaning and 24 fewer in motor vehicle mechanics. The contracted education and vocational training provided 55% of the contracted hours. There were significant staff shortages among teaching and training staff arising from sickness absences and staff resignations. This had greatly reduced the number of prisoners in sessions and had meant many long-term closures of activities. The contractor had recently appointed some new education and vocational training staff and the number of places on offer was beginning to increase.
We repeat the recommendation.

2.4 **Prisoners should spend 10 hours out of their cells on weekdays. (HP50)**
Not achieved. The amount of time prisoners could have out of their cells had hardly changed. The prison had a target of about eight hours a day but was reporting just over seven. The core day suggested that a few enhanced prisoners in full activity and who had a full session of evening association could achieve eight hours out of cell. A maximum of just over seven hours was possible for those young men who had partial evening association. However, many prisoners who were not fully engaged with the regime could have as little as between only 45 and 60 minutes out of cell each day and it was possible for some not to be unlocked at all until early evening.

2.5 **Association periods should be longer and should not be cancelled. (HP51)**
Not achieved. The situation was little changed. Evening association was scheduled from 6pm to 7.45pm but significant regime slippage meant less time was actually available. Association on weekday evenings was divided into two sessions so all prisoners not on the enhanced regime could have only about 45 minutes. Enhanced prisoners were often allowed the full session. Similar arrangements applied during daytime association on Fridays and at

weekends. Prisoners and staff said evening association was completely cancelled on each wing at least once a week.

Further recommendation

2.6 There should be a clear strategy to significantly increase the amount of time out of cell so that first, all prisoners achieve the prison's own target of eight hours a day and then, as the amount of purposeful activity increases and association becomes more reliable, move to achieving an average of ten hours a day.

2.7 **The reducing reoffending policy should cover all aspects of reducing reoffending, including the offender management unit, work with prisoners serving life sentences and indeterminate sentences for public protection, and public protection, along with the seven resettlement pathways. (HP52)**
Achieved. The reducing reoffending policy was comprehensive, covered each resettlement pathway and included offender management and public protection. Included within the policy were broad strategic objectives. The policy related to 2009-10 but many of the objectives were still relevant and the document was being updated to reflect current developments more accurately.

2.8 **There should be a clear strategy to ensure completion of missing and out-of-date offender assessment system (OASys) documents. (HP53)**
Partially achieved. Seventy-one prisoners had either an out-of-date or no OASys compared to 107 in 2009. All OASys for out-of-scope prisoners had been allocated to offender supervisors and were in the process of being completed. Some of the delays for this group were due to offender management unit staff being used to cover non-offender management duties elsewhere in the prison (see section on offender management and planning). Forty-six outstanding OASys, equal to 18% of all prisoners in scope for offender management phase 2 and 3 and a slight improvement on the 68 in 2009, were the responsibility of community-based offender managers. The prison had recently agreed a strategy to manage outstanding reports from offender managers through the area office to add weight to approaches to probation areas but this had not yet formally been written up and it was too early to see any significant impact.
We repeat the recommendation.

Recommendations

First days in custody

2.9 **Reception should be staffed to receive, process and locate new arrivals on to the induction unit without delay. (1.15)**
Not achieved. On average, there were six pre-planned new arrivals each week. Prisoners and staff said many of these arrived around lunchtime when reception was not staffed, although they were no longer routinely held on vehicles until staff returned from their lunch break. Reception was profiled to be staffed only until 5.30pm, when staff said they were deployed to other areas of the prison, which impacted on those prisoners who arrived late in the afternoon. It usually took about two hours to process each prisoner through reception, which was too long and acknowledged as such.
We repeat the recommendation.

2.10 **Conditions in all reception holding rooms should be improved. (1.16)**
Not achieved. Holding rooms were reasonably decorated with almost no graffiti but they remained stark and unwelcoming. Rooms were cold, contained no relevant notices and only limited reading material and there were no televisions to keep prisoners occupied.
We repeat the recommendation.

2.11 **Initial risk assessments and safety screening should be carried out with sensitivity and privately in appropriate surroundings. (1.17)**
Not achieved. Procedures were little changed. Staff spoke to prisoners at the main reception desk, which allowed limited privacy and was an inappropriate location for such an interview.
We repeat the recommendation.

2.12 **Prisoners' property should be processed on the day of their arrival. (1.18)**
Not achieved. Many prisoners described delays in receiving their property after arrival. Staff said they tried to process property on the actual day of arrival but that this was often not possible. Most property was processed within 24 hours, although a few prisoners experienced longer delays.
We repeat the recommendation.

2.13 **All new arrivals should receive all elements of the induction programme and attend all scheduled sessions. (1.19)**
Not achieved. Prisoners in groups said induction often lasted longer than the specified two weeks and many did not know whether they had completed the full induction programme. The records we looked at were incomplete, had not been signed off and gave no assurance that prisoners completed all sessions of the published induction timetable.
We repeat the recommendation.

2.14 **Prisoners on induction should not be locked in their cells during the core day. (1.20)**
Not achieved. Staff and prisoners said prisoners on induction were usually locked in their cells when not attending a session of the programme. Eighteen prisoners were undergoing induction during the inspection but on one day we found 15 locked in their cells and the three who were out at a session were returned to their cells by 10am.
We repeat the recommendation.

Accommodation and facilities

2.15 **Cells designed to hold one prisoner should not be used to hold two. (2.19)**
Not achieved. Cells designed to hold one prisoner were still used to hold two.
We repeat the recommendation.

2.16 **All double cells should have sufficient furniture for both occupants. (2.20)**
Achieved. Every double cell contained two cabinets, chairs and tables and all furniture was in a good state of repair.

2.17 **All in-cell toilets should be properly screened. (2.21)**
Not achieved. Most cells had insufficient or no screening around the toilet and most toilets in single cells were close to the bed head. Some cells had a stable door around the toilet and only a small minority of double cells had a separate en-suite toilet.
We repeat the recommendation.

2.18 **The published offensive displays policy should be consistently enforced. (2.22)**
Not achieved. The offensive display policy prohibited pictures of naked or partially naked people but such pictures were clearly displayed on all wings and prisoners said they had never

been challenged by staff to remove them.
We repeat the recommendation.

2.19 **All prisoners should have the opportunity to wear their own clothes. (2.23)**
Not achieved. Prisoners on the enhanced regime could buy four T-shirts and a pair of jeans from the prison shop but these could be worn only on the wing or during a domestic visit. Most prisoners we spoke to said these were too expensive and family and friends were not allowed to send such items in. All prisoners we saw were wearing prison-issue clothes.
We repeat the recommendation.

2.20 **All prisoners should be able to access their stored property within one week of making an application. (2.24)**
Not achieved. Each wing had a designated weekly time when prisoners could collect stored property from reception but prisoners said it usually took weeks and sometimes months for their stored property to be issued to them and we saw applications for access to stored property that were 12 weeks overdue.
We repeat the recommendation.

2.21 **Communal showers should be fitted with privacy screens, maintained in good condition and be well ventilated. (2.25)**
Partially achieved. A fan had been installed in the shower area on A wing that had previously been poorly ventilated but one area was still affected. Showers on A, F, G and H wings had semi partitions but this did not allow enough privacy and prisoners using the showers could clearly see each other. C wing had individual showers but some of the stable doors were broken and left a gap in the middle so prisoners using the showers could be seen from the windows. B, D and E wings had individual shower cubicles that allowed adequate privacy and decency.
We repeat the recommendation.

2.22 **Prisoners should be able to shower daily and immediately after work and before visits. (2.26)**
Not achieved. Prisoners could shower during association, with basic prisoners allowed a shower during the day. The limited number of shower cubicles meant not every prisoner could shower during association and association was often cancelled. Prisoners said showers after work or before a visit were rarely allowed and staff said staffing levels often meant they could not be offered.
We repeat the recommendation.

2.23 **Staff should encourage all prisoners to keep their cells clean and should record such encouragement in wing files. (2.27)**
Not achieved. Many cells were dirty and had graffiti on the walls. Prisoners said staff did not encourage them to keep their cells clean. No entries on P-Nomis indicated that staff had challenged prisoners about dirty or messy cells and staff said they did not routinely carry out cells inspections.
We repeat the recommendation.

Staff-prisoner relationships

2.24 **Staff should address prisoners by their preferred name or title. (2.33)**
Not achieved. We heard a few staff refer to prisoners by their preferred name and first names were occasionally used in documents but this was quite rare and not well embedded. Most prisoners we spoke to said they were addressed by surname alone and it was clear that too

many staff lacked the confidence to address others in a respectful and normal manner.
We repeat the recommendation.

2.25 **There should be management checks to assess the quality of staff record keeping and encourage a more meaningful staff engagement with prisoners. (2.34)**
Not achieved. Wing managers were required to make regular checks of P-Nomis files using a simple daily calendar recorded on wing briefing sheets. Comments and the quality of checks varied from wing to wing and manager to manager. Overall, however, what we read in wing files and saw and heard during the inspection indicated that these checks had not resulted in any discernable improvement in the quality of prisoner engagement. There were some examples of good engagement but the distant relationships evident in 2009 persisted. Prisoners had mixed views about staff and many said they were not respectful.
We repeat the recommendation.

Personal officers

2.26 **Personal officers should evidence in weekly wing file entries that the information about prisoners obtained during the introductory interview forms the basis of future interactions and engagement. (2.42)**
Not achieved. An aspirational personal officer policy defined what was required of personal officers, including an initial interview and two subsequent entries in P-Nomis every month. A computerised assessment document had been introduced the previous month and was beginning to be used on the induction wing but staff on other wings were less clear about its use. Entries in P-Nomis files were reasonably regular but, as in 2009, many related mainly to warnings and the incentives and earned privileges (IEP) scheme, with few reflecting more rounded relationships or systematic follow-up of information obtained at the initial interview. Management checks were reasonably systematic but their quality and effectiveness varied. The personal officer scheme appeared reasonably well promoted. Many prisoners could name their personal officer and most said there were staff they could turn to if they needed help.
We repeat the recommendation.

Bullying and violence reduction

2.27 **The safer custody team should have administrative support. (3.12)**
Partially achieved. The safer custody team was now supported by a part-time administration officer who worked 15 hours a week in the afternoons. However, safer custody staff said they still completed some administration tasks themselves.

2.28 **The safer custody team should provide targeted training to improve the quality of anti-bullying monitoring. (3.13)**
Not achieved. No training on the previous monitoring system had been delivered. A new monitoring system based on personal intervention plans (PIPs) had been introduced in April 2011 and plans to develop and deliver a new training package had not yet come to fruition. Many PIPs contained perfunctory daily observations such as ‘no issues’ or ‘no concerns’.
We repeat the recommendation.

2.29 **There should be annual anti-bullying surveys, which include questions on where and when prisoners feel at risk, and an analysis of the findings should be presented to the safer custody meeting. (3.14)**
Not achieved. A survey undertaken in the latter part of 2010 had generated only six replies from prisoners and the prison had not fully investigated how this could be improved. The survey had been in the form of a quiz and did not ask where or when prisoners felt at risk.

There had been 249 assaults and fights in 2010. Figures for the first quarter of 2011 were lower than compared to the first quarter of 2010 but incidents often involved use of weapons. **We repeat the recommendation.**

Vulnerable prisoners

2.30 **All prisoners on F wing should have regular reviews and reintegration plans. (3.96)**
Achieved. Most prisoners on F wing were sex offenders who were required to undertake the sex offender treatment programme (SOTP). Those who had completed the SOTP were risk assessed for reintegration on another wing and regular reviews were held until such a move was deemed appropriate. Those who were not sex offenders were risk assessed on arrival on F wing with regular reviews for possible reintegration. In the previous six months, about 15 prisoners had been successfully reintegrated into the main prison.

Self-harm and suicide

2.31 **Assessment, care in custody and teamwork (ACCT) documents should not be closed by a single member of staff. (3.27)**
Achieved. All the closed ACCT documents we looked at indicated that at least two and sometimes three staff and the prisoner concerned had been present at the case review when the decision to close had been made.

2.32 **Staff who cannot attend an ACCT case review should send a replacement or provide a written report. (3.28)**
Achieved. The open and closed ACCT documents we looked at indicated that case reviews were generally well attended, with replacements sent when required. There were also examples where staff who could not attend reviews sent a written report.

2.33 **Monitoring entries in ACCT documents should, wherever possible, provide evidence of positive engagement by staff. (3.29)**
Achieved. All ACCT documents we looked at indicated that staff interacted positively with prisoners in crisis, including talking about domestic visits, sporting events and the prisoner's general well being.

2.34 **A Listener should see each new arrival on their first day in reception or on the first night unit. (3.30)**
Achieved. A Listener worked on the first night and induction wing and saw all new arrivals.

2.35 **Prisoners should have access to Listeners at night. (3.31)**
Achieved. Listeners worked on a night time rota and records showed that any prisoner requesting a Listener during the night was moved to the crisis suite on H wing where he was supported by two Listeners for as long as required.

2.36 **The names and locations of Listeners should be prominently publicised on all wings. (3.32)**
Partially achieved. Listeners' names and location were not displayed prominently on all wings and no photographs were provided. Listeners wore easily identifiable sweatshirts and a list of trained Listeners was available to all staff on the electronic system.

2.37 **Staff should routinely check on the welfare of prisoners who request the Samaritans telephone (3.33)**
Not achieved. Staff were meant to make a note in the observation book whenever a prisoner

had been issued with the Samaritans telephone and check on the welfare of the prisoner concerned but there was no systematic check to ensure this happened routinely.
We repeat the recommendation.

2.38 **Some cells should be upgraded to meet the specification of a safer or reduced risk cell. (3.34)**
Not achieved. None of the cells met the specification of a safer cell. There were plans to upgrade cells on the first night and vulnerable prisoner wings and on the mainstream D wing.
We repeat the recommendation.

Applications and complaints

2.39 **Residential staff should be more active in helping prisoners pursue the outcome of simple applications and formal complaints. (3.77)**
Partially achieved. Prisoners said many staff tried to solve issues informally before they became applications or formal complaints and, if they did progress to this point, staff usually helped them pursue the outcome. However, they also said applications and complaints still took a long time to be answered and many lacked confidence in the processes.

Legal rights

2.40 **All legal services officers should receive appropriate training. (3.81)**
Achieved. The two staff designated to undertake legal services were fully trained. Prisoners described the service as perfunctory and said many issues were dealt with simply by issuing a solicitor's letter. They also said applications to see a legal services officer were not dealt with quickly.

2.41 **Legal visits should be available on afternoons when social visits do not take place. (3.82)**
Not achieved. Legal visits took place only on Tuesday and Friday mornings and there were no plans to introduce afternoon legal visits.
We repeat the recommendation.

Substance use

2.42 **All prisoners should have access to smoking cessation clinics without undue delay. (3.90)**
Achieved. There was a weekly smoking cessation clinic and six young men were on the programme. Young men were assessed at the first session and then attended for 15 minutes once a week for eight weeks to get nicotine replacement patches. Replacement patches were issued when empty boxes were returned. The one young man on the waiting list had been waiting 23 weeks but this was an unusual case due to other priorities for him and his choice to delay starting. Young men in paid employment did not get paid if they attended sessions, which acted as a disincentive.

2.43 **The mandatory drug testing suite should be refurbished, and an additional holding room provided. (3.91)**
Not achieved. The mandatory drug testing (MDT) room was small but in reasonable condition. The testing toilet was appropriately screened but it and the hand basin were very dirty. Cleaning was done by the MDT officers. The one small holding room adjacent to the testing room was in reasonable order but the floor and basin were dirty. Approximately 80% of suspicion tests were not carried out due to staffing capacity to comply with the timescales

required.
We repeat the recommendation.

Race equality

2.44 **There should be a strategy to address the perceptions of unfair treatment among black and minority ethnic prisoners. (3.53)**
Partially achieved. The prison had separate policies covering race equality, sexual orientation, disability and foreign nationals. The race equality policy did not outline how the prison aimed to address negative perceptions among black and minority ethnic prisoners and no specific actions were detailed in the race equality action plan. Despite this, some work had been undertaken to develop more positive perceptions and to increase confidence in prison systems. The full-time diversity/race equality manager and the coordinating chaplain had introduced racist incident report form (RIRF) forums to evaluate incidents and subsequent investigations with groups of black and minority ethnic prisoners using anonymised documents. There was some evidence of increased confidence in the process, with the number of RIRFs submitted increasing from 49 in the whole of 2010 to 47 to date in 2011. All wings also had race equality prisoner representatives who attended the bi-monthly diversity and race equality action team (DREAT) meetings and met as a group with the diversity manager and other senior managers on alternate months. Prisoners we spoke to expressed reasonable confidence in the prison's management of race and diversity.

2.45 SMART monitoring took place monthly and included both statutory and locally agreed dimensions. Black and minority ethnic prisoners were still over or under represented in a number of areas, including being over represented in the number of prisoners on the basic incentives and earned privileges level and under represented in the number of prisoners on the enhanced level. They were also fairly consistently either above range or on the cusp of the anticipated range for prisoners held in segregation. DREAT investigations into this indicated that black and minority ethnic prisoners were more likely to be involved in fights and assaults but no work had yet been undertaken to understand why this might be the case.
We repeat the recommendation.

2.46 **Reports of racist incidents should be fully investigated and pursued to their conclusion following examination of all evidence. (3.54)**
Achieved. All 35 RIRFs that we examined from the previous six months had been appropriately investigated and signed off by the governing governor. Where necessary, further actions had been implemented, including a staff member completing the 'challenge it, change it' diversity training.

2.47 **All staff, particularly in prisoner contact roles, should receive up-to-date diversity training. (3.55)**
Partially achieved. Sixty-two per cent of staff, including all members of the DREAT, had completed the 'challenge it, change it' training but this was still too low given that 53% of Aylesbury's population were from black and minority ethnic backgrounds. The prison could not tell us what proportion of staff in prisoner contact roles had received this training.
We repeat the recommendation.

Religion

2.48 **Provision for Muslim prayers should be adequate for the number of prisoners wishing to attend. (5.45)**
Achieved. Provision and support within the chaplaincy was generally good. An extensive

range of faith and non-faith support was available and the two full-time chaplaincy staff were active members of the prison community. Although the number able to attend any service regardless of denomination was limited to 60, the chaplaincy could offer multiple services, including Friday prayers, to meet need.

Foreign nationals

2.49 **There should be a distinct foreign national prisoners' policy with clear objectives and targets. (3.67)**
Partially achieved. The foreign national policy dated April 2010 was appropriately detailed and comprehensive but there were no specific development objectives for this group.
We repeat the recommendation.

2.50 **There should be a specific foreign nationals committee, chaired by a senior manager. (3.68)**
Not achieved. Foreign national issues were still incorporated in DREAT meetings. A monthly surgery for foreign national prisoners was attended by a representative of the UK Border Agency (UKBA) but there was no specific management committee. Foreign national prisoners made up 19% of the population. We were told that most had lived in the UK for many years and usually the only significant concern was their immigration status. One prisoner was being held solely on an IS91 authority to detain.
We repeat the recommendation.

2.51 **There should be a foreign nationals training plan for staff. (3.69)**
Achieved. The UKBA representative who attended monthly (see above) had also produced guidance for staff and delivered brief training sessions for them. We were told that all senior officers had received this training initially and that subsequent training sessions had been delivered as required.

2.52 **The establishment should invite an independent immigration advisory service to visit the prison to provide information and advocacy for foreign national prisoners. (3.70)**
Not achieved. We were told that the detention advice service (DAS) had been contacted but that funding limitations meant that it had not yet been able to offer support to prisoners at Aylesbury.
We repeat the recommendation.

2.53 **The foreign national prisoner survey should take place every six months, and there should be an action plan to deal with the issues raised, which is monitored by the foreign nationals committee. (3.71)**
Partially achieved. All foreign national prisoners were asked to complete a basic questionnaire on arrival. Most questions related to individual issues, particularly linked to immigration. This information was not collated to develop an overview of need. A more general survey undertaken in 2010 had generated only five responses and the exercise was being repeated during the inspection.

Health services

2.54 **All health care accommodation, including the meeting room, should be for the exclusive use of health care staff. (4.53)**
Partially achieved. Health care was based in a separate unit in the central prison area and all but one of the rooms was for the exclusive use of health care services. One office was still used by one of the governors, which was inappropriate. A multipurpose meeting room on the

second floor above health care was available for health care meetings and training.
We repeat the recommendation.

2.55 **There should be regular professional cleaning of the health care department so that standards of cleanliness meet NHS requirements for infection control. (4.54)**
Partially achieved. A civilian cleaner had recently started and cleaned daily on weekdays but there were no cleaning schedules to ensure compliance with NHS infection control standards. A prison cleaner cleaned the non-clinical areas daily and used prison cleaning schedules.
We repeat the recommendation.

2.56 **Unless the existence of the current inpatient unit can be justified, this facility should be closed. (4.55)**
Achieved. The inpatient unit had been closed for about a year. A cell on the second floor of H wing could be used if a young man returned from hospital and needed additional attention and access to staff for the first few days. Staff said care would primarily be the responsibility of the Prison Service but that the proximity to H wing meant there was easier access to primary care nurses during the day.

2.57 **Administrative support for the health care department should be increased as a matter of urgency. (4.56)**
Achieved. A full-time administrator was now responsible for scheduling internal clinics but nursing staff still arranged external appointments. The complement of band 5 staff nurses in post was reduced by 50% and we were told this had been the case for the previous year despite frequent efforts to recruit. Nursing staff were therefore overstretched with potential risk to services.

2.58 **An electronic clinical information system should be introduced as soon as possible. (4.57)**
Achieved. SystmOne had been in place for a year and was well used. All health care professionals recorded on the system and paper medical records were used only for reference to previous history. Recording appeared accurate, appropriate and timely. There were no care plans.

2.59 **Clinical supervision should be introduced and protected time given to staff to allow their participation. (4.58)**
Not achieved. There was a clinical supervision policy but no formal supervision arrangements, although we were told that staff could raise any issues at a daily debrief meeting. There was one GP supported by a second GP who worked across three prisons and provided cover for leave. We saw the GP having some difficulty communicating with a young man who was clearly anxious about his health. While the clinical diagnostic approach was appropriate, the style of consultation did not deal effectively with his concerns or anxieties.
We repeat the recommendation.

2.60 **A dedicated discipline officer should be deployed to assist health care functions and improve overall patient care. (4.59)**
Not achieved. A discipline officer was allocated daily to health care but was not dedicated so individual officers did not know the routine and there was no continuity for health care staff. We saw an officer standing in the doorway of the dental suite while a prisoner was undergoing treatment even though there was no specific risk. We understood this happened regularly and that other non-health care staff sometimes entered consulting rooms during appointments.
We repeat the recommendation.

2.61 **Health professional entries in clinical records should meet professional guidelines, and the name and designation of all health professionals should be legible. (4.60)**
Achieved. All health care professionals, including the dentist, used SystmOne so names and designations were clearly recorded. Entries were clinically appropriate, respectful and accurate. We did not see the paper records that were also used by the dentist and the mental health in-reach team.

2.62 **Old clinical records should be stored appropriately and only accessible to health care staff. (4.61)**
Achieved. All old paper medical records were stored in catalogued filing cabinets in a locked room. Only health care staff had keys to the room.

2.63 **There should be a health forum for prisoners to meet with senior clinical managers and discuss health services. (4.62)**
Partially achieved. Prisoner health representatives could ask questions and raise concerns about health care during a dedicated slot at the beginning of quarterly clinical governance meetings. Minutes of the meeting in February 2011 indicated that they had been told about the meeting only that morning but had still been able to raise several concerns.
We repeat the recommendation.

2.64 **Health clinics on wings should be restored to facilitate health promotion. (4.63)**
No longer relevant. No clinics were held on the wings and all health care apart from supervised medication took place in the health care unit. Some health promotion material was displayed in the health care waiting room and in some other areas of the prison. All young men were offered a Well Man clinic appointment during induction but it was not clear how many took this up.

2.65 **The bathroom area in the inpatient unit should not be used until it has been refurbished. (4.64)**
No longer relevant. The inpatient unit had been closed.

2.66 **The health care reception room should be refurbished to include hand washing facilities and an alarm bell, and it should be cleaned regularly. (4.65)**
Not achieved. The small health care room in reception was grim, uninviting, very untidy and dirty. There were no hand washing facilities and no panic alarm. There was also no SystmOne computer even though electronic records had been in use for about a year so nurses had to record reception screenings on paper before transferring the information to the electronic system. A new health care room not yet in use was clean and contained a hand basin but no panic alarm, telephone or signs of cabling for SystmOne. Both rooms were away from the main reception desk so nurses were often isolated from discipline staff and had no means of raising an alarm.
We repeat the recommendation.

2.67 **Triage algorithms should be used to ensure consistency of advice and treatment. (4.66)**
Partially achieved. The Manchester triage algorithms were used but were accessed using a book kept in the main office, so new or temporary nurses might not know where to find them when seeing a patient.
We repeat the recommendation.

2.68 **The number of prisoners failing to attend health care appointments should be recorded and monitored. (4.67)**
Achieved. The number of prisoners failing to attend health care for the various clinics was recorded and reported regularly. A survey had been undertaken to identify why young men did

not attend and, although there had been few responses, there was a consistent theme of young men not being informed about their appointments in time to attend. This was partly attributed to delays in the internal mail.

2.69 **Additional dental sessions should be introduced to reduce the waiting list. (4.68)**
Achieved. No regular additional sessions had been introduced but better specialist triage and management of appointments had reduced waiting times. Young men now waited up to five weeks for a first non-urgent assessment and up to 16 weeks for first treatment. Treatment programmes were completed sequentially as required. Young men could access the full range of NHS treatment as in the community. A tender process with a new specification was under way.

2.70 **The primary care trust should commission a decontamination survey and provide a washer disinfector. (4.69)**
Not achieved. No decontamination survey had been carried out and there was no washer disinfector.
We repeat the recommendation.

2.71 **The dental surgery should be refurbished to improve cross-infection controls and reduce clutter. (4.70)**
Achieved. The dental room was in reasonable order and tidy. There was good separation between clean and dirty areas and an autoclave for sterilising reusable instruments. There were plans to refurbish another room in health care as the dental suite with an adjacent separate contaminated instrument/cleaning room.

2.72 **The service level agreement with the pharmacy provider should include counselling sessions, pharmacist-led clinics, clinical audit and medication review. (4.71)**
Not achieved. The pharmacy service did not include clinics or counselling and it was not clear whether the pharmacist carried out audits or prescribing reviews. The pharmacy contract was due for retender and we were told that the specification included medication review and clinical audit. An appropriate prescribing audit carried out by a GP and the lead nurse for Care UK in November 2010 showed nurses were not routinely documenting the rationale for administering over-the-counter medicines. Diagnosis was not always recorded on the prescription charts. There was no local formulary.

2.73 **The pharmacist should make monthly visits to the prison to check the systems in operation, including professional control of the stock supplied and checks of faxed prescriptions against the originals. (4.72)**
Partially achieved. The pharmacist visited monthly and said he checked for missed doses, missing diagnoses, unusual prescribing and cost issues. A large amount of stock medicines in the cupboards was not in current use. We were told there was a special sick-type policy against which nurses could administer but were not given a copy. It was not clear whether faxed prescription charts were cross-checked against the originals. The controlled drug book showed several medications not currently in use and where the stock balance had not been checked for some time.
We repeat the recommendation.

2.74 **When a dual-labelled pre-pack is dispensed against a prescription, the chart should be faxed to the pharmacy for the pharmacist to check that the prescription was appropriate and the correct item supplied. (4.73)**
Not achieved. Most medication was for named patients. There was no dual labelling system in place and it was unclear how nurses could therefore administer appropriately from stock

medicines.
We repeat the recommendation.

2.75 **Secondary dispensing of daily medication by nursing staff should stop immediately. Daily medication should be dispensed by the pharmacy supplier in appropriately labelled containers for staff to administer directly to patients. (4.74)**
Not achieved. Nurses were routinely dividing blister packs of medication and putting them into Henley bags for administration on the wings, which constituted secondary dispensing and presented a risk of error. It also probably meant young men did not receive a patient information leaflet with their medication.
We repeat the recommendation.

2.76 **The administration of medication on the wings should take place in conditions of confidentiality and security. (4.75)**
Not achieved. Nurses took medication to the wings three times a day. They administered from a locked box either in a wing office or at the cell door or, if necessary, by the officers calling individual prisoners to collect their medication while other prisoners were clustered around. This did not allow for privacy or patient confidentiality. Up to 22 young men required medication in the evening, which was the busiest round. Medication administration by one nurse going to all the relevant wings took far too long and was an ineffective use of their time.
We repeat the recommendation.

2.77 **The medicines and therapeutics committee should formally review all procedures and policies to ensure they cover all aspects of the pharmacy service, and all staff should read and sign the agreed procedures. (4.76)**
Not achieved. The medicines and therapeutics committee minutes for February and April 2011 included no evidence of policy review or formulation and other policies had not been reviewed since 2008. We did not see any signature sheets indicating that nurses had read and accepted the policies.
We repeat the recommendation.

2.78 **The medicines and therapeutics committee should revise the special sick policy to enable the supply of all appropriate medicines. (4.77)**
Not achieved. We were told there was a policy but staff could not locate it.
We repeat the recommendation.

2.79 **Paracetamol soluble tablets for supply under the special sick policy should be stored appropriately in medicine cupboards. (4.78)**
Not achieved. Stock soluble paracetamol was kept in the main office in a locked filing cabinet. Staff said this practice was based on previous problems with large quantities of paracetamol being used and unaccounted for.
We repeat the recommendation.

2.80 **Patient group directions should be developed to enable nurses to supply more potent medicines. (4.79)**
Not achieved. There were patient group directions (PDGs) for immunisations only. We were told that other PGDs had been formulated but were awaiting ratification by the primary care trust.
We repeat the recommendation.

2.81 **There should be formal procedures to encourage appropriate recording of pharmaceutical interventions and incidents. (4.80)**

Achieved. All incidents related to medications were now routinely notified to the pharmacist or technician. There had been five such incidents in the previous six months.

2.82 **There should be day care facilities for prisoners less able to cope with life on residential units. (4.81)**
Not achieved. There was no stated requirement for day care facilities. There was no up-to-date mental health needs assessment to identify the needs of this population and no provision for interventions such as counselling and cognitive behavioural therapy for vulnerable young men with low level mental health problems such as anxiety and depression or a history of abuse. It was not clear what proportion of the population had learning disabilities and would benefit from appropriate interventions to help them cope more effectively on the wings.

2.83 **There should be an occupational therapist to provide day care support. (4.82)**
No longer relevant. See above.

2.84 **There should be a programme of regular mental health awareness training for all prison staff. (4.83)**
Not achieved. Only nine out of 273 staff had received any mental health awareness training. The mental health in-reach team had been commissioned to provide training but the prison had not allocated time for staff to attend. We were told that some staff dealt well with young men with mental health or learning disability needs but that this was variable and inconsistent across the prison.
We repeat the recommendation.

2.85 **Generic counselling services should be introduced. (4.84)**
Not achieved. There was no counselling service. One primary care nurse was a trained bereavement counsellor but staffing difficulties meant she did not use her skills.
We repeat the recommendation.

Time out of cell

2.86 **Unemployed prisoners should be allowed out of their cell each day for a shower and a telephone call. (5.55)**
Not achieved. Prisoners were not guaranteed a daily shower. No domestic time was included in the core day, although enhanced prisoners were allowed a shower instead of exercise at first unlock. Staff used their discretion to allow prisoners who were otherwise locked up to have a shower or make a telephone call. Limited association time in the evenings and its regular cancellation further curtailed access to basic amenities. During one roll check on a working day, we found 44% of prisoners locked in cell.
We repeat the recommendation.

2.87 **Exercise should be timed to maximise prisoner uptake. (5.56)**
Not achieved. Exercise was still scheduled in the early morning, which acted as a disincentive and take up across most wings was disappointing.
We repeat the recommendation.

2.88 **Exercise areas should be clean and contain benches and landscaping. (5.57)**
Not achieved. Exercise yards were still bleak, some were quite small and all were devoid of any facilities. Some yards were also dirty.
We repeat the recommendation.

2.89 **Staff should interact with prisoners during exercise and association sessions. (5.58)**
Not achieved. We observed several exercise and association sessions and, while not always

the case, many staff kept to themselves and did not fully engage with prisoners.
We repeat the recommendation.

2.90 **There should be sufficient seating in association areas for prisoners not participating in games. (5.59)**
Not achieved. Most association area had little seating.
We repeat the recommendation.

Learning and skills and work activities

2.91 **There should be reliable arrangements for initial assessment of prisoners' literacy and numeracy and English for speakers of other languages (ESOL) needs. (5.20)**
Achieved. Initial assessment of new prisoners' literacy, numeracy and language (ESOL) abilities took place during the education induction. Literacy and numeracy scores were recorded on the intranet and could be accessed by other members of staff, such as teachers, information, advice and guidance advisers and resettlement officers.

2.92 **New arrivals should be given clearly written and readily available information on all education, training and work opportunities. (5.21)**
Not achieved. Information on education, vocational training and work opportunities was given at the different stages of the three-week induction and on job adverts displayed on wing notice boards. There was no cohesive verbal or written presentation of the range of education, vocational training and work opportunities or how prisoners could combine activities to meet their needs. The process was inadequately coordinated, the information was conflicting and ambiguous and not all staff knew what was actually offered. The written information was not always clear and easy to read and in-cell television was not used to promote activities.

2.93 **There should be an effective and coherent application and allocation system to cover all education, vocational training and work. (5.22)**
Partially achieved. There was an effective application and allocations system for education, vocational training and work. Good communication between education managers and the allocations officer supported by access to centralised security risk assessments, sentence plans and prisoner information meant unemployed prisoners could be allocated to vacant places on education classes without waiting for the fortnightly application and allocation panel meetings. However, the wing-based application boxes emptied by the allocations officer were not always used and there was not complete confidence that the system was fully equitable. The depleted amount, range and level of education, vocational training and work also restricted opportunities for prisoners to have effective planning to meet their needs.

2.94 **The range of education and vocational training opportunities above level 1 should be improved.(5.23)**
Not achieved. The number of places in vocational training at level 2 and above had fallen by 72 due to the loss of staff in motor vehicle mechanics, industrial cleaning, painting and decorating, bricks and some education subjects. Some new staff had recently started and were preparing to offer accredited vocational training at level 2 in money management, barbering, motor vehicle mechanics and bricks. A business studies course at level 2 had also recently started in the education department. The amount of learning support available from education staff for prisoners on distance learning courses, mostly at level 2 and above, had decreased to only 12 prisoners.
We repeat the recommendation.

2.95 **There should be effective planning to meet the individual needs of learners. (5.24)**
Partially achieved. The activities allocation process and its panel effectively used sentence

planning targets when making decisions about prisoners' learning plans. However, the much depleted education and vocational training provision, the limited levels of accredited provision, the reduction of distance learning support and the cessation of most physical education courses meant that opportunities to meet the individual needs of prisoners were restricted.

2.96 **There should be appropriate programmes of literacy, numeracy and ESOL support and development to meet the needs of prisoners in vocational training or work. (5.25)**
Not achieved. There was no support to develop literacy, numeracy and language (ESOL) knowledge and skills of prisoners in vocational training and work. There were plans to offer this from June 2011 when newly appointed education staff started work.
We repeat the recommendation.

2.97 **Classes and activities should be provided during the evenings and at weekends. (5.26)**
Not achieved. Evening and weekend sessions were not offered due to financial constraints.

2.98 **There should be a greater range of programmes and work for prisoners considered vulnerable. (5.27)**
Partially achieved. Art, cookery and music sessions were offered separately in the education department to vulnerable prisoners on F wing on Friday mornings. A few vulnerable prisoners had also been encouraged and supported to join general education classes, such as information technology and art. Despite this, the range of education, accredited vocational training and work for vulnerable prisoners was inadequate.

2.99 **There should be sufficient appropriate education and training staff, and the amount of education, training and work that is cancelled, closed or operating below capacity should be reduced significantly. (5.28)**
Not achieved. Staffing numbers had actually decreased and progress had been hindered for over a year by staff losses through ill health and resignations and the removal of funding from the John Laing construction provision. These had a negative impact on prisoners, including the loss of 72 vocational training places. The contracted delivery hours delivered by The Manchester College, which had started as the offender learning and skills service contractor (OLASS) in August 2009, had dropped considerably to 28% in August 2010. The only accredited vocational training was for fewer than 20 prisoners in the painting and decorating and bricks workshops. Improvements in the contracted provision had been boosted with the appointment of a new management team in January 2011 and the delivery hours had further improved from 33% to 55% of its contract by March 2011. Following further contracted staff appointments, the acclaimed Toyota-sponsored accredited motor vehicle mechanics workshop was due to reopen in May 2011, albeit initially with eight rather than the planned 16 places. Numbers in the painting and decorating and bricks workshops were planned to increase by 50% to 32 places overall.
We repeat the recommendation.

2.100 **The personal and employability skills that prisoners acquire should be recognised and recorded through accreditation or other means. (5.29)**
Not achieved. This had yet to be implemented and ways to achieve it through visual and/or practical examples as well as written form had not been explored.
We repeat the recommendation.

2.101 **Quality assurance and improvement arrangements, including self-assessment and the monitoring of standards of teaching and training, should be effective. (5.30)**
Not achieved. The college's quality assurance arrangements had restarted to inform improvements. Since January 2011, 11 teaching and learning observations had taken place and training and support had been identified for staff. Lapsed award body registrations had

been renewed and 127 long-awaited certificates for prisoners who had completed courses had been sent for and prisoners on courses were being registered as they expected for qualifications. However, the learning and skills quality assurance cycle, policies and procedures had not been adequately reviewed and many were out of date. The quality improvement group met infrequently, with insufficient members attending. The latest self-assessment process had been too elongated and had not fully contributed towards continuous improvement because the draft 2009-10 self-assessment report included much out-of-date information and did not provide a useful basis from which effectively to action plan for improvements. The prison's post-inspection action plan was monitored and updated, showing slow progress, but the recently devised college action plan was good and successfully supported improvement.

2.102 **The proportion of the population who are unemployed should be significantly reduced, and opportunities for useful work increased. (5.31)**
Not achieved. Data concerning the allocation of prisoners to activity was unclear. We were told that the proportion of unemployed prisoners had increased from 20% to 27%. We were told that 49% of prisoners were in paid activities, although the college's education and vocational training provision was operating at only 55% capacity. Many prison jobs, particularly the 63 wing-based jobs, did not fully occupy prisoners during the core day. Off the wings, the number of jobs had appropriately increased to 96 and included work as orderlies, in the kitchen, staff mess, gardens, laundry, recycling and on the estates party. Apart from catering, prison work did not provide accredited learning opportunities. We were told that 27% of prisoners took part in some part-time education, training or work.
We repeat the recommendation.

2.103 **Library opening hours should be extended to include evenings and weekends, and prisoners should have greater access. (5.32)**
Partially achieved. Use of the library had increased significantly even though the prison had rejected the recommendation. The library was not open in the evenings and at weekends and the officer escort had been removed in 2010. The library timetables had been revised to offer greater access during the core day. A range of activities was offered to encourage prisoners to visit the library. Forty prisoners were reading for the 'six book challenge', for which 10 dictionaries had been donated as prizes by Buckinghamshire Association for Care of Offenders (BACO). The Toe by Toe mentored reading scheme was coordinated by the library orderly and had 18 mentors and five mentees. Library staff offered accredited parenting and family learning courses and had been involved in the recent prison family day. Black history month was celebrated and related books had been publicised. There had been a large increase in book issues in January and February 2011, from 592 and 672 respectively in 2009 to 1306 and 1364 in 2011. Two new library staff had started in the autumn of 2009 following around six months when the library had been closed due to staffing issues. These new staff had actively communicated with education and training about which books were required to support the courses offered and the library had purchased £4000 of new items.

Physical education and health promotion

2.104 **All prisoners should be able to attend physical education at least twice a week, and more prisoners should take part in PE. (5.37)**
Partially achieved. Most prisoners could attend at least twice a week but the overall proportion attending had not increased since 2009. The PE application form clearly outlined what was available, with standard level employed prisoners able to attend two sessions, enhanced level prisoners three sessions and basic or standard unemployed prisoners allocated only one session a week with the possibility of extra places if any were available. The PE timetable operated seven days and four evenings a week offering mostly recreational

activities and including specific activities such as exercise referral, special needs, physiotherapy, rugby squad training and matches and healthy living linked to offender behaviour programmes. The only accredited learning available was the Duke of Edinburgh bronze award.

Security and rules

2.105 **The almost complete ban on property being handed or posted in should be relaxed. (6.12)**
Not achieved. Prisoners on the enhanced level could have trainers sent in but otherwise there were no opportunities for prisoners to have property handed or posted in.
We repeat the recommendation.

Discipline

2.106 **All charges should be fully investigated and this should be evidenced in adjudication records. (6.32)**
Not achieved. The number of adjudications had fallen from 1917 in 2009 to 1845 in 2010, with an additional 277 minor reports in 2010. This appeared to have fallen further in the previous six months prior to the inspection, when the total stood at 759. A regular adjudication meeting was informed by a comprehensive report that produced some useful trend analysis and discussed areas for improvement. Prisoners told us they were not always given the opportunity to explain themselves during adjudications. The governor completed a quality check of 5% of adjudication records each quarter but there were still too many records where charges had not been sufficiently explored before a finding of guilt.
We repeat the recommendation.

2.107 **Senior managers should thoroughly investigate the increase in use of force figures, identify the causes, and implement procedures to reduce incidents. (6.33)**
Partially achieved. Incidents where force had been used had risen to 315 in 2009 and to 373 in 2010. However, between January and April 2011, there had been a significant decrease to 75. Records showed that 296 of the uses in 2010 had involved control and restraint and that special accommodation had been used 24 times but these figures were disputed and we had no assurance that all records were accurate or appropriately scrutinised. Batons had been drawn 34 times in 2010 and five times in 2011 and actually used three times in 2010 and once to date in 2011. These incidents were not consistently scrutinised and were viewed as acceptable by most prison managers. The statistics were the highest we have seen and we were not assured that all were justified. A monthly use of force committee was informed by a reasonably comprehensive report that allowed for some trend analysis but minutes of the meeting provided limited assurance that appropriate action had been identified or taken to reduce the number of incidents and we were concerned about the overall lack of governance around use of force.
We repeat the recommendation.

2.108 **Details of de-escalation techniques where used should be recorded in use of force documentation. (6.34)**
Partially achieved. The use of de-escalation techniques by staff was encouraged by prison managers and was clearly a priority at the use of force committee. It was, however, unacceptable that use of batons was praised as a method of de-escalation. Use of force committee meeting minutes repeatedly referred to the drawing of batons as an appropriate de-escalation technique. Insufficient appropriate guidance about de-escalation techniques had been issued to staff. A few of the use of force records we looked at referred to appropriate de-

escalation techniques, while some just indicated 'de-escalation' without describing what had actually been done. Most paperwork still contained no details of any de-escalation techniques used during use of force.
We repeat the recommendation.

2.109 **Planned use of force incidents should be video recorded. (6.35)**
Partially achieved. The prison now recorded all planned use of force incidents but did not routinely review the films. Videos we looked at did not indicate any inappropriate actions by staff but highlighted many lessons to be learned had prison managers reviewed the films. Briefings were mostly reasonable but the films did not show that health care staff, duty governors and members of the Independent Monitoring Board were always present. Films were sometimes inaccurately labelled and did not feature the planned intervention we were expecting to see.
We repeat the recommendation.

2.110 **All staff in the segregation unit should receive mental health awareness training. (6.36)**
Partially achieved. The prison had prioritised mental health awareness training for staff in the segregation unit and many, but not all, had undergone this.
We repeat the recommendation.

2.111 **Prisoners in the segregation unit should have daily access to showers. (6.37)**
Not achieved. Prisoners in the segregation unit could still have a shower only every second day. The action plan stated that this would 'make the segregation unit more attractive to prisoners than residential units' and that 'should the facility be available on a daily basis on residential units, this will be implemented'. Staff said they did not believe resources contributed to daily showers being prohibited.
We repeat the recommendation.

2.112 **Good order or discipline (GOOD) reviews should be more detailed and provide a full summary of the main points discussed and agreed. (6.38)**
Not achieved. Good order or discipline paperwork was often incomplete or poorly completed. Managers sometimes briefly recorded the level of engagement a prisoner had with the review but behaviour targets were set infrequently and those that were set were perfunctory and often meaningless.
We repeat the recommendation.

2.113 **Staff entries in segregation unit history files should provide evidence of positive engagement with prisoners. (6.39)**
Not achieved. Segregation unit staff did not record any routine engagement with prisoners on P-Nomis but did complete daily entries in paper history sheets. Entries were mainly observational and most lacked any evidence of positive engagement with residents of the unit. However, staff we spoke to had a reasonably good knowledge of the personal circumstances of the prisoners in their care.
We repeat the recommendation.

Incentives and earned privileges

2.114 **The role and purpose of H wing should be clearly stated in the incentives and earned privileges (IEP) policy. (6.53)**
Not achieved. The role and purpose of H wing was not mentioned in the IEP policy. The wing still provided accommodation for up to 22 prisoners on the enhanced privilege level who were given some extra privileges such as additional time unlocked. The wing had its own criteria

and there was a waiting list.
We repeat the recommendation.

2.115 **Prisoners on the enhanced level should have consistent access to the full range of privileges stated in the policy. (6.54)**
Partially achieved. The prison was trying to ensure that the additional periods of unlock enjoyed by enhanced prisoners on H wing were available to prisoners on other residential units but this was inconsistent. Residents of H wing were also regularly subject to curtailment of their regime, particularly during association times in the evenings and at weekends. Enhanced prisoners could wear some of their own clothing at certain times but delays in processing applications in reception meant this was also inconsistent.
We repeat the recommendation.

2.116 **Management checks of wing file entries should ensure that verbal warnings are issued appropriately, and that there is consistency in identifying patterns of behaviour that result in formal behaviour warnings. (6.55)**
Achieved. Regular management checks were made of P-Nomis case notes and there appeared to be some consistency in the use of formal behaviour warnings. However, some warnings appeared petty and could have been dealt with through more appropriate engagement with the individuals concerned.

2.117 **Managers should check the monthly behaviour report system to ensure that points are deducted fairly and that prisoners are not penalised more than once for a single incident or behaviour. (6.56)**
Partially achieved. The monthly behaviour report system appeared broadly fair. The system still deducted points arbitrarily as a result of proven adjudications and warnings received during the monthly reporting period but scores leading to regime reviews were now generally an average of the scores over a three-month period, which meant prisoners had an opportunity to improve their behaviour if it had gone below the required standard at any time. However, the prison had introduced a single incident policy whereby prisoners involved in incidents such as violence, possession of drugs or weapons or concerted indiscipline were subject to a regime review that could result in a downgrade to the standard or even basic privilege level depending on the severity of the behaviour concerned. Where regime review boards were convened as a result of a pattern of poor behaviour, there was evidence that managers gave prisoners further opportunities to amend their behaviour before any action was taken against them. However, records indicated that no discretion was applied with the single incident policy and all prisoners, even those on enhanced, were automatically downgraded to the basic regime, which was often in addition to being placed on report for the same incident and was inappropriate.
We repeat the recommendation.

2.118 **Behaviour improvement targets for prisoners on the basic level should address and challenge the underlying causes of their behaviour. (6.57)**
Not achieved. Under a recently implemented new system, prisoners placed on basic level were monitored using a personal intervention plan (PIP). Many of the records contained no behaviour improvement targets and, where set, targets were often perfunctory.
We repeat the recommendation.

2.119 **Daily entries in basic monitoring logs should evidence engagement with prisoners and record progress against behaviour improvement targets. (6.58)**
Not achieved. Entries in prisoner PIPs did not indicate any meaningful engagement. Progress against behaviour improvement targets was not routinely recorded and entries were overwhelmingly observational and often concentrated on negative behaviour. Reviews should

have been held every seven days but a number were late and prisoners said they were often not involved with reviews or the setting of behaviour targets.
We repeat the recommendation.

Catering

2.120 **Servery workers should be provided with sufficient quantities of clean, suitable clothing. (7.8)**
Achieved. Servery workers wore clean clothing and there were sufficient quantities of clean replacement items.

2.121 **Breakfast should be served on the morning it is eaten. (7.9)**
Not achieved. Breakfast packs were still inappropriately issued during the evening before use. Most prisoners said they generally ate their breakfast that evening and therefore had no breakfast and were often hungry in the morning.
We repeat the recommendation.

2.122 **Prisoners should be able to dine in association. (7.10)**
Not achieved. Most lunches consisted of a cold baguette, which was issued to prisoners at their cell door. In addition to the lack of opportunity to eat in association, this meant they were denied any social interaction at lunchtime.
We repeat the recommendation.

Prison shop

2.123 **The rate of repayment of the £5 advance for new arrivals should be reduced. (7.20)**
Achieved. Cash advances to new arrivals were now repaid at a more reasonable 50 pence a week.

2.124 **Aylesbury should make a suitable advance to a new arrival when his sending establishment fails to forward his money. (7.21)**
Achieved. Most prisoners' money was transferred using P-Nomis before and during their actual transfer. When money did not arrive, staff checked that the sending prison had it and then usually advanced the sum to prisoners.

2.125 **The range of products in the shop should be significantly increased, and should include a selection of fresh fruit. (7.22)**
Partially achieved. The prison now operated a standard DHL shop contract and service. The product list had increased by over 100 items but fresh fruit was still not available. The action plan suggested this was for the spurious reason that prisoners would have storage difficulties.

Strategic management of resettlement

2.126 **Objectives identified in the reducing reoffending action plan should relate directly to the strategy document and be reviewed through the resettlement committee. (8.5)**
Not achieved. The reducing reoffending strategy document outlined objectives for each pathway and offender management but was largely out of date. Many of the objectives related to 2009-10 and, while others had been added, it was unclear which objectives were contemporary. The reducing reoffending strategy was not regularly reviewed by the reducing reoffending group or through the bi-monthly meetings. The document was reviewed by the head of offender management but was not used as a live document to drive the strategic objectives of the group. A number of developments continued to operate in isolation of each

other and, in particular, the reducing reoffending committee. In July 2010, for example, the psychology department had undertaken a needs analysis based on completed OASys to assess the population's programme needs. While this report had been considered by the senior management team, it had never been reviewed by the reducing reoffending committee, even though one recommendation was specifically the responsibility of offender management.
We repeat the recommendation.

2.127 **All pathway leads, or their representatives, should attend the bi-monthly resettlement committee meeting. (8.6)**
Partially achieved. Attendance at the reducing reoffending meetings had improved but was still not consistent. In January 2011, there had been as many apologies as actual attendees. Psychology, security, learning and skills, resettlement and offender management all regularly attended. Meetings always included updates on pathway work but there had been no representative from health care or regarding the children and families pathway in the previous 12 months.

Offender management and planning

2.128 **Officer offender supervisors should be dedicated to work in the offender management unit. (8.24)**
Not achieved. There continued to be a significant problem with offender supervisors regularly being allocated to work away from the unit, equating to between 40% and 50% of allocated time. In March 2010, 321 hours had been re-profiled from a total offender management unit allocation of 754. This was compounded by the number of offender management staff having been reduced in the last two years by a probation service officer, a probation officer and three senior officers. Despite this, with the exception of the number of outstanding OASys, most of the work undertaken was being maintained, although often with lower frequency.
We repeat the recommendation.

2.129 **The level of offender supervisor contact with prisoners should be clearly defined and monitored, and the level and quality of their input should be subject to quality assurance. (8.25)**
Partially achieved. Although the level of offender supervisor contact with the 251 prisoners in-scope for offender management and 45 life-sentenced prisoners had been agreed as monthly, actual levels of contact still varied. Many prisoners were seen broadly every month but some others had very infrequent contact. As many offender supervisors also undertook wing duties due to staff shortages, it was not always clear if contact was formal and structured or merely in passing on wings or during movement to work. There were some examples of good engagement by offender supervisors orientated to assessments of offences, evaluation of risk and assessments of prison behaviour in the context of offending. However, in other cases, the focus of contact was quite limited with little evaluation or analysis of risk factors and behaviour. There was still no formal mechanism regularly to review cases or evaluate the effectiveness of engagement.
We repeat the recommendation.

2.130 **The role of personal officers in offender management should be clarified and implemented. (8.26)**
Not achieved. There was still no significant link between the work of offender supervisors and personal officers. Although some work had been undertaken to encourage wing-based staff to access sentence plans and OASys and use such information in their personal officer work, there was no indication that this was happening and no mechanism to evaluate its effectiveness.
We repeat the recommendation.

2.131 **Information and advice about release support services should be provided at induction and advertised throughout the prison. (8.27)**
Achieved. The two resettlement officers saw all prisoners during induction. This had previously been undertaken on a group basis but prisoners had recently been seen individually. Each wing had a resettlement notice board with information about local and national services.

2.132 **The pre-release assessment interview should be linked to the work of offender supervisors and offender managers. (8.28)**
Partially achieved. About 10 prisoners were released from Aylesbury every month. All were seen by one of the two resettlement officers three months before release and as often as necessary after that. Although there was some evidence of communication between resettlement staff and offender supervisors about release planning, this was rarely undertaken in a formal structured way and despite being identified in the reducing reoffending policy prisoners did not have pre-release sentence plans incorporating the work of both departments.
We repeat the recommendation.

2.133 **All prisoners should have a pre-release meeting that covers all aspects of resettlement and risk management. (8.29)**
Not achieved. There were still no pre-release boards that incorporated the work of all departments and pathways such as the counselling, assessment, referral, advice and throughcare (CARAT) service, health and education. Where appropriate, these departments saw prisoners separately and made separate arrangements.

2.134 **The basic offender resettlement questionnaire should ensure information collated is not replicated elsewhere. (8.30)**
Not achieved. The resettlement needs assessment undertaken during induction was fundamentally unchanged. The primary focus was still on housing, although it also included the work of education and training. This work was then largely replicated through the learning and skills department. At the pre-release stage, resettlement officers also included discussions with prisoners about their education and training needs post-release and it was not clear where their role and that of the Tribal worker began and ended.
We repeat the recommendation.

2.135 **Personal officers should make their prisoners aware of when they qualify for release on temporary licence consideration, and offender supervisors should support them to apply for it. (8.31)**
Achieved. Personal officers did not undertake a support role with release on temporary licence (ROTL) but the task was undertaken by the two resettlement officers. A booklet had been produced that outlined the process of applying for ROTL and who might qualify and copies were given to all prisoners. ROTL arrangements had improved. Four prisoners were working outside the prison, with another due to start the following week. Five further prisoners were being considered. While this number remained low, the prison appeared committed to increasing it.

2.136 **Attendance at the risk assessment and management panel (RAMP) should be improved. (8.32)**
Achieved. The RAMP had been replaced by the inter-departmental risk management team (IDRMT), which met twice a month. Attendance was good, with all significant departments represented.

2.137 **The RAMP should automatically review prisoners subject to public protection concerns when new information about them is received. (8.33)**

Achieved. Three prisoners had been identified as MAPPA level 3, 43 as MAPPA level 2, nine as MAPPA 1 and about 365 were likely to be MAPPA cases but their level had not yet been agreed. All prisoners were screened on arrival and reviewed initially by the IDRMT. Any issues or concerns were subsequently pursued by identified offender supervisors. Although not formally reviewed again until six months before release, if any member of staff (usually offender supervisors) had a concern or there was a change in circumstance, the board would consider the case and make any necessary recommendations. There were examples of good liaison undertaken regarding MAPPA cases as well as case conferences held at the prison and including community-based staff where there had been particular concerns about individuals.

2.138 **There should be a lifer strategy to ensure there are appropriate resources and systems to manage this population. (8.34)**
Achieved. The number of indeterminate-sentenced prisoners had fallen from 171 to 97 (52 indeterminate sentences for public protection and 45 lifers). The lifer policy had been written in December 2009 when the population had been significantly higher and was now out of date but most aspects of what was covered were still relevant.

2.139 **Prisoners on life sentences and indeterminate sentences for public protection (IPP) should be allocated to personal officers with specific training and/or experience of work with these groups. (8.35)**
Not achieved. As the number of prisoners serving indeterminate sentences had fallen, so their allocation to a specific wing had become less significant and they were now incorporated on all units. Personal officers allocated to these prisoners were not specifically trained in lifer work. Nevertheless, all indeterminate-sentenced prisoners were allocated to an offender supervisor who undertook work specifically orientated to their needs. All indeterminate-sentenced prisoners we spoke to had sentence plans and knew who their offender supervisor was. They also tended to be prioritised for offending behaviour programmes.

2.140 **There should be regular lifer and IPP prisoner groups. (8.36)**
Partially achieved. The prison had been running regular lifer groups until the middle of 2010, with the last one in November 2010. The meetings had started to lose their focus and most discussions tended to focus on individual needs. As an alternative, prisoner lifer representatives had been identified for each wing with the intention that they would meet regularly to reflect the needs of the wider population. This meeting format had yet to meet. The prison had developed a comprehensive document outlining the lifer system and this was available to prisoners on all wings. While comprehensive, it was not user friendly and the prison was developing a condensed and easier to understand version.

2.141 **The strategic development of public protection should be a standing item at the resettlement committee. (8.37)**
Achieved. Public protection was a standing item at the reducing reoffending committee. The head of offender management was also responsible for public protection and consistently attended the meeting.

Resettlement pathways

2.142 **There should be a suitable programme of short courses useful for employment for prisoners nearing release, and an appropriate pre-release course to help them secure employment, training or education on release. (8.47)**
Not achieved. Around ten prisoners were released each month but no pre-release course was offered. Vocational training courses relating to specific employment had been depleted for around a year. The education provision offered other courses useful for independent living on release, such as cookery, personal budgeting and family relationships. Curriculum vitae writing

was included only in the new level 2 business studies course. The 2010-11 statistics for progression on release exceeded targets. Prisoners going on to education/training on release had been above the target of 15% since July 2010, peaking in September 2010 at 20.41% and being consistently over 18% since January 2011. Prisoners going into employment on release in 2010-11 had been above the 15% target consistently, peaking at 26.83% in August 2010 and being 20% for seven months June-December 2010.

2.143 **Information, advice and guidance for new arrivals should enable effective planning of their training and education to meet their resettlement needs. (8.48)**
Partially achieved. Information, advice and guidance staff and resettlement officers provided support for new arrivals and sentence plans were used to decide allocations to activities and learning plans. The depleted amount, range and levels of education, vocational training and work available restricted the opportunities for prisoners.

2.144 **Specialist debt and finance support and help should be available to all prisoners. (8.49)**
Not achieved. Any prisoner indicating that he had a debt problem could access some support from one of the two resettlement officers able to offer some basic guidance and support in contacting debtors and helping to manage problems. There was no specialist debt advice. In practice, very few prisoners indicated a debt problem but it was not clear how accurate a reflection this was. A needs assessment had been given out to all prisoners in August 2010 but questions related exclusively to the work areas undertaken by the resettlement officers. The response rate was low at 15% (66 returns) but of this 18% indicated that they had outstanding debt or finance issues. If this was extended across the prison, around 77 prisoners might be expected to have such issues at any given time.
We repeat the recommendation.

2.145 **There should be formal health discharge clinics to ensure all prisoners released from prison are seen by a member of the health team and advised how to access health services in the community. (8.50)**
Achieved. All young men were called to a health care appointment about a week before release or transfer. They were given information about how to contact health services in the community, including a GP and dentist. All young men on ongoing prescriptions were given a week's supply of medication. Young men subject to the care programme approach were linked with their local community mental health team.

2.146 **The alcohol strategy should be developed and focus on service provision rather than testing. (8.65)**
Not achieved. There was no specific alcohol strategy. The drug strategy mentioned the need for alcohol interventions following a comprehensive alcohol survey undertaken in January 2011. The survey had been carried out by the CARAT service and linked to the alcohol use disorders identification test (AUDIT). Young men with alcohol-only problems could access the building skills for recovery programme (BSR) within strict criteria. Young men could also attend the weekly Alcoholics Anonymous meeting in the evening. Young men said they often could attend the meeting for only a short period due to restrictions on their time out of cell.
We repeat the recommendation.

2.147 **Counselling, assessment, referral, advice and throughcare (CARAT) provision should be extended to meet demand for the service. (8.66)**
Achieved. The CARAT service was provided by Inclusion. A needs assessment had been conducted in January 2011 with a 50% response rate. All young men were seen by a CARAT worker during induction and offered support. There were 100 young men on the active caseload and 70 suspended cases. There were 2.5 whole time equivalent posts, including two officers who worked half and half as CARAT and compact-based drug testing officers. One-to-

one work was offered and there was a range of in-cell packs. Group sessions focused on harm reduction and awareness raising and there was access to auricular acupuncture and a healthy living programme aligned to gym sessions. All young men were reviewed every six months to assess progress.

2.148 **There should be consistent administrative support for the CARAT team. (8.67)**
Achieved. Dedicated administrative support had recently reduced from full-time to 25 hours a week and it was too early to tell if this would meet CARAT needs.

2.149 **There should be dedicated gym sessions for P-ASRO participants. (8.68)**
Achieved. A weekly gym session for all programme participants, including BSR, was offered in addition to the normal gym sessions.

2.150 **There should be a peer support scheme to offer ongoing support to prisoners who complete the P-ASRO programme. (8.69)**
Not achieved. There was no peer support scheme. The prison had considered similar schemes in other prisons but had not implemented them. Young men completing the programme had continuing access to CARAT workers but no formal peer support.
We repeat the recommendation.

2.151 **All prisoners should have access to voluntary drug testing, and testing capacity should be increased. (8.70)**
Partially achieved. All young men had access to compact-based drug testing (CBDT) through the CARAT service during induction. There were 135 currently on the CBDT list and 35 waiting up to four months to join, a slight reduction from our last visit. There was no dedicated testing facility and prisoners were tested on their wings.
We repeat the recommendation.

2.152 **Visitors should be able to book their next visit while they are at the establishment. (8.87)**
Not achieved. Visitors were still not able to book a visit while at the prison.
We repeat the recommendation.

2.153 **Visits should start at the advertised time. (8.88)**
Not achieved. Visits were scheduled to start at 2pm and end at 4.15pm. Prisoners were moved from wings, usually around 1.45pm to facilitate a prompt start but there were problems with processing all visitors through to the visits hall in time. Visits staff said delays were not unusual but that they usually managed to get visitors in by 2.45pm. We saw visitors for five prisoners still being processed at 2.45pm even though they had all arrived well before the 2pm start. The visits hall was still rather austere. There was a small refreshment bar but no children's play area and no books or other activities to occupy young visitors.
We repeat the recommendation.

2.154 **Closed visits should be authorised only when there is significant risk justified by security intelligence. (8.89)**
Not achieved. Closed visits were used sparingly and only 12 prisoners had been subject to them in 2010. No prisoners were currently subject to closed visits. Decisions to enforce closed visits appeared proportionate and were generally as a result of incidents in or after visit sessions or an accumulation of intelligence related to visits. Reviews were timely and prisoners were not required to spend three months on closed visits if there was no further intelligence to suggest they should. Despite this, visitors could still be, and were quite frequently, subjected to a closed visit following a single indication by the drug dog and in the absence of any other intelligence.
We repeat the recommendation.

2.155 **Prisoners should not have to wear a bib in the visits room. (8.90)**
Not achieved. Prisoners still had to wear bibs during visits.
We repeat the recommendation.

2.156 **Closed visits facilities should be screened from the main visits room and offer privacy. (8.91)**
Not achieved. The three closed visits booths were still not screened from the main visits hall.
We repeat the recommendation.

2.157 **The fixed seating in the visits room should be replaced. (8.92)**
Not achieved. The seating in the visits hall was still fixed to the floor and was not conducive to supporting relaxed relationships.
We repeat the recommendation.

2.158 **The reducing reoffending policy and action plan should include clear targets for the delivery of objectives relevant to the children and families pathway. (8.93)**
Not achieved. There was no identified lead for the children and families resettlement pathway. Although the pathway was a standing item at the reducing reoffending meetings, a review of the minutes from the previous 12 months indicated few developments.
We repeat the recommendation.

2.159 **The provision of accredited programmes should be extended to meet prisoner needs. (8.102)**
Achieved. In July 2010, a comprehensive assessment of prisoner programme need was undertaken by the psychology department drawing on information from OASys documentation. This indicated that the range of programmes (thinking skills programme – TSP, controlling anger and learning to manage it – CALM, sex offender treatment programme – SOTP, and prisons addressing substance-related offending – P-ASRO) broadly met the needs of the population at Aylesbury. One area identified as lacking was an adapted version of the SOTP, 'becoming new me', which was due to be introduced later in 2011. Of all sentence plan objectives reviewed in the study, only 37 were orientated to accredited programmes other than those provided at Aylesbury. Although the assessment indicated that the number of programme places might actually exceed demand slightly, the actual number of programme places on CALM and TSP had fallen short of the target in 2010-11 (86 against a target of 130) due to staff shortages and the target for 2011-12 had been reduced to 115. The shortfall of five staff was being recruited to. It was anticipated that this shortfall would not impact unduly due to the length of sentence most prisoners were serving. Access to programme places was appropriately prioritised on the basis of release and parole reviews.

2.160 **A victim awareness programme should be introduced. (8.103)**
Achieved. The Sycamore Tree restorative justice programme had recently been introduced through the chaplaincy team. The programme had been adapted slightly to have greater impact on the population at Aylesbury and the chaplaincy team worked closely with both the psychology department and the offender management unit to ensure appropriate prisoners were selected. The first programme was under way and it was planned that four would run in the course of 12 months.

2.161 **There should be an annual needs analysis to identify and support the range of prisoner treatment needs. (8.104)**
Achieved. A needs analysis identifying offending behaviour need across Aylesbury had been undertaken in July 2010.

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

3.1 The quantity, range and quality of work, education and vocational training should be increased. (2.3)

3.2 There should be a clear strategy to significantly increase the amount of time out of cell so that first, all prisoners achieve the prison's own target of eight hours a day and then, as the amount of purposeful activity increases and association becomes more reliable, move to achieving an average of ten hours a day. (2.6)

3.3 There should be a clear strategy to ensure completion of missing and out-of-date offender assessment system (OASys) documents. (2.8)

Recommendations

First days in custody

3.4 Reception should be staffed to receive, process and locate new arrivals on to the induction unit without delay. (2.9)

3.5 Conditions in all reception holding rooms should be improved. (2.10)

3.6 Initial risk assessments and safety screening should be carried out with sensitivity and privately in appropriate surroundings. (2.11)

3.7 Prisoners' property should be processed on the day of their arrival. (2.12)

3.8 All new arrivals should receive all elements of the induction programme and attend all scheduled sessions. (2.13)

3.9 Prisoners on induction should not be locked in their cells during the core day. (2.14)

Accommodation and facilities

3.10 Cells designed to hold one prisoner should not be used to hold two. (2.15)

3.11 All in-cell toilets should be properly screened. (2.17)

3.12 The published offensive displays policy should be consistently enforced. (2.18)

3.13 All prisoners should have the opportunity to wear their own clothes. (2.19)

3.14 All prisoners should be able to access their stored property within one week of making an application. (2.20)

3.15 Communal showers should be fitted with privacy screens, maintained in good condition and be well ventilated. (2.21)

3.16 Prisoners should be able to shower daily and immediately after work and before visits. (2.22)

3.17 Staff should encourage all prisoners to keep their cells clean and should record such encouragement in wing files. (2.23)

Staff-prisoner relationships

3.18 Staff should address prisoners by their preferred name or title. (2.24)

3.19 There should be management checks to assess the quality of staff record keeping and encourage a more meaningful staff engagement with prisoners. (2.25)

Personal officers

3.20 Personal officers should evidence in weekly wing file entries that the information about prisoners obtained during the introductory interview forms the basis of future interactions and engagement. (2.26)

Bullying and violence reduction

3.21 The safer custody team should provide targeted training to improve the quality of anti-bullying monitoring. (2.28)

3.22 There should be annual anti-bullying surveys, which include questions on where and when prisoners feel at risk, and an analysis of the findings should be presented to the safer custody meeting. (2.29)

Self-harm and suicide

3.23 Staff should routinely check on the welfare of prisoners who request the Samaritans telephone. (2.37)

3.24 Some cells should be upgraded to meet the specification of a safer or reduced risk cell. (2.38)

Legal rights

3.25 Legal visits should be available on afternoons when social visits do not take place. (2.41)

Substance use

3.26 The mandatory drug testing suite should be refurbished, and an additional holding room provided. (2.43)

Race equality

3.27 There should be a strategy to address the perceptions of unfair treatment among black and minority ethnic prisoners. (2.44)

3.28 All staff, particularly in prisoner contact roles, should receive up-to-date diversity training. (2.47)

Foreign nationals

3.29 There should be a distinct foreign national prisoners' policy with clear objectives and targets. (2.49)

3.30 There should be a specific foreign nationals committee, chaired by a senior manager. (2.50)

3.31 The establishment should invite an independent immigration advisory service to visit the prison to provide information and advocacy for foreign national prisoners. (2.52)

Health services

3.32 All health care accommodation, including the meeting room, should be for the exclusive use of health care staff. (2.54)

3.33 There should be regular professional cleaning of the health care department so that standards of cleanliness meet NHS requirements for infection control. (2.55)

3.34 Clinical supervision should be introduced and protected time given to staff to allow their participation. (2.59)

3.35 A dedicated discipline officer should be deployed to assist health care functions and improve overall patient care. (2.60)

3.36 There should be a health forum for prisoners to meet with senior clinical managers and discuss health services. (2.63)

3.37 The health care reception room should be refurbished to include hand washing facilities and an alarm bell, and it should be cleaned regularly. (2.66)

3.38 Triage algorithms should be used to ensure consistency of advice and treatment. (2.67)

3.39 The primary care trust should commission a decontamination survey and provide a washer disinfector. (2.70)

3.40 The pharmacist should make monthly visits to the prison to check the systems in operation, including professional control of the stock supplied and checks of faxed prescriptions against the originals. (2.73)

3.41 When a dual-labelled pre-pack is dispensed against a prescription, the chart should be faxed to the pharmacy for the pharmacist to check that the prescription was appropriate and the correct item supplied. (2.74)

3.42 Secondary dispensing of daily medication by nursing staff should stop immediately. Daily medication should be dispensed by the pharmacy supplier in appropriately labelled containers for staff to administer directly to patients. (2.75)

3.43 The administration of medication on the wings should take place in conditions of confidentiality and security. (2.76)

3.44 The medicines and therapeutics committee should formally review all procedures and policies to ensure they cover all aspects of the pharmacy service, and all staff should read and sign the agreed procedures. (2.77)

3.45 The medicines and therapeutics committee should revise the special sick policy to enable the supply of all appropriate medicines. (2.78)

3.46 Paracetamol soluble tablets for supply under the special sick policy should be stored appropriately in medicine cupboards. (2.79)

3.47 Patient group directions should be developed to enable nurses to supply more potent medicines. (2.80)

3.48 There should be a programme of regular mental health awareness training for all prison staff. (2.84)

3.49 Generic counselling services should be introduced. (2.85)

Time out of cell

3.50 Unemployed prisoners should be allowed out of their cell each day for a shower and a telephone call. (2.86)

3.51 Exercise should be timed to maximise prisoner uptake. (2.87)

3.52 Exercise areas should be clean and contain benches and landscaping. (2.88)

3.53 Staff should interact with prisoners during exercise and association sessions. (2.89)

3.54 There should be sufficient seating in association areas for prisoners not participating in games. (2.90)

Learning and skills and work activities

3.55 The range of education and vocational training opportunities above level 1 should be improved. (2.94)

3.56 There should be appropriate programmes of literacy, numeracy and ESOL support and development to meet the needs of prisoners in vocational training or work. (2.96)

3.57 There should be sufficient appropriate education and training staff, and the amount of education, training and work that is cancelled, closed or operating below capacity should be reduced significantly. (2.99)

3.58 The personal and employability skills that prisoners acquire should be recognised and recorded through accreditation or other means. (2.100)

3.59 The proportion of the population who are unemployed should be significantly reduced, and opportunities for useful work increased. (2.102)

Security and rules

3.60 The almost complete ban on property being handed or posted in should be relaxed. (2.105)

Discipline

3.61 All charges should be fully investigated and this should be evidenced in adjudication records. (2.106)

3.62 Senior managers should thoroughly investigate the increase in use of force figures, identify the causes, and implement procedures to reduce incidents. (2.107)

3.63 Details of de-escalation techniques where used should be recorded in use of force documentation. (2.108)

3.64 Planned use of force incidents should be video recorded. (2.109)

3.65 All staff in the segregation unit should receive mental health awareness training. (2.110)

3.66 Prisoners in the segregation unit should have daily access to showers. (2.111)

3.67 Good order or discipline (GOOD) reviews should be more detailed and provide a full summary of the main points discussed and agreed. (2.112)

3.68 Staff entries in segregation unit history files should provide evidence of positive engagement with prisoners. (2.113)

Incentives and earned privileges

3.69 The role and purpose of H wing should be clearly stated in the incentives and earned privileges (IEP) policy. (2.114)

3.70 Prisoners on the enhanced level should have consistent access to the full range of privileges stated in the policy. (2.115)

3.71 Managers should check the monthly behaviour report system to ensure that points are deducted fairly and that prisoners are not penalised more than once for a single incident or behaviour. (2.117)

3.72 Behaviour improvement targets for prisoners on the basic level should address and challenge the underlying causes of their behaviour. (2.118)

3.73 Daily entries in basic monitoring logs should evidence engagement with prisoners and record progress against behaviour improvement targets. (2.119)

Catering

3.74 Breakfast should be served on the morning it is eaten. (2.121)

3.75 Prisoners should be able to dine in association. (2.122)

Strategic management of resettlement

3.76 Objectives identified in the reducing reoffending action plan should relate directly to the strategy document and be reviewed through the resettlement committee. (2.126)

Offender management and planning

3.77 Officer offender supervisors should be dedicated to work in the offender management unit. (2.128)

3.78 The level of offender supervisor contact with prisoners should be clearly defined and monitored, and the level and quality of their input should be subject to quality assurance. (2.129)

3.79 The role of personal officers in offender management should be clarified and implemented. (2.130)

3.80 The pre-release assessment interview should be linked to the work of offender supervisors and offender managers. (2.132)

3.81 The basic offender resettlement questionnaire should ensure information collated is not replicated elsewhere. (2.134)

Resettlement pathways

3.82 Specialist debt and finance support and help should be available to all prisoners. (2.144)

3.83 The alcohol strategy should be developed and focus on service provision rather than testing. (2.146)

3.84 There should be a peer support scheme to offer ongoing support to prisoners who complete the P-ASRO programme. (2.150)

3.85 All prisoners should have access to voluntary drug testing, and testing capacity should be increased. (2.151)

3.86 Visitors should be able to book their next visit while they are at the establishment. (2.152)

3.87 Visits should start at the advertised time. (2.153)

3.88 Closed visits should be authorised only when there is significant risk justified by security intelligence. (2.154)

3.89 Prisoners should not have to wear a bib in the visits room. (2.155)

3.90 Closed visits facilities should be screened from the main visits room and offer privacy. (2.156)

3.91 The fixed seating in the visits room should be replaced. (2.157)

3.92 The reducing reoffending policy and action plan should include clear targets for the delivery of objectives relevant to the children and families pathway. (2.158)

Appendix I: Inspection team

Martin Lomas	Team leader
Keith McInnis	Inspector
Kevin Parkinson	Inspector
Kellie Reeve	Inspector
Nicola Rabjohns	Health care 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.

(i) Status	Number of prisoners	%
Sentenced	427	*100*
Total	**427**	***100***

(ii) Sentence	Number of prisoners	%
12 months-less than 2 years	3	*0.7*
2 years-less than 4 years	70	*16.39*
4 years-less than 10 years	241	*56.44*
10 years and over (not life)	17	*3.98*
Life	96	*22.48*
Total	**427**	***100***

(iii) Length of stay	Number of prisoners	%
Less than 1 month	30	*7.03*
1 month to 3 months	56	*13.11*
3 months to 6 months	67	*15.69*
6 months to 1 year	115	*26.93*
1 year to 2 years	116	*27.17*
2 years to 4 years	43	*10.07*
4 years or more	0	*0*
Total	**427**	***100***

(iv) Main offence	Number of prisoners	%
Violence against the person	114	*26.7*
Sexual offences	120	*28.1*
Burglary	22	*5.15*
Robbery	98	*22.95*
Theft and handling	4	*0.94*
Drugs offences	22	*5.15*
Other offences	40	*9.37*
Offence not recorded/holding warrant	7	*1.64*
Total	**427**	***100***

(v) Age	Number of prisoners	%
18 years	41	*9.6*
19 years	120	*28.1*
20 years	189	*44.26*
21 years	76	*17.8*
22 years	1	*0.23*
Total	**427**	***100***

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	188	*44.03*
Between 50 and 100 miles of the prison	136	*31.85*
Over 100 miles from the prison	76	*17.8*
Overseas	2	*0.47*
No fixed address	25	*5.85*
Total	**427**	***100***

(vii) Nationality	Number of prisoners	%
British	349	*81.73*
Foreign nationals	78	*18.27*
Total	**427**	***100***

(viii) Ethnicity	Number of prisoners	%
White:		
British	193	*45.2*
Irish	2	*0.47*
Other white	24	*5.62*
Mixed:		
White and black Caribbean	20	*4.68*
White and black African	2	*0.47*
White and Asian	0	*0*
Other mixed	7	*1.64*
Asian or Asian British:		
Indian	4	*0.94*
Pakistani	9	*2.11*
Bangladeshi	7	*1.64*
Other Asian	9	*2.11*
Black or black British:		
Caribbean	67	*15.69*
African	65	*15.22*
Other black	7	*1.64*
Not stated:	7	*1.64*
Other ethnic group	4	*0.94*
Total	**427**	***100***

(ix) Religion	Number of prisoners	%
Church of England	76	*17.8*
Roman Catholic	73	*17.1*
Other Christian denominations	46	*10.77*
Muslim	99	*23.19*
Sikh	2	*0.47*
Hindu	1	*0.23*
Buddhist	6	*1.41*
Other	20	*4.68*
No religion	104	*24.36*
Total	**427**	***100***