Report on an unannounced short follow-up inspection of

HMP Blundeston

16–18 June 2008

by HM Chief Inspector of Prisons

Printed and published by:
Her Majesty's Inspectorate of Prisons
1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

Contents

Introduction

Blundeston is a category C training prison in Suffolk. By today's standards, it is a small establishment, holding 460 men, usually serving longer sentences, 40 of them in a therapeutic community.

This follow-up inspection found that, unlike many such training prisons recently inspected, Blundeston had improved since the last inspection. It remained a generally safe and respectful environment, but had also succeeded in improving its activity and resettlement work. Its main difficulty, however, was the fact that most of its prisoners were from London, not East Anglia.

The prison was reasonably safe, with little self-harm or violence, but procedures to support safer custody and violence reduction were not sufficiently robust and needed to be strengthened and managed consistently. Use of force and of the special cell was low. Drug use also appeared to be low – though there was a need to reduce and control opiate-based medication.

In the absence of in-cell sanitation, many of the prisoners at Blundeston continued to rely on a highly unsatisfactory night sanitation system. In spite of some recent improvements, its defects were evident, not least in the pervasive smell of urine on the exercise yards. Relationships between staff and prisoners were good and positive, though written documentation and personal officer work did not fully reflect this. Diversity, race and foreign nationals work had expanded, and needed to do so, given the divergence between the prison's population and its local environment and staffing.

Blundeston now had sufficient work and activity places for all its population, in spite of recently increased numbers. There was a good range of good quality education and vocational training, minimal waiting lists and good allocation arrangements. This was an area where we assessed the prison as performing well.

Resettlement had also improved significantly. The backlog of offender assessment system (OASys) assessments had been cleared, and the Foundation Training Company continued to provide excellent pre-release work. The new resettlement drop-in centre allowed prisoners easy access to the agencies and services providing advice and support. There were some areas that needed further development: there was insufficient contact between offender supervisors and prisoners, and work with lifers was underdeveloped. The main obstacle to effective resettlement, however, remained the distance from home of many prisoners, most of whom were from London or even further afield.

It is pleasing to be able to record progress at Blundeston, which is now an effective training prison with good resettlement support. It has the benefit of still being a relatively small training prison, able to rely on personal relationships and with the ability to assess and respond to its prisoners' needs. However, the continued use of unsanitary living accommodation and the distance from home of the majority of its prisoners stand as evidence of a pressurised prison system that struggles to provide decent environments and effective resettlement work for all its prisoners.

Anne Owers
HM Chief Inspector of Prisons

November 2008

Fact page

Task of the establishment
HMP Blundeston is a category C male training prison with a therapeutic community.

Area organisation
Eastern

Number held
520

Certified normal accommodation
481

Operational capacity
526

Last inspection
27 February – 3 March 2006

Brief history
HMP Blundeston opened in 1963 with four single cell wings for 288 prisoners. Two multi-cell wings were added in 1975, and the new 40-bed unit houses the therapeutic community. HMP Blundeston was a category B training prison until May 2002. The average age (30) and sentence length (mostly over four years) of the population is higher than in most category C prisons.

Description of residential units
Four wings of 72 single cells have no in-cell toilets and night sanitation arrangements apply. Two wings contain a mixture of two- and four-person cells with in-cell sanitation. The first night care unit has eight two-person cells, and a modern building houses the therapeutic community. A new unit, J wing, opened on 20 April 2008. It has 62 cells with in-cell sanitation and showers.

Section 1: Healthy prison assessment

Introduction

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

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

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

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

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

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

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

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

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

Safety

HP4 At the previous inspection in 2006, we considered that the prison was performing reasonably well against this healthy prison test. Of 18 recommendations in this area, nine had been achieved, one partially achieved and eight not achieved.

HP5 The majority of prisoners arrived from establishments in London. There were ongoing and sustained difficulties regarding the transfer of prisoners' property from these prisons, despite some efforts to resolve them.

HP6 Reception had improved slightly since the previous inspection but remained a poor facility overall. Booking-in processes were prompt, however, and prisoners did not experience unnecessary delays. All prisoners spent their first night on H wing (the induction unit). First night arrangements were appropriate. Induction was prompt and covered the necessary information. However, some prisoners were moved from the induction wing before completing all sections of the programme, and it was not clear that they were always seen later in order to complete the missing sections.

HP7 Some aspects of suicide and self-harm prevention were well managed day to day but strategic oversight was less impressive. The overarching safer custody strategy was too long and complex. Attendance at the safer custody committee was poor. Day-to-day management of prisoners in crisis was good; there had not been a self-inflicted death for many years and prisoners reported that they felt supported by the assessment, care in custody and teamwork (ACCT) process. The ACCT process was well managed overall. Listeners were well established but there was no care suite and no safer, reduced ligature accommodation.

HP8 Violence reduction was not effectively managed. Although the establishment was a relatively safe place and the number of violent incidents fairly low, the violence reduction policy did not contribute to this. There was no proper meeting structure – violence reduction issues were bolted on to the safer custody committee, and practice was inconsistent across the units. Staff had insufficient understanding of the key issues around violence reduction, and insufficient training. There was evidence of under-reporting of bullying and other violent incidents, which were not all adequately investigated. A full-time safer custody coordinator was due to be appointed in September 2008, with a view to improving consistency, raising staff awareness and better integrating the violence reduction and suicide prevention strategies.

HP9 The segregation unit was reasonably well run and prisoners spoke highly of their treatment by staff there. The unit was small, and H wing had to be used as an overspill on occasions. The regime was extremely basic. Use of force was relatively low, as was the use of special accommodation, although all prisoners located in the special cell went into strip clothing. Adjudication procedures were reasonable, although we found some cases that had not been sufficiently investigated. Some adjudication charges were trivial and could have been dealt with by other means.

HP10 Mandatory drug testing positive rates were low, at 6.8% for the 12-month period ending March 2008. Supply reduction measures worked well, and the prison had been successful in recovering a number of mobile telephones. Evidence suggested

that diverted opiate-based medication was the primary drug of use in the establishment.

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

Respect

HP12 At the previous inspection in 2006, we considered that the prison was performing reasonably well against this healthy prison test. Of 62 recommendations in this area, 29 had been achieved, 14 partially achieved, 18 not achieved and one was no longer relevant.

HP13 The quality of the environment was mixed; some parts were pleasant but there were some areas outside wings which were littered and had not been cleared for some time. Communal areas were mostly clean but the stairwells in the older units were dirty. Standards in cells were mixed. In spite of some attempts to improve access, the night sanitation arrangements remained unsatisfactory, demonstrated by the fact that parcels of excrement and bottles of urine were still thrown out of windows, as prisoners often found themselves unable to gain access to toilets when the prison was in patrol state. During the inspection, the exercise yards smelt of urine. Prisoners were able to wear their own clothes but were unable to have any clothing items sent in.

HP14 The incentives and earned privileges (IEP) scheme was ineffective. Only two prisoners were on the basic regime, and the facilities offered to prisoners on the enhanced regime did not motivate them to engage with the process. Monthly IEP reviews were meaningless and the local policy was not followed in the main.

HP15 Staff–prisoner relationships were positive and we found staff to be friendly and approachable. Many staff used prisoners' preferred name or addressed them as 'Mr...'. There was less evidence, however, that staff challenged prisoners' behaviour when necessary, and there was a general disinclination among the staff group to documenting interactions. Wing history sheets were (with some notable exceptions) very poor.

HP16 Personal officer work was also underdeveloped, and personal officers were insufficiently involved in other regime activities, such as sentence management. The local policy was not delivered. All lifers, however, had a lifer-trained personal officer.

HP17 Catering services were reasonable and the food well presented. Arrangements for the prison shop worked reasonably well and the product list was adequate.

HP18 Diversity work was developing. Initial disability pro-formas were completed by induction staff and forwarded to the disability liaison officer, but there were no personal evacuation plans for those with identified problems, and there were no specific services for older prisoners.

HP19 Around 39% of prisoners were from black and minority ethnic backgrounds, and race equality issues were, on the whole, well managed. The overarching race equality action team meetings were well structured and attended. The race equality officer was full time and supported by a deputy. The number of racist incident report forms

submitted was low, with only 16 so far in 2008. These were all handled well overall. There was good promotion of diversity, with the publication of the *Equality Matters* magazine. There were prisoner race equality representatives on each wing.

HP20 Foreign national prisoners were reasonably well catered for. Numbers had increased and foreign national prisoners now accounted for 20% of the prisoner population. A residential principal officer was the identified foreign nationals coordinator and was supported by a deputy. A monthly forum was held with prisoners to discuss foreign national issues, and staff from the UK Border Agency attended the establishment quarterly. The Immigration Advisory Service also attended. The biggest issue affecting foreign national prisoners was moving to open conditions. There was little translated material around the prison.

HP21 A carbon copy system for processing prisoner applications had been implemented owing to previous tracking problems. However, this system had been discontinued in recent months. Most responses to prisoner complaints that we reviewed were appropriate, although a small number did not deal with the issues raised. There was a quality assurance process but this did not evidence any contribution to improving standards. There were no legal services-trained officers, owing to the fact that there had been no national training course for several years. Although the demand for legal services was not especially high, there was a high and increasing number of prisoners subject to licence recall.

HP22 Chaplaincy services were good and there was a purpose-built Muslim prayer room, which, although a reasonable facility, had reached the limits of its capacity and was already too small to cater for the number of Muslim prisoners at the prison. The multi-faith room was also very small.

HP23 Links with the primary care trust were poor but had recently improved. Primary services were generally good and there was a good range of nurse-led clinics. Mental health services, however, were inadequate, although steps had been taken to address this with the recruitment of two mental health nurses, who were due to start imminently. Pharmacy provision was satisfactory, although fairly high levels of opiate-based medications were prescribed, which took on currency within the prison, given the relatively low levels of drug availability. The quality of dental services was generally good but the waiting lists, at up to six months for routine appointments, were too long.

HP24 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Purposeful activity

HP25 At the previous inspection in 2006, we considered that the prison was performing reasonably well against this healthy prison test. Of 17 recommendations in this area, 13 had been achieved, one partially achieved and three not achieved.

HP26 The education subcontractor had changed since the previous inspection, and the transition had gone well. Prisoner engagement with the education department was good and around 25% of prisoners took part in education. Some evening provision was available. The range of provision had increased, as had literacy and numeracy

support in the workshops. All prisoners had the option to attend education or work, or do both.

HP27 Library provision had improved. Library opening hours and access had increased and the library had been totally refurbished. Borrowing levels were up, and the library was well integrated with other departments. Good links had been made with embassies and other prisons to improve stock. Displays in the library and the corridor promoted reading in an interesting way, and good use was made of prisoners' talents to create displays.

HP28 There were now 546 activity places in total, which was sufficient to occupy nearly all prisoners. These included 211 places in workshops, 58 on the wings, 36 in gardens and recycling, 27 in the kitchen and eight as orderlies. A total of 186 prisoners participated in vocational training. A good range of vocational qualifications was available. Standards of work were good in workshops and the atmosphere was productive. Waiting lists were minimal and allocation arrangements were fair.

HP29 Recreational and accredited PE were well managed to maximise participation opportunities, despite staff shortages and limited facilities. A high percentage of the prison population (65%) participated in PE at least twice a week. Recreational gym use was well managed to avoid interrupting education and vocational training.

HP30 Time out of cell was satisfactory for most prisoners, and we did not observe large numbers of prisoners locked up during the core day. Exercise in the fresh air was scheduled daily.

HP31 The establishment had made considerable progress overall and was now able purposefully to occupy the overwhelming majority of prisoners, despite an increase in numbers. There was a good range of options and opportunities available to prisoners, and the prison was fulfilling its role as a training establishment. On the basis of this short follow-up inspection, we considered that the prison was now performing well against this healthy prison test.

Resettlement

HP32 At the previous inspection in 2006, we considered that the prison was not performing sufficiently well against this healthy prison test. Of 30 recommendations in this area, 12 had been achieved, 12 partially achieved and six not achieved.

HP33 The resettlement strategy was reasonable, although the needs analysis which informed it was over two years old and it did not mention the therapeutic community. The resettlement policy committee was weak and poorly attended.

HP34 The huge backlog of offender assessment system (OASys) assessments had largely been cleared, and there were only 33 outstanding at the time of the inspection. The prison attempted to apply the principles of the National Offender Management Service model to all prisoners serving over 12 months, all of whom had an offender supervisor assigned to them. However, there was insufficient contact between offender supervisors and prisoners, and prisoners were not effectively case managed.

HP35 There were 47 lifers and 21 prisoners serving indeterminate sentences for public protection (IPP). Sentence planning arrangements for IPP prisoners were the same

as those for determinate-sentenced prisoners. Lifer management was underdeveloped. The new lifer clerk had received no training and had not inherited any tracking systems for monitoring the progress of lifer reports. Several lifer dossiers were overdue, and one case had been handled extremely badly. J wing had been designated for lifers but it was too early to assess the impact of this. There had been some teething problems in transferring life sentence plans to OASys forms. Public protection procedures were generally reasonable.

HP36 Access to interventions across the resettlement pathways was generally good. There was a full-time housing advice officer, and very few prisoners were released with no fixed abode. The Foundation Training Company provided an excellent pre-release course, which was open to all prisoners. An information, advice and guidance service was also offered, and there were plans to provide prisoners with assistance in opening bank accounts. The use of release on temporary licence had increased slightly, and the resettlement drop-in centre, which had been established since the previous inspection, provided an excellent and innovative opportunity for prisoners to access information without making formal applications and appointments.

HP37 Given the location of the establishment, and the fact that many prisoners were a long distance from their homes, maintaining contact with prisoners' families and friends was extremely difficult. The prison had tried offering additional regular visits but the take-up had been low.

HP38 There had been progress in this area, and the overall provision of services, including the creation of the offender management unit (OMU), resettlement unit and drop-in centre, was significantly better than at the previous inspection. On the basis of this short follow-up inspection, we considered that the prison was now performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendation

To NOMS

2.1 There should be a long-term redevelopment plan to improve and/or replace all inadequate residential accommodation at Blundeston. (HP45)

Not achieved. There was no redevelopment plan to improve inadequate residential accommodation and no improvements had been made to the four-person cells on F and G wings, which had been deemed unacceptable for reasons of safety and decency at the previous inspection. A programme of redecoration had started, and F and G wings were being prioritised, but there had been no significant progress.
We repeat the recommendation.

Main recommendations

To the Governor

2.2 Staff should be trained in dealing with incidents that may occur through the night period, including how to access safety equipment. All night duty staff should carry anti-ligature knives. (HP44)

Achieved. All night staff had been trained in night procedures, including accessing safety equipment. All night duty staff carried anti-ligature knives, and a procedural instruction regarding their use had been issued.

2.3 A formal foreign national committee meeting should be established to ensure a holistic approach to the delivery of services to foreign national prisoners. (HP46)

Partially achieved. A foreign nationals committee meeting had not been established. However, there was a monthly foreign nationals forum, which addressed the delivery of services to foreign national prisoners and was chaired by the foreign nationals coordinator. We were unable to establish the membership of the meeting but the minutes suggested that it mainly consisted of the foreign nationals coordinator and foreign national prisoner representatives. The head of residence attended very few of the meetings, as did residential staff from some of the wings. The forum was well attended by foreign national prisoner representatives, and the coordinator utilised the meeting to share information and for consultation purposes. The meeting also addressed the services that were available to foreign national prisoners and areas that needed to be improved. The scope of the meeting and the discussions which took place were restricted by the limited membership. However, a foreign nationals strategy document, which had been written in May 2008, outlined that a foreign nationals policy committee would meet on a bi-monthly basis and consist of the heads of department from all areas of the prison, in addition to prisoner representatives.

Further recommendation

2.4 The foreign nationals policy committee, as described in the new foreign nationals strategy document, should be implemented.

2.5 The governor should approach the primary care trust to improve urgently the provision of primary mental health and in-reach services at the prison. Day care and counselling services should be introduced to improve support for prisoners. (HP47)

Partially achieved. The Norfolk and Waveney Mental Health Trust had acknowledged the need for improved mental health provision to meet the unmet needs of the prison population. They were currently advertising for two full-time registered mental health (RMN) nurses, a full-time support worker, a clinical psychologist and a staff grade psychiatrist working on a sessional basis, to supplement the current provision of one full-time in-reach RMN and a forensic psychiatrist who conducted assessments for one half-day every two weeks. There was no day care to support more vulnerable prisoners and very limited healthcare counselling services.

Additional information

2.6 The healthcare manager was keen for primary mental health and in-reach to function in a coordinated manner. Although there were two primary RMNs, one was the healthcare manager himself and the other was also a registered general nurse (RGN), a charge nurse, and involved in a variety of activities, including the smoking cessation clinic. These additional activities left them very little time to pursue their mental health interests and they did not have a caseload of primary mental health patients.

Further recommendations

2.7 All aspects of mental health provision, including primary care, in-reach and counselling services, should be developed to meet the assessed needs of prisoners.

2.8 There should be additional primary RMN provision to support the needs of more vulnerable prisoners and those with minor mental health problems.

2.9 The current backlog of OASys (offender assessment system) assessments should be reduced and an action plan developed to ensure future assessments are completed on time. (HP48)

Achieved. The backlog of OASys assessments had been reduced from around 250 in the summer of 2007 to 33 during the inspection, and there were sentence planning arrangements for nearly all newly arrived prisoners (the exception being those sentenced to under 12 months in custody). The 33 outstanding OASys assessments were mainly for longer-term and life-sentenced prisoners who had been at the prison before the offender management unit (OMU) had been set up. These were completed as and when assessor capacity allowed, and, for determinate-sentenced prisoners, at least three months before discharge. Nine lifer officers working on J wing had recently been OASys trained, and there were plans for these staff to take responsibility for this work.

2.10 There should be a full analysis of the resettlement needs of the population, as a basis for a written resettlement strategy that links in with the area rehabilitation strategy. (HP49)

Achieved. A full needs analysis of the prisoner population had been completed in the summer of 2006, and this had informed the resettlement policy, which had been published in July 2007. The psychology department provided monthly demographic data about the population for the

resettlement committee. This had resulted in changes to resettlement provision – for example, the advanced plan to introduce a healthy relationships course aimed at prisoners with a history of domestic violence.

Other recommendations — To NOMS

2.11 The progressive movement of category D prisoners with immigration issues should be addressed at national level. (6.12)

Not achieved. In the absence of clear guidance at a national level, the establishment made reference to appropriate Prison Service instructions and its own strategy document regarding the categorisation and movement of foreign national prisoners. However, the establishment appeared to be over-reliant on gathering information from the UK Border Agency (UKBA) regarding decisions to move foreign national prisoners to open conditions. At the time of the inspection, six foreign national prisoners were going through the recategorisation process, and UKBA had informed the establishment that they were pursuing a deportation order on two of the prisoners. The strategy document stated that a prisoner's deportation status remained a major factor in the risk assessment process, although it was not clear if this was the overriding factor which determined whether foreign national prisoners were transferred to open conditions. Foreign national prisoners were frustrated about the lack of clarity and the lack of movement to category D prisons, and during foreign national prisoner forum meetings they were given conflicting information about the recategorisation and allocation process.
We repeat the recommendation.

Other recommendations — To the Director General

2.12 Difficulties in the transfer of prisoner property between Blundeston and receiving establishments should be resolved to ensure that all property can be sent with prisoners when they are produced at court. (1.8)

Not achieved. One-third of all prisoner complaints were still about property. There were particular problems associated with newly arrived prisoners from London prisons, many of whom only arrived with their in-possession property. Delays of several weeks were commonplace before many prisoners received their possessions. Staff told us that dialogue had been entered into with some of the London prisons, some of which had recently made an effort to improve processes, even going as far as sending a mini-bus with bags of prisoners' property behind escort vehicles, but it was clear that significant problems remained.

Further recommendation

2.13 Prisoners' property should always travel with them when they are transferred between establishments.

2.14 The Prison Service should ensure that clinical records are transferred with all prisoners. (4.49)

Partially achieved. The transfer of clinical records with prisoners arriving from other establishments had improved, resulting in improved continuity of care. Occasionally, prisoners on medication arrived from some prisons without prescription charts and/or medicines,

resulting in medication delays for these prisoners.
We repeat the recommendation.

Other recommendations — To the Area Manager

2.15 The therapeutic community should be part of the establishment and area resettlement strategy, taking prisoners assessed as suitable from all establishments in the area. (8.36)

Partially achieved. The role of the therapeutic community was not outlined in the prison resettlement policy document, and prison managers were not aware of this being incorporated into any area-based strategy, although they were able to describe the ethos of the unit, and how this contributed to the whole prison and wider resettlement agenda. Steps had been taken to publicise the community more widely, both to prisoners at Blundeston and across the prison estate, resulting in an increase in applications from prisoners at other establishments, although the number of prisoners transferring to Blundeston specifically in order to participate in the programme was still fairly low.

Further recommendation

2.16 The aims, objectives and selection process for the therapeutic community should be included in the establishment resettlement policy.

Other recommendations — to the Governor

Arrival in custody

Courts, escorts and transfers

2.17 Unless there are good security reasons, prisoners should be told of planned moves 24 hours in advance. (1.7)

Achieved. Most prisoners were given as much notice as possible for transfers, although this depended, to some extent, on when the prison was given details of transfers by the population management unit and this sometimes only happened the day before the scheduled transfer.

First days in custody

2.18 The reception area should be refurbished and reorganised. (1.28)

Partially achieved. Limited refurbishment had taken place; a new counter had been installed and also a facility to interview prisoners in private. Holding rooms had improved and were reasonably clean, although the holding room that prisoners had to wait in when they first arrived remained a gated section of corridor. Overall, however, the environment was still far from ideal.
We repeat the recommendation.

2.19 There should be a private area in reception for healthcare staff to interview prisoners, and healthcare assessments of new receptions should take place on their day of arrival. (1.29)

Achieved. Health services staff interviewed newly arrived prisoners in the senior officer's office in reception. The room was adequate for purpose and a secure healthcare computer was installed in this office. Initial health screens took place on the day of arrival.

2.20 Prisoners should be able to make a free telephone call in private on reception or on the first night centre, and this should be documented. (1.30)

Achieved. Prisoners were given a £2.00 advance on their PIN telephone credit, which went into their account on the day of their arrival, of which only £1.50 was reclaimed. If there was a problem in accessing numbers, a free telephone call was provided from the wing office on H wing (the induction/first night unit).

2.21 Prisoners should have access to their stored property within seven days of making an application. (1.31)

Not achieved. There was a backlog of applications in reception, some of which were over three weeks old, although the number was not considerable.
We repeat the recommendation.

2.22 The strip cell area in reception should be in a more suitable environment. (1.32)

Achieved. The strip search area had been relocated within reception and provided reasonable levels of privacy.

2.23 The role of the first night centre should be clarified and an appropriately resourced strategy put in place. (1.33)

Achieved. H wing had been designated as the prison's induction unit, and all prisoners went onto this wing for their first night and subsequent induction. There was a clear strategy for inducting newly arrived prisoners, and the unit was staffed by a dedicated and enthusiastic staff group. The unit was, however, still used on occasions for prisoners unable to be located elsewhere – for example, on overspill from the segregation unit. During the inspection, one prisoner on the unit was waiting for transfer to another prison owing to mobility problems, and another had been assaulted on his normal location wing and had been relocated for his protection until his release, which was due in a few days time. However, staff told us that the frequency with which they had to deal with non-induction prisoners on the unit had reduced considerably.

2.24 Once induction is complete, prisoners in the first night centre should be given the opportunity to work and participate in the full prison regime. (1.34)

Achieved. In general, prisoners only spent two to three days in induction before being transferred onto their full-time wing and gaining access to the full range of activities. Prisoners who remained on the induction unit for longer, while waiting for a place on the main wings, were allowed to integrate with other prisoners in the rest of the prison, and participate in work and other regime activities.

2.25 All prisoners should be able to make a phone call on the day that they are received into prison. (1.35)

Achieved. See recommendation 2.20.

2.26 The first night centre should not form part of the prison's CNA. (1.36)

Not achieved. The cells in the induction unit remained part of the prison's certified normal accommodation (CNA). When the prison was full, these cells had to be filled and prisoners could then experience delays of up to two weeks before they were moved from the induction unit to their full-time unit. This was mitigated in part, however, by the improvement in the regime on this unit, and the fact that prisoners could access off-wing regime activities once they had completed induction (see recommendation 2.24).
We repeat the recommendation.

Further recommendation

2.27 The first night centre should be used only for those new to the prison.

Additional information

2.28 The reception area remained a poor facility overall, despite some superficial improvements. However, reception processes were prompt, and most of the ancillary processes took place on the first night/induction unit.

2.29 When new prisoners arrived, they were booked in by reception staff and seen by a member of the health services team. A member of staff from the induction unit attended reception to meet all new prisoners and complete the cell sharing risk assessment. Prisoners were then taken to H wing, where they were interviewed by a member of the induction team. They could shower and use the telephone on the unit. Theoretically, a duty Listener came to see all new receptions, but prisoner feedback forms showed that this often did not happen. No Insiders were used to facilitate induction.

2.30 H wing was the old inpatient facility, consisting of nine double cells. New arrivals could go into any of the cells. There were plans for one of the cells to be converted to a safer cell with fewer ligature points but progress was slow. The wing itself was clean and tidy but the cells were in a poor state of decoration.

2.31 The induction programme was variable in length. Most of it was delivered on the day after arrival and involved multidisciplinary input from staff from different departments. Education and PE induction took place on set days each week, frequently after a prisoner had moved on from the induction unit. The resettlement officer was supposed to see all new arrivals as part of their induction but, as there was no cover for his absences, he frequently had to track down new prisoners after they had moved off the induction unit. When we looked at the induction paperwork for many prisoners who had been through the process, there was often no evidence that several sections of the induction programme had been delivered.

2.32 Information to prisoners was provided through a range of leaflets. At the time of the inspection, these were being updated and compiled into a single booklet. However, no local information had been translated into foreign languages, although the national prisoner information booklet was available in a range of languages.

2.33 A brief questionnaire was given to prisoners just before they left H wing, although analysis of this feedback was underdeveloped. A brief report was sent to the head of residence each month but only focused on comments made by prisoners and missed some key data – for example, which sections of the induction programme had been missed.

2.34 Prisoners usually moved initially to F or G wing from H wing, as these were the cells with the dormitory accommodation. Occasionally, prisoners refused to move to these wings, as they did not want to go into shared accommodation. There was a local protocol for managing such cases, although it was not always followed (see paragraph 2.112).

Further recommendations

2.35 At least one Listener should be based on the induction unit.

2.36 The use of Insiders or other peer supporters should be introduced on the induction unit.

2.37 The new induction booklet should be translated into a range of appropriate foreign languages.

2.38 Prisoners should normally remain on the induction until they have completed all sections of their induction and the induction process should be expedited.

2.39 The content of the prisoner feedback forms, as well as the use that is made of the information provided, should be reviewed.

2.40 All the cells on H wing should be redecorated and subsequently maintained regularly.

Environment and relationships

Residential units

2.41 The policy on offensive displays should be promoted and consistently applied. (2.16)

Achieved. The offensive display policy statement outlined the types of materials that were permitted; this policy appeared to be observed, and prisoners and staff were aware of the materials that they could display in their cells. The policy applied to all areas of the prison, including staff offices and areas of work. Prisoners had notice boards on which they were allowed to display their art work and photographs.

2.42 There should be more telephones for prisoners on F and G wings. (2.17)

Achieved. An extra telephone had been installed on F and G wings, and they were appropriately located so that prisoners could make calls in private. During evening association, we did not observe any queues for use of the telephones and we received no specific complaints about access.

2.43 Information displayed should be kept up-to-date and be available in a variety of languages. (2.18)

Partially achieved. The information displayed on the wings was up to date. Information about the prison regime and diversity, as well as photographs of the race equality team and prisoner representatives, was displayed across the establishment. However, even though there were

over 50 different nationalities at the prison at the time of the inspection, very little displayed information was in languages other than English, although some material had been translated, such as applications and complaints forms (see recommendation 2.115). Consequently, prisoners who did not speak English had to rely on other prisoners for information.

Further recommendation

2.44 Published information should be available in a variety of languages.

2.45 Managers should ensure that staff supervise all areas of the residential units effectively. (2.19)

Achieved. Supervision of prisoners on F and G wings, as well as on the older wings, continued to be difficult owing to the location of the cells on the upper storeys, and poor sightlines. However, prison staff patrolled the wings, and during evening association they were actively present on the wings, association areas and corridors.

2.46 Staff should keep a current roll of prisoners on the unit at all times. (2.20)

Partially achieved. A basic roll board was kept on each wing and identified how many prisoners were unlocked and how many had left the wing. In addition, staff had a separate log of where each prisoner was during the morning and afternoon movements, including specialist appointments. Although staff were positive about this system, during movement back to the wings for lunch they told us that it was difficult to manage the list effectively, while supervising the return of prisoners and setting up for the lunchtime meal service.

2.47 Prisoners should be consulted monthly about the routines and facilities of the residential unit and informed of the outcome of the consultation. (2.21)

Partially achieved. There was a prisoner wing representative forum, which was chaired by a wing senior officer and attended by prisoner representatives from each of the wings. However, the meetings were only convened when issues were raised by prisoners, and were not a forum for routinely consulting with prisoners and disseminating information to them. The main issues raised concerned canteen, food and property. A meeting had been convened three times so far in 2008 but the terms of reference, membership and standing agenda items were not clear. Consequently, the appropriate staff were not always in attendance. Minutes were rudimentary and did not demonstrate that there was a breadth of discussion about prisoners' issues. As the meetings did not take place monthly, actions were not always followed up in a timely manner. We repeat the recommendation.

Further recommendation

2.48 There should be terms of reference for the prisoner consultation meetings, and the membership should be extended to include wing managers and representatives from key departments.

2.49 Prisoners who have saved for items at another establishment should be allowed to have them in possession. (2.22)

Not achieved. The establishment rejected this recommendation because the facilities list at

Blundeston allowed different items in-possession to those at other prisons.
We repeat the recommendation.

2.50 There should be additional opportunities for prisoners to use the toilet on those evenings when they are locked up for longer. (2.23)

Achieved. A, B, C and D wings continued to operate the night sanitation system, which allowed prisoners out of their cells during periods of lock-up. The night sanitation system was set according to the core day and had been reprogrammed since the previous inspection to provide more opportunities for prisoners to use these facilities during extended periods of lock-up, particularly at weekends, when prisoners were locked up from 6pm until 7.45am. Prisoners had three opportunities to use the sanitation system before evening lock-up. Once night staff came on duty, the system re-set to allow prisoners a further three exits before morning unlock (but see 2.55–2.57).

2.51 Access to toilets should not be withdrawn for misbehaviour but the incentives and earned privileges scheme should be used instead. (2.24)

Not achieved. Prisoners using the night sanitation system who exceeded the eight minutes allowed out were automatically prevented from attempting to access it for the remainder of the night. Control room staff were able to use their discretion and override this system but there was not a clear or definitive approach to dealing with such incidents. Some prisoners received incentives and earned privileges (IEP) warnings, although it was not clear if this was instead of or in addition to being denied access to the toilets.
We repeat the recommendation.

2.52 There should be separate washing facilities for prisoners to clean their eating utensils. (2.25)

Not achieved. F and G wings had no washing facilities for prisoners to clean their eating utensils; these had to be cleaned in the same basins in which they washed. The rest of the wings had washing facilities on the ground floor.
We repeat the recommendation.

2.53 Staff training records should record that staff have been trained in night procedures and fire safety. (2.26)

Achieved. Training records confirmed that, since the previous inspection, staff had been trained in night procedures and fire safety, and further refresher training was planned to ensure that staff were kept up to date on procedures.

2.54 There should be routine, targeted monitoring of mail and telephone calls by trained staff. (3.72)

Achieved. Fully trained staff carried out monitoring throughout the day and night. Night staff carried out the mandatory monitoring, and day staff random and target monitoring. Intelligence collected was submitted via a security information report and fed into the security intelligence system.

Additional information

2.55 Staff accepted that prisoners used the night sanitation system not only to access the toilets, but also to use the telephones and the showers. Prisoners complained about having to use this

system and about the length of time they had to wait in the queue. The system allowed eight prisoners to queue to be unlocked. However, if each prisoner used the full eight minutes allowed, it could take the prisoner who was last in the queue over an hour to be unlocked to use the toilets. Once the queuing system was full, prisoners had to press the call button periodically until the system had an available space.

2.56 Prisoners with medical conditions were either permitted a longer period out of their cell or were given more than three opportunities to access the night sanitation system. Control room staff were notified of prisoners who needed extra access to night sanitation.

2.57 The sanitation system was turned off during roll checks and during the night, when staff had to patrol the wings. During these times, prisoners could not use the toilets and consequently some prisoners used pots, which were issued on request.

2.58 With the opening of the 60-bed J wing in April 2008, the certified normal accommodation had increased to 481; the operational capacity was 526. J wing predominantly housed life-sentenced prisoners. During the inspection, prisoners on J wing complained that there were no chairs, which meant that they could not sit in their cells or in communal areas on the wing. Managers told us that chairs had been ordered but were still awaiting delivery.

2.59 F and G wings were in a poor decorative state, with cramped cells, and staff offices were located some distance from the cells. Despite this, prisoners we spoke to on these wings said that they preferred to be accommodated in a shared cell, as it was relaxed and they were able to share with acquaintances. Prisoners had the opportunity to move off the wing when accommodation became available on other wings but many decided to remain on these wings.

2.60 The condition of cells throughout the remainder of the prison was generally satisfactory. The main corridors displayed useful information and artwork which promoted race equality. Some of the corridors, the stairwells and parts of the grounds overlooked by some of the units were dirty and littered. The grounds were potentially a good space in which prisoners could take exercise and spend time, although the combination of litter and the smell of urine inhibited this. Managers told us that the latter was predominantly due to prisoners who relied on the night sanitation system emptying bottles of urine (and also parcels of excrement) out of their windows. The prison was trying to address this issue, although it would be difficult to eradicate while the night sanitation system was still in place.

2.61 Prisoners had the opportunity to clean their cells and laundry facilities were available on the wings. Prisoners were able to wear their own clothes but were not permitted to have any items sent in either through the post or on a domestic visit. They were allowed to purchase clothes from the catalogues available, subject to the property list and their IEP status. Prisoners had free access to telephones during association periods until 8pm.

Further recommendations

2.62 Prisoners should have access to toilets 24 hours a day.

2.63 Sufficient chairs should be available for prisoners housed on J wing.

2.64 Common internal and external areas should be cleaned daily.

2.65 Prisoners should have the facility to have their own clothes sent in to the prison, or exchanged during visits.

Staff–prisoner relationships

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

Additional information

2.66 Staff–prisoner relationships were generally good and there was ample evidence of good quality interaction between staff and prisoners, and the use of 'Mr...' and preferred names was commonplace. Staff were supportive of prisoners who had transferred to Blundeston from out of the local area, particularly on induction. The atmosphere in the prison was generally very positive, with high staff visibility, and prisoners reported that staff were some of the best they had come across.

2.67 There was less evidence, however, that staff challenged difficult behaviour as effectively. This was reflected in the poor use of the IEP system, and many adjudication charges being made for relatively trivial matters that could have been better dealt with at a lower level. We saw one case during the week where a prisoner subject to bullying procedures continued to show evidence of bullying behaviour. This had not been challenged by staff and the prisoner remained on discreet observation (see paragraph 2.74). In addition, staff were not, in general, good at recording information about prisoners in their history sheets (see section on personal officers).

Personal officers

2.68 Personal officers should be routinely involved in the sentence planning process. (2.37)

Not achieved. While personal officers were asked to provide written contributions to sentence planning boards, they were not routinely invited to attend, and rarely did. However, personal officers we spoke to were aware of the work being done by the offender management unit (OMU), and contacted them when they were required to provide reports – for example, when recategorisation was being considered.
We repeat the recommendation.

Additional information

2.69 All prisoners had an allocated personal officer. However, personal officers were, with a small number of notable exceptions, extremely poor at documenting any interactions with their prisoners, and the wing history sheets we inspected were extremely substandard. The sheets themselves had been specially designed with a view to providing direct links between personal officer comments and the IEP process. However, most files we looked at only consisted of one very brief entry from a personal officer each month, which in most cases did not reflect any meaningful contact. When talking to staff it was clear that they knew a considerable amount about their prisoners but simply did not record this anywhere, for the most part. The personal officer policy outlined an important role for them in supporting the resettlement process but did not detail how officers should achieve this and was not being followed. Personal officers were not routinely provided with information about the targets of the prisoners in their care.

Further recommendations

2.70 Personal officers' wing history entries should be detailed and demonstrate an understanding of the resettlement needs and targets of the prisoner concerned.

2.71 Personal officers should routinely be provided with a summary of the main sentence planning targets for the prisoners in their care.

Duty of care

Bullying and violence reduction

2.72 A programme of structured interventions should be drawn up and implemented to challenge bullying behaviour rigorously and effectively support victims. (3.7)

Not achieved. No interventions were available either to challenge bullies or support victims of bullying. Support was offered to victims by personal officers, and identified bullies were usually transferred out of the establishment.
We repeat the recommendation.

Additional information

2.73 Violence reduction was not effectively managed. Although prisoners reported that the establishment was a relatively safe place and the number of violent incidents was fairly low, the violence reduction policy did not contribute to this. Staff we spoke to had insufficient understanding of the key issues around violence reduction, and insufficient training. This work was managed on a temporary basis by a residential senior officer but no ring-fenced time had been allocated. A full-time safer custody coordinator was due to be appointed in September 2008, with a view to improving consistency, raising staff awareness and better integrating the violence reduction and suicide prevention strategies.

2.74 There were two discreet anti-bullying forms opened on bullies during the inspection. The quality of remarks on the forms was good. However, one of the forms clearly identified the prisoner as being involved in ongoing bullying behaviour, which staff had identified but had not followed up, and no further action was planned until the scheduled review date, which was still some time off. There was also some evidence of under-reporting, with bullying-related comments in wing history sheets not always being fed back to the safer custody officer. On one of the wings, a group of prisoners were suspected of being involved in organised bullying and, although some managers were aware of this, the information had not been passed on to the safer custody officer.

2.75 During the safer custody meeting we attended, the discussion on bullying centred on the number of complaints for which the 'bullying' box had been ticked and the number of unexplained injuries, but not all incidents were followed up or fully investigated, and trend analysis was weak. There was no discussion of the two open anti-bullying documents.

Further recommendations

2.76 A full-time violence reduction/safer custody coordinator should be appointed to manage this area of work.

2.77 Violence reduction issues should be discussed in detail at safer custody meetings.

2.78 Staff should be provided with adequate training in violence reduction and the anti-bullying processes in operation.

2.79 All complaints of bullying and unexplained injuries should be fully investigated.

Self-harm and suicide

2.80 The suicide prevention coordinator should be given allocated time for his responsibilities and a deputy should be appointed to support this role. (3.21)

Not achieved. At the time of the inspection, the full-time post of violence reduction/safer custody coordinator and the part-time (two afternoons a week) deputy post had not been permanently filled. There was a plan to fill the posts temporarily until September 2008 and permanently thereafter.
We repeat the recommendation.

2.81 Managers should look at possible duplication in suicide prevention and violence reduction work and devise a strategy to meet the needs of both areas. (3.22)

Not achieved. A safer custody approach had been developed. However, the focus of this and the safer custody meetings was predominantly suicide and self-harm prevention.
We repeat the recommendation.

2.82 Membership of the suicide prevention committee should be expanded to incorporate other departments in the prison and external agencies. (3.23)

Not achieved. The suicide prevention committee had been amalgamated into the safer custody committee, which covered suicide and self-harm, violence reduction and bullying. The membership had been expanded but did not include the anti-bullying coordinator. Attendance at the meetings was poor – there was no record of health services staff; wing staff; probation staff; Independent Monitoring Board (IMB) representatives; or counselling, assessment, referral, advice and throughcare (CARAT) workers attending the new format meetings.
We repeat the recommendation.

2.83 Family and friends should be consulted about prisoners who are at risk of self-harm and suicide, and this should be documented formally. (3.24)

Not achieved. This was not included in the new safer custody policy and was not generally considered as part of a prisoner's support plan.
We repeat the recommendation.

2.84 A care suite should be created. (3.25)

Not achieved. There was no care suite and no plan to provide one.
We repeat the recommendation.

2.85 External agencies should be consulted about the discharge protocols for prisoners at risk of self-harm. (3.26)

Not achieved. This was not included in the new safer custody policy document. All referrals were made without formal advice and guidance.
We repeat the recommendation.

2.86 There should be managerial quality checks of F2052SH (self-harm monitoring) forms. (3.27)

Achieved. Managerial quality checks of open assessment, care in custody and teamwork (ACCT) documents were carried out by the orderly officer and duty governor, and post-closure reviews by residential senior officers. Once these had been completed, an officer trained in suicide prevention carried out a quality check on all closed documents, and these were then checked by the deputy governor, who identified any issues to relevant staff. Day-to-day management of prisoners in crisis was good; there had not been a self-inflicted death for many years and prisoners reported that they felt supported by the ACCT process.

Additional information

2.87 There was insufficient training of new staff as they took up post – particularly night staff. Approximately 275 staff had received ACCT foundation training, and there were plans to deliver this to the remaining staff. All staff had been issued with anti-ligature knives but we observed several instances during the daytime period when staff were not carrying them.

2.88 There had been no permanent suicide prevention coordinator or anti-bullying coordinator for more than 12 months (see recommendation 2.80). The development of a safer custody approach to cover suicide and self-harm prevention and management, violence reduction and bullying lacked strategic leadership, and the policy was repetitive and unwieldy (141 pages). The policy was only available to staff on the Prison Service intranet.

2.89 The Listener scheme was well administered and the relationship with the Samaritans was positive. Listeners reported that they were fully supported and had no issues regarding access to prisoners at any time of the day or night. There were measures to address issues raised by prisoners with Listeners. An example of this was the provision of immigration information when the number of call-outs for immigration matters rose.

2.90 There was no safer accommodation in the establishment, although it was planned to convert a cell on the induction unit into a reduced ligature cell. We were particularly concerned about the use of the special cell in the segregation unit. All prisoners located there were strip-searched and placed in strip clothing, and these cells were used for prisoners on open ACCT documents who had self-harmed.

Further recommendations

2.91 All new staff, including those working on nights, should be given training in ACCT.

2.92 The safer custody policy document should be condensed into a more user-friendly format.

2.93 Special cells should not be used for prisoners who have self-harmed, except in exceptional circumstances.

Diversity

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

Additional information

2.94 The establishment did not have a diversity policy, and some of the diversity strands were shared among two principal officers. The race equality officer (REO) was tasked with addressing the needs of older prisoners. At the time of the inspection, 5% of the prison population (20) were over the age of 50, but the REO did not provide any specific services for such prisoners and their needs were not assessed. A principal officer who managed the offender management unit (OMU) had taken on the role of the disability liaison officer (DLO) but was not allocated any time to undertake this task. The disability policy was out of date.

2.95 The DLO had developed a disability questionnaire which staff on the first night centre were required to complete for all new receptions. This gave prisoners the option to declare any disabilities and identify how their disability affected their day-to-day activities. The forms were returned to the DLO, who then interviewed the prisoners and provided equipment and clothing to support their needs. The governor was also informed of all prisoners who declared that they had a disability.

2.96 Prisoners with hearing impairments were provided with portable hearing loops and teletext for their televisions. They could also be issued with a pager to notify them of a fire alarm, although none had been issued at the time of the inspection. The induction unit was the only accommodation that could reasonably house a prisoner with mobility issues. None of the other accommodation had adjustments for prisoners with disabilities and there were no personal emergency evacuation plans for prisoners who had been identified as having a disability. One prisoner was located in the induction unit while waiting for transfer to another prison owing to mobility issues.

2.97 At the time of the inspection, there were no prisoners receiving disability pay and the DLO told us that none of the prisoners he had assessed so far in 2008, eight in total, required equipment or additional support.

2.98 The DLO had surveyed all prisoners about their disabilities in January 2008, although only 32 questionnaires had been returned. No further action was taken as a consequence of the survey, and it appeared that the questionnaire satisfied an audit requirement rather than attempting to identify the needs of the population.

2.99 There were 263 staff in contact positions (as of March 2008), and according to training records only 52% of staff had undertaken diversity training. However, a programme of diversity training was scheduled throughout the remainder of the year.

Further recommendations

2.100 A diversity strategy should be developed, describing how the specialist needs of minority groups of prisoners, including those with disabilities, will be identified, assessed and met.

2.101 The disability liaison officer should take over responsibility for older prisoners.

Race equality

2.102 The race relations management team should discuss monitoring data, highlight potential factors as a warning and explore action where required. (3.38)

Achieved. The bi-monthly race equality action team (REAT) meeting was chaired by the governor and attended by senior managers, appropriate staff from across the establishment and race equality prisoner representatives. The membership of the REAT was well publicised across the establishment and prisoners were aware of who the REO and his deputy were. The meeting addressed all aspects of race equality across the establishment, and prisoner representatives were given the opportunity to feed back issues from prisoners. Ethnic monitoring data were discussed thoroughly, and any issues requiring action were explored.

2.103 A prisoner's cell sharing risk assessment should be reviewed whenever a finding from an investigation of a racist incident report suggests this is appropriate. (3.39)

Achieved. The REO and his deputy routinely reviewed cell sharing risk assessments (CSRAs) based on findings from investigations of racist incident report forms (RIRFs). They also carried out reviews of CSRAs on the basis of information from adjudications and the security department and wing staff. Although they managed these reviews well, there were plans for wing staff to take on this responsibility.

2.104 A list of prisoners who have been convicted of a racially motivated offence should be maintained, and residential staff should be made aware of this. (3.40)

Achieved. The REO maintained a list of all prisoners who had been convicted of a racially motivated offence and distributed it to residential staff when it was updated. The list included prisoners with previous such convictions, as well as those about whom wing staff had concerns owing to their expressing racist views.

Additional information

2.105 At the time of the inspection, 39% of the prison population were from black and minority ethnic backgrounds. There was a full-time REO, who was a principal officer, and a deputy REO, who was a prison officer and was profiled nine hours a week to undertake race equality duties. Both had been appropriately trained and had delivered training to the REAT and to the prisoner representatives. The REO was also trained in mediation techniques, although he had not provided any mediation in the year to date. Both contributed significantly to the REAT meetings and undertook racist incident investigations. All racist incident investigations were discussed in a confidential manner at the REAT. The REO provided a broad overview of the nature of the incidents and the outcome of the investigations.

2.106 There was a comprehensive race equality action plan, which incorporated actions from the REAT, relevant Prison Service Orders and previous inspection recommendations. All actions were discussed at the REAT, responsible managers were identified and the plan was continually updated.

2.107 In 2007, there had been 89 RIRFs submitted, over a quarter by staff in regard to prisoners. The REO had taken steps to address this, and a staff notice had been issued, clarifying what a racist incident was and the actions that staff should take in dealing with prisoners who identified themselves as racist.

2.108 Sixteen RIRFs had been submitted in 2008 to date. They had all been investigated thoroughly and had identified the ethnic origin of everyone involved in both the incident and investigation, to identify and address any emerging patterns. The REO had a good understanding of the complexities of racism and did not treat particular ethnic groups of prisoners homogeneously. The IMB quality checked a proportion of RIRFs and fed back to the REAT.

2.109 A monthly diversity magazine, entitled *Equality Matters*, was managed by the REO and included contributions from prisoners and staff across the establishment. Prisoners were paid £2 for their contributions .The magazine publicised who the REO and the prisoner representatives were and promoted race equality, religious events and healthy living, as well as learning and information about different departments. It also published ethnic monitoring data and encouraged prisoners to request any other types of data that they would like to see in the race equality section of the magazine.

2.110 Regular events were held to celebrate racial, ethnic and cultural diversity, and were publicised across the establishment and in the magazine. The REO was in the process of publicising Gypsy Roma Traveller month and tried to promote other cultures – not only those represented in the establishment, but also from the wider community.

2.111 During the inspection, we became aware of a prisoner on the induction unit who had told staff that he would not share accommodation with black prisoners on G wing (where he was supposed to move to). The prisoner was consequently kept on the induction landing for a few days while the matter was looked into, but then simply moved into a single cell on C wing – effectively bypassing the need to reside on F or G wings. When we looked at the prisoner's records, there was no written record of the sequence of events that had taken place. Moreover, the prisoner's CSRA had not been reviewed; the risk assessed continued to be low and he was still deemed suitable for a multi-occupancy cell. Additionally, staff on C wing were not aware that the prisoner had expressed concerns about sharing a cell with black and minority ethnic prisoners. Although the REO was told, informally, of the incident and had advised staff to interview the prisoner and then complete a RIRF, this had not taken place.

2.112 Staff told us that it was relatively common for newly arrived prisoners to refuse to share cells with particular groups or express racist views to try to avoid cell sharing in the dormitory accommodation on F and G wings. Although there was a procedure for staff to manage such situations through the disciplinary process, this was clearly not used consistently. The REO perceived it to be a situation that wing staff needed to be able to manage, submitting a RIRF, if necessary, so that the matter could be investigated.

Further recommendation

2.113 Recognised arrangements for managing and investigating prisoners who refuse to move from the induction unit to F and G wings should be applied consistently, and alleged reasons for not sharing a cell should be investigated and, where appropriate, challenged.

Foreign national prisoners

2.114 A formal and approved interpretation service should be used, especially in circumstances involving prisoner confidentiality. (3.56)

Not achieved. The Big Word interpretation service was available but we were unable to obtain information about the level of its use. However, staff told us that they rarely used it. We were

told by some foreign national prisoners that they had been used as interpreters in confidential situations, such as accompanying prisoners to the healthcare department. At a foreign nationals forum meeting, representatives had expressed the frustration of prisoners who did not speak English at not being able to communicate with staff. At this meeting, they were informed that there was a list of languages that prisoners and staff spoke and that this could be accessed by staff, but they were not informed about the interpretation service that they were entitled to use.
We repeat the recommendation.

2.115 Local documents should be translated into the range of languages appropriate to the needs of the foreign national population. (3.57)

Not achieved. Translated applications and complaints forms could be obtained by the foreign nationals coordinator, although it was not publicised across the establishment where these forms could be accessed or the fact that they were translated. Foreign national prisoners received an information and advice booklet produced by the Prison Reform Trust but received little other translated material.
We repeat the recommendation.

2.116 There should be links with the Immigration and Nationality Directorate to provide surgeries for foreign national prisoners. (3.58)

Achieved. Representatives from UKBA attended the prison quarterly to meet foreign national prisoners. They saw, on average, 12 prisoners at each visit, although up to 20 prisoners could access the service. To arrange an appointment, prisoners had to submit an application to the foreign nationals coordinator, and they were kept briefed of when UKBA was attending the establishment. The foreign nationals coordinator kept a log of the types of issue that prisoners raised (which were mainly deportation issues), as a means of providing extra support and information.

2.117 All staff should receive basic training on the distinct needs and issues facing foreign national prisoners. (3.59)

Achieved. The foreign nationals coordinator had developed a comprehensive training package for wing staff and foreign national representatives. Staff were selected by wing managers to participate in the training.

Additional information

2.118 The number of foreign national prisoners had increased. At the time of the inspection, 20% (105) of the prison population were foreign nationals; this included over 52 nationalities, with Jamaican, Nigerian and Chinese among the largest nationality groups. The full-time foreign nationals coordinator was also acting principal officer of all the residential areas, and was supported by a deputy. Prisoners were assessed on reception, and information on their nationality and language needs was recorded and passed on to the coordinator. The coordinator did not see each new foreign national prisoner but the prisoner representatives on each wing were expected to introduce themselves, and new foreign national prisoners were informed of the role of the coordinator during the induction process.

2.119 The prison had a foreign nationals policy but some of the information was out of date, and the document was lengthy and only in English. The Governor had recently signed a new strategy for the development of support and services for foreign national prisoners. The document was useful, not only to staff but also to foreign national prisoners, as it outlined all the services they

were entitled to, as well as important information concerning their options to return to their country of origin and the specialist support they could receive while at the establishment. The document had not yet been circulated.

2.120 The Immigration Advisory Service (IAS) attended the prison bi-monthly and provided legal advice to prisoners, but was unable to give advice on the progression of individual prisoners' deportation cases. This service was well used but there was some confusion from foreign national prisoners about the difference between UKBA and IAS. The foreign nationals coordinator had made attempts to clarify the difference between the two organisations.

2.121 Foreign national prisoners were given a free five-minute telephone call if they had not received a domestic visit in the preceding month. They were also able to purchase international blue telephone cards, which allowed them to make cheaper calls abroad, and they were not restricted in the amount of PIN telephone credit they were allowed to purchase.

2.122 The foreign nationals coordinator had written to the consulates and embassies of the 10 largest nationality groups among the foreign national prisoners, inviting them to send in newspapers and leaflets in their languages, and had received a good response.

2.123 Airmail letters were available to foreign national prisoners instead of the normal allocation of a prison letter, and in lieu of a visit they could receive an additional airmail letter at public expense.

2.124 An increase in the number of foreign national prisoners accessing Listeners had led the foreign nationals coordinator to provide training to Listeners. The number of foreign national prisoners accessing Listeners had decreased but was still monitored to help identify patterns of need.

Applications and complaints

2.125 There should be an auditable system for prisoner applications. All applications should be logged, and the response and date of reply recorded. (3.83)

Partially achieved. A system for applications, involving the use of carbon copy forms, had been implemented that fully met this recommendation. However, this system had been discontinued in recent months, although the reason for this was unclear. Each wing now had an applications book, although none of the wings recorded the responses or dates of reply. Some wings gave the reply directly to the prisoner, and some showed it to the prisoner and then filed it in the individual prisoner history sheets. Staff told us that the carbon copy application system was excellent and provided all the information they needed to manage applications. Since it had been discontinued, there was less confidence in the system. Prisoners told us that applications were sometimes lost or not responded to.

We repeat the recommendation.

2.126 A sample of complaint forms should be reviewed monthly by an appropriate manager to check the quality of replies to prisoners. (3.84)

Achieved. Monthly complaint form management checks were carried out, checking the quality, appropriateness and timeliness of responses. However, no record was kept of any issues raised or subsequent action taken, and it was not evident that these checks were sufficiently robust or contributed to improving standards. When we checked some completed forms, we found some responses that did not fully answer the complaint made, and evidence of inappropriate answers. For example, a prisoner who complained that he had received injuries at the prison was merely advised to contact his solicitor.

Further recommendation

2.127 The quality assurance process should be more systematic, and able to evidence actions taken when responses are found to be unsatisfactory.

Legal services

2.128 Prisoners should have ready access to effective advice from trained legal services officers. (3.89)

Not achieved. A number of staff had been identified as legal services officers. However, at the time of the inspection, the national training course had been suspended and therefore no training had been possible. Any prisoners raising legal issues were either referred to their own solicitor or a list of solicitors was provided for them to contact. While demand for this service was low, there was an increasing number of recalled prisoners requiring legal assistance.
We repeat the recommendation.

Further recommendation

2.129 The legal services course should be reinstated or alternative arrangements made to train staff in legal services.

2.130 Prisoners should be asked during their induction period if they have any outstanding legal issues. Referrals to trained staff should be made and logged. (3.90)

Not achieved. Although a resettlement officer attempted to see every prisoner on induction to identify legal issues, some were not seen. There were no trained staff for referrals (see recommendation 2.129), and therefore no log in place.
We repeat the recommendation.

Health services

2.131 The Governor should approach the primary care trust to seek a single point of focus with whom the prison could take forward the recommendations of the health needs analysis. (4.47)

Partially achieved. Although there had been some improvement with regard to more regular contact with the Great Yarmouth and Waveney Primary Care Trust (PCT), the PCT was not proactive in its involvement with the complexities of prison healthcare. There was no clear evidence that the PCT had embraced the health needs of prisoners in its overall strategy. The current health needs assessment (HNA), carried out in 2004, was out of date. However, health services staff told us that an HNA had recently been carried out and would be published in July 2008.
We repeat the recommendation.

2.132 There should be a full healthcare staffing and skill mix review to ensure that sufficient, appropriately qualified nursing, administrative and support staff are available to meet the healthcare needs of prisoners, and healthcare nursing cover should be extended to provide a more flexible service. (4.48)

Partially achieved. A staffing and skill mix review had been undertaken in 2006. This review had been informed by the HNA (see recommendation 2.132). The review identified the need for a nurse specialising in the care of older prisoners, and this post was shortly to be filled. A need for increased administrative support was also identified, and a full-time administrative officer was soon to be appointed. There were no nurses with specialist training in areas such as dual diagnosis (prisoners having both mental health and substance misuse problems) and learning disabilities. (See also 2.5–2.8 on deficits in mental health provision.)
We repeat the recommendation.

2.133 Nurses should receive professional updating to develop chronic disease management and health promotion services. (4.50)

Achieved. Access to ongoing professional training was supported. A nurse shortly to be in post was designated to develop services for lifelong conditions. A health promotion adviser from the PCT worked closely with the charge nurse. Together, they conducted a very successful smoking cessation clinic, with the best results in the county. Other health promotion initiatives were the well man and the sexual health clinics. A wide range of health promotion material was available in the healthcare waiting area.

2.134 Clinical supervision should be formally introduced. (4.51)

Not achieved. There were no formal arrangements for staff clinical supervision.
We repeat the recommendation.

2.135 Resuscitation equipment should be provided immediately, and staff should have annual training, including the use of an automated external defibrillator. (4.52)

Partially achieved. Resuscitation equipment had been purchased and a new emergency response procedure was being introduced. This involved a system of colour codes: red = life-threatening conditions, blue = less severe conditions and black = sports injuries. Discipline staff contacting the healthcare department would tell them the colour code of the emergency and health services staff would respond, taking the appropriate colour-coordinated grab bag. Three automated external defibrillators had been purchased. Discipline staff had been trained to use the defibrillator and underwent yearly updating. There was always a discipline officer on duty who had been trained in the use of the defibrillator. However, health services staff had not received this training, although they received mandatory PCT cardiopulmonary resuscitation and anaphylaxis training.

Further recommendation

2.136 Healthcare staff should be trained in the use of the automated external defibrillator.

2.137 Formal documented triage algorithms should be used to ensure consistency, continuity of care and advice to prisoners. (4.53)

Not achieved. There were no formal nurse triage algorithms. Given the diversity of experience of nursing staff, their assessments could differ greatly in the quality and outcomes. None of the nursing staff had completed any triage courses.
We repeat the recommendation.

2.138 Evidenced-based patient group directions (PGDs) should be established, and pharmacy staff should visit the prison regularly to check and reconcile medicines against

prescriptions. Stock levels should be agreed with the pharmacist at HMP Norwich and all pre-packs should be dual labelled. (4.54)

Achieved. Five PGDs had been introduced. The PCT community pharmacist visited the prison monthly and checked the balances of the controlled drugs, reviewed the prescription and administration charts, and checked the stock levels of medications. The pharmacy manager from HMP Norwich had an advisory role and attended the drugs and therapeutics committee meetings. All pre-packs were dual labelled.

2.139 Each patient should normally have one prescription and administration chart. If multiple charts are necessary they should be stapled together and numbered. (4.55)

Achieved. Most prisoners had one prescription and administration chart, and when it was necessary to have two, these were held together and numbered.

2.140 The risk assessments for in-possession provision should be targeted at those patients receiving medication, and such medicines given accordingly. (4.56)

Partially achieved. All prisoners on medication were risk assessed for in-possession (IP) supply. The IP algorithm used was very clear and took into account the relevant issues. The majority of prisoners had their medication IP for up to 28 days. Opiate-based medication was prescribed liberally, which presented a problem, as such drugs found their way onto the landings, with the potential for prisoners to be intimidated for their medication. The situation had improved slightly, with this type of medication usually being supplied IP daily and prisoners having to submit appointment slips to attend the dispensary hatch. Prisoners did not have to show identification when collecting their medications, and their photographs were not attached to the prescription charts, making it difficult to be certain of prisoners' identities.
We repeat the recommendation.

Further recommendations

2.141 Efforts should be made to reduce the amount of opiate-based medication prescribed.

2.142 Medication with the potential for abuse should not be prescribed in possession.

2.143 All prisoners should show proof of identity before medication is supplied to them.

2.144 There should be policies for the provision of notification of drug alerts and recalls, and out of hours medications. (4.57)

Achieved. Drug alerts and recalls were received by fax from the PCT and the pharmacy at HMP Norwich. Out-of-hours medication was supplied by a local pharmacy.

2.145 An electronic patient record system with supporting IT should be installed, and the healthcare manager should have a dedicated computer system. (4.58)

Achieved. SystmOne had been introduced in October 2007 and all staff had received appropriate training. The healthcare manager had a dedicated SystmOne terminal.

2.146 A healthcare box should be installed on each wing. (4.59)

No longer relevant. The free movement of prisoners around the prison meant that prisoners

passed the healthcare box, located outside the dispensary, several times a day. This box was locked, and emptied by health services staff twice a day. Prisoners and health services staff told us that the system worked well.

2.147 Cancellation of outpatient appointments should be reduced. (4.60)

Achieved. In the previous three months there had been 105 outpatient appointments, of which 11 had been cancelled for various reasons, which was a lower rate than at the previous inspection, and only one cancellation was because of the unavailability of escorting staff.

2.148 The healthcare department should hold prisoner focus groups to address prisoner issues and to inform them of changes to healthcare routines. (4.61)

Not achieved. The healthcare department had not introduced a prisoner forum in which issues of concern to prisoners could be discussed.
We repeat the recommendation.

2.149 All dental instruments should be held securely in the dental surgery. (4.63)

Achieved. All dental instruments were held in a large locked wall cabinet with clear glass doors.

2.150 The dental appointment system should be revised to include establishment of a recall system, and record keeping should comply with current legislation. (4.64)

Achieved. All patients were triaged by a primary care nurse and their details entered into the computer system as high, normal or low priority, depending on the nature of their problem. Once the prisoner had been seen by the dentist, the dental nurse used a paper-based recall system, which was later entered onto the computer. Record keeping was in line with current legislation.

2.151 The dental surgery should be reorganised to ensure the safe storage of patients' records, and the safe disposal of clinical waste. (4.65)

Achieved. The dental surgery provided appropriate locked cabinets for patients' medical records and all waste was collected by a local private contractor.

2.152 The dispensary should have additional work benches and a telephone, the floor should be replaced with a covering that meets infection control guidelines, and the hatch between the pharmacy and the corridor should be enlarged to ease communication between prisoners and staff. (4.66)

Partially achieved. Additional work benches, a telephone and new flooring had been installed. The two hatches through which medication was administered, and through which nurse triaging took place, however, were too small and this hindered effective communications.

Further recommendation

2.153 The hatch between the dispensary and the corridor should be enlarged.

2.154 There should be an emergency cupboard in the healthcare department with an agreed stock list and an out-of-hours book. (4.67)

Achieved. There was a lockable metal cupboard in the main healthcare office, with an agreed stock list of medication. A limited stock of out-of-hours medication was available in case a prisoner arrived from another prison without essential medication. This was entered into an out-of-hours book and recorded in the prisoner's clinical records.

2.155 There should be a refrigerator in the pharmacy, with daily records of maximum and minimum temperatures. (4.68)

Achieved. There was a fridge in the dispensary. Daily records of maximum and minimum temperatures were kept.

2.156 The use of Henley bags should cease. (4.69)

Partially achieved. Henley bags were used for some daily issue medication, all of which came from HMP Norwich on a named prisoner basis. All paracetamol and ibuprofen was administered to prisoners in their original packs.
We repeat the recommendation.

2.157 Medication supplies from HMP Norwich should be sealed and tamper-proof. (4.70)

Achieved. All medication from HMP Norwich was transported in a red plastic box with tamper-proof seals.

Additional information

2.158 The healthcare manager had commissioned the making of a DVD, in which health services staff promoted many of the services available at the prison, such as the well man, sexual health, smoking cessation and diabetic clinics, and dental services. This DVD was to be shown on the prison channel loop system and also in the waiting area in the healthcare department.

2.159 Triage took place on the main corridor in the healthcare department, through the small hatch from the room adjoining the dispensary. This did not offer the prisoner sufficient confidentiality, or the nurse the opportunity fully to assess prisoners' concerns. There was a private room adjoining the dispensary, which would have been perfectly adequate for triage purposes.

2.160 There were three part-time pharmacy technicians in post (1.3 whole-time equivalent). This was insufficient to promote the pharmacy service and to introduce pharmacy-led clinics. The pharmacist only attended once a month and had no prisoner contact.

2.161 Dental services were comparable to those available in the community. The dentist attended the prison one full day a week and was assisted by a dental nurse. There were 131 prisoners on the dental waiting list, resulting in lengthy waiting times for routine treatment of up to six months. Oral health promotion was only offered by the dentist during consultations. The primary care nurses conducting the dental triaging did not use the dental triage algorithm tool produced by the dentist.

2.162 Prisoners generally had good access to health services. All interactions we observed between health services staff and prisoners were polite and courteous. The healthcare manager wanted to expand the provision of healthcare services but was hampered by insufficient staff and lack of space. GP cover was satisfactory and prisoners benefited from a wide range of nurse-led clinics and visiting specialists. Mental health services were poor (see 2.5–2.8) but there were plans to address them.

Further recommendations

2.163 Nurse triaging should take place inside the room adjoining the dispensary.

2.164 There should be additional pharmacy technician and pharmacist provision to improve the service and offer pharmacy-led clinics.

2.165 A dental triage algorithm should be used to ensure appropriate prioritisation of prisoners for dental treatment.

2.166 The number of dental sessions should be increased to reduce the lengthy waiting times.

2.167 The dental nurse should provide oral health promotion clinics.

Activities

Learning and skills and work activities

2.168 The education department should provide sufficient support to the development of prisoners' numeracy and literacy skills in work activities and on residential wings. (5.12)

Achieved. Good literacy and numeracy support was provided in the workshops. One numeracy tutor and one literacy and numeracy tutor visited the workshops twice a week. The learning support assistant worked with below entry level learners on the wings and in workshops to increase their confidence. Links between education and PE had improved, and learners on accredited PE programmes received appropriate literacy and numeracy support from education staff.

2.169 The education curriculum should provide a range of more challenging educational opportunities. (5.13)

Achieved. A broad range of information technology modules at levels 1 and 2 was offered. Some modules were available at level 3, but were limited by the lack of internet access. Entry level computer classes were also available. The level of provision for longer-sentenced prisoners had increased, including Open University and distance learning. Mentoring and citizenship courses were offered. There was good learndirect provision for basic food hygiene, fork-lift truck driving and business start-up, and National Vocational Qualifications (NVQs) in supported reading and customer care.

2.170 Prisoners should have at least weekly access to a properly equipped, organised library run by trained staff. (5.14)

Achieved. A qualified librarian was employed for 30 hours each week. An assistant librarian was also employed for one day a week. Four orderlies worked part time in the library. The library was open for two days and two evenings during the week, and on Saturday morning. Groups from education visited the library each week. There was no specific daytime provision for prisoners in the workshops to visit the library but they could visit in the evenings. There were plans for a trolley service

2.171 The library stock should be improved and increased to meet the needs of prisoners. (5.15)

Achieved. Much work had been done to improve the library stock. Foreign language material, easy reading material, spoken books and the range of CD-ROMS had all improved significantly. However, the stock relating to vocational training areas, for example carpentry and welding, was still limited. A small number of legal texts and Prison Service Orders were still unavailable but the librarian had plans to address this. Book drops placed on the wings had improved the return of stock and also encouraged prisoners to donate their own books.

2.172 Plans to establish a resource-based learning centre should be progressed and implemented. (5.16)

Not achieved. The library was small, which restricted the amount of stock and the number able to access it at any time. Although there were two computers in the library, there was insufficient space for private study and relaxation.
We repeat the recommendation.

2.173 All prisoners should have the opportunity of full-time employment. (5.26)

Achieved. There were 546 purposeful activity places available in the morning and 520 available in the afternoon, for a population of 526. Apart from the 26 prisoners who were on the three-day induction, only 11 were not employed.

2.174 The pay structure should not disadvantage prisoners who have not been allocated to work. (5.27)

Achieved. Those on induction and waiting for allocation to work had lower pay than other prisoners. However, induction only lasted for three days and there was full employment, so pay soon increased.

2.175 Staff should ensure that prisoners arrive punctually for classes. (5.28)

Achieved. Prisoners arrived punctually for classes. The 10-minute movement window and penalties for late arrivals encouraged punctuality.

2.176 Classroom facilities should be available to support learning in industries. (5.29)

Achieved. Classroom facilities were available for welding, fork-lift truck driving, printing and carpentry. There were no classroom facilities for laundry workers. However, there were plans for a new laundry building, including a classroom.

2.177 Further industry-recognised vocational qualifications should be introduced (such as performing manufacturing operations in printing and packaging). (5.30)

Achieved. Progress had been made to introduce a relevant and wide range of qualifications. Effective market research had been carried out to identify skills shortages and employers' needs. New qualifications included a level 1 award in food preparation, stainless steel welding at levels 1 and 2, fork-lift truck driving, abrasive wheels, preparation for employment, waste management, horticulture and customer service. The certificate of site competence and safety, essential to those wanting to work in the construction industry, was offered. The information, advice and guidance level 3 NVQ had also been introduced. This effectively supported plans for prisoners' progression to an adult teaching certificate and then to paid employment when they left the prison. A good pre-release course ran every five weeks to help prisoners to find employment. Laundry had no accredited training, or literacy and numeracy support. The

environment was noisy and not conducive to learning. A new bricklaying workshop was planned.

2.178 Prisoners working in the kitchen or on the wing serveries should be given training for a basic hygiene certification within eight weeks of commencing work. (5.31)

Achieved. All prisoners took the qualification within eight weeks. This was checked by internal audit.

2.179 The physical resources for horticulture training should be improved, and accreditation secured for horticulture and waste management. (5.32)

Achieved. Accreditation was available and used for horticulture and waste management. A waste management block had been built containing a classroom area.

2.180 Fire exits in workshops should be kept clear. (5.33)

Achieved. Fire exits in workshops were kept clear.

Additional information

2.181 A4E had taken over as the education subcontractor. The transition had been well managed. Almost a quarter of prisoners took part in education. Three information, advice and guidance staff had been employed since the previous inspection. All prisoners had the option to attend education or work, or do both. Education and work were available full time or part time, and there was some evening provision. Sessions lasted too long, without breaks, although staff managed this well by changing activities to hold prisoners' attention. Interactive whiteboards had been fitted in some classrooms and staff were being trained in their use.

2.182 The library had been completely refurbished. The new librarian managed the library well, liaising effectively with other staff to promote its use and address prisoners' needs. She had made good links with embassies and other prisons to improve stock. Displays in the library and the corridor promoted reading in an interesting way. The prison television channel was also beginning to promote the library – for example, by featuring prisoners' book reviews. Good use was made of prisoners' talents to create library displays: for example, one prisoner had designed a graphical alphabet to assist dyslexic learners to find books.

2.183 At the time of the inspection, 186 prisoners participated in vocational training. Not all learners working in vocational training workshops opted to take qualifications. Standards of work and the quality of equipment were good in workshops. Waiting lists were minimal, and allocation to work and education was fair. Staff absences led to some workshops not operating at full capacity but most prisoners were effectively redeployed. Data were insufficiently used to monitor the quality of the provision.

Further recommendation

2.184 Data should be used effectively in education and workshops to monitor success rates on programmes and the quality of provision.

Physical education and health promotion

2.185 We repeat the recommendations in our last two reports that the physical education facilities should be improved so that more prisoners can use them and have more opportunities for purposeful activity. (5.40)

Partially achieved. A new outdoor volleyball court had been installed and was in use. Most weights equipment had been replaced and additional cardiovascular equipment had been purchased. However, no other actions had been taken to address this recommendation, despite the growth in the prison population and requests by staff for a range of developments. Although there was a small computer room, classroom facilities were inadequate. There were plans to provide a portakabin for use as a classroom.
We repeat the recommendation.

2.186 The current provision of industry-recognised qualifications in PE should be maintained. (5.41)

Achieved. NVQs at levels 1, 2 and 3 were offered, with 51 prisoners on programmes. Learners on higher level qualifications gained valuable experience coaching learners on lower levels. Level 3 learners also took the nationally recognised assessor qualification and the level 3 information, advice and guidance award. Learners could also take the community sports leader award, BAWLA Leaders Award and the customer service NVQ at level 2. Access to courses was good, and courses ran three times a year.

Additional information

2.187 Recreational and accredited PE were well managed to maximise participation opportunities, despite staff shortages and limited facilities. According to the prison's data, 65% of the prison population participated in PE at least twice a week. Recreational gym use was well managed to avoid interrupting education and vocational training. Staff were fully qualified assessors and either had or were working towards teaching awards.

Faith and religious activity

2.188 The areas used for worship should be improved to accommodate all faith needs adequately. (5.48)

Not achieved. A new Muslim prayer room had been built and opened three months before the inspection. This was located in the main corridor of the prison and accommodated up to 60 men; however, up to 65 prisoners attended Friday prayers. The multi-faith room was small and basic, accommodating up to six people at a time. It did not provide an appropriate meeting space for the range of faiths at the establishment, and contained little information or paraphernalia to indicate that it was a multi-faith room.
We repeat the recommendation.

Additional information

2.189 There were visiting chaplains of all the faiths represented among the prisoners. The Muslim chaplain was active in the prison and worked at the establishment 20 hours a week. He led

Friday prayers on alternate weeks and Muslim prisoners led the prayers in his absence, although cover arrangements were being sought.

2.190 The coordinating chaplain was not part of the senior management team but came under the management of the head of interventions. As a result, the chaplaincy team could not respond quickly to proposed changes but they felt that they had an influence at the establishment and with senior managers.

2.191 The chapel was located above the education department, up a flight of stairs, so prisoners with mobility difficulties could not access it. It was a bright, welcoming area, with space for groups and meetings to take place at the back. However, there were no toilets in the chapel.

2.192 There was a good range of faith-based classes most evenings, in addition to evening prayers, Arabic classes and a bereavement course.

Time out of cell

2.193 Prisoners not engaged in activities who remain on the wing should spend more time unlocked during the day. (5.53)

Not achieved. This recommendation had been accepted in principle; however, prisoners who were not engaged in activities remained locked up on the wings. The establishment had mitigated this to some extent by providing more work opportunities. At the time of the inspection, there were employment activities for almost half of the population, and we observed very few prisoners left on the wings during the day.

2.194 Evening association should take place each weekday. (5.54)

Not achieved. This recommendation had been accepted in principle but not achieved owing to resource implications. Prisoners continued to have access to association only from Tuesday to Friday, between 6pm and 7.50pm. The new core day was due to be introduced on 6 July 2008, which meant that association would be available on Monday to Thursday and not during the evenings on Friday to Sunday.
We repeat the recommendation.

Additional information

2.195 The establishment reported that the average time out of cell was just over 10 hours during the week and eight hours at the weekend. However, this could only be achieved by enhanced level prisoners, who had extra association during the lunchtime lock-up period seven days a week, and over the teatime lock-up period on Tuesday to Friday. Enhanced level prisoners could achieve over 11 hours out of cell.

2.196 The core day allowed a maximum of just over nine hours out of cell during the week for standard and basic level prisoners, and this would have been less for the very small number of prisoners who were unemployed.

2.197 Exercise in the fresh air was scheduled daily.

Good order

Security and rules

2.198 The location, layout and content of information for prisoners, especially that relating to the prison rules and routines, should be standardised across all wings. (6.10)

Achieved. Information about prison rules and routines was provided during induction. We did not observe any inconsistencies between displays across the different units.

2.199 There should be a system of management quality checks to ensure that categorisation guidelines are adhered to. (6.11)

Partially achieved. The system for reviewing prisoners' categorisation had changed, with a principal officer from the offender management unit (OMU) now having overall responsibility for carrying out the reviews. Personal officers completed initial assessments, which were then countersigned by their wing managers before being sent to the OMU principal officer for consideration. The quality of personal officer reports was extremely variable. Many were acceptable but some were poor. This caused delays while certain issues were re-checked by the principal officer. Although prisoners complained to us about delays in the categorisation review process, a reasonable number of prisoners (on average seven to 10 each month) were recategorised to D and moved to open conditions. Prisoners were allowed to submit representations in support of their application but this opportunity was not publicised. Individual applications were considered when the principal officer had time to fit them in.

Further recommendations

2.200 A formal recategorisation board should be convened monthly to consider all prisoners' categorisation reviews.

2.201 Prisoners should be told when their categorisation level is due for review and invited to submit representations in support of their application.

Discipline

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

Additional information

2.202 Adjudications were carried out from an appropriate room in the segregation unit. We reviewed a large number of completed records. Some of the charges were fairly trivial in nature and could have been better dealt with by other means, such as through the IEP process. The majority of completed adjudications had been appropriately conducted. However, we found examples where charges had not been fully investigated, particularly following a guilty plea. It was not clear that there was any quality assurance of completed adjudication records.

2.203 Use of force levels were relatively low. We reviewed a number of forms and were mostly satisfied that force had been authorised appropriately and used as a last resort. A use of force committee meeting was held but this focused on staffing issues, such as training and equipment, and there was no evidence of any trend analysis.

2.204 The segregation unit was small, containing 10 regular cells and two special cells. H wing was used as an overspill on occasions. The unit contained five prisoners at the time of the inspection, three for good order or discipline (GOOD) and two for their own protection. All prisoners were strip searched on first location to the unit, even those seeking protection. The regime was basic but all prisoners were offered a shower, exercise and telephone call daily. If requested, the education department would offer a cell pack to prisoners but they could not continue courses outside the unit. The only off-unit activity that prisoners could access was Friday prayers, subject to risk assessment. Prisoners that we spoke to spoke highly of the staff on the unit.

2.205 Use of the special cells was also low, although it was difficult to evidence this, as no separate log was maintained of the use of the special cells. Completed paperwork was filed with the associated use of force forms. The average length of stay in the special cells was relatively short. Some of the forms had not been clearly authorised with reasons why a prisoner was located in the special cell, rather than a normal segregation unit cell. All prisoners were strip searched on location to a special cell and placed in strip clothing, even though the special cells could also be used by prisoners on open assessment, care in custody and teamwork (ACCT) documents who had self-harmed (see 2.90).

Further recommendations

2.206 All adjudication charges should be fully investigated, regardless of plea.

2.207 A system of quality assurance should be introduced for completed adjudications.

2.208 Staff should be encouraged to deal with minor misdemeanours without always resorting to the adjudication process.

2.209 Prisoners should not be subject to routine strip-searching on admission to the segregation unit.

2.210 Subject to risk assessment, prisoners should be allowed off the segregation unit to participate in regime activities such as offending behaviour programmes.

2.211 Prisoners should only be placed into strip clothing in the special cell following the specific authorisation of the duty manager, which should be clearly indicated on the accompanying paperwork.

2.212 The use of force committee should review all use of force incidents for appropriateness and learning points, and review trends.

Incentives and earned privileges

2.213 The basic regime of the incentives and earned privileges (IEP) scheme should give prisoners the opportunity to demonstrate improvements in their behaviour, and permit them at least two hourly visits a month. (6.29)

Achieved. The IEP policy stated that prisoners on the basic regime could have at least two hourly visits each month. Prisoners were not kept for unduly long periods of time on the basic regime and were given every opportunity to progress back to the standard regime.

2.214 The necessary paperwork for prisoners on basic regime should always be completed. Staff working on the residential units should be aware of the location of this documentation, and there should be regular entries to inform review boards. (6.30)

Achieved. Staff were able to locate the paperwork for prisoners on the basic regime easily. This showed that staff had made regular written entries in the files and had good knowledge of individual circumstances.

2.215 There should be sufficient difference between the IEP levels to encourage all prisoners to aspire to enhanced status. (6.31)

Not achieved. In practice, there was little difference between standard and enhanced regime levels, particularly as the additional opportunity for visits made very little difference to most prisoners, given the overall low take-up of visits (see recommendation 2.273).

2.216 The IEP policy should specify how the scheme applies to occupants of the four-person cells to ensure that it is not undermined. (6.32)

Not achieved. The IEP policy made no specific mention of the four-person cells on F and G wings.
We repeat the recommendation.

Additional information

2.217 The IEP policy was not effective. The policy document itself was out of date and some parts were not delivered. The basis of the scheme was that personal officers were supposed to conduct a monthly review based on prisoners' behaviour, details of which should have been recorded in wing history files. However, in practice, these reviews were largely meaningless – at best, they consisted of a series of ticks on a pro-forma, but often there was no review at all, and in many of the wing history files that we looked at there were no written entries about prisoners from one month to the next.

2.218 There were only two prisoners on the basic regime at the time of the inspection, which appeared inconsistent with the high number of adjudications that took place (see paragraph 2.202). On A and C wings, the top landings were reserved for enhanced level prisoners, where they had access to a fridge; prisoners were expected to move onto this landing if they were enhanced and a space became available. The effectiveness of this system had not been evaluated, and the enhanced landings actually acted as a disincentive to some prisoners, who were settled in their existing cells and did not want to move locations. The IEP policy mentioned a system of colour-coded warnings but there was no evidence that these were used or even understood by staff. It was not clear what motivated prisoners to achieve enhanced status.

Further recommendation

2.219 The IEP policy should be subject to wholesale review, in consultation with prisoners.

Services

Catering

2.220 The food should be presented in a more attractive and palatable manner. (7.6)

Achieved. The food we observed on serveries during the inspection was well presented and plentiful. Most hot meals were served in sealed foil trays, which kept the food hot and fresh and ensured that portions were equal for all.

2.221 Servery utensils for serving halal food should be clearly identified and used only for that purpose. (7.7)

Partially achieved. Separate red serving utensils were available on serveries for halal food, although some servery workers claimed that they did not know what they were for. A set of green serving utensils was used to serve vegetable and vegetarian options in all cases we observed.

Further recommendation

2.222 The catering manager should ensure that all servery workers are aware of the purpose of the red halal-serving utensils.

Prison shop

2.223 Black and minority ethnic prisoners should be consulted to ensure that the range of goods in the prison shop meets their needs. (7.13)

Not achieved. There was no evidence of consultation with black and minority ethnic prisoners regarding the range of goods in the prison shop, despite the fact that these prisoners made up over a third of the prison population. The shop was discussed in prisoner forum meetings but these involved all prisoners, and the minutes did not indicate that there were any specific discussions regarding products that black and minority ethnic prisoners might have requested for addition to the shop list.
We repeat the recommendation.

2.224 Shop prices should more closely reflect prisoners' capacity to afford the goods on offer. (7.14)

Not achieved. A new shop list was provided each quarter. We looked at three shop lists from December 2007 to June 2008 and found that, for each quarter, over 40 products had increased in price. In the previous six months, many of the sweet products had increased twice. While the increase was nominal in most cases, for some products it was a significant increase compared with prisoners' wages. During the same period, only eight products had reduced in price. Prisoners were not told about increases in product prices, though this information would have helped them to make an informed decision about how to spend their money. Prisoners were advised of special offers.
We repeat the recommendation.

Further recommendation

2.225 Prisoners should be made aware of price increases and decreases on the shop list.

Additional information

2.226 The prison shop was managed inhouse. There were over 300 items available on the list and new receptions were able to access the shop within 24 hours.

2.227 Prisoners received their shop list on Thursday and had to submit it to staff on Monday morning. All prisoners were issued with a list with the amount available to spend. Goods were distributed to different units throughout the week, and prisoners were able to purchase fresh fruit, which was delivered once a week. All goods were delivered to prisoners' doors in a clear bag, so that errors could be identified before opening the bag.

2.228 Foreign nationals committee meetings provided an opportunity for this group to discuss the shop list, among other issues, and it was clear that some of the products that they had requested had been placed on the list.

2.229 The most recent prisoners' survey was conducted in 2007; however, staff were unable to provide the results or inform us of any action taken as a result. The range of products for black and minority ethnic prisoners was reasonable but it lacked products for Muslim prisoners, and we were told that it was difficult to source some products because of the location of the prison. There was poor consultation with black and minority ethnic prisoners (see 2.223).

2.230 At the time of the inspection, the products on sale were being reviewed as part of a national review, therefore any requests for further additions to the shop list were frozen until the review was completed.

Resettlement

Strategic management of resettlement

2.231 The resettlement policy committee should meet more regularly to oversee the implementation of the resettlement strategy and monitor progress against a detailed action plan. The role of the resettlement officer's clear up meeting (including attendance) should be agreed and formalised. (8.5)

Partially achieved. The resettlement meeting was held every other month and discussed a range of resettlement issues, but levels of attendance were often poor and we could find no evidence of residential managers in attendance. A detailed resettlement action plan had been developed, and the action points discussed and actioned. Most of the items on the plan had been achieved but some current initiatives were not included. The previous resettlement officer meeting had been replaced by a twice-monthly practitioners' meeting, which was attended by a variety of people involved in resettlement. There were terms of reference and the meeting's main aim was to discuss individually all prisoners who were within two months of release in order to ensure that all their resettlement needs had been met.

2.232 The role of personal officers in the resettlement of prisoners should be clarified. They should receive information about their prisoners from induction through to the

discharge interview. (8.6)

Not achieved. See recommendation 2.68.

Additional information

2.233 Data collected by the psychology department indicated some important changes to the demographics of the population at Blundeston. Determinate-sentenced prisoners arrived at the prison later in their sentence than was previously the case, which meant that they had less time available to complete sentence planning targets in custody. There had also been a significant decrease in the number of prisoners arriving with convictions for drug-related offences, which may have contributed to problems filling all the places available on the prison-addressing substance related offending (PASRO) accredited course. In addition, there had recently been a large influx of prisoners with indeterminate sentences for public protection (IPP), who typically had a complex range of resettlement needs (see recommendation 2.10). These changes and trends were not reflected in the needs analysis carried out in 2006, and were not dealt with in the resettlement policy document.

Further recommendations

2.234 The resettlement meeting should be attended by all key departments in the prison, and partner organisations. It should include input from a residential manager.

2.235 The resettlement action plan should be updated to reflect current priorities and initiatives.

2.236 A full resettlement needs analysis should again be conducted to establish the nature and needs of the population at the prison, and any trends identified should be reviewed by the resettlement committee to establish if current provision is adequate and appropriate to meet the needs identified.

2.237 The resettlement policy document should be updated to reflect the needs analysis, and any changes that result.

Offender management and planning

2.238 All prisoners subject to multi-agency public protection arrangements (MAPPA) should be prioritised and assessed at the earliest opportunity so that the establishment and the prisoner can address their offending behaviour and resettlement needs. (8.12)

Achieved. MAPPA cases were flagged by the custody office and referred to the public protection coordinator based in the OMU. The post-holder ensured that any MAPPA cases not already picked up through the offender management process were prioritised for offender assessment system (OASys) assessment and sentence planning.

2.239 Sentence planning boards should be reintroduced with all relevant departments invited to contribute. Families should have the opportunity to contribute, where appropriate. (8.13)

Partially achieved. Sentence planning boards were run for all in-scope prisoners, and most of those requiring an OASys review. At the time of the inspection, this constituted all but eight of the prisoner population. However, attendance at boards was usually limited to the prisoner

concerned, his offender supervisor/OASys assessor and, in some cases, an offender manager. Families were not involved in the process.

Further recommendation

2.240 Sentence planning boards should be attended by all staff working with the prisoners concerned, and families should be involved in supporting the process.

2.241 No prisoner should reach the point of discharge without a completed offender assessment system (OASys) assessment. Where possible, all identified offending behaviour needs should have been addressed before discharge. (8.14)

Achieved. Nearly all prisoners had a completed OASys and sentence plan before release, the only exceptions being those released or transferred at short notice. Places on the enhanced thinking skills (ETS) course were limited, and it was possible for some prisoners requiring the course to be released before starting it, although steps were taken to minimise this or offer alternatives.

2.242 The public protection coordinator should be given clear guidance on his role, and allocated time to carry out this task. (8.65)

Achieved. Public protection systems were well developed and implemented by a trained member of the seconded probation team, supported by a senior officer in the OMU. Both post-holders had these duties outlined in their job descriptions and were allocated sufficient time for the work.

2.243 All staff should be trained in public protection matters. There should be entries on prisoner history sheets to make staff aware of any restrictions. (8.66)

Partially achieved. Some training had been delivered to staff in public protection matters, although the package used was being revised at the time of the inspection, which meant that it had been put on hold for several months. All prisoners subject to public protection or harassment restrictions were clearly identified on the local inmate database system (LIDS).

Further recommendation

2.244 All staff in prisoner contact roles should be trained in public protection matters.

2.245 Prisoners subject to public protection measures should be made aware of the restrictions that apply to them and avenues for appeal. (8.67)

Achieved. Prisoners subject to public protection measures were notified of this in writing, and seen individually by the responsible OMU senior officer to discuss any restrictions verbally.

2.246 There should be a properly managed strategy for life-sentenced prisoners. (8.21)

Not achieved. A lifer strategy had been produced and published, but this did not reflect current systems and processes, including the use of J wing as a lifer unit.
We repeat the recommendation.

2.247 All staff working with life-sentenced prisoners should have sufficient time allocated for this work. (8.22)

Partially achieved. The newly opened J wing had been designated as a lifer wing, and staff on this unit had some allocated time to carry out basic lifer duties, including OASys assessments and sentence planning. The 16 hours a week allocated for OASys work were spread between the nine trained staff, and the work was designated as a flexible task, which meant that in reality these hours were used for other duties. This resulted in a lack of continuity and practical experience in the work, and contributed to delays in completing these assessments. Lifer officers operated in other areas of the prison, and while they were not provided with additional time to complete these duties, they did not identify this as a problem.
We repeat the recommendation.

Further recommendation

2.248 Time allocated for OASys assessments for lifers should be ring fenced, and the work delivered by a smaller number of trained officers, giving them the opportunity to develop greater expertise.

2.249 The work of lifer trained officers should be coordinated and managed by lifer managers. (8.23)

Partially achieved. The lifer manager had direct line management responsibility for lifer staff working on J wing but did not have formal responsibility for those operating on other wings, although there was liaison between the lifer manager and these staff. A number of staff working with lifers, including the lifer manager, had not been trained. This was the result of Prison Service delays in providing the new lifer training.

Further recommendation

2.250 All staff working as lifer officers and managers should attend Prison Service lifer training.

2.251 There should be effective arrangements to ensure that all relevant reports are commissioned and available on time for Parole Board hearings. (8.24)

Not achieved. Some systems that underpinned lifer work were seriously underdeveloped, which could have been a contributory factor in the cases we found where Parole Board hearings had been deferred, and dossiers late. There were significant delays in completing OASys assessments for lifers (see recommendations 2.9 and 2.247). There were also delays in receiving reports from outside probation officers, which resulted in incomplete dossiers being disclosed to prisoners before parole reviews.
We repeat the recommendation.

Further recommendation

2.252 Community-based probation officers should ensure that all reports are completed and returned to the prison by the deadline given.

2.253 Applications for escorted absences should be dealt with promptly, and prisoners should be kept informed of the progress of their applications. (8.25)

Achieved. Applications for escorted absences were dealt with promptly, although there were some delays with reports from community-based probation staff (see recommendation 2.253). There had been 14 escorted absences in the preceding year.

Additional information

2.254 The OMU dealt with 150 in-scope prisoners, comprising 98 high-risk cases, 31 prolific offenders and 21 IPPs. All these prisoners were informed within a few days of arrival at the prison who their offender supervisor was, and when they would be seen. OASys assessments were completed and sentence planning boards held within nine or 16 weeks, depending on the type of prisoner. Outside offender managers only attended these boards in about 50% of cases, although there was extensive use of telephone conferencing when face-to-face contact was not possible. Links between the OMU and other departments at the prison appeared to be strong.

2.255 The OMU was also responsible for completing OASys and sentence plans for prisoners not in-scope of offender management but who were sentenced to over 12 months in custody. Lifer management, public protection and discretionary release work was also managed from the unit.

2.256 The small number of prisoners serving sentences of less than 12 months was not provided with any form of a sentence plan, although they were seen by the resettlement officer and other relevant staff during induction, and were discussed at the practitioners' meeting two months before discharge.

2.257 The 47 life-sentenced prisoners were managed by a full-time principal officer, supported by a senior officer and lifer clerk. Some of these staff were relatively new in post and were not fully conversant with their roles. This was particularly the case for the lifer clerk, who was new to the Prison Service and to lifer work, and had not inherited good systems to manage her work.

Further recommendations

2.258 Offender managers should provide the OMU with completed and up-to-date OASys assessments within the agreed timescales.

2.259 Offender supervisors should provide more regular ongoing support to prisoners on their caseloads, with a minimum contact of once every two months.

2.260 A simple sentence planning process should be introduced to coordinate and manage resettlement work for prisoners serving less than 12 months.

2.261 The lifer clerk should be given the opportunity to shadow an experienced clerk in a nearby prison.

Resettlement pathways

2.262 Information gathered on induction about prisoners' resettlement needs should be available to all relevant departments, including personal officers. (8.58)

Partially achieved. Liaison between the various departments and external agencies working

to resettle prisoners was good, and information was exchanged to the benefit of prisoners. However, personal officers operated largely outside this process (see recommendation 2.68).

2.263 A discharge board should take place at least six months before discharge, and prisoners given assistance in addressing any outstanding resettlement needs. (8.59)

Achieved. Although the practitioners working with prisoners did not meet as a group until two months before discharge (see recommendation 2.231), this was an effective meeting, which ensured that all relevant resettlement needs were addressed before release. Each of the departments and partner agencies delivering resettlement services had a key deadline to review prisoners they had worked with before this meeting, and there was good information sharing. However, the healthcare department was not involved in this meeting.

Further recommendation

2.264 Health services staff should be represented on the discharge/pre-release board to ensure coordinated care and assistance for prisoners, so that all their healthcare needs are met.

2.265 Release on temporary licence (ROTL) should be used to meet the resettlement needs of the prisoner, and the ethnicity of prisoners gaining it should be monitored. (8.60)

Achieved. In the few months before this inspection, a more generous approach had been adopted to prisoners applying for ROTL. Out of 11 applications in the preceding year, four had been granted. Examples of ROTL being granted included leave to attend an interview, a Listeners' conference and to work outside of the establishment.

2.266 Prisoners being released from the establishment should be given assistance to find and register with a GP, if necessary. (4.62)

Not achieved. Prisoners were not given help to register with a GP.
We repeat the recommendation.

2.267 The drug strategy should be informed by a comprehensive needs analysis. (8.46)

Partially achieved. A comprehensive needs analysis had been conducted in January 2008. It consisted of a prisoner survey, a collation of drug testing data and an examination of counselling, assessment, referral, advice and throughcare (CARAT) case files to establish clients' drug- and/or alcohol-using patterns. The results had been collated in February 2008 but the strategy's action plan had not yet incorporated the findings.

Further recommendation

2.268 The needs analysis should be incorporated into the drug strategy's annual drug/alcohol action plan.

2.269 Alcohol use should be covered explicitly in the drug strategy. (8.47)

Partially achieved. The current provision of alcohol services was included in the drug strategy but prevalence, gaps in service provision and plans to address this had not yet been incorporated.
We repeat the recommendation.

2.270 Attendance at drug strategy group meetings should be improved and better reflect the membership detailed in the drug strategy. (8.48)

Not achieved. The drug strategy group met monthly but attendance was still poor. At the May 2008 meeting, only five members were represented and, in particular, there was no participation from security and residential departments. The head of reducing reoffending had recently taken over as drug strategy lead; he was assisted by a dedicated drug strategy senior officer. While there was a good level of joint work at an operational level, the strategy did not have a sufficiently high profile within the establishment.
We repeat the recommendation.

2.271 All staff on A wing should receive the training required to enable them to perform the full range of tasks. (8.49)

Not achieved. A wing, the prison's drug support unit, was staffed by 12 dedicated officers and a senior officer. All had received drug awareness training but only four had undertaken group work training. New members of staff, in particular, required further training.
We repeat the recommendation.

2.272 Substance-related work should be integrated into sentence planning. (8.50)

Achieved. The establishment now had an OMU, consisting of ring-fenced staff. The OMU and the CARAT service cross-referred clients, and CARAT care plans were incorporated into sentence plans. The P-ASRO (prison addressing substance-related offending) programme team also provided progress reports to inform sentence planning.

2.273 The visits arrangements should be improved to increase the take-up of visits, particularly for prisoners whose families live at a distance or abroad, to maintain good family contact. (3.73)

Partially achieved. Two additional visits sessions had been provided on a Friday to take account of the new accommodation and increased number of prisoners. However, take-up of visits was still poor. Only 234 of 496 available visits (47%) took place in the month preceding the inspection.
We repeat the recommendation.

Further recommendation

2.274 The views of prisoners and visitors should be sought as to how visiting could be improved or made easier.

2.275 The visits searching area should be improved to allow quicker and more appropriate searching by the drug dog. (3.74)

Achieved. The area had been improved to speed up the search process, and made child friendly. The area was now more appropriate for searching.

2.276 The higher quality visits offered to enhanced and life-sentenced prisoners should be extended to more of the general prisoner population and their visitors. (3.75)

Partially achieved. Family visits were available on the fourth Friday of every month for all prisoners, except those on the basic regime, but at the expense of some of the enhanced/lifer

visits, which took place in those months containing a fifth Friday (approximately four each year). Take-up for family visits was very good.
We repeat the recommendation.

2.277 Referrals to offending behaviour programmes should be part of a structured sentence planning process, and there should be fewer self-referrals to programmes. (8.35)

Achieved. Nearly all referrals for offending behaviour courses were made by offender supervisors working in the OMU. This was complicated for the P-ASRO accredited course, which required direct input from CARAT workers, but communication between the two departments was good.

Additional information

2.278 Prisoners had adequate access to accurate information regarding resettlement services, which were generally good. The resettlement drop-in centre was very well used. Nearly 1,000 prisoner interviews had been conducted there in the preceding year. A full-time resettlement officer and Nacro housing adviser operated out of the centre, as did a range of other providers, including Citizens Advice (CAB), Jobcentre Plus, New Deal and debt support services. In addition, a pre-release resettlement course and a range of one-to-one information, advice and guidance services were provided by the Foundation Training Company (FTC), which worked closely with the drop-in centre. Prisoner peer support workers were used to assist in this work. Prisoners we spoke to praised the resettlement support offered to them.

2.279 The resettlement officer operating out of the drop-in centre had no cover, which could result in delays when he was absent, although he ensured that all newly arrived prisoners were seen on his return to work.

2.280 The Nacro worker saw all prisoners with housing issues on arrival, and pre-discharge, to provide a range of housing advice and support. Only two prisoners had been released with no fixed abode in the preceding year, and in both cases this had been the preference of the individuals concerned. There was a tenancy awareness course, which looked at how to be a good tenant, and also dealt with rent arrears and anti-social behaviour orders. There were plans to develop this with the introduction of a prisoner peer course deliverer.

2.281 A range of vocational training opportunities was provided. Jobcentre Plus and New Deal surgeries assisted prisoners with benefit claims and job searches, and the FTC pre-release course had a strong emphasis on reintegration, elements of vocational training and employment skills, and produced CVs for those in attendance.

2.282 Health services staff did not conduct any pre-release clinics to ensure that the best possible throughcare for prisoners was achieved. If they knew about a prisoner's imminent release, they would ensure that the prisoner, if on medication, had a supply to take with him, and a discharge letter for his GP. Resettlement provision for prisoners with general and primary mental health needs was poor. Prisoners with severe and enduring mental health needs were subject to the safeguards of the care programme approach.

2.283 Debt advice was provided by CAB workers, who operated out of the drop-in centre, and Ipswich Housing Action Group provided bi-monthly individual debt counselling sessions. Plans were well developed for the FTC to provide a bank account opening service.

2.284 The establishment had introduced the integrated drug treatment system (IDTS) in December 2007. So far, only two prisoners had arrived requiring methadone maintenance. This low

number was due to a delay in the implementation of the IDTS in local prisons. Appropriate procedures and clinical protocols had been developed but there was little privacy when methadone was administered; prisoners received their medication from a hatch in a corridor, where they could be observed by other prisoners, especially as the door to B wing was left open when we attended. Prisoners requiring a treatment review or secondary detoxification could access a specialist substance misuse nurse, contracted on a sessional basis from the local community service; a specialist community GP was also available. There was good joint work between health services and CARAT staff.

2.285 CARAT services were provided by a manager and three drug workers from Alcohol and Drug Addiction Prevention and Treatment (ADAPT), who offered daily induction input, structured one-to-one work and validated group work modules: harm reduction, drug awareness and relapse prevention. Morning drop-in sessions made the service easily accessible to prisoners. The team's active caseload stood at 277, with another 100 files suspended. The CARAT contract excluded ongoing work with primary alcohol users but the service offered a five-session alcohol awareness module quarterly. At the time of the inspection, 55 prisoners were waiting for a place on the next course. There were plans for to extend the alcohol service provision. The CARAT team had developed good throughcare links with a range of drug intervention programmes, and with local community services.

2.286 Prisoners could also access the P-ASRO programme, run by a treatment manager and three facilitators, all directly employed; there was one vacancy. In the previous year, 84 prisoners had started the course, against a target of 96. Seventy participants had completed the programme, against a target of 62. A mentor scheme offered additional support during the course.

2.287 The prison operated a compliance testing scheme for the majority of its population, with 454 existing compacts against a target of 370. The scheme was well coordinated and wing officers achieved the required testing frequency. On A wing, testing took place twice a month. Positive results were discussed at a 'review and support' panel. The establishment's mandatory drug testing positive rate averaged 6.8% for the 12-month period ending March 2008, against a target of 11%. The main drug of use was diverted opiate-based medication. Comprehensive supply reduction measures had been developed, with a large number of mobile telephones found, but the level of suspicion testing was low and only resulted in a 20% positive rate.

2.288 The location of Blundeston in the Suffolk countryside made it a difficult place for visitors to get to. In addition, many prisoners were a long distance from their homes (over 400 at the time of the inspection). Many out-of-area prisoners stated that they did not have visits owing to the distances and costs involved for their families. There were a number of complaints regarding transfers to prisons nearer prisoners' homes. However, efforts had been made to make visits more accessible (see recommendation 2.273).

2.289 The prison provided transport from the local train station to the establishment, and this could be booked at the time of booking the visit. There were no complaints about the bookings process.

2.290 Families were not routinely involved in matters affecting prisoners, including sentence planning and safer custody matters. An SOS helpline was advertised to visitors to encourage families and friends to contact staff if they had concerns about family members.

2.291 Information about assisted visits and visits in general, including accumulated visits, was provided at induction. These were available by application, although few prisoners had applied in recent months. Prisoners could also apply for additional family/child visits in the case of

urgent need, and these would be considered by the head of residence. No recent applications had been received. Prisoners who did not receive regular visits were not able to exchange visiting orders for additional telephone calls/PIN telephone credit.

2.292 The Ormiston Trust had provided a parenting skills course, although funding for this had just ended. Prisoners who had undertaken the course were encouraged to book family visits and use the skills learnt during these visits. The Trust also provided a facility for prisoners to record stories on CD for their children.

2.293 There were no visits sessions scheduled during the inspection. The governor provided written evidence from visitors that visits staff were friendly, polite, helpful and the best they had come across. It was therefore also not possible to observe whether the improved dog search facility worked to speed up visits, although anecdotally this appeared to be the case. The visiting area was reasonable, and efforts had been made to make it bright and comfortable. The dog searching team had gone to considerable lengths to make their procedures child friendly.

2.294 The prison offered three accredited offending behaviour courses. These were ETS (with 54 places available each year), controlling anger and learning to manage it (CALM; with 28 places available) and P-ASRO (with 96 places available). While there was a waiting list for ETS, this was not the case for CALM and P-ASRO. Plans were well advanced to deliver the healthy relationship course.

2.295 There were plans to abandon the Friday domestic visits in favour of enhanced visits for prisoners undertaking an offending behaviour course. This would entail families being invited to pre-course assessments and becoming involved in the process of addressing offending behaviour.

Further recommendations

2.296 The resettlement officer should have a deputy to cover for him when he is absent from work.

2.297 Sufficient services should be provided for prisoners with alcohol problems.

2.298 The establishment should ensure that the mandatory drug testing programme is adequately resourced to undertake the required level of target testing.

2.299 Prisoners who do not receive regular visits should be able to exchange visiting orders for additional telephone calls/PIN telephone credit.

2.300 The parenting course should be reinstated and made available to all prisoners with children.

Section 3: Summary of recommendations

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

Main recommendation (from the previous report) — To NOMS

3.1 There should be a long-term redevelopment plan to improve and/or replace all inadequate residential accommodation at Blundeston. (2.1)

Other recommendations — To NOMS

3.2 The progressive movement of category D prisoners with immigration issues should be addressed at national level. (2.11)

3.3 Prisoners' property should always travel with them when they are transferred between establishments. (2.13)

3.4 The Prison Service should ensure that clinical records are transferred with all prisoners. (2.14)

3.5 The legal services course should be reinstated or alternative arrangements made to train staff in legal services. (2.129)

3.6 All staff working as lifer officers and managers should attend Prison Service lifer training. (2.250)

3.7 Community-based probation officers should ensure that all reports are completed and returned to the prison by the deadline given. (2.252)

3.8 Offender managers should provide the OMU with completed and up-to-date OASys assessments within the agreed timescales. (2.258)

Other recommendations — To the Area Manager

3.9 The aims, objectives and selection process for the therapeutic community should be included in the establishment resettlement policy. (2.16)

Recommendations — to the Governor

First days in custody

3.10 The reception area should be refurbished and reorganised. (2.18)

3.11 Prisoners should have access to their stored property within seven days of making an application. (2.21)

3.12 The first night centre should not form part of the prison's CNA. (2.26)

3.13 The first night centre should be used only for those new to the prison. (2.27)

3.14 At least one Listener should be based on the induction unit. (2.35)

3.15 The use of Insiders or other peer supporters should be introduced on the induction unit. (2.36)

3.16 The new induction booklet should be translated into a range of appropriate foreign languages. (2.37)

3.17 Prisoners should normally remain on the induction until they have completed all sections of their induction and the induction process should be expedited. (2.38)

3.18 The content of the prisoner feedback forms, as well as the use that is made of the information provided, should be reviewed. (2.39)

3.19 All the cells on H wing should be redecorated and subsequently maintained regularly. (2.40)

Residential units

3.20 Published information should be available in a variety of languages. (2.44)

3.21 Prisoners should be consulted monthly about the routines and facilities of the residential unit and informed of the outcome of the consultation. (2.47)

3.22 There should be terms of reference for the prisoner consultation meetings, and the membership should be extended to include wing managers and representatives from key departments. (2.48)

3.23 Prisoners who have saved for items at another establishment should be allowed to have them in possession. (2.49)

3.24 Access to toilets should not be withdrawn for misbehaviour but the incentives and earned privileges scheme should be used instead. (2.51)

3.25 There should be separate washing facilities for prisoners to clean their eating utensils. (2.52)

3.26 Prisoners should have access to toilets 24 hours a day. (2.62)

3.27 Sufficient chairs should be available for prisoners housed on J wing. (2.63)

3.28 Common internal and external areas should be cleaned daily. (2.64)

3.29 Prisoners should have the facility to have their own clothes sent in to the prison, or exchanged during visits. (2.65)

Personal officers

3.30 Personal officers should be routinely involved in the sentence planning process. (2.68)

3.31 Personal officers' wing history entries should be detailed and demonstrate an understanding of the resettlement needs and targets of the prisoner concerned. (2.70)

3.32 Personal officers should routinely be provided with a summary of the main sentence planning targets for the prisoners in their care. (2.71)

Bullying and violence reduction

3.33 A programme of structured interventions should be drawn up and implemented to challenge bullying behaviour rigorously and effectively support victims. (2.72)

3.34 A full-time violence reduction/safer custody coordinator should be appointed to manage this area of work. (2.76)

3.35 Violence reduction issues should be discussed in detail at safer custody meetings. (2.77)

3.36 Staff should be provided with adequate training in violence reduction and the anti-bullying processes in operation. (2.78)

3.37 All complaints of bullying and unexplained injuries should be fully investigated. (2.79)

Self-harm and suicide

3.38 The suicide prevention coordinator should be given allocated time for his responsibilities and a deputy should be appointed to support this role. (2.80)

3.39 Managers should look at possible duplication in suicide prevention and violence reduction work and devise a strategy to meet the needs of both areas. (2.81)

3.40 Membership of the suicide prevention committee should be expanded to incorporate other departments in the prison and external agencies. (2.82)

3.41 Family and friends should be consulted about prisoners who are at risk of self-harm and suicide, and this should be documented formally. (2.83)

3.42 A care suite should be created. (2.84)

3.43 External agencies should be consulted about the discharge protocols for prisoners at risk of self-harm. (2.85)

3.44 All new staff, including those working on nights, should be given training in ACCT. (2.91)

3.45 The safer custody policy document should be condensed into a more user-friendly format. (2.92)

3.46 Special cells should not be used for prisoners who have self-harmed, except in exceptional circumstances. (2.93)

Diversity

3.47 A diversity strategy should be developed, describing how the specialist needs of minority groups of prisoners, including those with disabilities, will be identified, assessed and met. (2.100)

3.48 The disability liaison officer should take over responsibility for older prisoners. (2.101)

Race equality

3.49 Recognised arrangements for managing and investigating prisoners who refuse to move from the induction unit to F and G wings should be applied consistently, and alleged reasons for not sharing a cell should be investigated and, where appropriate, challenged. (2.113)

Foreign national prisoners

3.50 The foreign nationals policy committee, as described in the new foreign nationals strategy document, should be implemented. (2.4)

3.51 A formal and approved interpretation service should be used, especially in circumstances involving prisoner confidentiality. (2.114)

3.52 Local documents should be translated into the range of languages appropriate to the needs of the foreign national population. (2.115)

Applications and complaints

3.53 There should be an auditable system for prisoner applications. All applications should be logged, and the response and date of reply recorded. (2.125)

3.54 The quality assurance process should be more systematic, and able to evidence actions taken when responses are found to be unsatisfactory. (2.127)

Legal rights

3.55 Prisoners should have ready access to effective advice from trained legal services officers. (2.128)

3.56 Prisoners should be asked during their induction period if they have any outstanding legal issues. Referrals to trained staff should be made and logged. (2.130)

Health services

3.57 All aspects of mental health provision, including primary care, in-reach and counselling services, should be developed to meet the assessed needs of prisoners. (2.7)

3.58 There should be additional primary RMN provision to support the needs of more vulnerable prisoners and those with minor mental health problems. (2.8)

3.59 The Governor should approach the primary care trust to seek a single point of focus with whom the prison could take forward the recommendations of the health needs analysis. (2.131)

3.60 There should be a full healthcare staffing and skill mix review to ensure that sufficient, appropriately qualified nursing, administrative and support staff are available to meet the healthcare needs of prisoners, and healthcare nursing cover should be extended to provide a more flexible service. (2.132)

3.61 Clinical supervision should be formally introduced. (2.134)

3.62 Healthcare staff should be trained in the use of the automated external defibrillator. (2.136)

3.63 Formal documented triage algorithms should be used to ensure consistency, continuity of care and advice to prisoners. (2.137)

3.64 The risk assessments for in-possession provision should be targeted at those patients receiving medication, and such medicines given accordingly. (2.140)

3.65 Efforts should be made to reduce the amount of opiate-based medication prescribed. (2.141)

3.66 Medication with the potential for abuse should not be prescribed in possession. (2.142)

3.67 All prisoners should show proof of identity before medication is supplied to them. (2.143)

3.68 The healthcare department should hold prisoner focus groups to address prisoner issues and to inform them of changes to healthcare routines. (2.148)

3.69 The hatch between the dispensary and the corridor should be enlarged. (2.153)

3.70 The use of Henley bags should cease. (2.156)

3.71 Nurse triaging should take place inside the room adjoining the dispensary. (2.163)

3.72 There should be additional pharmacy technician and pharmacist provision to improve the service and offer pharmacy-led clinics. (2.164)

3.73 A dental triage algorithm should be used to ensure appropriate prioritisation of prisoners for dental treatment. (2.165)

3.74 The number of dental sessions should be increased to reduce the lengthy waiting times. (2.166)

3.75 The dental nurse should provide oral health promotion clinics. (2.167)

Learning and skills and work activities

3.76 Plans to establish a resource-based learning centre should be progressed and implemented. (2.172)

3.77 Data should be used effectively in education and workshops to monitor success rates on programmes and the quality of provision. (2.184)

Physical education and health promotion

3.78 We repeat the recommendations in our last three reports that the physical education facilities should be improved so that more prisoners can use them and have more opportunities for purposeful activity. (2.185)

Faith and religious activity

3.79 The areas used for worship should be improved to accommodate all faith needs adequately. (2.188)

Time out of cell

3.80 Evening association should take place each weekday. (2.194)

Security and rules

3.81 A formal recategorisation board should be convened monthly to consider all prisoners' categorisation reviews. (2.200)

3.82 Prisoners should be told when their categorisation level is due for review and invited to submit representations in support of their application. (2.201)

Discipline

3.83 All adjudication charges should be fully investigated, regardless of plea. (2.206)

3.84 A system of quality assurance should be introduced for completed adjudications. (2.207)

3.85 Staff should be encouraged to deal with minor misdemeanours without always resorting to the adjudication process. (2.208)

3.86 Prisoners should not be subject to routine strip-searching on admission to the segregation unit. (2.209)

3.87 Subject to risk assessment, prisoners should be allowed off the segregation unit to participate in regime activities such as offending behaviour programmes. (2.210)

3.88 Prisoners should only be placed into strip clothing in the special cell following the specific authorisation of the duty manager, which should be clearly indicated on the accompanying paperwork. (2.211)

3.89 The use of force committee should review all use of force incidents for appropriateness and learning points, and review trends. (2.212)

Incentives and earned privileges

3.90 The IEP policy should specify how the scheme applies to occupants of the four-person cells to ensure that it is not undermined. (2.216)

3.91 The IEP policy should be subject to wholesale review, in consultation with prisoners. (2.219)

Catering

3.92 The catering manager should ensure that all servery workers are aware of the purpose of the red halal-serving utensils. (2.222)

Prison shop

3.93 Black and minority ethnic prisoners should be consulted to ensure that the range of goods in the prison shop meets their needs. (2.223)

3.94 Shop prices should more closely reflect prisoners' capacity to afford the goods on offer. (2.224)

3.95 Prisoners should be made aware of price increases and decreases on the shop list. (2.225)

Strategic management of resettlement

3.96 The resettlement meeting should be attended by all key departments in the prison, and partner organisations. It should include input from a residential manager. (2.234)

3.97 The resettlement action plan should be updated to reflect current priorities and initiatives. (2.235)

3.98 A full resettlement needs analysis should again be conducted to establish the nature and needs of the population at the prison, and any trends identified should be reviewed by the resettlement committee to establish if current provision is adequate and appropriate to meet the needs identified. (2.236)

3.99 The resettlement policy document should be updated to reflect the needs analysis, and any changes that result. (2.237)

Offender management and planning

3.100 Sentence planning boards should be attended by all staff working with the prisoners concerned, and families should be involved in supporting the process. (2.240)

3.101 All staff in prisoner contact roles should be trained in public protection matters. (2.244)

3.102 There should be a properly managed strategy for life-sentenced prisoners. (2.246)

3.103 All staff working with life-sentenced prisoners should have sufficient time allocated for this work. (2.247)

3.104 Time allocated for OASys assessments for lifers should be ring fenced, and the work delivered by a smaller number of trained officers, giving them the opportunity to develop greater expertise. (2.248)

3.105 There should be effective arrangements to ensure that all relevant reports are commissioned and available on time for Parole Board hearings. (2.251)

3.106 Offender supervisors should provide more regular ongoing support to prisoners on their caseloads, with a minimum contact of once every two months. (2.259)

3.107 A simple sentence planning process should be introduced to coordinate and manage resettlement work for prisoners serving less than 12 months. (2.260)

3.108 The lifer clerk should be given the opportunity to shadow an experienced clerk in a nearby prison. (2.261)

Resettlement pathways

3.109 Health services staff should be represented on the discharge/pre-release board to ensure coordinated care and assistance for prisoners, so that all their healthcare needs are met. (2.264)

3.110 Prisoners being released from the establishment should be given assistance to find and register with a GP, if necessary. (2.266)

3.111 The needs analysis should be incorporated into the drug strategy's annual drug/alcohol action plan. (2.268)

3.112 Alcohol use should be covered explicitly in the drug strategy. (2.269)

3.113 Attendance at drug strategy group meetings should be improved and better reflect the membership detailed in the drug strategy. (2.270)

3.114 All staff on A wing should receive the training required to enable them to perform the full range of tasks. (2.271)

3.115 The visits arrangements should be improved to increase the take-up of visits, particularly for prisoners whose families live at a distance or abroad, to maintain good family contact. (2.273)

3.116 The views of prisoners and visitors should be sought as to how visiting could be improved or made easier. (2.274)

3.117 The higher quality visits offered to enhanced and life-sentenced prisoners should be extended to more of the general prisoner population and their visitors. (2.276)

3.118 The resettlement officer should have a deputy to cover for him when he is absent from work. (2.296)

3.119 Sufficient services should be provided for prisoners with alcohol problems. (2.297)

3.120 The establishment should ensure that the mandatory drug testing programme is adequately resourced to undertake the required level of target testing. (2.298)

3.121 Prisoners who do not receive regular visits should be able to exchange visiting orders for additional telephone calls/PIN telephone credit. (2.299)

3.122 The parenting course should be reinstated and made available to all prisoners with children. (2.300)

Appendix I: Inspection team

Jonathan French	Team leader
Vinnett Pearcy	Inspector
Karen Dillon	Inspector
Sean Sullivan	Inspector
Sigrid Engelen	Substance misuse inspector
Margot Nelson-Owen	Healthcare inspector
Marina Gaze	Ofsted inspector
Tim Gardner	Ofsted inspector

Appendix II: Prison population profile

(i) Status	Number of prisoners	%
Sentenced	523	99.5
Convicted but unsentenced	0	
Remand	0	
Civil prisoners	0	
Detainees (single power status)	3	0.5
Detainees (dual power status)		
Total	**526**	**100**

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	4	0.7
6 months to less than 12 months	4	0.7
12 months to less than 2 years	20	3.8
2 years to less than 4 years	127	24.3
4 years to less than 10 years	285	54.5
10 years and over (not life)	15	2.9
Life	68	13.1
Total	**523**	**100**

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month				
1 month to 3 months				
3 months to 6 months				
6 months to 1 year				
1 year to 2 years				
2 years to 4 years				
4 years or more				
Total				

(iv) Main offence	Number of prisoners	%
Violence against the person		
Sexual offences		
Burglary		
Robbery		
Theft and handling		
Fraud and forgery		
Drugs offences		
Other offences		
Civil offences		
Offence not recorded/ Holding warrant		
Total		

(v) Age	Number of prisoners	%
21 years to 29 years	242	46
30 years to 39 years	168	32
40 years to 49 years	87	16.5
50 years to 59 years	18	3.3
60 years to 69 years	10	2
70 plus years	1	0.1
Please state maximum age	70	
Total	**526**	**100**

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison		
Between 50 and 100 miles of the prison		
Over 100 miles from the prison		
Overseas		
NFA		
Total		

(vii) Nationality	Number of prisoners	%
British	420	80
Foreign Nationals	106	20
Total	**526**	**100**

(viii) Ethnicity	Number of prisoners	%
White		
British	265	50
Irish	6	1.1
Other White	53	10.2
Mixed		
White and Black Caribbean	7	1.3
White and Black African	1	0.2
White and Asian	2	0.4
Other Mixed	4	0.8
Asian or Asian British:		
Indian	7	1.3
Pakistani	1	0.2
Bangladeshi	7	1.3
Other Asian	19	3.6
Black or Black British		
Caribbean	96	18.2
African	30	5.8
Other Black	14	2.7
Chinese or other ethnic group		
Chinese	5	1
Other ethnic group	9	1.7
Total	**526**	**99.9**

(ix) Religion	Number of prisoners	%
Baptist	3	0.6
Church of England	133	25.3
Roman Catholic	93	17.7
Other Christian denominations	11	2.1
Muslim	94	17.9
Sikh	3	0.6
Hindu	1	0.2
Buddhist	15	2.8
Jewish	1	0.2
Other	34	6.5
No religion	138	26.2
Total	**526**	**100.1**