Report on an unannounced short follow-up inspection of

HMP Bristol

3–6 March 2008

by HM Chief Inspector of Prisons

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Introduction

HMP Bristol is a local prison, holding around 600 prisoners – 26% above its uncrowded capacity. It suffers from many of the problems associated with population pressure: 300 prisoner movements a week, some unsuitable accommodation, insufficient activity spaces and difficulties in resettlement planning for a transient population. It is a measure of the task facing managers that, although this inspection did find improvements, the prison still remained deficient in relation to safety, respect and purposeful activity.

Prisoners arriving at Bristol faced long delays in court and on escort vehicles, as well as a cramped and inadequate reception environment. Population pressure meant that not all new arrivals were allocated to the first night centre, and therefore missed out on important first night support and procedures. There were weaknesses in safer custody work, including the cross-deployment of the manager responsible, and a shortfall in staff training and awareness of contingency arrangements. While the segregation unit was in general well-managed, some records of adjudications showed that there had been wholly inadequate investigation of the charges.

Accommodation remained inadequate, with prisoners sharing cells meant for one, and no internal sanitation on one wing. Although staff–prisoner relationships were in general good, there was no effective personal officer scheme and black and minority ethnic prisoners continued to report worse treatment than white prisoners. In that context, it was disappointing that race relations work was significantly underdeveloped, with an ineffective race equality action team and little interrogation of data. Conversely, we were extremely encouraged by the significant developments in all aspects of health services.

Purposeful activity had improved since the last inspection, when it was assessed as poor – with more education and better links between learning and sentence planning. However, a third of prisoners were unable to engage in activity at any one time, and there was still a dearth of vocational training to provide employment-related skills. In spite of recorded time out of cell of eight and a half hours a day, we found 45% of prisoners locked in their cells during the core day.

Resettlement had also improved, with an effective strategy and partnerships with local community groups. There were still some shortfalls in sentence and custody planning, and a lack of support for life-sentenced prisoners who remained for too long at Bristol. But overall, the prison was now performing reasonably well in this area, and a planned new resettlement unit would further improve this work.

Managers at Bristol had succeeded in reversing the decline we recorded at the last inspection. As a consequence, we were able to raise two of our assessments. However, in spite of these efforts, the effects of continued population pressure meant that Bristol was not yet performing well enough in three crucial areas – safety, respect and activity.

Anne Owers — June 2008
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Bristol is a local prison serving the courts in Avon, Somerset and Wiltshire.

Area organisation
South West

Number held
597

Certified normal accommodation
476

Operational capacity
606

Last inspection
10–14 January 2005

Brief history
HMP Bristol is a Victorian prison, which opened in 1883. In recent years, it has changed its role from a category A to category B prison.

Description of residential units
The accommodation consisted of a mixture of Victorian galleried landings, with B and C wings being of 1960s T-shape closed landing design.

A wing – Induction, detoxification, first night centre
B wing – General and resettlement
C wing – Voluntary drug testing and integrated drug treatment system unit
D wing – Safer custody and vulnerable prisoner unit
E wing – Segregation unit
F wing – Dedicated resettlement unit for release on temporary licence
G wing – General wing
HCC – Healthcare centre

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 2005, we considered that the prison was not performing sufficiently well against this healthy prison test. Of 36 recommendations in this area, 14 had been achieved, 11 partially achieved and 11 not achieved. We have made 12 further recommendations.

HP5 Changes to prison staff attendance arrangements now meant that escorts were despatched more promptly in the mornings and there were fewer delayed arrivals in court as a result. However, there were still significant numbers of occasions when prisoners were held back in court cells for lengthy periods before being returned to the establishment.

HP6 The number of prisoners passing through reception had increased significantly since 2005, with over 300 passing through the area weekly. Prisoners were held on escort vehicles for lengthy periods. The prison reception building had been severely criticised as inadequate at the time of the previous inspection. Holding rooms for prisoners still had no natural light and there was little private space in which confidential interviews could take place. However, it was clean and tidy, and there was a redecoration programme underway. Closed-circuit television coverage had been introduced. There was a Listener in reception.

HP7 Trained Insiders worked on the first night centre, but not all new receptions were allocated directly there because of pressure on space, so access to Insiders was not guaranteed for all new receptions. There was no evidence that first night work was subsequently carried out with prisoners who did not go directly to the first night centre.

HP8 The induction programme started on the day after reception and provided a useful set of information for new arrivals. However, there was inadequate tracking to ensure that every prisoner passed through the system.

HP9 A safer custody/violence reduction manager post had recently been established but the post holder was regularly cross-deployed to other duties. A new policy document had been published and there was better analysis of data, and the investigations we reviewed were good. Nevertheless, there were examples of under-reporting of bullying incidents. There were no interventions for persistent bullies or victims.

HP10 Listeners reported that they felt supported by staff and had unhampered access to prisoners. Not all staff had completed assessment, care in custody and teamwork (ACCT) training, and awareness of contingency arrangements was weak.

HP11 Segregation unit staff had had some mental health training, but not enough, and there was a programme to ensure that all those working in this area were trained. Prisoners held in the segregation unit were now offered a daily shower.

HP12 There were fewer uses of the special cell than at the time of the previous inspection and we found evidence that prisoners were not being held there for longer than was

necessary. Some records of adjudications showed that there had been wholly inadequate investigation.

HP13 There was good clinical management of drugs, with needs-based prescribing. The integrated drug treatment system (IDTS) rollout within a few weeks of the inspection would provide additional support. Of those tested under the mandatory drug testing programme, 11.3% tested positive.

HP14 A small number of prisoners under the age of 21 were being held and, other than a few designated cells, there were still no specific arrangements to manage them.

HP15 On the basis of this short follow-up inspection, we considered that the prison was still not performing sufficiently well against this healthy prison test.

Respect

HP16 At the previous inspection in 2005, we considered that the prison was not performing sufficiently well against this healthy prison test. Of 52 recommendations in this area, 23 had been achieved, 13 partially achieved and 16 not achieved. We have made 14 further recommendations.

HP17 Some single cells accommodated two men, and cells on B wing still had no internal sanitation. There were limitations on the frequency with which prisoners could have showers. Consultation arrangements with prisoners were not consistent and there were delays in posting out mail.

HP18 The personal officer scheme had been re-launched, but there was little recorded evidence in wing files of contacts between staff and prisoners. Observed staff–prisoner relationships appeared to be good, but some prisoners, particularly from minority backgrounds, were more alienated from staff than their white counterparts.

HP19 The race equality agenda was significantly underdeveloped. The work of the race equality officer was not sufficiently supported, the race equality action team was ineffective, and there was little interrogation of data. The race investigations we reviewed were generally good, but there were some delays in dealing with them. The establishment had identified the need to re-establish links with relevant external organisations, but these remained underdeveloped.

HP20 A foreign nationals policy had been written and some training delivered to staff, but the policy was not well developed and little was being done to provide support for these prisoners.

HP21 Health services had significantly improved since the previous inspection. There was strong clinical leadership, and good relationships with both the primary care trust and the mental health trust. Primary care services were good, with a wide range of nurse-led clinics in operation. Inpatient services were also good, although there were too many prisoners in the healthcare centre who were not there because of clinical need. Mental health services provided a holistic care pathway for prisoners.

HP22 Applications were not consistently recorded by staff, and there was no quality assurance of replies. Although trends in prisoner complaints were monitored, no quality assurance of the responses was taking place.

HP23 The incentives and earned privileges (IEP) scheme was well understood by staff and prisoners. There were only two prisoners on the basic level at the time of this inspection.

HP24 Duty governors were required to carry out a daily check of the quality of food, but prisoner consultation in this area was limited. The services provided by the shop were generally good.

HP25 On the basis of this short follow-up inspection, we considered that the prison was still not performing sufficiently well against this healthy prison test.

Purposeful activity

HP26 At the previous inspection in 2005, we considered that the prison was performing poorly against this healthy prison test. Of 16 recommendations in this area, six had been achieved, five partially achieved and five not achieved. We have made two further recommendations.

HP27 There was still insufficient activity to occupy all prisoners. A maximum of 64% of prisoners could be engaged in activity daily. Work was offered on both a full-time and part-time basis to maximise the number involved. During a standstill roll check conducted during the inspection, around 45% of the population was locked in-cell.

HP28 Work and activity allocation processes had been reorganised to try to meet prisoners' needs. There was better linkage between the planning of individual learning and sentence planning.

HP29 Education quality assurance arrangements had been significantly improved, but not completely implemented. There was a wider range of educational courses available, although the education budget had not been increased. There was provision for social and life skills programmes, and assistance with preparation for resettlement. All prisoners had weekly access to the library but not at weekends or during the evenings.

HP30 Work was available in a contract services workshop and a Prisons Information Communication Technology Academy (PICTA) workshop. The contract services workshop offered low level qualifications and there were advanced plans to develop existing provision in other workshops. A small number of prisoners were able to gain qualifications in industrial cleaning, and prisoners involved in information, advice and guidance work could also gain accreditation.

HP31 The physical education (PE) department provided a good service, chiefly in the area of recreational PE. Facilities had improved. There was a purpose-built facility with cardiovascular equipment. Outside exercise areas were not used for recreational PE purposes.

HP32 Time out of cell was recorded as around 8.5 hours daily.

HP33 On the basis of this short follow-up inspection, we considered that the prison was not performing sufficiently well against this healthy prison test.

Resettlement

HP34 At the previous inspection in 2005, we considered that the prison was not performing sufficiently well against this healthy prison test. Of 29 recommendations in this area, 17 had been achieved, four partially achieved and eight not achieved. We have made five further recommendations.

HP35 A three-year resettlement strategy had been developed and drawn up by reference to the local resettlement database. There was evidence of developments against all the resettlement pathways, although links with the personal officer scheme were underdeveloped. There was a full-time partnership coordinator, and work was underway to identify gaps in provision from voluntary sector and community groups. Partnership agencies were represented on the resettlement pathway committees.

HP36 There were shortfalls in the quality of sentence and custody planning. Sentenced prisoners who did not meet the offender management criteria did not have a structured offender assessment. There was no custody planning for remand prisoners, and there were backlogs in sentence planning for life-sentenced prisoners.

HP37 Although the establishment's lifer unit had been disbanded, many life-sentenced prisoners remained at the prison, with no dedicated services, and reviews occurring late or not at all. Access to specially trained lifer staff was more difficult, as life-sentenced prisoners were allocated to many different parts of the prison.

HP38 There had been some use of release on temporary licence to enable prisoners to take part in community training programmes. A small unit was due to open a week after the inspection to provide additional opportunities for selected prisoners to participate in community projects.

HP39 Visits operated well, although the visitors' centre was very small and basic. Visits arrangements for vulnerable prisoners were less positive.

HP40 On the basis of this short follow-up inspection, we considered that the prison was performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from previous report) to the Governor

2.1 The reception environment, including the Listener interview room, should be improved to make it more welcoming and fit for purpose. (HP41)

Not achieved. At the time of inspection, the reception building was being repainted and most areas were clean and tidy. A closed-circuit television system had been installed so that prisoners in the holding rooms could be monitored more easily. Apart from this, there had been no changes to the building or layout. Holding rooms had no natural light, those designed for vulnerable prisoners were too small and the Listener interview room was extremely cramped. There was a shortage of facilities for private interviews; with the exception of healthcare, all interviews took place with prisoners and staff standing at a long counter which was divided up into several workstations. There was no privacy between these workstations, and up to four prisoners could be dealt with at the same time. Confidential information required to complete cell-sharing risk assessment forms was discussed during our visit, and could be overheard.
We repeat the recommendation.

2.2 Effective anti-bullying procedures and interventions should be in place. (HP42)

Partially achieved. There was a safer custody manager at senior officer level who had responsibility for anti-bullying, violence reduction, and suicide and self-harm. The post was full time, with the exception of a requirement to provide weekend cover to the residential units. The safer custody manager was also occasionally redeployed to cover midweek shortages. These arrangements had been in place for approximately four months, and in this time the safer custody manager had made a significant impact. The policy document had been updated, and anti-bullying procedures were fully explained on induction and widely publicised across the establishment. The safer custody manager had also improved the quality of the monitoring data, which was submitted to the safer custody committee for analysis. Outstanding investigation reports were now tracked effectively and the quality of the investigations we saw was generally good. There had been 48 anti-bullying books opened in 2007 (22 victim support books and 26 bully monitoring books). There had been only three books opened in the first two months of 2008 (two victim support books and one bully monitoring book) and there was clear evidence of under-reporting of bullying incidents. We found a disparity in the number of bullying-related security information reports and the number of investigations. We also found that several alleged bullying incidents that had been recorded in wing observation books had not been reported to the safer custody manager in accordance with publicised procedures. There was little evidence that relevant information was cross-referred to wing history files, and there were no interventions for persistent bullies or victims.
We repeat the recommendation.

2.3 The area manager should commission a review of mental health need and management[1] to examine the need for a court diversion scheme, ensure an integrated health care provision (including day care) and identify and provide for staff training needs. (HP43)

Achieved. Mental health services were provided by the Avon and Wiltshire Partnership Trust. A senior manager from the Criminal Justice Liaison Service worked closely with the

magistrates' court and mental health providers to ensure that the court diversion scheme worked successfully. Senior mental health workers were based at the court and carried out assessments and referrals. They had excellent links with the prison and ensured that detainees or prisoners attending court were managed appropriately. Any detainees with a history of mental illness who were remanded in custody by the courts were seen by the team, and all relevant information passed on to the prison. It was evident that there was good joint working between the courts and prison systems.

Additional information

2.4 Mental health services had improved considerably since our previous inspection. An in-reach team had been established and two well qualified and experienced registered mental health nurses provided a high level of care to prisoners. The team worked well with the primary care mental health team and there was evidence of good multidisciplinary joint working between all those involved in the care of prisoners with mental health needs. Access to professional training for staff was fully supported and provided where necessary. Mental health awareness training for generic prison staff was provided through a rolling programme delivered by members of the mental health team. Day care was now provided (see recommendation 2.126).

2.5 There should be a dedicated detoxification unit. (HP44).

Partially achieved. Prisoners stabilising or detoxifying were initially located in the first night centre, and then moved on to landing 3 of C wing, which was being converted into a dedicated first-stage stabilisation unit. The unit accommodated up to 40 prisoners. Building work included fitting new cell doors with observation hatches and creating a suitable area for dispensing medication. The clinical substance misuse team was based on the landing, and the counselling, assessment, referral, advice and throughcare (CARAT) team was due to be co-located there shortly.
We repeat the recommendation.

2.6 Action should be taken to improve the experience of black and minority ethnic prisoners, through consultation with them and the establishment of effective procedures to promote equality. (HP45)

Not achieved. A race equality policy had been signed by the Governor and the area manager in January 2008; this outlined how race equality would be promoted and managed at the establishment and how it planned to consult with prisoners. The policy said that consultation with black and minority ethnic prisoners was to be done via the prisoner race equality representatives on each wing, who would work closely with the race equality officer (REO). The establishment had not developed any other methods of consulting with black and minority ethnic prisoners, and there was no measure of whether the experiences of such prisoners at the establishment had improved. In the black and minority ethnic prisoner group held during the inspection, some prisoners felt that their needs were not adequately met. Prisoners new to the establishment said that they were not aware of some of the processes and procedures because they had not completed a formal induction, and not all of the prisoners were aware of who their prisoner race equality representative was. They knew who the REO was, but not how they could communicate their views to him.
We repeat the recommendation.

Additional information

2.7 At the time of the inspection, 20% of the population were from black and minority ethnic backgrounds. The race equality action team (REAT) had held regular meetings in 2007 and had produced an action plan. However, many of the target dates for the race equality action plan had slipped and were not being followed up.

2.8 Measuring the quality of prison life (MQPL) surveys had been conducted in 2006 and 2007. The establishment had developed an action plan following the survey in 2007, which included setting an objective to improve black and minority ethnic prisoners' perceptions, as there continued to be disparities between the responses of these prisoners and those of white prisoners. The target date for completing this objective was April 2008; however, the plan provided no details of how this was to be achieved. The REO was not aware of any action that the REAT was taking to address the negative perceptions of black and minority ethnic prisoners at the establishment, and despite REAT minutes recording that the MQPL survey was to be discussed at subsequent meetings, this had not been done.

2.9 Appropriate arrangements for the effective transfer of healthcare services to local primary care trust (PCT) should be in place, and include a strategy for staff recruitment and retention. (HP46)

Achieved. The transfer of health services to the Bristol PCT had been completed and was working effectively (see recommendation 2.104).

Additional information

2.10 There were robust links between the establishment and the PCT. Health services were strongly supported by the Governor and there was robust and effective operational and clinical leadership. Health services were fully assimilated into the regime and there were innovative working practices in the healthcare department. All health services staff were employed by one of three organisations: the PCT, the Avon and Wiltshire Partnership Trust or the prison. However, from May 2008, staff would only be employed by either the PCT or the Avon and Wiltshire Partnership Trust. Staffing and managerial issues were beginning to reach a steady state and there were only two nursing vacancies at the time of the inspection. There had been a lengthy period of staff sickness but this had been addressed through the occupational health service. Administrative support was efficient, and current staffing levels and skill mix were good, and included registered nurses, healthcare officers and healthcare assistants. PCT bank nurses were used where necessary and the number of agency nurses had been significantly reduced.

2.11 All prisoners should be engaged in appropriate education or training on a daily basis. (HP47)

Not achieved. The prison offered a maximum of 386 education, work, training and gymnasium places, which meant that a maximum of 64% of the prisoner population could be engaged in these activities. Work was offered on a full- and part-time basis, and education part-time, to maximise available provision. In February 2008, 53% of prisoners were engaged in work, education, training or gymnasium activities. There had been significant changes in the education curriculum to align it better with the resettlement pathways and the reducing reoffending strategy. There was a focus on providing programmes which could be completed within the relatively short length of time that most prisoners remained at the establishment.

Systems for following up reluctant learners were now more effective. However, many prisoners felt that they spent too much time without purposeful activity.
We repeat the recommendation.

2.12 Physical education facilities (PE) should be improved (HP48)

Achieved. Overall, the PE facilities for prisoners had improved. The former temporary weights room and fitness suite had been replaced by a purpose-built facility which was well equipped with cardiovascular equipment.

Additional information

2.13 The gymnasium was still available but was under-used. There had been limited improvements to it since the previous inspection. New showers had been installed, but there were not enough for all prisoners using the weights room, and sessions had to be cut short to enable all prisoners to shower. It could be used effectively for circuit training and some team games; however, the courts were not full sized and could not be used for volleyball, basketball or some other team games. We were told that staffing shortages meant that it was not possible for gymnasium staff to provide accredited training opportunities.

2.14 The outside exercise area had been out of use but a risk assessment had recently been carried out.; as a result of this, an order had been placed for sports equipment, and there were plans to use the outside exercise area for cricket, football and circuit training on receipt of this equipment.

Further recommendation

2.15 Staffing levels should be increased to enable the PE department to provide accredited training and to make full use of all PE facilities.

2.16 Resettlement services should be based on the identified needs of the population and there should be coordination of agencies providing services. (HP49)

Achieved. A three-year resettlement strategy and action plan had been published in June 2007 and was informed by data from the local resettlement database; this had shown that two-thirds of prisoners had home addresses within 50 miles of the establishment and that the average length of stay was 149 days. The strategy required an annual needs assessment, and the first of these had been produced in October 2007, based on completed survey results from 27% of the prisoner population. The various resettlement agencies considered data collected by the relevant prison departments and partnership agencies. A full-time partnership coordinator post at principal officer level had been created in September 2007, and until recently had been shared by two officers. The job description for this post included producing a list of all the agencies currently working with the prison; a directory of voluntary and community services had been compiled and was due to be published to staff and prisoners. This exercise had helped to highlight possible gaps in provision, and a partnership event had been held in December 2007 to try to engage more community groups, agencies and businesses. Managers and staff felt that this had been successful, and the coordinator was following up those groups who had expressed an interest in working with the establishment. Partnership agencies were represented on the resettlement pathway committees, and the partnership coordinator also attended these meetings. Actions required to improve coordination and integration of partnership groups further was set out in the strategic plan.

2.17 Stage 2 life-sentenced prisoners should not be held at Bristol. (HP50)

Not achieved. In June 2005, managers at the establishment were told that the prison was to lose its status as a first- and second-stage lifer centre and that all life-sentenced prisoners would be moved to other prisons within six months. Not all prisoners had been transferred, and by the middle of 2007 the population of indeterminate-sentenced prisoners had risen to over 100; this included a growing number of prisoners sentenced to the indeterminate sentence for public protection (IPP), who had been managed in a similar way to life-sentenced prisoners until being incorporated into offender management arrangements in January 2008 (see section on offender management and planning). While the 27 IPP prisoners currently at the establishment had allocated offender supervisors in the prison and a nominated offender manager in the community, the resources available to the 64 life-sentenced prisoners, including 14 recalled prisoners, were inadequate.

Additional information

2.18 The establishment's lifer unit had been disbanded, with the loss of dedicated probation and psychology staff. Two principal officers acted as lifer managers alongside other duties, and the governor with responsibility for life-sentenced prisoners estimated that he spent five to six hours each day dealing with lifer issues raised mainly by the Parole Board and prisoners' legal representatives. The establishment was not providing the specialist reports required for lifer reviews, and many hearings did not take place on time or had to be deferred. This undoubtedly had an impact upon the ability of many life-sentenced prisoners to progress through the system. While 14 lifers (22%) had been at the establishment for less than six months, 29 (45%) had been there for two years or more.

2.19 Life-sentenced prisoners were now located throughout the establishment, which meant that many did not have access to prison staff who had been trained in lifer issues. No lifer meetings or family days were taking place, and the regime and facilities for lifers were no different from those of other prisoners. Overall, the arrangements for the management of life-sentenced prisoners were unsatisfactory.

Further recommendations

2.20 Life-sentenced prisoners should be transferred out of Bristol by a set date (within the next six months) and sent to establishments better able to address their needs.

2.21 Resources should be made available to ensure that lifer hearings are not deferred unnecessarily so that life-sentenced prisoners held at Bristol can progress through the system.

2.22 Effective public protection measures should be in place. (HP51)

Achieved. Staffing resources had been increased to two full-time Probation Service officers. Thorough systems had been introduced for identifying promptly prisoners subject to child protection, harassment and sex offender registration procedures. Information was shared appropriately with relevant departments within the establishment and a 'non-disclosure' insert file had been introduced to store relevant but sensitive information about high-risk prisoners in their wing history sheet. Targeted monitoring of telephone calls and mail was taking place and there were examples of robust plans for managing some particularly high-risk and challenging prisoners.

Additional information

2.23 Public protection officers had access to the police national computer and three staff had been trained in its use. In addition to the required identification of prisoners subject to child and public protection procedures, public protection officers also notified the establishment's fire officer of any prisoners with offences for arson, and brought to the attention of health services staff any prisoners previously subject to hospital orders. Neither the public protection team nor the REO kept details of prisoners with a history of racially motivated or aggravated offending. At the time of the inspection, 15 prolific or priority offenders and 79 high-risk prisoners were being managed by the offender management unit.

Further recommendation

2.24 A system should be developed to identify and bring to the attention of staff any prisoner convicted of a current or previous racially aggravated offence.

Other recommendations to the Director General

2.25 Prisoners prescribed methadone should be able to continue this at other prisons. (8.81)

Partially achieved. Transfer protocols had been developed with a number of category C establishments in the south-west, but acceptance criteria varied and were restrictive. Only a small number of prisoners on low levels of methadone could be moved on after staying at the establishment for 28 days. At the beginning of March 2008, 20 prisoners stabilised on methadone were awaiting transfer. Those prescribed buprenorphine (subutex) or naltrexone could not continue this treatment elsewhere.

Further recommendation

2.26 Transfer protocols for prisoners stabilised on methadone or buprenorphine should be consistent, and efforts should be made to speed up the transfer process.

2.27 Efforts should be made to discharge prisoners to category C establishments more swiftly once they have been stabilised.

Other recommendations to the Governor

Arrival in custody

Courts, escorts and transfers

2.28 Prison and Reliance managers should review discharge procedures to ensure that all prisoners are produced at court on time. (1.5)

Achieved. Since the previous inspection, staff attendance arrangements had been changed to provide four prison officers each midweek morning specifically to unlock prisoners for court. These members of staff commenced duty at 6.30am. Reliance, who operated the contract for

court escorts, also provided two members of staff each morning in reception to act as loading marshals; they were responsible for ensuring that the dispatch of escort vehicles was appropriately prioritised. These arrangements had led to a significant improvement in the number of court escorts being dispatched on time. Monitoring figures for a three-month period (December 2007 to February 2008) showed that court escorts were only dispatched late on two occasions: once when Reliance was unable to provide loading marshals and once when a prisoner had to wait for his medication.

2.29 Prisoners should be held in court cells for the minimum possible period. (1.6)

Not achieved. Prisoners were still being held for long periods in court cells after they had been dealt with, before being returned to the establishment. Staff in reception told us that this was a daily occurrence, and we found examples in prisoner escort forms where prisoners had been sentenced by the court at around midday but not received back in the establishment until 8pm.
We repeat the recommendation.

First days in custody

2.30 Prisoners should not spend long periods in reception without anything to occupy them. (1.20)

Achieved. There were two main holding rooms, one on each side of the reception area. Relevant information had been publicised in both of them and a television installed in one of them. Staff were committed to moving prisoners through reception as quickly as possible. A freeze on internal movements took place between 4.30pm and 6.15pm, which stopped prisoners being located. Despite this, we received few complaints and saw no evidence of prisoners being held in reception for unacceptably long periods.

2.31 There should be clear procedures for dealing with prisoners who are in custody for the first time. (1.21)

Not achieved. Prisoners in custody for the first time were prioritised for a place on the first night landing (A4); due to the high level of receptions, this placement could not always be guaranteed for others. Apart from this, there was still no noticeable difference in the treatment of prisoners experiencing prison for the first time.
We repeat the recommendation.

2.32 Prisoners should be given information about what is going to happen to them on reception. (1.22)

Achieved. Prisoners were issued with a written guide in reception that explained what would happen during their first 24 hours in the establishment. A local information booklet was also issued. Translated copies of this booklet were available on the A4 landing.

2.33 Interviews with prisoners, especially those for the purpose of completing a cell-sharing risk assessment, should be conducted in private. (1.23)

Not achieved. With the exception of healthcare interviews in reception, none were completed in private (see recommendation 2.1). The lack of appropriate interview facilities resulted in confidential information used to complete documents such as the cell-sharing risk assessment being discussed in an open setting, often with other prisoners present.
We repeat the recommendation.

2.34 Better use should be made of prisoners trained as Listeners or Insiders to advise and support prisoners during the reception process. (1.24)

Partially achieved. One of the orderlies employed in reception was a trained Listener but he did not routinely see all new arrivals. He would speak to any prisoners that staff had particular concerns about. Trained Insiders were available in the first night centre and routinely saw all new arrivals who were located on that unit. Their role was to help to settle prisoners in and advise them of basic prison routines. They had a checklist which was completed for each prisoner. However, as not all new arrivals were located on the first night landing (see recommendation 2.36), access to Insiders was not guaranteed for all new receptions.

Further recommendation

2.35 All new receptions should be routinely seen by trained Listeners and Insiders as part of the first night arrangements.

2.36 All prisoners spending their first night at Bristol should be located in the first night centre or receive comparable access to essential first night information and procedures. (1.25)

Not achieved. The high level of movements in and out of the establishment meant that it was not always possible to locate new arrivals on the first night landing. Staff on the A4 landing interviewed prisoners individually but we were not assured that this routinely took place for new arrivals located in other areas. One example was a prisoner held overnight in the healthcare centre owing to a lack of space on the A4 landing; we could find no evidence that he had received formal first night procedures.
We repeat the recommendation.

2.37 All prisoners should have the opportunity to make a telephone call and take a shower before being locked up on their first night. (1.26)

Partially achieved. New arrivals were issued with PIN telephone credit to the value of 50 pence, which they did not have to repay. We spoke to a number of new arrivals, including those who had not been located initially on the first night landing, and they all confirmed that they had been allowed to make a telephone call before being locked up for the night. However, the majority of them had not been offered the opportunity to shower.

Further recommendation

2.38 All prisoners should have the opportunity to take a shower before being locked up on their first night.

2.39 Prisoners should be kept fully occupied through a comprehensive and structured induction programme. (1.27)

Partially achieved. The induction programme was held on the day after reception. Prisoners who had been at the establishment previously could be fast tracked. The course amounted to a presentation from induction staff and interviews/assessments by staff from various departments. The induction presentation covered all key areas and generally met our expectations. Information was reinforced to prisoners via publicised notices and through the local information pack (see recommendation 2.32). Induction staff operated from the A4

landing and used a computerised reception list to track those prisoners who had not spent the first night on this landing. Other members of staff involved in the induction programme were also responsible for identifying the locations of new arrivals and going to see them, as part of the process. The fact that prisoners had been interviewed by induction officers was confirmed in some individual prisoner wing history files, although we found many examples where this had not taken place. We also found that there was no central monitoring system to confirm that other elements of the programme had been delivered to each individual prisoner. Due to these gaps, we were not assured that prisoners consistently received all elements of the induction programme.

Further recommendation

2.40 A central monitoring system should be introduced to confirm that all elements of the induction programme are delivered to each prisoner.

Additional information

2.41 The number of new arrivals had increased significantly since 2005, when we reported that the average number of weekly movements (including outgoing and incoming) was around 150–200. In the week before the inspection, there had been 323 prisoner movements through reception. The establishment regularly received prisoners who had been held overnight in court cells or police stations under Operation Safeguard.

2.42 Regular meetings were held with Reliance. Inter-prison escorts and immigration removals were the responsibility of Global Solutions Limited and G4S, respectively. Relationships between reception and contractor staff were good, and prisoners in our groups confirmed that they had been treated well. Escort vehicles were clean and appropriately equipped. There continued to be problems with late arrivals, but staff were flexible in their attendance and tried to limit any negative effects on prisoners. Despite the pressure they were under and the poor facility they worked in, reception staff took time to engage prisoners in the reception process.

2.43 New arrivals were held on vehicles while all documentation was checked, after which prisoners were escorted from the vehicle one at a time. Each prisoner was then identified and received a rub-down search before the next prisoner was allowed off the vehicle. On the larger cellular vehicles, this often resulted in a wait of over an hour before the last prisoner was taken off the vehicle.

Further recommendation

2.44 New arrivals should be disembarked from escort vehicles without undue delay.

Environment and relationships

Residential units

2.45 Cells designated for single occupancy should not be used to hold two prisoners. (2.11)

Not achieved. A number of cells designated for single occupancy were still being used to

accommodate two prisoners.
We repeat the recommendation.

2.46 Cells on B wing should be converted to in-cell sanitation. (2.12)

Not achieved. Cells on B wing still had no internal sanitation. Instead, there was a computerised system which allowed one prisoner at a time per landing to leave his cell for six minutes to use the toilet. On occasion, this could result in long waits to use the toilet.
We repeat the recommendation.

2.47 Cell call bells should be answered promptly. (2.13)

Not achieved. We tested some call bells and these were answered promptly, and on examining the call bell recording system we found that this was the case in the vast majority of instances reviewed. However, we found examples of much longer waits for a response in the healthcare department, in one case for over 30 minutes. In another case, a Listener rang the bell to be removed from a cell after finishing a session, and waited over 20 minutes for a response, potentially putting him at risk. In addition, the call bell information system was not monitored.
We repeat the recommendation.

Further recommendation

2.48 Managers should monitor the call bell information system weekly.

2.49 There should be prisoner consultation committees. (2.14)

Partially achieved. Some general prisoner consultation meetings had taken place but these had not been regular, and because of this lack of continuity there was limited evidence of any action being taken forward as a result.

Further recommendation

2.50 Prisoner consultation groups should be held monthly, and any action points taken forward.

2.51 All prisoners should be able to have daily showers. (2.15)

Not achieved. For those prisoners on standard incentives and earned privileges (IEP) status, the opportunity to have a daily shower was limited to a 45-minute period in the morning on the five days a week when they had no evening association. During this time, they also had to collect and eat breakfast, make applications, use the telephone and so on. This provided an extremely limited window during which to have a shower, and prisoners confirmed with us that this often resulted in them being unable to shower daily. Prisoners could also request a shower by application to staff, but this depended upon sufficient staff being available to facilitate these requests. In addition, some showers and toilets on B and C wings were in need of refurbishment.
We repeat the recommendation.

Further recommendation

2.52 Showers and toilets on B and C wings should be refurbished.

2.53 All prisoner mail should be posted within 24 hours. (3.63)

Not achieved. The staffing and systems in use in the correspondence room remained the same as at the previous inspection. Incoming mail was prioritised and distributed to wings on the day of arrival. However, with limited staffing, outgoing mail was not always posted within 24 hours. On one day of the inspection, mail was collected by the postal service at 4.10pm. A small bundle of mail containing visiting orders and vouchers requesting property to be sent in remained in the correspondence room, despite being there since 2pm. Correspondence staff confirmed that they found it difficult to ensure that all mail was posted within 24 hours, and tended to use the weekends to catch up on any backlog from the latter part of the week.
We repeat the recommendation.

2.54 Access to telephones should be improved and telephones should be switched on when needed and prisoners informed. (3.64)

Partially achieved. Although the number of telephones per wing did not meet the Inspectorate's expectations, each landing had association at different times and therefore had access to all the telephones on the wings. However, in our prisoner groups, prisoners complained that they were unable to make telephone calls during morning unlock, and that due to the limited time out of cell there were very few opportunities to use the telephones, particularly for those who were unemployed. Telephones were switched on during association but were not available during collection of lunch or evening meals, as it delayed the serving of food.
We repeat the recommendation.

Staff–prisoner relationships

2.55 Staff and managers should develop the existing relationships with prisoners to underpin dynamic security. (2.22)

Achieved. The staff–prisoner relationships we observed were generally good, and wing staff were knowledgeable about those in their care. However, some groups of prisoners, including black and minority ethnic and life-sentenced prisoners, told us that their needs were not being met by staff, and we observed little use of preferred names or 'Mr'. Although we could find no evidence that a programme of training in dynamic security had been delivered, as stated in the prison's action plan following the last inspection, briefings had taken place about the importance of dynamic security and security intelligence reports were more frequently used.

Personal officers

2.56 The personal officer scheme should be reviewed and re-launched. (2.26)

Achieved. The personal officer scheme had been reviewed and re-launched, with a revised set of local operating procedures published. At the time of the inspection, this was again being

reviewed, with the aim of simplifying the information provided and to introduce a monthly management check.

2.57 Regular entries should be made in prisoners' history sheets and these should be quality checked by managers. (2.27)

Not achieved. We reviewed prisoner history files on all wings and found personal officer entries to be variable – from very detailed to none at all. No management checks of wing file entries were being undertaken, and while prisoners we talked to were aware of who their personal officer was, some told us that they had no, or little, contact with them.
We repeat the recommendation.

Duty of care

Bullying and violence reduction

2.58 Wing staff should be encouraged to report all incidents of bullying behaviour. (3.6)

Not achieved. Wing staff did not always submit security information reports (SIRs) or bullying referral forms on becoming aware of a suspected bullying incident. Related information from SIRs was not always referred to the safer custody manager and there were several bullying-related entries recorded in wing observation books that had not been passed on to him.
We repeat the recommendation.

2.59 Wing observation books and security information reports (SIRs) should be routinely checked and incidences of bullying referred for action to the safer custody unit. (3.7)

Not achieved. See recommendation 2.58.
We repeat the recommendation.

2.60 Wing staff should closely supervise the dispensing of medication on their wings. (3.8)

Partially achieved. Discipline officers supervised the dispensing of medication in most areas. However, on C wing this was not the case, and officers were observed to be absent on many occasions when medication was being administered. Being the detoxification wing, supervision would have been particularly necessary because of the potential for bullying for medication.
We repeat the recommendation.

2.61 Courses that address anti-social behaviour and provide structured support to victims should be provided. (3.9)

Not achieved. There were still no interventions provided for persistent bullies or victims. Persistent bullies had sanctions imposed on them, including basic status and possible transfer. Monitoring books had been introduced for victims but their value was mainly restricted to heightening the awareness of staff.
We repeat the recommendation.

Additional information

2.62 In the middle of 2007, there had been some slippage in managing this area, with safer custody committee meetings not always taking place as scheduled. Since the new safer custody

manager had taken over in October 2007, anti-bullying and violence reduction had been given fresh impetus. The frequency of meetings had been increased to monthly, in line with new national instructions, and attendance levels had improved. Listener representatives and Samaritans regularly attended these meetings, as did key members of staff. Safer custody liaison officers had been identified for each wing, and they also attended where possible. The system of wing liaison officers had been set up to increase the level of expertise in each residential area. Recent initiatives also included a safer custody helpline, which could be accessed free of charge by prisoners through the PIN telephone system, and also by visitors.

2.63 Prisoners in our groups told us that bullying was not a serious problem at the establishment, and this was borne out by our own observations. There was, however, some under-reporting, and as a consequence not all alleged incidents were investigated. When monitoring books were opened for prisoners, either as bullies or victims, regular entries were made, but they were generally observational and provided little evidence of positive engagement by staff.

Further recommendations

2.64 All alleged incidents of bullying should be properly investigated.

2.65 Entries in bully and victim monitoring books should demonstrate good levels of engagement from staff.

Self-harm and suicide

2.66 There should be a safer custody strategy that specifies what will be done to help reduce the risk of self-harm and clarifies the role and responsibilities of Listeners. (3.18)

Achieved. The establishment had recently written a new safer custody policy document which was comprehensive and outlined, among other things, the role and responsibilities of Listeners. It also provided information about the detailed systems for supporting prisoners on open assessment, care in custody and teamwork (ACCT) documents.

2.67 Prisoners should have unhindered access to Listeners at all times. (3.19)

Achieved. Listeners and the Samaritan coordinator told us that there were no restrictions on prisoners accessing Listeners at any time during the day or night. They also stated that they felt well supported by the violence reduction manager and senior management.

2.68 Listener/crisis suites should be of sufficient size to meet the needs of the population and be furnished and equipped to a good standard, providing a more relaxed and less institutional environment. (3.20)

Partially achieved. There were care suites on both D and A wings, with the latter also accessible for prisoners held on G wing. Prisoners on B wing were all in single cells, so the establishment had decided that no special facility was required. A room had been identified on C wing for this purpose; however, it had been without a door for some considerable time, so was not in use. This meant that during the night, Listeners had to see prisoners on C wing in-cell, as was the case in the healthcare centre. Nevertheless, the rooms on A and D wing were of an adequate size, and furnished informally, although the toilets in both were inadequately screened.

Further recommendations

2.69 A Listener care suite should be available on C wing.

2.70 The toilets in the A and D wing care suites should be adequately screened to maintain privacy when being used.

2.71 All staff should be trained in suicide prevention and understand contingency and intervention plans. (3.21)

Not achieved. At the time of the inspection we were told that only 47% of staff at the establishment had completed ACCT training, although we were also told that this figure was higher for those in daily contact with prisoners. After the inspection we were told that 77% of staff had received training. Wing staff we spoke to were not all clear about the first-on-the-scene arrangements and contingencies in the event of an incident of self-harm or attempted suicide.
We repeat the recommendation.

2.72 Information about prisoners at risk of self-harm should be shared with relevant people and a support plan in the community instigated before the prisoner is released. (3.22)

Not achieved. While the establishment told us that they had plans to address the discharge and community support needs of prisoners at risk of self-harm and suicide, there was no system to ensure that these issues were dealt with at the pre-discharge board, or that outside agencies were always involved in release from custody planning for these prisoners.
We repeat the recommendation.

Race equality

2.73 Senior managers should closely manage and monitor the prison's race relations strategy. (3.30)

Not achieved. The race equality action team (REAT) was the main forum where managers should have monitored the race relations strategy; however, very little monitoring took place, except of the number of racist incident report forms (RIRFs) submitted and the completion of impact assessments. This monitoring was quantitative and offered no qualitative measure of whether the race equality strategy was being implemented across the establishment.
We repeat the recommendation.

Additional information

2.74 REAT meetings were held regularly; however, during 2007 they were chaired by five different managers, resulting in very little progress in managing, monitoring or promoting race equality across the establishment. There was a lack of stability in the membership of the meeting. In addition, ethnic monitoring data were not discussed in any depth, and areas that required action to be taken were not followed up by the responsible managers and were not reported back to the REAT. Senior managers were aware that the REAT was not functioning effectively, and had recently invited the Prison Service adviser on race to the establishment with a view to drawing up an action plan on how race equality could be better managed and integrated across the establishment. The prison had previously taken similar action before our inspection in 2005, but we could see little evidence of any progress made as a consequence. The

minutes of the REAT meeting in February 2008 described the REAT as 'ineffective' and recorded that very little had been achieved by the REAT in the previous 18 months.

2.75 Race relations liaison officers (RRLOs) should have adequate profiled time to do their task. (3.31)

Achieved. The full-time REO was cross-deployed infrequently; however, there was no cover provided for him, and any RIRFs submitted during his absence would not be responded to until his return. Significant demands were made upon the REO from wing staff to deal with issues that black and minority ethnic prisoners presented which did not involve a racist element or require his expertise. It was clear that the REO had accepted responsibility for race equality across the establishment, but that other prison staff did not take personal responsibility for equality issues, and this impacted upon the REO's ability to undertake his daily tasks and develop the scope of his role.

Additional information

2.76 There were plans for the REO to be supported by prison officer wing representatives on each wing who could address all residential issues and promote race equality. The prison officers had been identified, had volunteered to undertake these extra tasks, and were awaiting training from the REO before they could start supporting him. However, the wing representatives would not be given any facility time for the additional responsibility.

2.77 A new administrative officer had recently been appointed on a part-time basis to help the REO to manage his work more effectively and start to monitor the work that he was undertaking.

2.78 Wing managers should ensure that matters relating to racial bias are identified and addressed. (3.32)

Not achieved. Ethnic monitoring data were distributed before each REAT meeting, and any areas requiring further exploration were briefly discussed there. Functional heads and wing managers were expected to address any areas of concern and feed back at the REAT meeting or to the REO. However, this did not happen, despite the data highlighting that action needed to be taken.
We repeat the recommendation.

2.79 A separate prisoner representative group should be introduced and group comments fed into race relations management team (RRMT) meetings. (3.33)

Partially achieved. At the time of the inspection, three of the four wings had prisoner representatives. However, in one of our prisoner groups, not all prisoners were clear about who their wing representative was or what their role was. Although the race equality representatives were encouraged to talk to all black and minority ethnic prisoners on the wing before meeting with the REO, there was no evidence that all the black and minority ethnic prisoners were consulted. The REO had scheduled meetings with the prisoner wing representatives before each of the REAT meetings; however, these pre-REAT meetings did not take place regularly. One of the prisoner representatives attended the majority of REAT meetings and raised issues from black and minority ethnic prisoners. There continued to be no separate wing-based meetings for black and minority ethnic prisoners so that this group of prisoners could raise their issues either with the REO or the wing representative in a formal setting or receive feedback from the REAT meetings.
We repeat the recommendation.

Additional information

2.80 One of the prisoner race equality representatives was a red band, which allowed him access to the other wings so that he could liaise with other wing representatives and meet with prisoners. He had also recently become involved in the induction programme, giving verbal information to prisoners about race equality; however, this was not structured, did not involve the REO and was not consistently delivered to all new receptions. A basic leaflet informing prisoners how to submit a RIRF was distributed to prisoners, and the induction pack included a race relations statement.

2.81 A newsletter, called Equality Focus News, which was put together by the prisoner race equality representatives and the REO, had been published in December 2007. It had been distributed around the establishment and contained useful information about the prison, including how to complete RIRFs, as well as articles from prisoners. It was hoped that in the future the newsletter would receive contributions from more prisoners and be used as a method of communicating with prisoners and staff about equality issues.

2.82 Links with external organisations should be re-established. (3.34)

Partially achieved. The REO had made links with external organisations, and representatives from some of these, such as Support Against Racist Incidents and the British Muslim Organisation, had attended the REAT meetings. However, attendance at the meetings was sporadic and the organisations' expertise was not used to improve or promote race equality or diversity issues across the establishment.
We repeat the recommendation.

2.83 Ethnic monitoring statistics should include a wider range of regime and activities. (3.35)

Partially achieved. The range of regime activities that were monitored had been extended since the previous inspection and included employment, location of prisoners, discipline and use of force, as well as a breakdown of prisoners on different IEP scheme levels. The statistics were produced on a monthly basis and distributed to all members of the REAT and functional heads. However, little action was taken to explore any racial bias that the statistics might have highlighted, and consequently the data were not used to their full potential.

2.84 Range setting should reflect each main ethnic group. (3.36)

Achieved. At the previous inspection, range setting had been limited to white and non-white. However, the establishment now monitored the main minority ethnic groups represented in the prison, which included Asian, black, mixed and other (which included Chinese and other ethnic groups).

2.85 The investigation of racist incident complaints should be properly supervised, complainants should be informed in writing of the outcome, senior managers should satisfy themselves that investigation findings are based on thorough examination, and paperwork should be signed off by a senior manager. (3.37)

Partially achieved. The REO had received 12 RIRFs in 2008 to date, and a total of 40 in the previous six months. We looked at a random sample of completed RIRFs, and the majority of them had copies of letters attached, addressed to the complainant, outlining the findings of the investigation. The majority of RIRFs were answered promptly; however, three RIRFs submitted between 24 December 2007 and 5 February 2008 contained no information from the REO to

indicate that the matter had been investigated. In addition, there were no letters outlining the findings of the REO. One of the RIRFs concerned a prisoner who felt that there was racial bias in the allocation of jobs and wanted an explanation of the system for allocating jobs in the prison. This could have been responded to fairly swiftly by the REO but had not yet been dealt with. The process for dealing with a RIRF involved the REO conducting a simple investigation, after which he clearly outlined to the complainant the steps taken to address the complaint; the depth of the investigations appeared to be adequate. All completed RIRFs were signed off by a senior manager, and a log of all closed RIRFs was kept, detailing when the investigations had been completed and what the outcomes were, and this too was signed off by a senior manager.

Additional information

2.86 The REO had made contact with Bath Race Equality Council with a view to adding a representative from this organisation to the REAT meeting, and for them to evaluate independently the quality of the RIRF investigations.

2.87 The REO did not have an overview of the black and minority ethnic population in the establishment and could not identify if there were any particular ethnic groups in the prison who were submitting RIRFs more often than others. There was no analysis of the RIRFs, and therefore no means of identifying any emerging patterns so that potential issues could be dealt with quickly.

Further recommendation

2.88 Racist incident report forms should be monitored to identify any trends and to respond to any potential issues.

Foreign national prisoners

2.89 The foreign nationals policy should be published as soon as possible. (3.43)

Partially achieved. A foreign nationals policy statement was available and had been revised in January 2008. The document outlined which personnel were involved in the work with foreign national prisoners and where they were located, and also the role and remit of the various groups that met to develop this work. It did not outline the services that foreign national prisoners could expect or were entitled to. The policy statement had not been published on all the residential units and some foreign national prisoners we spoke to were unsure of their entitlements.

Additional information

2.90 Relevant staff across the establishment had received training in foreign national issues in February 2008. The training was delivered by the foreign nationals coordinator and a representative from the immigration services, and covered detailed information, from the definition of a foreign national prisoner to information about the role of the Border and Immigration Agency (now the UK Border Agency). The training booklet provided useful contact details and examples of immigration documents.

2.91 Each of the wings had an average of two foreign national prisoner liaison officers, who had all completed the training, and a foreign nationals clerk kept up-to-date information on all foreign national prisoners, including the range of languages they each spoke.

2.92 An immigration services officer (ISO) attended the establishment weekly to carry out immigration status checks and asylum interviews. The ISO issued IS91 immigration detention orders and saw foreign national prisoners referred by the foreign nationals coordinator.

Further recommendation

2.93 The foreign nationals policy statement should be expanded to include details of the services to which foreign national prisoners were entitled to, and published on all residential units.

2.94 A peer support group that meets regularly should be established. (3.44)

Not achieved. Peer support group meetings did not take place. A foreign nationals policy statement outlined the framework for working with such prisoners, including the development of a foreign nationals steering committee and foreign nationals working group. None of these forums included prisoner representatives, and the statement did not include any information about a peer support group for these prisoners.
We repeat the recommendation.

Applications and complaints

2.95 All wing applications should be recorded and replies should be sampled by wing and senior managers. (3.77)

Not achieved. All general prisoner applications from A and D wings were logged, but this did not take place in other residential areas. There was no system to ensure that applications had been responded to, and managers did not sample replies.
We repeat the recommendation.

2.96 Complaints should be resolved within target dates. (3.78)

Achieved. Records indicated that, over the preceding 12 months, an average of 98.3% of complaints had been dealt with within the relevant target date.

2.97 Replies to complaints should be sampled by senior managers. (3.79)

Not achieved. We were told that the deputy governor sampled the quality of responses to prisoner complaints, but the post holder was unavailable during the inspection and we could find no evidence of any discussion of this issue at relevant meetings, or of feedback being provided to managers.
We repeat the recommendation.

Legal services

2.98 The potential for sharing offender assessment system (OASys) assessments with resettlement staff should be explored. (3.86).

Achieved. Bail information work now formed part of the remit of the offender management unit, so information about prisoners was easily available to resettlement staff.

Substance use

2.99 Drug strategy meetings should include treatment and security staff to facilitate the integration of demand and supply reduction measures, and the strategy should include alcohol services. (8.79)

Achieved. The principal officer of C wing was responsible for coordinating the drug strategy. He chaired monthly meetings, which were attended by treatment and security staff. The strategy incorporated alcohol services and contained a detailed action plan, as well as performance measures; it had been informed by an annual needs analysis.

2.100 The substance misuse management team should be provided with additional administrative support to monitor the service and free up clinical time. (8.80)

Achieved. A full-time administrator had been in post for the previous year, and an additional half-time administrator had recently been appointed under the integrated drug treatment system (IDTS) initiative.

2.101 Prisoners undergoing detoxification should be in an environment where they can be observed by specialist staff and have access to a supportive regime. A dedicated detoxification unit should be developed to meet this need. (8.82)

Partially achieved. Landing 3 of C wing was being converted into the establishment's dedicated stabilisation unit, and substance misuse nurses were already based there. The team currently consisted of a band 7 clinical lead nurse (who was also a nurse prescriber), one band 6 and three band 5 nurses, and a healthcare officer. Two additional band 5 nurses were awaiting security clearance; once in post, this staffing level would allow for 24-hour cover. Some supportive group work was already taking place on C wing, and prisoners could access Alcoholics Anonymous and Narcotics Anonymous meetings, as well as information sessions provided by outside community groups. Funding for four additional staff posts was likely to enable the counselling, assessment, referral, advice and throughcare (CARAT) service to roll out the IDTS group work module. A draft regime for the stabilisation unit had already been developed, with an implementation date of mid-April 2008.
We repeat the recommendation.

Additional information

2.102 The establishment was making good progress in implementing the IDTS. Appropriate clinical management protocols and flexible prescribing regimes were already in operation. Following the introduction of the IDTS, evening general practitioner cover would allow for treatment to start immediately, and C wing would offer 142 spaces for first- and second-stage stabilisation/detoxification. The establishment's year-to-date random MDT positive rate stood at 11.3% against a target of 12.5%.

2.103 There should be a clear separation between voluntary and mandatory drug testing in terms of staffing and location. (8.84)

Partially achieved. Officers from C wing undertook voluntary drug testing (VDT) in the afternoons, while mandatory drug testing (MDT) was carried out by officers from the security

department in the mornings; however, VDT and MDT took place at the same drug testing station. Both schemes were well coordinated.

Health services

2.104 The Governor should work closely with the chief executive of Bristol North Primary Care Trust (PCT) to ensure that there is adequate senior management and operational support for the transfer of commissioning of healthcare. (4.67)

Achieved. The transfer of health services had taken place in 2005. A new Governor was providing good operational support to the head of health services and her staff. The Bristol PCT provided robust professional support and guidance, and there were regular joint meetings between senior management from the PCT and the establishment (see recommendation 2.9).

2.105 A primary care compatible electronic information system should be installed. (4.68)

Partially achieved. Wiring for the information technology (IT) system had been installed but no decision had been made as to which operating system would be used. All clinical records and healthcare appointments continued to be paper based.
We repeat the recommendation.

Additional information

2.106 There were five full-time administrators providing good support to the team, and there was no evidence of abuse of nursing time. An administrator was responsible for the overall management of all appointments, and these were managed well. Very few clinics had waiting lists of more than four weeks, and the majority of prisoners were seen within two weeks at the relevant clinic, including the dental surgery. Prisoners were able to see a chiropodist, optician, general practitioner (GP) and sexual health specialists without undue delay. Prisoners who did not attend healthcare appointments were given a further two opportunities, after which they were removed from the waiting list. The level of non-attendees was manageable.

2.107 The head of healthcare, together with staff from the primary care trust (PCT), should review the nursing staff/skill mix and develop a joint plan for recruitment, training and retention, to include the roles of healthcare assistants (HCAs) and healthcare officers and the reduction of use of agency staff. (4.69)

Achieved. A comprehensive nursing staff and skill mix review had recently been completed, and was reviewed regularly.

Additional information

2.108 The skill mix was good, providing clinical leadership and progression for staff, and the department received many applications for nursing posts. Healthcare officers played a pivotal part in the overall smooth running of the department, and in particular the inpatient unit, where they regularly managed shifts supervised by trained nurses. There were two healthcare assistants on permanent night duty. The use of agency staff was limited, and was confined to those who worked at the establishment on a regular basis and were key trained. Facilities for professional training were good, and staff could participate, free of charge, in all training opportunities within the PCT and at some local hospitals. We found staff to be highly motivated.

2.109 Regular nurse-led clinics should be established. (4.70)

Achieved. A wide range of nurse-led clinics had been established and included diabetes, epilepsy, high blood pressure, smoking cessation and chronic heart disease.

Additional information

2.110 Skilled clinicians from the PCT and local hospital came to the establishment to hold phlebotomy and immunisation clinics. Immunisation against communicable diseases such as meningitis, hepatitis B and influenza was offered to prisoners during the reception screening. The whole system was well structured and organised, and was delivered effectively.

2.111 The head of healthcare, lead GP and primary care trust (PCT) staff should review medical staffing with a view to joint prison/primary care trust posts. The review should include out of hours provision. (4.71)

Achieved. GP support was well structured and effective. Medical staffing had been reviewed and a new contract was in place. A local GP practice provided cover from 8am until 6pm Monday to Friday, and on Saturday and Sunday for three hours. Cover at other times was provided by the local out-of-hours services.

Additional information

2.112 The GPs provided 15 clinical sessions each week, and at least one GP was in the prison every day. The lead GP held an 'enhanced clinic' once a week, where complex patients or those requiring regular reviews were seen. Nursing staff were well supported by the GPs, and prisoners appeared to be satisfied with the service they received.

2.113 Discipline officers should be available to escort patients to clinics so that nurses are not being used for non-clinical duties. (4.72)

Achieved. Discipline officers were allocated from G wing to act as runners for the healthcare centre. The officers were paid 'volunteers', and a regular pool had been established to collect and return prisoners to and from the healthcare centre. This had significantly improved healthcare attendance figures and ensured that prisoners arrived on time, and also that nurses were fully employed on nursing duties.

2.114 There should be an evening medication round for prisoners on night sedation. (4.73)

Achieved. Night sedation was only prescribed under strict controls and regular monitoring by the GP. There were no prisoners on long-term night sedation.

Additional information

2.115 Prisoners requesting night sedation were carefully assessed by the GP. Alternatives were offered but if it was clinically assessed as appropriate by the doctor, the patient was prescribed a suitable medicine and was regularly reviewed.

2.116 Disabled access to the primary care/day care facility should be installed. (4.74)

Not achieved. Although all of the primary care functions were on the first floor of the

healthcare centre, disabled prisoners could only access the ground floor.
We repeat the recommendation.

Additional information

2.117 Wherever possible, disabled prisoners were seen on the wings or in the inpatient treatment room. However, prisoners needing dental treatment or to see the optician had to be carried up the stairs by staff or shuffle up the stairs on their bottom.

2.118 Pharmacy staff should deliver direct patient care and undertake medicine reviews. (4.75)

Partially achieved. The pharmacist had held asthma clinics, but these were in abeyance owing to staffing issues. Medication reviews were paper based, and at the time of the inspection there was no contact between pharmacy staff and the prisoners.
We repeat the recommendation.

Additional information

2.119 The pharmacy supplied other prisons, and this had an impact on its ability to deliver direct care to Bristol. The pharmacist was supported by two permanent technicians, one locum and a pharmacy assistant. The pharmacy was located outside of the establishment, and this added to the difficulties in having face-to-face contact with prisoners. There was a clear intention to provide clinics for minor illness, but such provision was dependent on staffing. The provision of pharmacy goods was good, and a same-day service was provided.

Further recommendation

2.120 The primary care trust should work with the establishment to establish an area within the prison where the pharmacist can hold clinics, such as for minor illness, and be able to hold a confidential advice service to prisoners. Resources should be increased to improve staffing levels.

2.121 The in-possession policy (IP) should be reviewed with the pharmacy team and endorsed by the medicines and therapeutics committee. (4.76)

Achieved. A documented risk assessment tool was in use and the IP policy had been approved and endorsed by the medicines and therapeutics committee.

Additional information

2.122 IP medication was the default position for all prisoners. Prisoners were allowed medication in multiples for up to 28 days, and were encouraged to reorder their prescriptions as they would in the community. The system worked well but there were no lockable boxes in which those prisoners sharing cells could store their medication securely.

Further recommendation

2.123 All shared cells should have secure lockable boxes in which prisoners can store their medicines.

2.124 An audit trail of controlled drugs should be established in the prison. (4.77)

Achieved. All controlled drugs (CDs) were checked weekly by pharmacy staff, and standing operating procedures were in use for the management of CDs. CDs were transported from the pharmacy to the prison in locked boxes.

2.125 The respective roles and responsibilities of all mental health professionals providing care to prisoners should be clarified within an overall mental health strategy based on needs. (4.78)

Achieved. There was good mental health support for prisoners. Two Avon and Wiltshire Partnership Trust band 6 registered mental health nurses (RMNs) provided support to prisoners on a full-time basis. One was qualified in cognitive behavioural therapy, as well as dual diagnosis. Three psychiatrists, including one forensic psychiatrist, provided seven sessions a week. The team was supported by a full-time administrator. The team had a caseload of 50 clients, and referrals were accepted from anywhere, including from the prisoner himself. Triage clinics, where problems were discussed and ongoing management decided, were held weekly. A multidisciplinary single point of entry meeting was held every week to discuss cases and their ongoing treatment. Care pathways were initiated and carried through to release or transfer. There were good links with community mental health teams, which were invited to participate in continuing care. The team was fully integrated within the establishment and attended all prison meetings relevant to their clients.

2.126 The day care centre should be resourced. (4.79)

Achieved. There were dedicated staff working in the day care centre. Two RMNs worked with clients, and education staff provided additional support. The facility provided good support to prisoners. Group and one-to-one work was undertaken. There had been over 60 referrals to the service since November 2007 and approximately 20 prisoners attended the centre every day. All referrals to the centre were discussed during the single point of entry meeting, to see if the prisoners would benefit from day care. We observed prisoners interacting well with staff, and those we spoke to were complimentary of the staff and the work they were doing to help them. Counselling services worked within day care and included specialists in the management of sexually abused clients.

2.127 The requested works in the inpatient unit, such as moving the gate for better access to the association room and the modifications to the bathroom for disabled patients, should be undertaken. (4.80)

Partially achieved. Only the modifications to the bathroom had been completed. Movement for prisoners within inpatients remained restricted.

Additional information

2.128 Twenty beds in the inpatient unit were included in the certified normal accommodation, and currently there were 14 prisoners held there, four of whom were there for non-medical reasons. We were told that the inappropriate use of beds had been a long-standing issue. Facilities for inpatients were reasonable but could be improved considerably by reducing the number of beds to create additional facilities such as a dining area, where patients could improve their social skills and self-confidence. The inpatient area had been redecorated and was a pleasant area. An association room with a television and a rickety billiard table was provided, along with a selection of library books. A gate separated the main corridor from the association room; this

restricted patient movement around the inpatient unit. The exercise area was dirty and bare, and not conducive to improving patients' well-being.

Further recommendations

2.129 The primary care trust and Avon and Wiltshire Partnership Trust should review the requirement for inpatient beds with a view to reducing the numbers and to ensuring that only prisoners with a clinical need are admitted to the inpatient unit.

2.130 The gate at the end of the inpatient corridor should be moved to allow free movement throughout the inpatient area. A dining area should be identified in the inpatient unit.

2.131 The exercise area should be cleaned up and improved to provide a therapeutic area for inpatients.

2.132 There should be dedicated discipline officers as part of the inpatient staff. (4.81)

Achieved. Discipline officers were used to support inpatient services, and worked well to increase substantially the clinical time available to health professionals.

Activities

Learning and skills and work activities

2.133 The schedules for work, education and training should to be coordinated so that clashes of interest are avoided. (5.12)

Achieved. The system had been reorganised to provide education on a part-time basis and offer greater flexibility. Work could be combined with part-time education. Through liaison with staff responsible for physical education (PE), additional gymnasium sessions had been organised for those prisoners following education programmes. Two additional officer posts provided more effective support and follow-up to move prisoners to the appropriate locations for their work or education classes. The information, advice and guidance (IAG) session now focused more sharply on expectations about attendance and punctuality. Liaison and communication with other prison departments had improved and had begun to minimise regime clashes.

2.134 Quality assurance procedures should to be fully implemented for all areas of learning. (5.13)

Partially achieved. There had been a significant improvement in the development of quality assurance and quality improvement arrangements, but they had not yet been fully implemented. The self-assessment process was now more effectively linked to development and action planning. A well planned set of quality checks carried out by the learning and skills coordinator supported the teaching and learning and development planning process.

2.135 The education provision should to be extended in range and level to meet the needs of prisoners. (5.14)

Partially achieved. The budget for learning and skills had not increased, and the education provision had not been extended overall in terms of contracted hours. However, the range had

been extended to meet identified needs more effectively, to cater for the majority of short-stay prisoners and for better links with employment needs in the local community. The revised curriculum also had a greater focus on social and life skills programmes such as housing, budgeting, family programmes and preparation for work, to meet resettlement pathway needs. The focus of most programmes was below level 2, and the establishment had carried out further work with prisoners at entry and pre-entry level, and for those who needed English for speakers of other languages (ESOL). There was little provision for prisoners whose abilities were above level 2, other than distance learning programmes and the peer adviser course.

2.136 Individual learning plans should be linked with sentence plans to inform a prisoner's progression through his sentence and to meet his personal needs. (5.15)

Partially achieved. There was now greater coherence between sentence planning and the planning of individual learning. The communication between the offender management unit (OMU), the resettlement unit and learning and skills provision had improved, and services were better coordinated. However, the quality of individual learning planning was variable and it was not yet being used effectively to plan learning through custody and beyond. In some plans, initial assessment and interview details had not been fully completed, and follow-up reviews of initial plans for learning and training had not been carried out appropriately.

Further recommendation

2.137 Individual learning plans should be used effectively to plan learning through custody and beyond, and initial assessments and follow-up reviews should be carried out as appropriate.

2.138 Prisoners should have weekly access to the library. (5.16)

Achieved. All prisoners now had weekly access to the library. Allocated wing access was identified in a standard schedule. Two additional officer posts provided support to collect and deliver prisoners to the library. Provision was made for those who missed their allocated library slot owing to legal visits or other commitments. However, the library was not open during the evenings or at weekends.

2.139 All work should be allocated and managed fairly and should take account of each prisoner's needs and ability. (5.21)

Achieved. The allocation systems to work, education and training had improved. Allocation and management of the process was now fairer, taking better account of individual prisoners' needs and abilities. All prisoners received an initial IAG intervention during induction and a follow-up interview by invitation. This provided better information on each prisoner's needs and abilities before allocation. An individual recommendation form was passed to the administrator, who liaised with the OMU and the resettlement units.

2.140 Skills acquired at work should be accredited and professionally recognised qualifications introduced wherever possible. (5.22)

Partially achieved. Work was available in a contract services workshop and a Prisons Information Communication Technology Academy (PICTA) workshop and as reception orderlies, wing cleaners, kitchen workers, recycling orderlies and peer advisers. There had been some overall development in accrediting work related skills. The contract services workshop offered some basic work related qualifications and the wood workshop was in the early stages of discussion with an outside employer to offer wood-working machining skills and

accreditation. The PICTA workshop offered a range of IT-related training and qualifications. A rolling programme of British Institute of Cleaning Sciences training and accreditation was offered to 10 wing cleaners at any one time. Five prisoners were currently following an IAG peer adviser programme to National Vocational Qualification (NVQ) level 3, provided by the St Giles Trust, and six prisoners had recently completed this programme. Plans were at an advanced stage to offer a catering and hospitality accreditation to NVQ level 1 to a small group of around six prisoners from March 2008. The learning and skills department had no formal system to recognise and record non-accredited skills development.
We repeat the recommendation.

Physical education and health promotion

2.141 All new receptions should be included in the initial physical education (PE) induction session. (5.29)

Achieved. Most new prisoners were escorted from the prison induction for a separate PE induction. For those who were not covered by this arrangement, information about PE programmes was displayed in the first night and reception centres and on the wings. PE inductions were held each Wednesday. Prisoners did not have to book in advance for these sessions. After the PE induction, and completion by prisoners of a health-related questionnaire, they were issued with a laminated induction card to indicate eligibility to attend PE sessions. Prisoners had to produce this card when attending each session.

2.142 Physical education (PE) equipment should be repaired or replaced as necessary. (5.30)

Partially achieved. The establishment had a contract for the repair of PE equipment, but machinery was often not repaired and was therefore out of action for long periods of time. There were currently 16 items awaiting repair. Delayed repairs to equipment limited the range of activities that could be carried out by prisoners in this facility.

Additional information

2.143 The nature of the contract meant that the establishment had to pay higher overall costs for repair to equipment. A fixed annual payment of around £1,700 only covered standard repairs, and not those which might have been caused by prisoners, which had to be paid for as an extra.

Time out of cell

2.144 The larger yard adjacent to B wing should be used for exercise. (5.44)

Not achieved. The yard in question was seen as a high-risk area, where it was relatively easy for contraband to be thrown into the establishment. There were plans to screen the yard more effectively.
We repeat the recommendation.

2.145 Prisoners should be issued with weatherproof clothing when taking exercise in poor weather. (5.45)

Not achieved. Wet weather clothing had been ordered, but when delivered turned out to have hoods attached. These items were not issued, as prisoners could not have been identified in

the event of any disorder on the yard.
We repeat the recommendation.

2.146 The advertised timings for association should be adhered to. (5.46)

Achieved. Although there were a number of occasions when association had been cancelled (see recommendation 2.147), the timings were mostly honoured, and prisoners we spoke to did not complain that association timings were not adhered to.

2.147 Association periods should not be cancelled. (5.47)

Not achieved. Association periods had been cancelled on 38 occasions in the previous six months, chiefly because of short notice needs to staff a bed watch. Records were kept in the prison central regulating office in order to try to ensure that there was equitable distribution, by wings, of cancellations. However, it was hard to interpret the records, which appeared to be highly subjective, and entries were frequently made out of chronological order.
We repeat the recommendation.

2.148 Prisoners should spend 10 hours out of their cell each day. (5.48)

Not achieved. The establishment was recording 8.4 hours per day out of cell. Over the previous 12 months, the figures had risen by an average of one hour per day through more accurate and diligent recording. On one day during the inspection, around 45% of prisoners were locked in their cells.
We repeat the recommendation.

Good order

Security and rules

2.149 The principles of dynamic security should be developed. (6.12)

Achieved. Briefings had taken place about the importance of dynamic security. Security intelligence reports were more frequently used, and the generally sound quality of relationships between staff and prisoners supported the development of the principles of dynamic security.

2.150 Categorisation and allocation should take place in consultation with the prisoner. Information about other establishments and the regime offered should be available to all prisoners. (6.13)

Achieved. Sentenced prisoners were seen on reception immediately and were placed in an appropriate security category. There were discussions with prisoners about the relative merits of the different (chiefly) category C prisons to which Bristol allocated.

2.151 Prisoners should be allocated and transferred to establishments that best suit their individual needs. (6.14)

Achieved. Individual needs assessments were drawn up by the OMU, and in cases where these were identified as having implications for allocation, they were passed through to the observation, classification and allocation (OCA) unit for action.

2.152 Effective systems should be introduced to ensure that prisoners are placed on hold for justifiable reasons. Systems should be established to identify the numbers of sentenced prisoners awaiting transfer, their security category and allocation. (6.15)

Achieved. There were a limited number of reasons that had been agreed for holding a prisoner back from onward transfer to a category C prison. The largest single category was on medical grounds. The list of those on hold changed daily as circumstances changed, and this was monitored by the OCA department.

2.153 Systems should be established to ensure that prisoners requiring transfer to a specific establishment are moved as quickly as possible and that transport is rebooked if cancelled. (6.16)

Achieved. Prisoners allocated to training establishments were moved very quickly, and usually within two weeks once their names were on lists for transfer.

Discipline

2.154 The use of the special cell should be reviewed and reduced. (6.32)

Achieved. At the time of the previous inspection, there had been 76 uses of the special cell in the preceding 12 months. In the year immediately before this inspection, there had only been 12 uses of the special cell. We examined the written records of the use of the special cell and found them to be well maintained. There were a number of cases where prisoners had been taken out of the special cell during the night, having been placed there earlier in the day.

2.155 Segregation unit staff should be given special training in dealing with prisoners with mental illness. (6.33)

Partially achieved. Some segregation staff had received special training in mental health awareness issues, but as there had recently been a rotation in staff duties, most staff in the segregation unit had not been trained. A programme of additional mental health awareness training was planned.
We repeat the recommendation.

2.156 Prisoners in the segregation unit should have daily access to showers. (6.34)

Achieved. Although the information sheet for prisoners about segregation unit routines indicated that showers were only available on alternate days, the segregation unit staff accepted requests for daily showers and these were being provided.

Further recommendation

2.157 The information provided to prisoners should make it clear that they can request a daily shower when segregated.

Additional information

2.158 Adjudication records for the previous six months were examined. Most adjudication records had been properly investigated and most awards consistently applied. It was clear, however, that one adjudicator consistently failed to record that any coherent investigation had taken

place. This adjudicator was no longer at the establishment but inspectors passed details of these adjudications to the Governor for review.

Further recommendation

2.159 Adjudication records should be quality assured by senior operational managers to ensure that the awards made are safe.

Integration of young prisoners

2.160 Young offenders should be clearly identified and their integration subject to rigorous risk assessment. (6.39)

Not achieved. There were very few prisoners under the age of 21, and the majority were unconvicted. Those few who were convicted were held in one of three identified cells on one wing. The prison action plan following the previous inspection had referred to a commitment to including reference to the needs of young prisoners in the local public protection policy document, but this had not taken place.
We repeat the recommendation.

Further recommendation

2.161 Convicted young offenders should be allocated to a young offender institution and be transferred immediately.

Incentives and earned privileges

2.162 There should be a locally published incentives and earned privileges (IEP) policy. (6.43)

Achieved. The local IEP policy had been updated in July 2007 and was well publicised and understood, both by prisoners and by staff.

2.163 The number of prisoners on each level of the incentives and earned privileges (IEP) scheme should be recorded and monitored. (6.44)

Partially achieved. At the time of the inspection, 420 prisoners were on the standard regime and 159 were on enhanced, with only two on basic. A record of the numbers on each level of the scheme was kept on the prison P drive. The head of residence told us that he monitored this to ensure that no adverse trends were emerging, although he was unable to provide us with evidence to confirm this.

2.164 Staff comments on warning sheets should be clear and unambiguous in their guidance on how to improve behaviour. (6.45)

Not achieved. The majority of IEP written warnings we observed were supported by generic and standardised behavioural goals about how to improve behaviour. These did not deal with the specific behaviour concerned or clearly state what the prisoner needed to address in order to improve. Nevertheless, there were a few cases where this had been attempted, and the stated goals provided clear guidance about what needed to be changed in order to improve the

problem behaviour.
We repeat the recommendation.

2.165 Decisions to move prisoners across incentives and earned privileges (IEP) levels should be randomly checked by wing and senior managers. (6.46)

Partially achieved. While a senior manager checked the paperwork of all cases in which a prisoner had been moved to the basic level of the IEP scheme, this did not happen in other cases, such as movement from enhanced to the standard level.
We repeat the recommendation.

Services

Catering

2.166 Managers should satisfy themselves that prisoners' food is consistently of an acceptable quality. (7.7)

Achieved. The tasting of the food on the wing serveries was part of the duty governor's overall check of the establishment, and the duty governor log showed that this was being carried out. The catering manager had devised a senior management team inspection checklist, which required managers to comment on the cleanliness of the serving areas and check that prisoners on the servery were correctly dressed, so that the inspection could be more thorough. The new inspection sheet had not yet been implemented.

Additional information

2.167 In one of our prisoner groups, prisoners on D wing expressed some concern about their food being adulterated. The catering manager confirmed that there had been some complaints from D wing and that more recently he had had to dismiss two prisoners from the kitchen for actively sabotaging a meal prepared for prisoners on the wing. Despite this, the catering manager had not introduced any procedures to eradicate, or even lessen the likelihood of, meals allocated to D wing being adulterated.

2.168 The catering manager did not attend the prisoner consultative group or the race equality action team meetings. Prisoners from the consultative committee had been invited to tour the kitchens and ask the kitchen manager any questions, but a date had not been set. The catering manager had no records of the most recent prisoner food survey, but had devised a new food questionnaire in three parts: menu selection, food quality, and cultural and dietary needs. The catering manager hoped to conduct the survey in the near future.

Further recommendations

2.169 Systems should be introduced in the kitchen to ensure that food prepared and served to vulnerable prisoners is not adulterated.

2.170 Prisoner food surveys should be conducted every six months.

2.171 The catering manager should attend the race equality action team and the prisoner consultative committee meetings, and a deputy should attend in his absence.

2.172 Prisoners working in the kitchen should be offered accredited training. (7.8)

Not achieved. Prisoners working in the kitchen had still only been trained in basic food handling. The catering manager was undertaking discussions with Stroud College to deliver accredited training, but there was no specific timeframe for its implementation.
We repeat the recommendation.

Prison shop

2.173 The prison shop should provide a wide range of products at a reasonable cost. (7.16)

Achieved. The number of items on the shop list had more than trebled since the previous inspection and now provided a full range of goods.

2.174 The range of goods available should meet the needs of black and minority ethnic prisoners. (7.17)

Achieved. The improved range of goods available included special items that were likely to be of interest to prisoners from minority backgrounds.

2.175 Prisoners should be able to buy items from the shop within 24 hours of arrival. (7.18)

Partially achieved. Prisoners could place an order on arrival but, depending on the day of their arrival, it could take several days to receive goods.
We repeat the recommendation.

2.176 Staff should systematically consult with prisoners at least every three months about items they would like to see on the shop list. (7.19)

Not achieved. Prisoner consultation arrangements were inconsistently managed and these did not take place on a quarterly basis.
We repeat the recommendation.

Strategic management of resettlement

2.177 Representatives from all parts of the prison should attend the resettlement committee meetings. (8.5)

Partially achieved. Following the previous inspection, the resettlement committee had been divided into a fortnightly strategic planning meeting, involving senior managers, and a monthly reducing reoffending committee. Membership of the reducing reoffending committee had been widened to include partnership agencies, but notes of meetings showed general attendance to be inconsistent and not all prison departments were represented. To address the strategic plan better, a revised schedule of meetings, relating to the seven resettlement pathways, had been introduced in 2007; to date, attendance at these meetings had been good.

2.178 The resettlement committee meetings should be more strategically focused in order to drive resettlement forward. (8.6)

Achieved. The resettlement committee meeting had a strong strategic focus, and resettlement issues were also discussed at the senior management team meeting.

Additional information

2.179 Although the head of reducing reoffending had left the establishment just before the inspection, she had been in post for some time, providing strong and consistent leadership. She had represented the establishment on the management boards and commissioning groups for the Safer Bristol/ Prospects House/Homelessness consortium and the offender management forum. Her deputy was acting up into the post pending the appointment of a replacement.

2.180 A resettlement strategy should be developed. (8.7)

Achieved. The strategy was available for all staff to read on the prison's intranet (see recommendation 2.16).

2.181 A thorough needs analysis of the population should be undertaken to assess what services are required. (8.8)

Achieved. See recommendation 2.16.

Offender management and planning

2.182 Assessment and sentence planning should be in place for all eligible prisoners. (8.16)

Partially achieved. All prisoners received some form of initial assessment in their first few days. Resettlement staff completed a case management record on all convicted prisoners serving less than 12 months – 83 prisoners (14% of the population) at the time of the inspection. This covered accommodation; employment, education and training; and health and drug and alcohol issues. A total of 215 prisoners (37%) were subject to offender management, which meant that a community-based offender manager was responsible for ensuring that assessments and sentence plans were up to date. However, sentenced prisoners who did not meet the offender management criteria did not undergo a structured offender assessment system (OASys) assessment. Managers acknowledged this error when we highlighted it, and immediate action was taken to identify the eligible prisoners. There was no custody planning for remand prisoners (29% of the population) and there were significant backlogs in sentence planning for the life-sentenced prisoner population (11%).
We repeat the recommendation.

2.183 Custody planning should be established for prisoners on remand. (8.17)

Not achieved. There was still no structured custody planning for remand prisoners (see recommendation 2.182).
We repeat the recommendation.

2.184 The case management record (CMR) should be a live document to which all departments of the prison contribute. (8.18)

Not achieved. The case management record was used only by members of the resettlement team.
We repeat the recommendation.

2.185 The backlog of reports should be eliminated. (8.23)

Not achieved. See recommendation 2.18.

2.186 There should be management checks of report contributions to ensure they contain thorough and insightful comments. (8.24)

Achieved. The two lifer managers quality assured the written contributions from wing staff. It was acknowledged that not all staff had received training in how to write these reports, but written guidance notes had been issued. Unsatisfactory contributions were returned.

2.187 The regime for life-sentenced prisoners should be reviewed to include cooking facilities, lifer days and support groups. (8.25)

Not achieved. The arrangements for life-sentenced prisoners were more impoverished than at the time of the previous inspection (see recommendation 2.19).

2.188 Funding should be secured to ensure that the prolific offenders unit continues. (8.58)

Achieved. Matched funding by the establishment and the Safer Bristol partnership had allowed the unit to continue. It now formed part of the OMU.

2.189 The two days a week provided to the Probation Service officer for public protection work should be increased to full-time. (8.59)

Achieved. The public protection team comprised two full-time Probation Service officers (see recommendation 2.22).

2.190 Public protection should be given a high priority in the establishment. Wing staff should be trained in public protection measures. (8.60)

Partially achieved. A public protection policy had been published in May 2007, and the profile of public protection work was higher than at our previous inspection. A public protection meeting was held monthly, but during 2007 it had been chaired by several different people, and representation from other prison departments had been poor and inconsistent; there had been no input from prison psychology staff. The police intelligence officer told us that he did not consider these meetings to be a good use of his limited time. The new governor responsible for public protection had signalled his intention to improve the effectiveness of these meetings, and the January 2008 meeting had been better attended. There had been two presentations on multi-agency public protection arrangements (MAPPA) at full staff meetings in 2005 and 2007, with specific sessions for health services staff and B wing officers.
We repeat the recommendation.

2.191 Systems should be established to identify all prisoners, regardless of sentence length or status, who pose a risk to children and the public. (8.61)

Achieved. Concerns about prisoners arriving from courts on holding warrants with no supporting information had been taken up at area level (see recommendation 2.22).

2.192 An effective system should be introduced to ensure that the establishment is aware of which prisoners are subject to multi-agency public protection arrangements (MAPPA) and it should actively engage in the process. (8.62)

Achieved. The public protection team highlighted all potential MAPPA cases by identifying those prisoners whose offences met the MAPPA criteria; records showed more than 592 in 2007. At the time of the inspection, 13 prisoners were subject to MAPPA but only one of these was at the highest level (MAPPA 3). Offender supervisors provided information to (and occasionally attended) MAPPA meetings held in the community.

Resettlement pathways

Reintegration planning

2.193 All prisoners should have an initial resettlement assessment following reception so that they can access services to address their needs early in their sentence. This assessment should then link in to sentence and custody planning. (8.44)

Achieved. All prisoners were seen by a member of the resettlement team or the OMU, and an appropriate initial needs assessment was carried out, normally within five days of prisoners' arrival at the establishment. Referrals were then made to the relevant department or agency. Services were also well publicised around the establishment and during induction, and prisoners were able to make applications directly to the service providers. A number of prisoners were trained by St Giles Trust to act as peer advisers, assisting other prisoners in accessing services during and after their time in custody. For prisoners serving less than 12 months, this assessment formed their case management record. Assessments on prisoners subject to offender management were stored on the case files and used to inform the OASys assessment.

2.194 Voluntary agencies should be coordinated and effectively integrated to ensure that they complement rather than compete with each other. (8.45)

Achieved. See recommendation 2.16.

2.195 A review of the discharge board should be held to determine whether 14 days before release provides sufficient time to tackle outstanding areas of need. (8.46)

Achieved. An initial review conducted in 2005 had endorsed the 14-day period as the best option. Following the introduction of the end of custody licence (whereby more prisoners were released at short notice), there had been another review and the discharge board had been moved to 28 days before the release date. IAG workers; the chaplaincy; the counselling, assessment, referral, advice and throughcare (CARAT) team; Jobcentre Plus and the resettlement team all attended the discharge board. An invitation had been extended to the healthcare centre, but no worker had yet been available to attend.

2.196 The resettlement database should be used to inform resettlement strategy and developments. (8.47)

Achieved. There was evidence of the database being used in this way (see recommendation 2.16).

2.197 Increased use should be made of release on temporary licence (ROTL) to prepare prisoners for release. Criteria for this should be made available to prisoners. (8.48)

Achieved. We were not provided with figures for the number of prisoners granted ROTL in the previous 12 months, but records held by the resettlement team showed that since September

2007 six prisoners had been released from the establishment on temporary licence to attend training opportunities in the community; these varied from three-day to 10-week courses. An eight-bedded resettlement unit had been set up, and was due to open in the week following the inspection. Suitable prisoners would be accommodated there, with no contact with prisoners outside this unit, and would be given ROTL to attend a structured resettlement programme of voluntary and then paid work in the community (known as 'Working Life Out'). They would be given help to open a bank account in order to save a proportion of their wages for their release; in addition, under some of the partnership arrangements with local firms, prisoners would have a strong possibility, or even a guarantee, of paid work following their release. The criteria for the scheme had been advertised across the establishment, and one of the prisoners we spoke to who would be starting the scheme was clear about what was expected of him and how the scheme would work. Two of the first eight prisoners were aged over 60 years. Managers told us that if this project was successful, it could be extended to more prisoners.

Drugs and alcohol

2.198 The CARAT service should offer structured one-to-one and group work intervention and focus on the special needs of young offenders. (8.83)

Partially achieved. The CARAT service had offered structured one-to-one work to 74 clients in February 2008, but group work sessions had not been run since September 2007. The team had prioritised meeting their target of 1,060 triage assessments per year. One worker coordinated services for young adults, which included regular consultation on service development. She planned to introduce age-appropriate group work modules to supplement one-to-one work. Young adults were able to access the establishment's four-week short-duration programme (SDP), which had replaced the establishment's previous treatment programme.
We repeat the recommendation.

Additional information

2.199 The CARAT team had grown to eight workers, including two recent appointments, but until four weeks before the inspection the service had not been consistently managed. The open active caseload stood at 134 in March 2008. The target of 120 starts had been met, and the completion target of 78 exceeded. All prisoners could access VDT, independent of location; 260 VDT compacts were in operation, and the required level of testing took place.

Children and families

2.200 Visiting orders should be reprinted to show the correct number for the visits booking line. (3.65)

Achieved. The visiting orders showed the correct telephone numbers for the visits booking line. However, they stated that the telephone line was operational all day, when in fact the booking line was closed for one hour during the lunch hour, and any family or friends attempting to book a visit between 12.30pm and 1.30pm would be greeted with an answering machine informing them when the line would be open again. The visits line was also open all day on Sunday, although the visiting order showed that it was only open until midday. Additionally, the information on the visiting order stated that prisoners on the enhanced regime had evening visits from 7–8pm, but this was incorrect, as there were no evening visits at the establishment.

Further recommendation

2.201 Visiting orders should be reprinted to show the correct information about visits entitlements and when booking lines are open.

2.202 Additional resources should be made available to the visiting booking line to reduce the difficulties in getting through. (3.66)

Not achieved. The visits booking line continued to be staffed by a team of two operational support grades, one taking legal and probation visit bookings and the second booking domestic visits. There was one booking line, and while the staff in the booking office were competent and dealt with bookings swiftly, we observed the booking database running slowly, which meant that the bookings took longer than was necessary. In addition, many callers booked multiple visits, which meant that the telephone line would be engaged for some time to other callers.
We repeat the recommendation.

Further recommendation

2.203 Visitors should be able to book further domestic visits during their current visit.

2.204 The visitors' centre should be redesigned to make maximum use of the space available. More seating should be provided and refreshments should be made available. (3.67)

Achieved. The visitors' centre was staffed by prison advice and care trust (PACT) volunteers and staff. The accommodation was cramped, although the available space was utilised optimally. The centre had a well equipped children's play area, toilets and baby changing facilities, as well as a vending machine for refreshments. There were a number of chairs, although the centre could not comfortably hold more than 10–15 visitors at any one time. Although the main entrance area provided a wide range of information on the walls and on a table, the area was not used to maximum advantage. A member of PACT told us that there were plans to improve the space so that it was more usable for visitors.

2.205 Closed visits and refused entry should be used only following drug dog indications that are supported by additional security intelligence. (3.68)

Not achieved. The establishment continued to use closed visits when drug dog indications were not supported by additional intelligence. All domestic visitors were required to sign a form declaring that they were aware of the consequences of bringing in prohibited items, and confirming that they had no prohibited items in their possession.
We repeat the recommendation.

2.206 The vulnerable prisoner visits area should be redesigned to reduce the possibility of vulnerable prisoners being clearly identified as such. (3.69)

Not achieved. The vulnerable prisoners visits area consisted of three tables set to one side of the visits hall, which were visible to all prisoners and their visitors. Prisoners on D wing were automatically booked into the vulnerable prisoners seating area. Once all three tables were booked, no further prisoners from D wing would be permitted a visit during that session. Vulnerable prisoners also had the opportunity to have morning visits; however, the same three tables continued to be used, despite the fact that the general prisoner population did not have

morning visits so more space was available.
We repeat the recommendation.

Further recommendation

2.207 Vulnerable prisoners should have more than three seats available per visiting session, particularly during morning visits.

Section 3: Summary of recommendations

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

Main recommendations — to the Governor

3.1 The reception environment, including the Listener interview room, should be improved to make it more welcoming and fit for purpose. (2.1)

3.2 Effective anti-bullying procedures and interventions should be in place. (2.2)

3.3 There should be a dedicated detoxification unit. (2.5)

3.4 Action should be taken to improve the experience of black and minority ethnic prisoners, through consultation with them and the establishment of effective procedures to promote equality. (2.6)

3.5 All prisoners should be engaged in appropriate education or training on a daily basis. (2.11)

3.6 Staffing levels should be increased to enable the PE department to provide accredited training and to make full use of all PE facilities. (2.15)

3.7 Life-sentenced prisoners should be transferred out of Bristol by a set date (within the next six months) and sent to establishments better able to address their needs. (2.20)

3.8 Resources should be made available to ensure that lifer hearings are not deferred unnecessarily so that life-sentenced prisoners held at Bristol can progress through the system. (2.21)

3.9 A system should be developed to identify and bring to the attention of staff any prisoner convicted of a current or previous racially aggravated offence. (2.24)

Recommendations — to the Director General

3.10 Transfer protocols for prisoners stabilised on methadone or buprenorphine should be consistent, and efforts should be made to speed up the transfer process. (2.26)

3.11 Efforts should be made to discharge prisoners to category C establishments more swiftly once they have been stabilised. (2.27)

3.12 Prisoners should be held in court cells for the minimum possible period. (2.29)

Recommendations — to the Governor

First days in custody

3.13 There should be clear procedures for dealing with prisoners who are in custody for the first time. (2.31)

3.14 Interviews with prisoners, especially those for the purpose of completing a cell-sharing risk assessment, should be conducted in private. (2.33)

3.15 All new receptions should be routinely seen by trained Listeners and Insiders as part of the first night arrangements. (2.35)

3.16 All prisoners spending their first night at Bristol should be located in the first night centre or receive comparable access to essential first night information and procedures. (2.36)

3.17 All prisoners should have the opportunity to take a shower before being locked up on their first night. (2.38)

3.18 A central monitoring system should be introduced to confirm that all elements of the induction programme are delivered to each prisoner. (2.40)

3.19 New arrivals should be disembarked from escort vehicles without undue delay. (2.44)

Residential units

3.20 Cells designated for single occupancy should not be used to hold two prisoners. (2.45)

3.21 Cells on B wing should be converted to in-cell sanitation. (2.46)

3.22 Cell call bells should be answered promptly. (2.47)

3.23 Managers should monitor the call bell information system weekly. (2.48)

3.24 Prisoner consultation groups should be held monthly, and any action points taken forward. (2.50)

3.25 All prisoners should be able to have daily showers. (2.51)

3.26 Showers and toilets on B and C wings should be refurbished. (2.52)

3.27 All prisoner mail should be posted within 24 hours. (2.53)

3.28 Access to telephones should be improved and telephones should be switched on when needed and prisoners informed. (2.54)

Personal officers

3.29 Regular entries should be made in prisoners' history sheets and these should be quality checked by managers. (2.57)

Bullying and violence reduction

3.30 Wing staff should be encouraged to report all incidents of bullying behaviour. (2.58)

3.31 Wing observation books and security information reports (SIRs) should be routinely checked and incidences of bullying referred for action to the safer custody unit. (2.59)

3.32 Wing staff should closely supervise the dispensing of medication on their wings. (2.60)

3.33 Courses that address anti-social behaviour and provide structured support to victims should be provided. (2.61)

3.34 All alleged incidents of bullying should be properly investigated. (2.64)

3.35 Entries in bully and victim monitoring books should demonstrate good levels of engagement from staff. (2.65)

Self-harm and suicide

3.36 A Listener care suite should be available on C wing. (2.69)

3.37 The toilets in the A and D wing care suites should be adequately screened to maintain privacy when being used. (2.70)

3.38 All staff should be trained in suicide prevention and understand contingency and intervention plans. (2.71)

3.39 Information about prisoners at risk of self-harm should be shared with relevant people and a support plan in the community instigated before the prisoner is released. (2.72)

Race equality

3.40 Senior managers should closely manage and monitor the prison's race relations strategy.(2.73)

3.41 Wing managers should ensure that matters relating to racial bias are identified and addressed. (2.78)

3.42 A separate prisoner representative group should be introduced and group comments fed into race relations management team (RRMT) meetings. (2.79)

3.43 Links with external organisations should be re-established. (2.82)

3.44 Racist incident report forms should be monitored to identify any trends and to respond to any potential issues. (2.88)

Foreign national prisoners

3.45 The foreign nationals policy statement should be expanded to include details of the services to which foreign national prisoners were entitled to, and published on all residential units. (2.93)

3.46 A peer support group that meets regularly should be established. (2.94)

Applications and complaints

3.47 All wing applications should be recorded and replies should be sampled by wing and senior managers. (2.95)

3.48 Replies to complaints should be sampled by senior managers. (2.97)

Substance use

3.49 Prisoners undergoing detoxification should be in an environment where they can be observed by specialist staff and have access to a supportive regime. A dedicated detoxification unit should be developed to meet this need. (2.101)

Health services

3.50 A primary care compatible electronic information system should be installed. (2.105)

3.51 Disabled access to the primary care/day care facility should be installed. (2.116)

3.52 Pharmacy staff should deliver direct patient care and undertake medicine reviews. (2.118)

3.53 The primary care trust should work with the establishment to establish an area within the prison where the pharmacist can hold clinics, such as for minor illness, and be able to hold a confidential advice service to prisoners. Resources should be increased to improve staffing levels. (2.120)

3.54 All shared cells should have secure lockable boxes in which prisoners can store their medicines. (2.123)

3.55 The primary care trust and Avon and Wiltshire Partnership Trust should review the requirement for inpatient beds with a view to reducing the numbers and to ensuring that only prisoners with a clinical need are admitted to the inpatient unit. (2.129)

3.56 The gate at the end of the inpatient corridor should be moved to allow free movement throughout the inpatient area. A dining area should be identified in the inpatient unit. (2.130)

3.57 The exercise area should be cleaned up and improved to provide a therapeutic area for inpatients. (2.131)

Learning and skills and work activities

3.58 Individual learning plans should be used effectively to plan learning through custody and beyond, and initial assessments and follow-up reviews should be carried out as appropriate. (2.137)

3.59 Skills acquired at work should be accredited and professionally recognised qualifications introduced wherever possible. (2.140)

Time out of cell

3.60 The larger yard adjacent to B wing should be used for exercise. (2.144)

3.61 Prisoners should be issued with weatherproof clothing when taking exercise in poor weather. (2.145)

3.62 Association periods should not be cancelled. (2.147)

3.63 Prisoners should spend 10 hours out of their cell each day. (2.148)

Discipline

3.64 Segregation unit staff should be given special training in dealing with prisoners with mental illness. (2.155)

3.65 The information provided to prisoners should make it clear that they can request a daily shower when segregated. (2.157)

3.66 Adjudication records should be quality assured by senior operational managers to ensure that the awards made are safe. (2.159)

Integration of young prisoners

3.67 Young offenders should be clearly identified and their integration subject to rigorous risk assessment. (2.160)

3.68 Convicted young offenders should be allocated to a young offender institution and be transferred immediately. (2.161)

Incentives and earned privileges

3.69 Staff comments on warning sheets should be clear and unambiguous in their guidance on how to improve behaviour. (2.164)

3.70 Decisions to move prisoners across incentives and earned privileges (IEP) levels should be randomly checked by wing and senior managers. (2.165)

Catering

3.71 Systems should be introduced in the kitchen to ensure that food prepared and served to vulnerable prisoners is not adulterated. (2.169)

3.72 Prisoner food surveys should be conducted every six months. (2.170)

3.73 The catering manager should attend the race equality action team and the prisoner consultative committee meetings, and a deputy should attend in his absence. (2.171)

3.74 Prisoners working in the kitchen should be offered accredited training. (2.172)

Prison shop

3.75 Prisoners should be able to buy items from the shop within 24 hours of arrival. (2.175)

3.76 Staff should systematically consult with prisoners at least every three months about items they would like to see on the shop list. (2.176)

Offender management and planning

3.77 Assessment and sentence planning should be in place for all eligible prisoners. (2.182)

3.78 Custody planning should be established for prisoners on remand. (2.183)

3.79 The case management record (CMR) should be a live document to which all departments of the prison contribute. (2.184)

3.80 Public protection should be given a high priority in the establishment. Wing staff should be trained in public protection measures. (2.190)

Drugs and alcohol

3.81 The CARAT service should offer structured one-to-one and group work intervention and focus on the special needs of young offenders. (2.198)

Children and families

3.82 Visiting orders should be reprinted to show the correct information about visits entitlements and when booking lines are open. (2.201)

3.83 Additional resources should be made available to the visiting booking line to reduce the difficulties in getting through. (2.202)

3.84 Visitors should be able to book further domestic visits during their current visit. (2.203)

3.85 Closed visits and refused entry should be used only following drug dog indications that are supported by additional security intelligence. (2.205)

3.86 The vulnerable prisoner visits area should be redesigned to reduce the possibility of vulnerable prisoners being clearly identified as such. (2.206)

3.87 Vulnerable prisoners should have more than three seats available per visiting session, particularly during morning visits. (2.207)

Appendix I: Inspection team

Francis Masserick	Team leader
Gail Hunt	Inspector
Vinnett Pearcy	Inspector
Steve Moffatt	Inspector
Sean Sullivan	Inspector
Bridget McEvilly	Health services inspector
Sigrid Engelen	Substance misuse inspector
Linda Truscott	Ofsted inspector

Appendix II: Prison population profile

(i) Status	Number of prisoners	%
Sentenced	331	56.98
Convicted but unsentenced	73	12.56
Remand	171	29.43
Civil prisoners		
Detainees (single power status)	6	1.03
Detainees (dual power status)		
Total	**581**	

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	53	13.80
6 months to less than 12 months	30	7.81
12 months to less than 2 years	39	0.26
2 years to less than 4 years	59	15.36
4 years to less than 10 years	50	13.02
10 years and over (not life)	9	2.34
Life	91	23.70
Total	**331**	

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month	95	28.70	112	44.80
1 month to 3 months	94	28.40	102	40.80
3 months to 6 months	36	10.88	19	7.60
6 months to 1 year	39	11.78	16	6.40
1 year to 2 years	38	11.48	1	0.40
2 years to 4 years	25	7.55	0	0
4 years or more	4	1.21	0	0
Total	**331**		**250**	

(iv) Main offence	Number of prisoners	%
Violence against the person	178	30.64
Sexual offences	62	10.67
Burglary	75	12.91
Robbery	48	8.26
Theft and handling	36	6.20
Fraud and forgery	17	2.93
Drugs offences	59	10.15
Other offences	84	14.46
Civil offences		
Offence not recorded/ Holding warrant	22	3.79
Total	**581**	

(v) Age	Number of prisoners	%
21 years to 29 years	160	27.54
30 years to 39 years	223	38.38
40 years to 49 years	113	19.45
50 years to 59 years	57	9.81
60 years to 69 years	21	3.61
70 plus years	7	1.20
Please state maximum age	73	
Total	**581**	

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	254	43.72
Between 50 and 100 miles of the prison	130	22.26
Over 100 miles from the prison	89	15.32
Overseas		
NFA	108	18.59
Total	**581**	

(vii) Nationality	Number of prisoners	%
British	503	87.78
Foreign nationals	70	12.22
Total	**573**	

(viii) Ethnicity	Number of prisoners	%
White		
British	448	77.51
Irish	4	0.69
Other White	16	2.77
Mixed		
White and Black Caribbean	10	1.72
White and Black African	2	0.35
White and Asian	3	0.52
Other mixed	3	0.52
Asian or Asian British		
Indian	14	2.42
Pakistani	4	0.69
Bangladeshi	0	0
Other Asian	5	0.87
Black or Black British		
Caribbean	39	6.75
African	12	2.08
Other Black	13	2.25
Chinese or other ethnic group		
Chinese	3	0.52
Other ethnic group	2	0.35
Total	**578**	

(ix) Religion	Number of prisoners	%
Baptist	0	0
Church of England	97	16.90
Roman Catholic	61	10.63
Other Christian denominations	12	2.09
Muslim	28	4.88
Sikh	0	0
Hindu	1	0.17
Buddhist	5	0.87
Jewish	2	0.35
Other	17	2.96
No religion	351	61.15
Total	**574**	