Report on an unannounced short follow-up inspection of

HMP Dorchester

2–4 July 2012

by HM Chief Inspector of Prisons

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Introduction

HMP Dorchester is a small local prison built around 1880. At the time of the inspection it held just over 250 prisoners, including sentenced and unsentenced, adult and young prisoners. At our last full inspection in 2009 we found that Dorchester was overcrowded and there was insufficient activity, but it was a safe prison with excellent staff-prisoner relationships and a sound focus on resettlement. In our healthy prison tests we found it was achieving good outcomes in safety and reasonably good outcomes in respect, purposeful activity and resettlement. During this unannounced short follow-up inspection, we found the prison had made sufficient progress in implementing our recommendations in three of those healthy prison areas, but progress under the safety heading had been insufficient. Short follow-up inspections focus on recommendations made at the last full inspection and so do not provide an assessment of the prison as a whole.

Although prisoners told us that Dorchester remained a safe prison there had been little progress on monitoring and analysing incidents of violence or self-harm to provide reassurance that everything possible was being done to maintain prisoner safety. The lack of a prison-wide commitment to safer custody, low levels of staff training and the absence of key staff implied that there was a worrying degree of complacency around prisoner safety. Substance misuse services, however, had improved. There was now clear strategic direction, support for newly arrived prisoners with substance dependencies, and improved group work facilities.

The prison remained very overcrowded, holding significantly more prisoners than the certified normal accommodation. While some refurbishment had been done to improve physical conditions on wings, cells were not adequately furnished, laundry facilities were poor and more attention to cleanliness was required in some areas.

Progress had been made in developing a diversity strategy and prisoners had been recruited to promote equality. However, commitment from operational areas was lacking and there were insufficient staff with dedicated time to undertake diversity-related tasks.

The building of new health care facilities noted in the last report had still not been completed but there had been significant improvement in services and management of health care generally. The mix of residential and health care accommodation on B wing was poorly managed, which impeded the delivery of health services and reduced the level of residential support for prisoners located there.

Prisoners continued to spend too much time locked up. New training courses, education places and work opportunities had been introduced since the last inspection but there was still insufficient purposeful activity for the population. There were welcome improvements in the range and quality of education, as we recommended, including new courses to improve basic skills and learning English.

The prison had addressed our previous concerns about the strategic planning of reducing reoffending but there was still insufficient attention paid to the specific needs of young adults. Since the last inspection planning for the resettlement needs of remand prisoners had been reduced. Public protection arrangements, however, had improved.

Although 7% of prisoners were released without an address to go to, this was a reduction from the 12% we found at our last inspection. Accommodation services were provided for both remand and sentenced prisoners.

Since our last inspection a new visits facility had been opened and there had been other improvements, including easier booking and extended visiting times. However, remand prisoners still could not receive a daily visit.

HMP Dorchester has responded positively to some key findings from our last inspection but there are some enduring concerns. Although the new health care facility has not materialised, management and delivery of health services has progressed. Good work has been done to improve purposeful activity but there is still not enough available. The prison remains overcrowded and staff need to guard against complacency concerning prisoner safety and relationships if they are to remain strengths of the prison.

Nick Hardwick **August 2012**
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Dorchester is a local category B remand prison holding adult male prisoners, including vulnerable prisoners, and some young adult prisoners aged 18–21, serving local courts and allocation to local training establishments.

Prison status
Public

Region
South West

Number held
254

Certified normal accommodation
145

Operational capacity
271

Date of last full inspection
March 2009

Brief history
HMP Dorchester is a small Victorian local prison in the centre of the county town, built around 1880.

Short description of residential units
A typical Victorian build, the accommodation comprises two main spurs – A and B wings; a recent addition to accommodation numbers was provided by the release of the health care cells, now known as B1. There are two further residential units: a first night centre (C wing) and a vulnerable prisoner unit (D wing).

Name of governor
Gavin O'Malley

Escort contractor
GeoAmey

Health service
Commissioner: Dorset NHS Primary Care Trust
Provider: Dorset Healthcare University NHS Foundation Trust

Learning and skills providers
A4e

IMB chair
Judith Anstice

Section 1: Summary

Introduction

1.1 Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, immigration detention facilities and police custody.

1.2 All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

1.3 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2009 and assess the progress achieved. All full inspection reports include a summary of outcomes for prisoners against the model of a healthy prison. The four criteria of a healthy prison are:

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

1.4 Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected and giving an overall assessment against the following definitions:

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

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

Safety

1.5 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were good. We made 17 recommendations in this area, including one main recommendation,

of which six had been achieved, three partially achieved, including the main recommendation, and eight had not been achieved. We have made no further recommendations.

1.6 The redecorated and upgraded reception facilities provided an improved environment. A separate room had been introduced to cater for prisoner interviews in privacy but the holding rooms were still small and cramped. A record of new receptions was passed to the night orderly daily, allowing night staff to be briefed on the location and special needs of all new arrivals.

1.7 Most prisoners we spoke to, including vulnerable prisoners, said that they felt safe and that staff challenged bullying behaviour.

1.8 Attendance at the safer prisons meetings was poor and there was still no analysis of trends or patterns in violent incidents presented to the meeting. With the absence of the regular safer custody manager over recent months, safer custody data had not been reported consistently.

1.9 The available data suggested low levels of violence. On average, around four prisoners a month were suspected of involvement in bullying. There were some good investigations, and most case records had daily monitoring entries, but there were no specific interventions to challenge bullying behaviour, other than to demote perpetrators to the basic regime. Victim support plans were opened and were well documented but it was often the victim, rather than the perpetrator, who was moved to a different wing.

1.10 Although the care for prisoners at risk of suicide or self-harm remained reasonable, little progress had been made with recommended improvements. There had been no self-inflicted deaths for nearly five years and there were few incidents of self-harm, although self-harm data were not collated in order to evaluate trends over time and inform strategic development. The quality of self-harm monitoring documentation was reasonable, although in some cases the timing of monitoring entries was too regular and predictable. Management checks were completed and relevant managers alerted to deficiencies but these were largely focused on audit compliance rather than on the quality of the outcome for the prisoners concerned. Duty governor checks did not adequately comment on the quality of care being offered.

1.11 A log was kept to record the occasions when prisoners at risk of suicide or self-harm had been issued with strip-clothing; it was commendable that this occurred infrequently and for relatively short periods. The log for 2011 was incomplete. A protocol outlined guidance for the use of safer cells and gated cells but the use of these cells was not monitored at safer custody meetings. A protocol on the use and availability of the Listener suite had been published and there was good access to Listeners.

1.12 Assessment, care in custody and teamwork (ACCT) foundation training had been replaced by more generic safer custody training but few staff had completed this. Training sessions were regularly cancelled and many staff, including some ACCT managers, were still in need of initial or refresher training.

1.13 The range of privileges available to enhanced prisoners had been increased but was still insufficient to encourage improved behaviour. Enhanced prisoners without access to sufficient funds were unfairly disadvantaged by the restrictions on their own property being sent in, while newly purchased goods were allowed. Records of incentives and earned privileges reviews showed the information considered and who had attended the board, and prisoners were able to attend and contribute. The logs demonstrated little engagement with prisoners or recording of their progress against targets.

1.14 The drug strategy was reviewed annually, with regular review of the action plan. The services continued to be delivered in a cramped environment but the team provided a good level of care. The management of opiate-dependent prisoners had improved but those requiring stabilisation continued to overflow into cells that were not suited for appropriate monitoring and observation.

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

Respect

1.16 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 65 recommendations in this area, including three main recommendations, of which 30 had been achieved, 14 partially achieved, including two main recommendations, and 20 had not been achieved, including one main recommendation. One recommendation was no longer applicable. We have made one further recommendation.

1.17 We found most cells to be clean and tidy but cells designed for one prisoner continued to be used to hold two. The furnishing of some cells had improved but there were no lockable storage cabinets, most prisoners did not have sufficient space to eat meals at a table together and too many toilets were inadequately screened. The physical condition of A and B wings had improved but they were not clean enough. Shower blocks on these wings were poorly ventilated, dirty and had only partial screening. Telephone provision was not adequate for the number of prisoners held on the wings.

1.18 Young adults were still required to wear distinguishing clothes. Wing laundry facilities were not available, restricting prisoners from wearing their own clothes. Prisoners were dissatisfied with the standard of service provided by the clothing exchange store.

1.19 There was a sound personal officer policy and some good practice but it was variable, staff were poorly trained in the role, and quality assurance practices were inconsistent.

1.20 Good work had been done on some of the diversity recommendations emerging from the previous inspection but progress in developing a prison-wide commitment was limited. A comprehensive diversity policy and action plan had been developed. The diversity committee met every two months to monitor delivery of diversity objectives but attendance was poor and there was insufficient involvement of some important departments, including health care and education.

1.21 There had been progress in identifying and meeting the needs of older prisoners and those with disabilities but the disability liaison officer had insufficient time to carry out his duties. Monitoring of the access of minority groups to the regime was poorly developed, except for black and minority ethnic prisoners, limited to reporting numbers rather than representation in the regime.

1.22 There were few black and minority ethnic staff in prisoner contact roles but this was mitigated by the promotion of equality through celebratory events, with the aim of making prisoners from minority backgrounds feel included. Prisoners who demonstrated racist behaviour were identified and interviewed but there was no structured intervention to address their attitudes. Diversity complaints were well managed. The diversity action plan did not address the needs of foreign national prisoners but services for these prisoners were being developed. A limited range of translated material was available.

1.23 Prisoners said that staff were approachable and that they could often resolve issues without formal complaints. Most responses to complaints were reasonably courteous and answered the complaint but they often simply re-stated the rules, few offered apologies where there had been mistakes and they were not always personalised.

1.24 Legal services provision had deteriorated. There was no dedicated time for legal services officers. No records were kept of prisoners' legal applications and there was no register of appellants. There was no information about legal services in the induction booklet and limited information around the wings. Regular support for bail was provided.

1.25 The new build for the delivery of primary care services had been delayed and health care services continued to be delivered on the ground floor of B wing. Inpatient cells were now used for normal accommodation, which was an unsatisfactory arrangement that at times encroached on the delivery of services.

1.26 Improvements in health care recommended following the previous inspection had mostly been achieved. The department was well managed, with good support for clinical staff. Pharmacy services had improved, with a pharmacist visiting the prison every week, although not providing clinics for patients. Dental services were good, with acceptable waiting times.

1.27 A hot breakfast had been introduced but the evening meal was still served too early. There were no facilities for prisoners to eat their meals out of their cells.

1.28 New arrivals could still wait over 10 days to purchase goods from the prison shop, although those with money could buy additional reception packs. Minimum delivery charges were passed on to prisoners but no administration fee was charged. Although there had been no survey of prisoners' views of the shop, regular opportunities were provided for them to influence the local product list and prison shop issues were regularly raised at the staff–prisoner forums.

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

Purposeful activity

1.30 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 19 recommendations in this area, including one main recommendation, of which 12 had been achieved, one partially achieved (the main recommendation), and five had not been achieved. One recommendation was no longer applicable. We have made no further recommendations.

1.31 Provision of evening association was still poor. Most prisoners got just one evening period a week, with only enhanced prisoners who worked off the wing getting additional sessions. Recording of time out of cell had improved; at an average of 5.7 hours a day, this was well below our expectation of 10 hours a day out of cell.

1.32 The number of work and education places available had increased with the introduction of new vocational skills training, better recruitment of learners and in-cell education but there was still insufficient work, especially for vulnerable prisoners. Recommended improvements in education and training had been mostly achieved. Provision for the teaching of English for speakers of other languages was flexible and well resourced, support for literacy and

numeracy needs was good and accreditation of achievement had been extended. Prisoners were not discouraged from participating by inequitable wage rates.

1.33 Although management of the library had improved, prisoners did not have a full library induction.

1.34 The range of courses offered by the gym had improved but showers and changing facilities remained poor.

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

Resettlement

1.36 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 25 recommendations in this area, including one main recommendation, of which 13 had been achieved, including the main recommendation, and 11 had not been achieved. One recommendation was no longer applicable. We have made no further recommendations.

1.37 The reducing reoffending strategy required updating to reflect the current resettlement and offender management provision. The accompanying action plan was reviewed at the reducing reoffending meetings. There was no specific provision for young adults, of which there were between 20 and 25 at any one time.

1.38 A large number of organisations provided resettlement services; they met the head of reducing reoffending at various meetings and were aware of the reducing reoffending strategy and the part they played in helping the establishment to achieve identified priorities.

1.39 Formal custody planning for remand prisoners had ceased. These prisoners underwent only a basic resettlement needs assessment on reception and were signposted to the services they required. The lack of custody planning had highlighted some issues around public protection for potential multi-agency public protection arrangements (MAPPA) prisoners who had not been assigned to an offender supervisor. This gap had been filled by the allocation of resources from the public protection team, which had ensured that the risk was managed appropriately.

1.40 There had been no formal evaluation of the personal officer scheme with regard to sentence planning and delivery. Personal officers' participation in the decision-making process and delivery of aspects of sentence management was inconsistent.

1.41 Public protection was effectively organised, with a designated manager in post. There were improved systems for assessing prisoners on reception who required public protection interventions, and well used procedures for staff to report ongoing concerns during a prisoner's time in custody.

1.42 Life-sentenced prisoners did not wait for long periods to be transferred to suitable establishments. Lifer training had been suspended by the Prison Service but advice and support from lifer-trained staff for colleague offender supervisors ensured a consistent level of service. There were no formal forums or events for lifers. They were all seen individually by the head of offender management and had been offered their own forums and events but none had chosen to take up the offer.

1.43 Accommodation information for remand prisoners was given on the first night centre and they were signposted to accommodation services. There were adequate services to find bail accommodation when required. A central Dorset gateway service was used for securing accommodation for sentenced prisoners and was a good resource which to some extent mitigated the loss of the housing officer.

1.44 The visits booking system had improved. Visiting time had been extended but it took too long for visitors to be admitted. Remand prisoners could not get the daily visit to which they were entitled. None of the visits staff we spoke to had been trained in safeguarding children. The views of visitors were kept under review by annual surveys and the most recent was due to be analysed to identify further improvements.

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

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 **A log should be kept to record cases where prisoners at risk of suicide or self-harm have their clothing removed when placed in the special accommodation in the health care centre, and there should be appropriate safeguards in accordance with an agreed protocol and published policy. (HP48)**

Partially achieved. A log was kept of the occasions when prisoners at risk of suicide or self-harm had been issued strip-clothing. This recorded only four occasions since 2010; on two of these occasions this had been for one overnight period. The log for 2011 was incomplete and omitted the time that personal clothing had been returned to prisoners. A protocol (dated April 2012) outlined guidance for the use of safer cells and gated cells but this did not include sufficient and appropriate safeguards. The use of gated cells was not monitored at the monthly safer custody meetings.
We repeat the recommendation.

2.2 **The prison should draw up a prisoner diversity policy and establish a diversity committee focused on prisoner issues, which is attended by key staff responsible for delivering equality of opportunity, including health services and activity providers. (HP49)**

Partially achieved. There was a comprehensive diversity policy, which addressed all identified characteristics, with an accompanying action plan. A diversity officer was responsible for implementing the strategy, supported by members of staff with specific responsibility for disability and for foreign national prisoners. A diversity committee, which met every two months and was attended by prisoner representatives, had been established but attendance was poor and there was insufficient contribution to the delivery of the strategy from relevant prison departments, including health care and education.
We repeat the recommendation.

2.3 **Cells designed for one prisoner should not hold two. (HP50)**

Not achieved. Cells designed for one prisoner continued to be used for two. The certified normal accommodation of the prison was 145, but at the time of the inspection the population was 254.
We repeat the recommendation.

2.4 **The physical condition of A and B wings should be improved. (HP51)**

Partially achieved. The flooring on A and B wings had been replaced and the walls redecorated. On the upper landings, walls were still dirty and stained above head height where the paintwork had not been renewed.
We repeat the recommendation.

2.5 **There should be sufficient work and education places for the prisoner population. (HP52)**

Partially achieved. There were only 132 work and education places regularly available, with 35 part-time places for a population of more than 250 prisoners. The prison had introduced new courses in barbering, fork-lift truck driving and driver theory training. Along with better recruitment of learners onto courses and more in-cell education to support basic skills, the prison had increased the number of education places from an average of 44 places to 70 places every morning and afternoon. The number of work places had been slightly increased through the introduction of more part-time working in areas such as the kitchen and clothing exchange stores but there were still insufficient for the current prisoner population. The prison recognised this deficit, particularly with the planned increase in the prisoner population, and action had already been taken to identify areas where additional work could be introduced. There were also plans to introduce more work for prisoners on release on temporary licence, and links had been created with external companies to facilitate this.

2.6 **Prisoners should have access to association every evening. (HP53)**

Not achieved. Most prisoners still had evening association only once a week. Enhanced prisoners working off the wing were offered additional evening association.
We repeat the recommendation.

Recommendations – safety

Courts, escorts and transfers

2.7 **Reception should be refurbished to provide appropriate facilities. (1.21)**

Partially achieved. Reception had been redecorated and upgraded to provide a larger booking-in area, and a separate room had been built to facilitate prisoner interviews in private. The main holding rooms were the same size as at the time of the previous inspection and were cramped. A small amount of graffiti was found in two of the holding rooms and one contained broken seating.

2.8 **Night staff should be made aware of the location and special needs of all new arrivals. (1.22)**

Achieved. Staff on C wing (the first night centre) completed a daily list of new receptions. This was passed to the night orderly, detailing the location and special needs of new arrivals, enabling night staff to be thoroughly briefed.

Bullying and violence reduction

2.9 **Information collected monthly by the safer custody team should be analysed over time to identify patterns and trends. (3.9)**

Not achieved. There was still no analysis of trends or patterns in violent incidents over time. Only the latest month's data were presented at monthly safer custody and violence reduction meetings. The safer custody manager had been absent over recent months, and during this time data had not been reported consistently. Attendance at the meetings was poor. However, our prisoner groups indicated that levels of violence were low and that most prisoners,

including vulnerable prisoners, felt safe. There had been an average of three adjudications per month for assaults and only one fight per month.
We repeat the recommendation.

2.10 **There should be interventions to support prisoners subject to anti-bullying victim logs, and to address and challenge the inappropriate behaviour of bullies. (3.10)**

Not achieved. On average, around four prisoners a month were suspected of involvement in bullying. There was evidence of some good investigations and in most cases records showed that staff had routinely monitored suspected bullies. However, there were still no specific interventions to challenge bullying behaviour, other than to demote perpetrators to the basic regime. Victim support plans were opened, and these were well documented, but it was often the victim, rather than the perpetrator, who was moved to a different wing to reduce tensions.
We repeat the recommendation.

Self-harm and suicide

2.11 **Information collated by the suicide and self-harm coordinator should be evaluated for trends over time and used to inform strategic development. (3.20)**

Not achieved. Information on self-harm incidents was not collated in order to evaluate trends, and the reporting of the details of incidents had been inconsistent over recent months. There had been one serious incident of self-harm since the previous inspection but this had not been investigated to establish any learning. There had been no self-inflicted deaths for nearly five years and there were only an average of seven incidents of self-harm each month, often involving the same prisoners. On average, around 14 self-harm monitoring documents were opened monthly, which was similar to the number at the time of the previous inspection.
We repeat the recommendation.

2.12 **There should be an effective quality assurance scheme for assessment, care in custody and teamwork (ACCT) documentation, and areas of concern should be taken forward with clearly identified objectives. (3.21)**

Not achieved. The quality of self-harm monitoring (ACCT) documentation was reasonable, with some detailed assessments and reviews, although in some cases the timing of monitoring entries was too regular and predictable and review meetings were not always multidisciplinary. Management checks were completed by the safer custody manager, and relevant managers were alerted to deficiencies, but these still largely focused on audit compliance rather than on the quality of the outcome for the prisoners being cared for. Duty governor checks did not comment on the quality of care being offered.
We repeat the recommendation.

2.13 **A clear policy on the use and availability of the Listener suite should be publicised across the establishment and to all staff. (3.22)**

Achieved. A protocol on the use and availability of the Listener suite had been published as part of the local policy and the suite had been used on four occasions in the current year. Prisoners told us that there was good access to Listeners. The prisoner who acted as lead Listener said that the scheme was well supported by staff.

2.14 **All staff should receive ACCT foundation training and refresher courses after three years. (3.23)**

Not achieved. ACCT foundation training had recently been replaced by more generic safer custody training but few staff had completed this. Although foundation training had regularly been offered over the previous year, it had frequently been cancelled and many staff, including some ACCT managers, were still in need of initial or refresher training.
We repeat the recommendation.

Incentives and earned privileges

2.15 **The range of privileges available to enhanced prisoners should be increased. (6.37)**

Achieved. The range of privileges available to enhanced prisoners had been increased making achievement of enhanced status more attractive for most prisoners, although some prisoners in our groups complained that the facility to have additional items was too dependent on them having someone with sufficient funds to send them in.
We repeat the recommendation.

2.16 **Records of incentives and earned privileges (IEP) reviews should clearly indicate who attended the board and all the information considered in reaching a decision. (6.38)**

Achieved. Records of reviews that we examined showed who had attended the board, and copies of all information considered at the board were attached to the review document.

2.17 **Prisoners should be able to attend and contribute to IEP reviews. (6.39)**

Achieved. The IEP policy stated that prisoners could attend review boards. The records we examined showed that prisoners attended and were able to contribute fully to the reviews.

2.18 **Daily entries in basic-level prisoner monitoring logs should evidence engagement with prisoners and record progress against behaviour improvement targets. (6.40)**

Not achieved. In the monitoring logs that we examined, daily entries indicated little active engagement with prisoners or recording of progress against the targets set.
We repeat the recommendation.

Substance misuse

2.19 **Treatment for opiate-dependent prisoners should be provided on their first night. (3.103)**

Achieved. Prisoners identified as opiate dependent when they arrived at the prison were provided with treatment starting on their first night. A consultant psychiatrist was available for those prisoners when required and the out-of-hours service was used appropriately.

2.20 **Prisoners should be stabilised in an environment that allows for appropriate monitoring and observation. (3.104)**

Not achieved. There continued to be an overflow of prisoners requiring stabilisation, resulting in them being accommodated in cells that were not suitable. Some were held in cells with no observation windows, which inhibited the ability of prison staff to monitor and observe them adequately.
We repeat the recommendation.

2.21 **Plans for the new health care building should include the co-location of integrated drug treatment system (IDTS) and counselling, assessment, referral, advice and throughcare (CARAT) services on a dedicated stabilisation unit with appropriate facilities to carry out their work. (3.105)**

Not achieved. Plans for the new health care building had been modified, with a reduction in the size of the facility making it no longer possible to accommodate all services. It remained an aspiration to co-locate IDTS and CARAT services following the move of health care to the new centre.
We repeat the recommendation.

2.22 **Prisoners should be able to access disinfecting tablets for cleaning injecting equipment, and there should be means of safe disposal. (3.106)**

Partially achieved. Disinfecting tablets were now available but there was some reluctance to distribute them around the prison to make them easily available. Each wing office provided the facility for the safe disposal of hazardous sharp materials, including needles.
We repeat the recommendation.

2.23 **The drug and alcohol strategy document should include a detailed annual action plan. (8.63)**

Achieved. A comprehensive drug and alcohol strategy document was produced annually. It contained a detailed action plan which was reviewed regularly.

2.24 **A drug awareness programme should be provided. (8.64)**

Achieved. East Dorset Drug and Alcohol Services provided a wide variety of programmes and training specifically for prisoners with problems relating to alcohol. Alcohol awareness was also provided by the CARAT and IDTS teams, with brief interaction programmes. The Crime Reduction Initiative was also involved in the care for prisoners.

2.25 **Facilities for interviewing and group work should be improved. (8.65)**

Achieved. Despite the cramped facilities that were used by the IDTS service, new arrangements had been made to enhance the delivery of group work and consultation. One of the rooms in the education department had been made available for larger groups on the programme, and two new rooms were available on the wings for interviews and consultations.

Recommendations – respect

Residential units

2.26 **All cells should be clean, properly furnished and have toilet screening. (2.15)**

Partially achieved. Cell conditions were variable, as the responsibility for cleaning them rested with the occupants and vacated cells were not always cleaned before the next prisoner moved in. Most cells we saw were clean and tidy but cramped. Some had been fitted with new wooden furnishings, although no lockable storage was available. Many toilets were inadequately screened, with shower curtains being used for this purpose. In several cells, these did not close properly, were damaged or were missing. Most prisoners did not have

sufficient space in their cells to eat meals at a table together.
We repeat the recommendation.

2.27 **Young adults should not be required to wear distinguishing clothes. (2.16)**

Not achieved. Young adults were still required to wear orange shirts so that they could be easily identified by staff.
We repeat the recommendation.

2.28 **All prisoners should be permitted to wear their own clothes. (2.17)**

Not achieved. All prisoners were required to wear prison-issue clothing, unless they had special permission to wear their own clothes.
We repeat the recommendation.

2.29 **There should be facilities on residential units for prisoners to wash their clothes. (2.18)**

Not achieved. There were no laundry facilities, which restricted prisoners from wearing their own clothing (see recommendation 2.28). All prison-issue clothing was taken to HMP Portland for washing, although some prisoners told us that they washed their underwear in the sink in their cells. Many prisoners were dissatisfied with the service provided by the clothing exchange store, with items being returned which were incorrectly sized and poorly cleaned.
We repeat the recommendation.

2.30 **Communal showers should be kept clean and in working order. (2.19)**

Partially achieved. The communal showers were in working order but those on A and B wings were dirty, damp, poorly ventilated, in need of decoration and had only partial screening.
We repeat the recommendation.

2.31 **There should be at least one telephone for every 20 prisoners. (8.77)**

Not achieved. No additional telephones had been provided, so there were still only eight outgoing telephones in the prison (three on A wing, three on B wing and one each on C and D wings), which at the time of the inspection was holding 254 prisoners. The prison had introduced a 10-minute limit for calls, and prisoners in our groups indicated that this had made the system of access fairer.
We repeat the recommendation.

Staff–prisoner relationships

2.32 **The published personal officer policy should provide clear guidance to staff on how to use the information provided by the offender management unit and the personal officer checklist to support prisoners and help them prepare for release. (2.32)**

Achieved. A revised personal officer policy had been introduced in June 2011, extending the scope of the scheme to cover all prisoners entering the establishment. The previous personal officer checklist had been withdrawn at that time; however, the new policy clearly described the personal officer role and the sources of information available to staff carrying out the role, the offender management unit being just one of many sources.

2.33 **Residential managers should provide ongoing support and training for personal officers to ensure they understand and can meet the requirements of the personal officer policy. (2.33)**

Not achieved. Staff taking on the personal officer role received no specific training and, because of operational duties, had limited time to spend on this work. Managers monitored P-Nomis entries documenting contact between personal officers and the prisoners in their care, and provided feedback to staff, although this was mainly for the purposes of managing the IEP scheme rather than supporting the personal officer role.

2.34 **A quality assurance scheme for personal officer work should be incorporated into the policy and implemented. (2.34)**

Partially achieved. The published policy stated that wing managers should monitor 10% of P-Nomis files monthly, to check personal officer entries. However, there was no clear direction regarding the level of detail that this monitoring should entail, and this had led to managers introducing inconsistent practices. Most wing managers focused on establishing that personal officers had made contact with their prisoner twice a month, as stipulated in the policy, rather than commenting on quality, good practice or areas for improvement.
We repeat the recommendation.

Equality and diversity

2.35 **The disability liaison officer should be allocated enough time to carry out all their duties. (3.31)**

Not achieved. The care for prisoners with disabilities was shared between a designated officer and the health and safety officer. These posts were incorporated into existing duties, with no time allocated to them on the staff detail, which meant that the time available depended on the demands of other responsibilities.
We repeat the recommendation.

2.36 **All new arrivals should be assessed to establish whether they have a disability. Initial assessments should be forwarded to the disability liaison officer and reviewed at least annually. (3.32)**

Achieved. All newly received prisoners were asked if they had a disability. All those identified were referred to the disability liaison officer and the health and safety officer, who undertook assessments to identify any care needs and prepare an evacuation plan.

2.37 **The disability policy should be informed by an up-to-date needs analysis and underpinned by an action plan. (3.33)**

Achieved. A prisoner survey published in May 2011 included a thorough needs analysis of prisoners with disabilities. Issues arising from the survey included reliable identification of prisoners with disabilities, meeting specific needs and eliminating discrimination. The issues identified in the survey were addressed in the prison's diversity action plan, with practical action points.

2.38 **All prisoners with disabilities and older prisoners with identified needs should have a care plan that is informed by health services and residential staff, and about which they should be consulted. (3.34)**

Partially achieved. Care plans were prepared in consultation with the prisoner and identified some needs; however, they contained limited detail about how these needs would be met or by whom. Prisoners with specific health needs, including an amputee and a man suffering from a progressive disabling illness, had plans informed by health services staff. The planning document had been redesigned with the help of a prisoner with disabilities and was now more detailed but it was not commonly in use at the time of the inspection.

2.39 **All staff should be familiar with the location and content of evacuation plans for prisoners with disabilities and older prisoners. (3.35)**

Achieved. Residential staff were aware of evacuation plans which had been prepared by the prison's health and safety officer. Plans were kept in prisoner case files and those requiring assistance were highlighted on notices in wing offices.

2.40 **Support forums for prisoners with disabilities should be facilitated. (3.36)**

Achieved. Support forums for older prisoners and those with disabilities met monthly. Those we spoke to told us that the meetings were helpful and that staff were responsive to their needs. Minutes of the meetings showed that they were used to consult prisoners, resolve problems, and share information from internal departments and also through presentations by external groups concerned with the support of older people and those with disabilities.

2.41 **Designated liaison officers should be appointed for each of the diversity strands. (3.37)**

Not achieved. With the exception of a recently appointed disability liaison officer and the chaplaincy taking responsibility for religious diversity, the responsibility for all strands of diversity resided with the diversity officer. Knowledge and understanding of diversity issues was poorly shared.
We repeat the recommendation.

2.42 **There should be regular monitoring of prisoners from minority groups to ensure they have equitable access to amenities and activities. (3.38)**

Not achieved. Although the diversity officer reported the numbers of prisoners with identified characteristics to the diversity committee, there was no monitoring of their representation in the regime, except for black and minority ethnic prisoners.
We repeat the recommendation.

2.43 **The number of black and minority ethnic staff in contact roles should be increased. (3.53)**

Not achieved. There was one estates member of staff from a black and minority ethnic background. The prison was situated in an area with a low black and minority ethnic population, which made recruitment of staff from this background difficult. The prison mitigated the effect of a predominantly monocultural environment by promoting celebrations of cultural and religious diversity throughout the year, with the aim of making prisoners from minority backgrounds feel included (see recommendation 2.47).

2.44 **The membership of the race equality action team (REAT) should include the catering manager, the head of health care and the head of learning and skills. (3.54)**

Partially achieved. The REAT had been incorporated into the diversity and equality action

team. The membership specified in the terms of reference included the catering manager, a health services representative (not the head of health care) and the learning and skills manager. Attendance by these representatives was not consistent.

2.45 **All racist incident complaints should be investigated, even if the complainant is no longer in the prison. (3.55)**

Achieved. Diversity complaints were all investigated and a recent example of one from a prisoner subsequently transferred to HMP Pentonville had been completed in liaison with that establishment.

2.46 **There should be appropriate interventions for prisoners who demonstrate racist behaviour. (3.56)**

Not achieved. Prisoners who demonstrated racist behaviour were identified from criminal records and from security reports. They were interviewed by wing managers and given specific advice about their behaviour but there was no structured intervention to address their attitudes. **We repeat the recommendation.**

2.47 **There should be a planned calendar of events to celebrate and promote cultural, racial and ethnic diversity, to which all departments should contribute. (3.57)**

Achieved. A wide range of events was planned through the prison's quality improvement group. These included celebration of religious festivals, black history, the abolition of slavery and the achievements of those with disabilities. The planning group for these events included the education department, chaplaincy, library, reducing reoffending team and gym.

2.48 **There should be an annual race equality survey to inform and develop the race equality action plan and policy. (3.58)**

Partially achieved. The prisoner survey completed in May 2011 incorporated coverage of race equality, including a comparison between the responses from black and minority ethnic prisoners and those from white prisoners. This was used to inform the diversity action plan. At the time of the inspection there had not been a further survey.
We repeat the recommendation.

2.49 **The foreign national policy should be based on an up-to-date analysis of the needs of foreign national prisoners and include a time-bound action plan. (3.70)**

Partially achieved. There were 18 foreign national prisoners at the time of the inspection. The prisoner survey (see recommendation 2.48) included a needs analysis of foreign national prisoners; however, the number of responses was low, which made it difficult to draw reliable conclusions. In the prison's diversity action plan, the needs of foreign national prisoners were not addressed but services were being developed in line with relevant Prison Service Instructions.

Housekeeping point

2.50 The development of services for foreign national prisoners should be included in the diversity action plan, so that they may be monitored and reviewed.

2.51 **Local policy documents should be available in a range of languages. (3.71)**

Partially achieved. The local complaints policy had been translated into more than 20 languages and was readily available. Other local policies were available only in English; if required in another language, they could only be provided through submission to a professional translation service.
We repeat the recommendation.

2.52 **Prisoners should not have to make repeat applications each month for free international telephone calls. (3.72)**

Achieved. Foreign national prisoners could make an application for a free five-minute international telephone call and, once the application was approved, credit was added to their account every month if they had not had any social visits.

Complaints

2.53 **Complaint replies should be personalised. (3.79)**

Not achieved. Most responses to complaints were reasonably courteous and answered the complaint but often simply re-stated the rules. Few offered apologies when there had been mistakes and they were not always personalised. Although a member of the senior management team quality assured a sample of complaints, the exercise was not recorded. Other aspects of the management of the complaints procedures, including a newsletter to prisoners when there were common complaints, were good.
We repeat the recommendation.

2.54 **Residential staff should encourage and support prisoners to pursue informal means to deal with complaints. (3.80)**

Achieved. Prisoners said that most staff were approachable and that they could often resolve issues without submitting a formal complaint.

Legal rights

2.55 **Records of prisoners' legal applications and an appellants' register should be kept. (3.86)**

Not achieved. There was no profiled time for legal services officers. No records were kept of prisoners' legal applications and there was no register of appellants.
We repeat the recommendation.

2.56 **The availability of legal services information leaflets should be widely advertised across the prison. (3.87)**

Not achieved. There was no information about legal services in the induction booklet and only limited information around the wings. The first night centre contained only details of solicitors from the local telephone directory. It was planned to provide additional information through the Insiders (peer support) information desks. Regular support was provided for those wanting information about bail.
We repeat the recommendation.

Health services

2.57 **Health services staff should be involved from the design stage in the building of the new health care centre. (4.41)**

Achieved. The provider health care manager and head of health care were involved in the design of the new health care facility. The new build had been delayed but we were assured that funding had been acquired and work was due to start soon after the inspection, with a completion date of early 2013.

2.58 **The lead nurse manager should be a permanent member of the partnership board. (4.42)**

Achieved. The provider lead nurse manager was responsible for the cluster of prisons and had a regular presence at the prison. She was a member of the partnership board, along with the prison governor. The head of health care was a member of the senior management team. The management structure worked well and relationships with commissioning and provider trusts were good.

2.59 **All clinical areas should be clean, tidy and fit for purpose. (4.43)**

Partially achieved. All clinical areas were clean and efforts had been made to keep rooms tidy. However, with constrictions on space this was difficult and some of the clinical rooms were cluttered with equipment.
We repeat the recommendation.

2.60 **Health information should be available in a range of languages, and notices should indicate the language help that is available. (4.44)**

Partially achieved. Health care information was available in the health care centre and on a noticeboard at the entrance. One member of the team was responsible for providing information and was well known by prisoners as a useful resource. Leaflets were available in a range of languages but there remained little information on the wings.
We repeat the recommendation.

2.61 **Patients should have the opportunity to become more involved in the planning of their care. (4.45)**

Achieved. Patients with both physical and mental health care needs were involved in the planning of their care and this was noted in their clinical notes on the electronic recording system, SystmOne. A range of consultations with the GP and nurses afforded the opportunity for patients to become more involved.

2.62 **All staff should have access to clinical supervision. (4.46)**

Achieved. All staff had access to clinical supervision, which was provided predominantly on a one-to-one basis.

2.63 **Clinical records should only be accessible to health services professionals. (4.47)**

Achieved. Clinical records were managed more robustly and greater use of the electronic record ensured that privacy and confidentiality of the records were maintained.

2.64 **National service frameworks and standards should be used to influence policies and guide clinical practice. (4.48)**

Achieved. Information was provided mainly via the primary care trust intranet and, when appropriate, hard copies were provided. National service frameworks and National Institute for Health and Clinical Excellence (NICE) guidelines were used to inform and influence practice. The head of health care was the main conduit through which information was distributed via notices and meetings.

2.65 **A prisoner health forum should be available. (4.49)**

Achieved. Prisoners were able to raise health care issues through representatives at the health promotion action group. However, the aims for this group were not sufficiently broad.

2.66 **Health services staff should have access to the computerised SystmOne for reception screening. (4.50)**

Achieved. SystmOne had been developed considerably and was now more widely available to health services staff, including access in the health care room in reception.

2.67 **Nursing staff should use triage algorithms to ensure consistency of treatment. (4.51)**

Not achieved. Although some of the staff were well qualified in the care and treatment of emergencies and patients with minor injuries, they did not use triage algorithms that would ensure consistency of treatment by all team members.
We repeat the recommendation.

2.68 **The pharmacist should visit the prison at least once a month to make checks and to hold pharmacist-led clinics. (4.52)**

Partially achieved. Regular checks were made by the pharmacist, who visited the prison weekly under the terms of the new contract. Prisoners were not able to see the pharmacist.
We repeat the recommendation.

2.69 **The controlled drugs cabinet key should be held securely. (4.53)**

Achieved. The controlled drugs cabinet key was signed for by one of the nursing staff for each shift and remained securely in the possession of the nurse.

2.70 **The use of the out-of-hours cupboard and any medicines taken from the pharmacy room under the emergency procedure should be audited and all checks recorded. (4.54)**

Achieved. There was no longer an out-of-hours medicines cupboard. Medicines taken from the pharmacy room under emergency procedures were audited and checked daily.

2.71 **Named-patient medication, rather than general stock, should be used wherever possible. (4.55)**

Achieved. Most patients now received named-patient medication, as supplied using the pharmacy procedures. Stock medicines continued to be available if required but these were mainly given by exception.

2.72 **The in-possession risk assessments for each drug and patient should be documented and reasons for the determination recorded. (4.56)**

Not achieved. Although the drug in-possession policy clearly stated the procedure for risk assessment, this was not carried out.
We repeat the recommendation.

2.73 **Prescriptions should not be transcribed, and pharmacists should dispense from original prescriptions. (4.57)**

Achieved. All original prescriptions were faxed to the pharmacy before their dispensing. In addition, the move to electronic prescribing via SystmOne was being developed.

2.74 **Secondary dispensing should stop immediately. (4.58)**

Achieved. We found no evidence of secondary dispensing by health services staff.

2.75 **Prescribing data should be used to demonstrate value for money, and to promote effective medicines management. (4.59)**

Achieved. The pharmacist and lead nurse manager for the provider trust regularly used prescribing data to monitor medicine usage and demonstrate value for money. The data were also used to promote effective medicines management.

2.76 **The medicines and therapeutics committee should review and adopt all pharmacy procedures and policies, and all health staff should read and sign the agreed adopted procedures. (4.60)**

Achieved. The medicines and therapeutics committee met regularly and adopted all pharmacy policies and procedures. A copy of the signatures of all the health services staff who had read and agreed the adopted procedures was available in the health care administration office.

2.77 **The dental care available in the new dental contract should be in accordance with the requirements of the current provisions of the NHS General Dental Council contract. (4.61)**

Achieved. Prisoners had access to a good level of dental care, with acceptable waiting times. There were only 40 prisoners on the waiting list and the care provided under the new contract was in accordance with the NHS General Dental Council contract.

2.78 **The dental X-ray, autoclave and compressor equipment should be repaired and recertified. (4.62)**

Achieved. The dental suite had been fully refurbished and a new contract had started. All equipment was in good order and some had been replaced. All equipment had been certified.

2.79 **Oral health education sessions should be commissioned. (4.63)**

Achieved. The new contract included the provision of oral health education. This was mainly carried out by the dentist while the patient was in the chair.

2.80 **Health care beds should not be included in the certified normal accommodation. (4.64)**

No longer relevant. There was no longer an inpatient unit and all the cells were now being used as normal accommodation. This was an unsatisfactory arrangement, as the cells formed an integral part of the health care centre, impeding the delivery of health care. The support provided to this part of the wing by discipline staff was poorly managed, which meant that health services staff were often drawn into managing or helping prisoners accommodated on the ground floor.

Further recommendation

2.81 Prisoners on B1 (ground floor B wing) should receive a greater level of management and support, so that it is equivalent to that provided elsewhere on the wings and to avoid the disruption of health care delivery.

2.82 **Data for prisoner attendance at outside specialist appointments should be accurately recorded. (4.65)**

Achieved. Data for prisoner attendance at outside hospital appointments were accurately recorded by part-time administration staff and health services staff.

2.83 **Prisoners should have access to general counselling services. (4.66)**

Not achieved. Prisoners continued to have no access to professional counselling services.
We repeat the recommendation.

Catering

2.84 **The lunch meal should not be served before midday and the evening meal not before 5pm. (7.9)**

Not achieved. The lunch meal was served between 11.45am and noon and the evening meal at 4.45pm.
We repeat the recommendation.

2.85 **Prisoners should be given breakfast in the morning and not be issued with breakfast packs the night before. (7.10)**

Achieved. A hot breakfast had replaced the breakfast packs which had previously been issued on the night before consumption.

2.86 **Prisoners should be able to dine out of their cells. (7.11)**

Not achieved. There were no facilities for prisoners to eat their meals out of their cells.
We repeat the recommendation.

Purchases

2.87 **All new arrivals should have access to the prison shop within their first 24 hours. (7.18)**

Not achieved. New arrivals could still wait over 10 days to purchase goods from the prison shop. All new prisoners were offered a reception pack and those who had money could purchase additional packs. In exceptional cases, advances were given to those with no money

of their own.
We repeat the recommendation.

2.88 **Prisoners should not be charged a delivery/administration fee for catalogue orders. (7.19)**

Partially achieved. Prisoners could order from a range of catalogues, only one of which charged for delivery. This cost was divided between those prisoners who had placed an order. No administration fee was charged.

2.89 **There should be a survey of prisoners' views of the prison shop at least annually. (7.20)**

Achieved. There had been no survey of prisoners' views of the shop. However, some prisoners were invited to a meeting, which gave them opportunities to influence the local product list. Prison shop issues were also raised at the staff–prisoner forums.

Recommendations – purposeful activity

Time out of cell

2.90 **The prison should record accurately the time that prisoners spend out of cell. (5.52)**

Achieved. There had been a review of the procedures for monitoring the regime. This had resulted in the elimination of some double counting of prisoners' time out of cell, which had improved the accuracy of recording it.

2.91 **All prisoners should have 10 hours a day out of their cell. (5.53)**

Not achieved. The prison was recording an average of 5.7 hours per day out of cell on weekdays and 6.16 hours at weekends – well below our expectation of 10 hours a day out of cell.
We repeat the recommendation.

Learning and skills and work activities

2.92 **Facilities for activities on the vulnerable prisoner unit should be improved. (3.114)**

Not achieved. Vulnerable prisoners could access a limited variety of work and education courses, which had not improved since the previous inspection. Most education courses were low level and did not take full account of the wide range of abilities of prisoners. However, additional support had been provided for prisoners on wing-based education courses. The prison recognised the need to offer a broader range of jobs and had immediate plans to introduce a kitchen garden where vulnerable prisoners could work.
We repeat the recommendation.

2.93 **Evening and weekend education classes should be provided. (5.18)**

No longer relevant. Although no evening and weekend classes had been introduced, prisoner focus groups had indicated that they did not require this. With the introduction of more part-time working (see recommendation 2.99), prisoners could now access the full range of courses on offer.

2.94 **There should be more structured support for prisoners who need English for speakers of other languages (ESOL), and appropriate accredited awards. (5.19)**

Achieved. A range of ESOL courses was offered when the need was identified. The number of prisoners who required these courses was generally small, and courses were put on when needed; one-to-one support was also given when required. An additional teacher was now qualified to teach on ESOL courses. Due to the short amount of time that prisoners stayed at the establishment, many prisoners did not complete a full ESOL course. However, most gained literacy and numeracy qualifications as part of their programme.

2.95 **There should be better use of data about learners to support continuous improvement. (5.20)**

Achieved. The analysis and use of data and other management information had improved considerably. New procedures for the collation of data relating to education and training had been introduced and data were now well used to inform improvements. A wide range of data was used for discussion at the regular quality improvement group meetings and learning and skills meetings, and staff were well informed about individual learners' progress. As a result, improvements had been made to the range of courses and support provided for vulnerable prisoners on wing-based education courses.

2.96 **There should be more short courses in literacy and numeracy. (5.21)**

Achieved. Additional courses had been introduced to account for the wide range of prisoners' literacy and numeracy needs. Functional skills courses were available for those who were more capable, and a new entry level course for those requiring the development of their speaking, writing, reading and listening skills. An entry level 3 studies skills course was offered to those who needed it but were only at the prison for a short time. The Toe by Toe reading scheme was popular and well subscribed. Achievement of these qualifications was high, at around 75%.

2.97 **There should be increased resources for all short employment-related training and basic skills courses. (5.22)**

Achieved. There continued to be good use of the recognition and recording of progress and achievement (RARPA) across a range of work areas and this had been extended to mentors on Storybook Dads and Toe by Toe. Learners on art courses were now able to achieve unit accreditation at level 1 and a new barber's course had been introduced, for which learners were able to gain units of a level 1 qualification that fully recognised their work-related skills. Better promotion of the employability course had resulted in increased participation.

2.98 **Painting and decorating work should be accredited. (5.23)**

Not achieved. Prisoners employed as painters and decorators were currently unable to access accredited training, although the prison had plans to rectify this with the imminent introduction of a new Offender Learning and Skills Service (OLASS) provider and contract arrangements.
We repeat the recommendation.

2.99 **There should be more part-time work. (5.24)**

Achieved. More part-time work had been introduced across a variety of work areas. This

included the kitchen, clothing exchange store and wing work. However, the prison recognised that even more part-time work should be introduced to be able to offer all prisoners jobs.

2.100 **Pay rates for prisoners should provide equity between participation in education and work. (5.25)**

Achieved. New pay scales had been introduced and pay between education and work areas was now equitable. Pay did not discourage prisoners from completing education courses.

2.101 **A formal library induction should be included in the induction programme. (5.26)**

Achieved. A basic library introduction was now included in the main induction programme and a useful leaflet was given to prisoners. However, prisoners were not introduced to the library facility until they started using the provision.

2.102 **The use of the library should be monitored. (5.27)**

Achieved. Thorough monitoring had been introduced and the librarian tracked usage by wing. Detailed information was also kept on prisoners participating in the Toe by Toe reading scheme.

2.103 **The library should be better promoted across the prison. (5.28)**

Achieved. The library facility had been moved to a more accessible location and was better promoted on the wings and through induction. The use of wing representatives had increased the profile of the library, and prisoners were able to give books back to them. A variety of reading initiatives had been introduced, such as the 'six book challenge' and 'world book night'.

2.104 **All items on the mandatory items list should be available in the library. (5.29)**

Achieved. Access to Prison Service Orders and Instructions was good. Many were on display, and prisoners could request access to other legal materials if needed. HMIP and Independent Monitoring Board reports were on display.

Physical education and health promotion

2.105 **The PE staff should include those trained in specialist skills, such as GP referral and fitness industry instructor/assessor awards, to allow a wider range of activities and courses to be delivered. (5.38)**

Achieved. A PE staff training needs analysis had been completed, following which all staff had been trained in sports injuries up to level 3, and in smoke cessation. There were close links with the health care department. A wide range of courses was now offered to prisoners, including level 1 to level 3 personal trainer, fitness and trainer awards. The range of activities had been increased to offer all prisoners adequate access to PE.

2.106 **The gym changing and shower facilities should be improved. (5.39)**

Not achieved. The changing facilities and showers remained a poor facility, although the ceiling in the showers had been renewed.
We repeat the recommendation.

Recommendations – resettlement

Strategic management of resettlement

2.107 **The reducing reoffending strategy should include an action plan for the year ahead on each of the resettlement pathways, which is reviewed by the reducing reoffending committee. (8.7)**

Achieved. The reducing reoffending strategy and action plan included all the resettlement pathways and the action plan was reviewed at the reducing reoffending meetings. The strategy required updating to reflect the current resettlement and offender management provision.

2.108 **Pathway leads should be publicised to staff. (8.8)**

Not achieved. There was no information displayed or notices to staff identifying the individual resettlement pathway leads.
We repeat the recommendation.

2.109 **The reducing reoffending strategy should address the needs of young adult prisoners. (8.9)**

Not achieved. There were 20–25 young adults in the prison at any one time, and there was no indication that their needs had been considered in the development of the reducing reoffending strategy.
We repeat the recommendation.

2.110 **The prison should meet providers of resettlement services periodically to ensure they are briefed on the reducing reoffending strategy. (8.10)**

Achieved. The head of reducing reoffending met the large number of providers of resettlement services at various local and regional forums and they were aware of the contents of the reducing reoffending strategy.

Offender management and planning

2.111 **There should be custody planning arrangements for remand prisoners. (8.25)**

Not achieved. Custody planning for remand prisoners had ceased in April 2012 under the new arrangements for managing custodial services. These prisoners underwent an initial assessment of their resettlement needs on the first night centre and were signposted to any support services they required, but this did not result in a custody plan. The lack of custody planning highlighted some issues around public protection for potential multi-agency public protection arrangements (MAPPA) prisoners who had not been assigned to an offender supervisor. This gap had been met by assigning additional resources from the public protection team, which had ensured that the risks were appropriately managed before sentencing or release.
We repeat the recommendation.

2.112 **The recently introduced personal officer scheme should be formally evaluated after an introductory period to ensure it meets the needs of prisoners in relation to sentence planning and delivery. (8.26)**

Not achieved. The personal officer scheme had not been reviewed in terms of its effectiveness in meeting prisoners' sentence planning needs. P-Nomis notes showed that personal officers were involved to differing degrees with sentence planning matters for individual prisoners, ranging from no involvement to contributing to or attending sentence planning, recategorisation and home detention curfew review boards.
We repeat the recommendation.

2.113 **A public protection policy should be developed, and a clear policy lead should be identified for public protection work. (8.27)**

Achieved. The public protection policy was in draft form and due for implementation in July 2012. In the meantime, public protection was guided by the public protection manual and there was an identified lead. There were sound systems for identifying prisoners on reception who required public protection interventions, and well used procedures for staff to report ongoing matters of concern during a prisoner's time in custody.

2.114 **Release on temporary licence should be used to support the development of resettlement plans. (8.28)**

Not achieved. There was little use of release on temporary licence, with only three prisoners released on temporary licence in the previous six months.
We repeat the recommendation.

2.115 **Prisoners should be able to attend categorisation boards. (6.9)**

Achieved. Prisoners were invited to attend categorisation boards or, if they chose not to, they could submit written representations to the board.

2.116 **Life-sentenced prisoners should be allocated to staff who have received specific lifer training. (8.29)**

Achieved. Lifer training had been suspended by the Prison Service. To overcome this issue, the three lifer-trained staff in the offender management unit either directly managed lifer prisoners or offered appropriate support to offender supervisors as required.

2.117 **Life-sentenced prisoners should be moved to suitable establishments at the earliest opportunity. (8.30)**

Achieved. There appeared to be no problem in moving life-sentenced prisoners to suitable establishments.

2.118 **There should be forums and events for life-sentenced prisoners. (8.31)**

Achieved. Although there were no formal forums or events for life-sentenced prisoners, all were seen individually by the head of offender management and offered these facilities, although none had chosen to take up the offer.

Reintegration planning

2.119 **The housing officer should be given support with strategic and administrative tasks to increase the availability of services to prisoners. (8.44)**

No longer relevant. There was no longer a housing officer post. Alternative arrangements had been made for prisoners to receive housing advice.

2.120 **There should be more support for prisoners designated as without fixed accommodation on reception. (8.45)**

Achieved. There was no longer a housing officer post (see recommendation 2.119). Information for remand prisoners was given on the first night centre and they were signposted to accommodation services. Accommodation could also be provided for those seeking release on bail. A central Dorset gateway service, which provided accommodation for offenders, was used for securing accommodation for sentenced prisoners. However, the no fixed abode rate stood at about 7% at the time of the inspection and this was attributed to prisoners with short sentences for whom there was insufficient time and resources to arrange accommodation on release.

2.121 **The discharge policy should allow sufficient time for the adequate preparation of prisoners before their release. (8.46)**

Not achieved. Following the previous inspection, arrangements had been made for health services staff to attend resettlement meetings and advance notice to be given for the health care discharge arrangements for patients. These arrangements had subsequently lapsed and reverted to health services staff being informed on the night before a patient's release.
We repeat the recommendation.

2.122 **The prison should introduce daily visits for remand prisoners. (8.78)**

Not achieved. Although remand prisoners were entitled to receive a daily visit, because of the number of prisoners held at the prison, the maximum number of visits that they could achieve was restricted to three (two on weekdays and one at the weekend).
We repeat the recommendation.

2.123 **The visits booking system should be improved and extended to meet the needs of prisoners' families. (8.79)**

Achieved. In addition to booking future visits by telephone, they could now be booked via email and during weekday visits in the main visits hall.

2.124 **The prison should supply babies' nappies during visits. (8.80)**

Achieved. A supply of disposable nappies was available in the visitors search area.

2.125 **The length of visits should be extended to improve the quality of the visit for prisoners and their families. (8.81)**

Achieved. Visits had been extended from one hour to one hour and 45 minutes (from 2pm to 3.45pm). Visitors we spoke to appreciated the length of the visits available.

2.126 **Visits should last for the specified period of time. (8.82)**

Not achieved. In the visits session we observed, it took over 25 minutes from the scheduled start time of visits until the last of the visitors had been searched and admitted into the main visits hall. Prisoners we spoke to in the visits hall indicated that this was a regular occurrence.
We repeat the recommendation.

2.127 **There should be regular visitors surveys when the new visits facility is opened. (8.83)**

Achieved. The new visits facility had opened in September 2009 and visitors surveys had been carried out in May 2011 and April 2012. The most recent survey had yet to be analysed to identify any improvements that could be made to visits.

2.128 **Staff involved in the supervision of visits should receive training in safeguarding children. (8.84)**

Not achieved. None of the visits staff we spoke to had been trained in safeguarding children. **We repeat the recommendation.**

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.

Recommendations **To the governor**

Bullying and violence reduction

3.1 Information collected monthly by the safer custody team should be analysed over time to identify patterns and trends. (2.9)

3.2 There should be interventions to support prisoners subject to anti-bullying victim logs, and to address and challenge the inappropriate behaviour of bullies. (2.10)

Self-harm and suicide prevention

3.3 A log should be kept to record cases where prisoners at risk of suicide or self-harm have their clothing removed when placed in the special accommodation in the health care centre, and there should be appropriate safeguards in accordance with an agreed protocol and published policy. (2.1)

3.4 Information collated by the suicide and self-harm coordinator should be evaluated for trends over time and used to inform strategic development. (2.11)

3.5 There should be an effective quality assurance scheme for assessment, care in custody and teamwork (ACCT) documentation, and areas of concern should be taken forward with clearly identified objectives. (2.12)

3.6 All staff should receive ACCT foundation training and refresher courses after three years. (2.14)

Incentives and earned privileges

3.7 The range of privileges available to enhanced prisoners should be increased. (2.15)

3.8 Daily entries in basic-level prisoner monitoring logs should evidence engagement with prisoners and record progress against behaviour improvement targets. (2.18)

Substance misuse

3.9 Prisoners should be stabilised in an environment that allows for appropriate monitoring and observation. (2.20)

3.10 Plans for the new health care building should include the co-location of integrated drug treatment system (IDTS) and counselling, assessment, referral, advice and throughcare (CARAT) services on a dedicated stabilisation unit with appropriate facilities to carry out their work. (2.21)

3.11 Prisoners should be able to access disinfecting tablets for cleaning injecting equipment, and there should be means of safe disposal. (2.22)

Residential units

3.12 Cells designed for one prisoner should not hold two. (2.3)

3.13 The physical condition of A and B wings should be improved. (2.4)

3.14 Prisoners should have access to association every evening. (2.6)

3.15 All cells should be clean, properly furnished and have toilet screening. (2.26)

3.16 Young adults should not be required to wear distinguishing clothes. (2.27)

3.17 All prisoners should be permitted to wear their own clothes. (2.28)

3.18 There should be facilities on residential units for prisoners to wash their clothes. (2.29)

3.19 Communal showers should be kept clean and in working order. (2.30)

3.20 There should be at least one telephone for every 20 prisoners. (2.31)

Staff–prisoner relationships

3.21 A quality assurance scheme for personal officer work should be incorporated into the policy and implemented. (2.34)

Equality and diversity

3.22 The prison should draw up a prisoner diversity policy and establish a diversity committee focused on prisoner issues, which is attended by key staff responsible for delivering equality of opportunity, including health services and activity providers. (2.2)

3.23 The disability liaison officer should be allocated enough time to carry out all their duties. (2.35)

3.24 Designated liaison officers should be appointed for each of the diversity strands. (2.41)

3.25 There should be regular monitoring of prisoners from minority groups to ensure they have equitable access to amenities and activities. (2.42)

3.26 There should be appropriate interventions for prisoners who demonstrate racist behaviour. (2.46)

3.27 There should be an annual race equality survey to inform and develop the race equality action plan and policy. (2.48)

3.28 Local policy documents should be available in a range of languages. (2.51)

Complaints

3.29 Complaint replies should be personalised. (2.53)

Legal rights

3.30 Records of prisoners' legal applications and an appellants' register should be kept. (2.55)

3.31 The availability of legal services information leaflets should be widely advertised across the prison. (2.56)

Health services

3.32 All clinical areas should be clean, tidy and fit for purpose. (2.59)

3.33 Health information should be available in a range of languages, and notices should indicate the language help that is available. (2.60)

3.34 Nursing staff should use triage algorithms to ensure consistency of treatment. (2.67)

3.35 The pharmacist should visit the prison at least once a month to make checks and to hold pharmacist-led clinics. (2.68)

3.36 The in-possession risk assessments for each drug and patient should be documented and reasons for the determination recorded. (2.72)

3.37 Prisoners on B1 (ground floor B wing) should receive a greater level of management and support, so that it is equivalent to that provided elsewhere on the wings and to avoid the disruption of health care delivery. (2.81)

3.38 Prisoners should have access to general counselling services. (2.83)

Catering

3.39 The lunch meal should not be served before midday and the evening meal not before 5pm. (2.84)

3.40 Prisoners should be able to dine out of their cells. (2.86)

Purchases

3.41 All new arrivals should have access to the prison shop within their first 24 hours. (2.87)

Time out of cell

3.42 All prisoners should have 10 hours a day out of their cell. (2.91)

Learning and skills and work activities

3.43 Facilities for activities on the vulnerable prisoner unit should be improved. (2.92)

3.44 Painting and decorating work should be accredited. (2.98)

Physical education and health promotion

3.45 The gym changing and shower facilities should be improved. (2.106)

Strategic management of resettlement

3.46 Pathway leads should be publicised to staff. (2.108)

3.47 The reducing reoffending strategy should address the needs of young adult prisoners. (2.109)

Offender management and planning

3.48 There should be custody planning arrangements for remand prisoners. (2.111)

3.49 The recently introduced personal officer scheme should be formally evaluated after an introductory period to ensure it meets the needs of prisoners in relation to sentence planning and delivery. (2.112)

3.50 Release on temporary licence should be used to support the development of resettlement plans. (2.114)

Reintegration planning

3.51 The discharge policy should allow sufficient time for the adequate preparation of prisoners before their release. (2.121)

3.52 The prison should introduce daily visits for remand prisoners. (2.122)

3.53 Visits should last for the specified period of time. (2.126)

3.54 Staff involved in the supervision of visits should receive training in safeguarding children. (2.128)

Housekeeping point

3.55 The development of services for foreign national prisoners should be included in the diversity action plan, so that they may be monitored and reviewed. (2.50)

Appendix I: Inspection team

Andrew Rooke	Team leader
Karen Dillon	Inspector
Fiona Shearlaw	Inspector
Paul Fenning	Inspector
Mick Bowen	Health inspector
Neil Edwards	Ofsted inspector

Appendix II: Prison population profile

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

Status	18–20 yr olds	21 and over	%
Sentenced	10	137	57.4
Recall	1	35	14.1
Convicted unsentenced	6	24	11.7
Remand	4	35	15.2
Civil prisoners	0	0	0
Detainees	1	1	0.8
Other	0	2	0.8
Total	**22**	**234**	**100**

Sentence	18–20 yr olds	21 and over	%
Unsentenced	12	65	30.1
Less than 6 months	4	24	10.9
6 months to less than 12 months	0	9	3.5
12 months to less than 2 years	3	29	12.5
2 years to less than 4 years	1	29	11.7
4 years to less than 10 years	2	24	10.2
10 years and over (not life)	0	37	14.5
ISPP	0	11	4.3
Life	0	6	2.3
Total	**22**	**234**	**100**

Age	Number of prisoners	%
Please state minimum age		
Under 21 years	22	8.6
21 years to 29 years	80	31.3
30 years to 39 years	70	27.3
40 years to 49 years	55	21.5
50 years to 59 years	19	7.4
60 years to 69 years	7	2.7
70 plus years	3	1.2
Please state maximum age		
Total	**256**	**100**

Nationality	18–20 yr olds	21 and over	%
British	20	215	91.8
Foreign nationals	2	16	7
Not stated	0	3	1.2
Total	**22**	**234**	**100**

Security category	18–20 yr olds	21 and over	%
Uncategorised unsentenced			
Uncategorised sentenced	1	0	0.4
Category A	0	0	0
Category B	0	9	3.5
Category C	0	148	57.8
Category D	0	2	0.8

Other	21	74	37.1
Total	**22**	**234**	**100**

Ethnicity	18–20 yr olds	21 and over	%
White			
British	18	187	80.1
Irish	0	4	1.6
Other white	1	9	3.9
Mixed			
White and black Caribbean	0	2	0.8
White and black African	0	1	0.4
White and Asian	0	0	0.0
Other mixed	0	0	0.0
Asian or Asian British	2	3	2.0
Indian	0	0	0.0
Pakistani	0	1	0.4
Bangladeshi	0	1	0.4
Other Asian	0	0	0.0
Black or black British	1	5	2.3
Caribbean	0	8	3.1
African	0	0	0.0
Other Black	0	4	1.6
Chinese or other ethnic group	0	1	0.1
Chinese	0	0	0.0
Other ethnic group	0	1	0.4
Not stated	0	7	2.7
Total	**22**	**234**	**100**

Religion	18–20 yr olds	21 and over	%
Baptist			
Church of England	2	45	18.4
Roman Catholic	1	39	15.6
Other Christian denominations	1	23	9.4
Muslim	3	17	7.8
Sikh	0	0	0
Hindu	0	0	0
Buddhist	1	6	2.7
Jewish	0	0	0
Other	0	1	0.4
No religion	12	98	43
Not stated	2	5	2.7
Total	**22**	**234**	**100**

Sentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month	6	2.3	46	18
1 month to 3 months	2	0.8	49	19.1
3 months to 6 months	2	0.8	42	16.4
6 months to 1 year	0	0	22	8.6
1 year to 2 years	0	0	10	3.9
2 years to 4 years	0	0	0	0
4 years or more	0	0	0	0
Total	**10**	**3.9**	**169**	**66**

Unsentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month	6	2.3	32	12.5
1 month to 3 months	1	0.4	18	7
3 months to 6 months	4	1.6	11	4.3
6 months to 1 year	1	0.4	4	1.6
1 year to 2 years	0	0	0	0
2 years to 4 years	0	0	0	0
4 years or more	0	0	0	0
Total	**12**	**4.7**	**65**	**25.4**

Main offence	18–20 yr olds	21 and over	%
Violence against the person			
Sexual offences			
Burglary			
Robbery			
Theft and handling			
Fraud and forgery			
Drugs offences			
Other offences			
Civil offences			
Offence not recorded/holding warrant			
Total			