Report on an unannounced short follow-up inspection of

HMP & YOI Eastwood Park

21–23 February 2012

by HM Chief Inspector of Prisons

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Introduction

Eastwood Park is a women's prison in Falfield, Gloucestershire, serving the courts of the South West, Wales and West Midlands. It also takes women from some London courts. It holds a complex and vulnerable population including women, young adults and mothers and babies. The prison has a small unit for 17 year old girls, the Mary Carpenter Unit, which was inspected separately and not included as part of this short follow-up inspection.

The large area from which the prison receives women means that many are a significant distance from their homes. This impacts on the levels of support available from families and professionals to help women return to their communities and increases their feelings of isolation. There is still no local provision for the many women who come from the large conurbations of the West Midlands.

The average length of stay for the majority of women is 29 days, and only 12.5% remained at the prison for longer than this. It is therefore a significant task for the prison to assess women who arrive from the courts with high levels of need, often severe drug and mental health problems, and respond effectively in the crucial early days of custody to support them and ensure their safety.

At the last full inspection of Eastwood Park in 2008 we found the prison to be performing reasonably well in all four of our healthy prison tests. This short unannounced follow-up inspection found the prison was making sufficient progress against previous recommendations in only three of the four areas. Many of our previous recommendations in the areas of respect, purposeful activity and resettlement had been achieved but a renewed focus was needed on safety – particularly in the areas of reception, first night and induction.

Reception procedures focused too much on information giving rather than listening to prisoners' immediate needs and more could be done once women were on their first night unit rather than in reception. Since our last inspection the prison had opened Kinnon Unit, a detoxification and maintenance unit, and services to drug users in the unit were good.

There was little indication that bullying was a major problem although some staff acknowledged that trading medications was a concern. Women said they felt safe and described relationships with most staff as supportive and respectful.

Young adults were now integrated with other prisoners and we were concerned that their specific needs were not identified and addressed in a number of areas. Young adult men are much more consistently recognised as a distinct group with separate need from older adults than young adult women. A failure to identify and address the specific needs of young adult women is becoming a consistent feature of our inspections of women's prisons.

There had been no self-inflicted deaths since our last inspection but some previously good support services for women at risk of self-harm had been lost with a reduction in psychology services. This had included counselling, psychology and crisis interventions. Residential 4, previously known as K wing, was still providing short-term interventions for a small number of women.

Some shared cells were very small. Toilets were unscreened and there was insufficient space for both women to sit at the table so women had to eat some meals sitting on the bunks next to the unscreened toilet.

Due to an extensive refurbishment of the health care centre, services were being provided in a number of alternative areas around the prison but, despite this, good progress was being made to implement previous recommendations. There was good access to wing-based nurses.

Progress had been made in the provision of purposeful activity with the introduction of shorter courses which were more appropriate to prisoners' length of stay. This had improved retention and achievement rates. During this inspection the outcome on the contract bids were announced which was to lead to a change of provider for the OLASS contract.

Around 70% of our previous recommendations in the area of resettlement had been achieved in whole or in part. However, offender management required improvement. In our view, all women should have had a custody or sentence plan but the complete lack of custody plans for remanded women and those serving short sentences was a serious omission. This would have had the potential to improve links with the developing pathways for resettlement. As so many women were held a long way from their homes, the poor facilities for visitors needed significant improvement.

A short follow-up inspection such as this focuses on the progress the prison has made in implementing the recommendations made at the last inspection and so does not provide a complete picture of the whole. Nevertheless, despite some good progress in many areas it is a real concern that the prison was making insufficient progress on safety. Eastwood Park holds an exceptionally transient population of women with high levels of need. The loss of counselling, psychology and crisis interventions is therefore particularly regrettable and it is surprising that the required level of drug testing did not take place because staff had been redeployed. It is a significant concern that there was no custody planning. The prison has a new governor and it is important that he moves quickly to address the lack of progress on safety this report identifies.

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

Fact page

Task of the establishment
Local/remand women's prison for adults, young adults and girls of 17

Prison status
Closed female

Region
South West

Number held
309 (at the time of inspection)

Certified normal accommodation
315

Operational capacity
363

Date of last full inspection
October 2008

Brief history
HMP & YOI Eastwood Park is situated on the edge of the Cotswolds, on the outskirts of the small village of Falfield, on land that was once part of the Eastwood Park Estate. It opened as a female prison in March 1996, taking in prisoners from HMP Pucklechurch. The establishment opened a mother and baby unit in 2004, the Mary Carpenter Unit in October 2005, which holds 17 year old girls, and the Kinnon Unit – a detoxification (substance misuse) unit in 2009.

Short description of residential units
Some residential units had been renamed since our last inspection. A and C wings were closed.

B wing	First night induction unit (capacity of 43). (Along with A and C, referred to as Residential 1 in our previous report).
D wing	Enhanced prisoners (capacity of 58).
E wing	Established mix of sentenced and unsentenced prisoners (capacity of 110). (D and E referred to as Residential 2 in our last report).
F wing	Enhanced prisoners (capacity of 40 prisoners). (Referred to as Residential 3 in our previous report).
Kinnon Unit	Detoxing and maintenance unit (capacity of 84).
Residential 4	Residential-based short-term interventions (capacity of 10). (Referred to as K wing in our previous report).
Mother and baby unit	Capacity for 12 mothers and their babies (normally up to 18 months old).
Mary Carpenter Unit	Capacity for 16 girls aged 17. (Not inspected)

Name of governor
Simon Beecroft

Escort contractor
GeoAmey

Health service commissioner and provider
Commissioner: South Gloucestershire PCT
Providers: Bristol Community Health, Lloyds Pharmacy, Serco, Hanham Health
Mental health provider: Avon and Wiltshire Mental Health Trust

Learning and skills providers
A4E (Learning and skills)
Strode College (Learning and skills)
Tribal (Careers information and advice service)

IMB chair
Jonathan Doran

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 2008 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 October 2008 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 52 recommendations in this area, of which 17 had

been achieved, eight partially achieved and 27 had not been achieved. We have made a further two recommendations.

1.6 Some prisoners still had long waits in court cells and long journeys to Eastwood Park due to the large catchment area covered by the prison. Some women still shared escort vehicles with men, and women reported additional waits in vans outside reception at busy times.

1.7 The average wait in reception was approximately two hours, much of which was spent in the holding room as women waited to see health care staff or for another member of staff to take them to the induction unit.

1.8 Interview facilities in reception had not changed and still did not provide enough privacy or calm for women who were distressed. Prisoners had mixed views about their treatment in reception and more formalised peer support would help.

1.9 Although a first night strategy had been developed, first night procedures focused on obtaining information from women, rather than providing them with information they needed to help them feel supported and settled on their first night. All women could make a telephone call and have a shower on their first night, but a private conversation with a member of staff was not usually offered until the afternoon of the following day.

1.10 Induction lacked focus and both staff and prisoners were inconsistent in describing what was delivered. Some women who had completed induction were still unaware of basic information.

1.11 Most women said that they felt safe, but not all data had been disaggregated from data related to the juvenile unit or young adults, and no action plan had been developed since the last survey nearly two years ago. Investigations into violent incidents had improved and more included supporting statements. However, monitoring comments were uninformative and there were no senior management checks. The effectiveness of the anti-social behaviour programme had not been monitored.

1.12 There had been no self-inflicted deaths since our last inspection. Effective procedures enabled the prison to learn from deaths in custody investigations, including those in other prisons in the area. Investigations took place to learn from serious near fatal incidents.

1.13 As with the data on violence more could be done to disaggregate self-harm figures from those for the Mary Carpenter Unit (juveniles) and for young adults. The quality of assessment, care in custody and teamwork (ACCT) procedures was mixed. There were some effective assessments, but not all reviews were multi-disciplinary.

1.14 The chaplaincy and health care services offered vulnerable women support, although much of what had been provided, including counselling psychology, crisis intervention and the Carousel programme for women who self-harmed, was no longer available. Listener numbers were low, but a service had been maintained and the prison was recruiting more. There was still no Listener suite, however.

1.15 The prison still operated without a segregation unit. Governance arrangements for rule 53 (prisoners segregated pending adjudications) had improved to an appropriate standard. Women were now unlocked more often on Residential 4 (formerly K wing). However, as it functioned as a short-term intervention unit, holding adjudications in the unit not only impacted on this time, but was inappropriate.

1.16 While most women relocated to Residential 4 were doing so for short periods and benefiting from the support there, care plans did not reflect this work and were little more than weekly updates on behaviour. Some contained little reference to care plans as part of ACCT procedures.

1.17 The use of force had fallen considerably. It remained unacceptable that women on the basic level of privileges had had their electricity turned off; this was not part of the formal incentives and earned privileges (IEP) policy.

1.18 Services for substance users were well managed – they received appropriate treatment and care plans. Methadone administration had improved and was generally safe, but the treatment room in D and E wings (previously Residential 2) was still not fit for purpose. The counselling, assessment, referral, advice and throughcare service (CARATS) was effective, and women were seen within three working days and provided with continued support throughout their time there. Liaison between CARATS and the community drugs teams was good.

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

Respect

1.20 At our inspection in October 2008 we found that outcomes for prisoners against this healthy prison test were reasonable. We made 96 recommendations in this area, of which 45 had been achieved, 15 partially achieved and 34 had not been achieved. Two recommendations were no longer applicable. We have made a further three recommendations.

1.21 A and C wings had been mothballed and detailed plans for their refurbishment had been developed and costed. Standards of cleanliness were generally acceptable and women could get access to cleaning materials. There was a lot of graffiti in cells on B wing, which were in urgent need of redecoration.

1.22 Not all cells were adequately furnished and some were too small for double occupancy. There were still problems with the temperature in some cells, particularly on B wing and on Residential 4. The practice of routinely turning off electricity in the cells of all women who were not in an activity was inappropriate. We were told that the new governor had plans to review this.

1.23 Since our last inspection young adults had been integrated into the rest of the population. This meant that there was a risk that their specific needs were not being met.

1.24 There was now a coherent policy for the mother and baby unit, and nursery workers and the health visitor felt more involved in the management of the unit. Women whose applications for the unit had failed were suitably supported, and separation plans were comprehensive, including plans for support after they had left the establishment. Pregnant women received appropriate antenatal and midwifery support on the wings. However, mothers were still unable to take full responsibility for cooking for their baby.

1.25 Women did not like the food, particularly the sandwich packs offered at weekends. Supervision of servery standards still needed to be improved. The canteen worked satisfactorily. Access to catalogue shopping was limited and restricted to prisoners on enhanced conditions. This should be extended to others.

1.26 In general, women described most staff as being respectful and supportive. There was no personal officer scheme, but many women said that there was a member of staff to whom they could turn for help.

1.27 The prison's newly established diversity and equality policy did not outline the arrangements for meeting the needs of minority groups and was not based on a needs analysis. The race equality officer (REO) and disability liaison officer (DLO), who worked effectively, had been trained; however, the DLO was not always allocated the hours designated for this work. There were no specific meetings for black and minority ethnic women. Systematic monitoring was still focused exclusively on ethnicity rather than extended to include other protected characteristics.

1.28 Prisoners were being used as translators in appropriate circumstances; accredited translation services were used regularly for personal or official matters.

1.29 Women were very positive about the support they received from the chaplaincy department, and there were now Buddhist and Muslim faith leaders.

1.30 There was no evidence that women were under pressure to withdraw complaints. Official forms were used to make complaints about members of staff, and the women felt confident enough to make such complaints. There was still no system for tracking applications.

1.31 There was good access to bail information, but legal service officers had still not been trained.

1.32 Overall, health care was good. The management of chronic diseases had been improved and there was regular input from specialist nurses and good access to wing-based nurses. Medicine management too had improved considerably, with a specialist team of nurses managing all medicine issues, including ordering, stock checks and administration.

1.33 Delivering health care services had been difficult because the health care centre was being refurbished. However, on completion this should significantly improve patients' experience. Mental health support was very effective. Access to GPs was reasonable and in line with NHS standards, as was access to a dentist.

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

Purposeful activity

1.35 At our inspection in October 2008 we found that outcomes for prisoners against this healthy prison test were reasonable. We made 11 recommendations in this area, of which six had been achieved, three partially achieved and two had not been achieved.

1.36 Prisoners were not given enough time in the open air – only half an hour every day. This did not always take place at a fixed time, which meant that the women were unable to judge when to have a shower, make phone calls, and so on, and often missed exercise. Most employed women could spend around 10 hours out of their cell each day.

1.37 Most women were allocated to activities within one week of completing their induction. However, a minority could wait for up to two weeks. The allocation to courses was better managed and waiting lists were short.

1.38 The range of education and vocational training programmes had been extended to better reflect the needs of the women most of who were at the prison for a relatively short time. The women were very positive about the provision.

1.39 There were sufficient education and work activities for around 80% of the women and approximately 78% of available places were occupied. The remainder were unemployed, undergoing detoxification or in induction.

1.40 There was little provision above level two. A few women were given support to undertake A level and degree courses, but more needed to be done to develop the curriculum and promote and support study at a higher level.

1.41 PE activities were severely restricted for some due to low staffing levels. There was no weekend PE provision, and evening activities were offered to prisoners on enhanced conditions on only one evening per week. Women in full-time employment and education had limited access to PE activities during the day.

1.42 The library continued to provide a satisfactory resource, but opening hours had been reduced and not all women were able to get to the library weekly.

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

Resettlement

1.44 At our inspection in October 2008 we found that outcomes for prisoners against this healthy prison test were reasonable. We made 36 recommendations in this area, of which 17 had been achieved, eight partially achieved and eight had not been achieved. Three recommendations were no longer applicable.

1.45 The prison was no longer completing custody planning for remanded women or those serving less than 12 months.

1.46 Not all women had an initial or up to date assessment through the offender assessment system (OASys), which reflected the number of women entering and leaving the prison. Some continued to be transferred without a completed assessment. Where they had been carried out, OASys targets were appropriate and included timescales for completion. Recalled women were quickly identified. Case administration staff tracked and chased recall packs as necessary.

1.47 Visits normally lasted one hour; two hours on Sundays. A prisoner could request a two-hour visit on other days, but had to use two visiting orders and visitors had to leave the visits room and wait outside the prison before returning for the second hour. The women were no longer wearing bibs.

1.48 There was still no visitors' centre, although shelter and information was provided in a portacabin by the main gate.

1.49 The use of a video link for inter-prison visits was still available for women on the enhanced regime but less frequently for those on other levels of the incentive scheme.

1.50 Effective support for debt management had been introduced and specific pathways for women developed. They were accompanied by services to support women who had faced abuse and to provide information and support for sex workers. There were also links to workers in the community.

1.51 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 **There should be additional provision for women offenders in the West Midlands. (HP44)**

Not achieved. There continued to be no provision for women offenders in the West Midlands. Despite the establishment being located in the south west, the needs analysis undertaken in February 2011 identified that 36% of women prisoners came from the south west, while 50% came from south Wales and the West Midlands.
We repeat the recommendation.

2.2 **Staff should be trained in the use of care mapping and action planning for women on K wing, and other vulnerable prisoners, such as those at risk of suicide and self-harm or bullying. (HP45)**

Not achieved. K wing had been re-designated Residential 4 and was a short-term interventions unit. Staff offered effective care, but this was not reflected in care maps, which were little more than weekly updates of prisoners' behaviour. There was little coordination with the care maps for women subject to assessment, care in custody and teamwork (ACCT) procedures. Staff had had no specific training in care mapping and action planning (see recommendation 2.54).
We repeat the recommendation.

2.3 **A and C wings should be refurbished (HP46)**

No longer relevant. A and C wings had been mothballed. Detailed plans for their refurbishment had been prepared and submitted to the prisons board, but had not yet been approved.

2.4 **Prisoners should be given further encouragement and incentives to engage with activities and there should be consultation about the range of activities available. (HP47)**

Achieved. The prison had carried out frequent needs analyses since the last inspection. All women had been included in the surveys and a significant number had responded. Most responses confirmed that the range of programmes was meeting prisoners' resettlement needs. However, areas for development were identified and the prison had responded positively. Additional business courses were provided to help women interested in self-employment. A work experience programme had been introduced; it recognised that practical and interpersonal skills development was important. Detailed portfolios of evidence aimed to provide women with a record of their progress.

Accredited peer mentoring courses for Toe by Toe mentors were well attended and gave women the opportunity to develop self-confidence and self-esteem in a supportive environment. The prisoner pay policy had been reviewed and rates of pay were equitable and fair across the prison; those attending learning and skills activities were not at a disadvantage.

A good range of support programmes was provided by the education providers, including drugs and alcohol awareness, stress management and victim awareness.

2.5 **All women should have a sentence or custody plan that reflects individual need and is followed up by offender supervisors or personal officers. (HP48)**

Not achieved. Custody planning had ceased, and there was no such planning for unconvicted women or those serving short sentences.
We repeat the recommendation.

Recommendations

Courts, escorts and transfers

2.6 **Women should be held in court cells for the minimum possible period. (1.11)**

Not achieved. Few court escort vehicles arrived at the prison within core hours – most did not arrive before 4pm. Women who had had their cases heard before lunchtime were still routinely held in court until later in the day before being taken to the prison.
We repeat the recommendation.

2.7 **Prisoners should arrive before 7pm and should receive essential first night procedures, irrespective of their time of arrival. (1.12)**

Not achieved. Prisoners were still arriving after 7pm, but not as regularly as during the previous inspection. A reception officer completed a template identifying potential issues, but many were incomplete and provided no information relating to the action taken in response to identified issues. Completed templates were simply filed in prisoners' wing files.

There were no set procedures for officers receiving prisoners in the first night unit from reception, and staff gave varying accounts of what information they provided to women. Few appeared to give them necessary information, regardless of when they arrived in the unit.

We were informed that all women received a welcome booklet; this detailed a range of useful information, but some of it was out of date. Few women who had arrived in the induction unit had a copy.
We repeat the recommendation.

2.8 **Women should have breakfast on the morning they go to court. (1.13)**

Not achieved. Women attending court were given a small breakfast pack containing cereal, UHT milk and bread the night before they went to court.
We repeat the recommendation.

2.9 **Escort vans should be comfortable. (1.14)**

Not achieved. Escort vans, although new due to a change in contractors, were already appearing to deteriorate and were no more comfortable than the vehicles used to transport the women previously.
We repeat the recommendation.

2.10 **Female and male prisoners should be transported separately. (1.15)**

Not achieved. Staff reported that, while not happening as regularly as previously, vehicles were arriving in the prison transporting men as well as women.
We repeat the recommendation.

2.11 **Prisoners should be given information at court about the prison. (1.16)**

Not achieved. No information was provided.
We repeat the recommendation.

Early days in custody

2.12 **Prisoners should be held in reception for as short a time as possible. (1.38)**

Not achieved. A log was maintained in reception to record when prisoners arrived and when they went to the first night unit; this indicated that the average length of stay was approximately two hours. This was too long for the processes that took place – a reception interview, the processing of property and an initial health care screen.
We repeat the recommendation.

2.13 **Sentenced women should not share cells with unsentenced women. (1.39)**

Not achieved. Sentenced and unsentenced women continued to share cells.
We repeat the recommendation.

2.14 **There should be a first night strategy and all women should receive the same information and support, irrespective of their time of arrival. (1.40)**

Partially achieved. A first night strategy had been drafted since the previous inspection. However, it did not provide specific detail on what information and support should be given to new arrivals (see recommendation 2.7).

2.15 **All women should have the opportunity for a non-smokers/smokers pack. (1.41)**

Achieved. A choice of either was provided to all prisoners on arrival.

2.16 **The one-to-one interviews in reception should not be disturbed by noise. (1.42)**

Not achieved. Initial interviews were conducted in reception as they had been previously, which meant that there was little privacy.
We repeat the recommendation.

2.17 **The video shown in induction about the reception process should be used in reception. (1.43)**

Not achieved. Neither of the televisions in reception was working. Reception staff reported that the video had not been available in their area.
We repeat the recommendation.

2.18 **Women should undertake a gym induction in the first week of their arrival. (1.44)**

Achieved. A gym induction was held for all women who needed it every Wednesday.

Bullying and violence reduction

2.19 **Attendance at the safer prisons committee should be improved and new arrangements should be considered for managing such a large membership. (3.15)**

Achieved. The membership of the safer prisons committee (now referred to as the safer prisons meeting) had been reviewed, and the policy now required fewer people to attend. Attendance had improved and, where department representatives were unable to attend, minutes recorded that they had submitted reports.

2.20 **There should be more opportunities to consult prisoners about safety. Particular attention should be given to those who are new to the prison and to young adults. (3.16)**

Not achieved. Safety was now a standing agenda item at the monthly prisoners' representatives meetings and issues were raised periodically. New prisoners were told about the consequences of bullying as part of a brief induction talk, but this was not in-depth. The last survey into prisoners' experiences and perceptions of bullying had taken place in 2010 (see recommendation 2.22). Young adults were now integrated into the general population and there was no specific focus on this group. At the last inspection, young adults had reported higher levels of victimisation than others.
We repeat the recommendation.

2.21 **All staff in contact with prisoners should receive training in the violence reduction strategy. Principles of mediation should be included in this training. (3.17)**

Not achieved. There had been no training for staff in the violence reduction strategy. Staff had signed a briefing sheet to say that they understood the strategy. Some staff who had previously worked on the juvenile unit had had some experience of mediation.
We repeat the recommendation.

2.22 **An action plan should be developed in response to the prison's own survey of bullying and violence, which should include more active supervision of women when they are congregated together. (3.18)**

Not achieved. The last survey of anti-bullying and violence had been in 2010. This had made 11 recommendations. The survey had identified that women felt most unsafe in communal areas, including during association and in stairways. No action plan had been developed in response to this survey. There appeared to be no active staff supervision of the women.
We repeat the recommendation.

2.23 **The governance of the violence prevention protocol should be improved to ensure that appropriate authorisation is obtained and recorded if a prisoner is locked in cell after an incident. (3.19)**

Not achieved. The prison did not have a segregation unit. The violence reduction protocol allowed officers to lock up prisoners in their cells to stop incidents escalating. Since the last inspection, the lock-up period had been extended from one to two hours. The protocol had been used on 414 occasions in 2011. The inspection found that, in some cases, there was no evidence that authorisation by a senior officer had been obtained.
We repeat the recommendation.

2.24 **Investigations of antisocial behaviour should be more thorough and, where appropriate, include supporting statements and corroboration. (3.20)**

Achieved. Investigations showed some evidence of improvement and included interviews with all parties; some included supporting statements.

2.25 **An evaluation should be completed of the seven-day antisocial behaviour programme. (3.21)**

Not achieved. Seventy-two women had been placed on the programme in the previous eight months. The loss of psychology staff had meant that plans to evaluate its effectiveness had not taken place.
We repeat the recommendation.

2.26 **Senior managers should quality check the monitoring of prisoners subject to the violence reduction strategy. (3.22)**

Not achieved. Senior officers checked monitoring documents daily, but there was no routine check by a senior manager.
We repeat the recommendation.

2.27 **Violence reduction statistics for juveniles, young adults and adults should be disaggregated so that the prison can track trends in each of these groups. (3.23)**

Not achieved. Some comprehensive statistics were provided, but not all figures for juvenile prisoners and young adults were disaggregated in a way that would have made it possible to identify emerging trends (for example, data on victims and perpetrators). Young adults were now integrated with the rest of the population and were not specifically identified in the statistics.
We repeat the recommendation.

Self-harm and suicide prevention

2.28 **Action plans from deaths in custody should be regularly reviewed and include any findings from inquests to ensure that changes in practice have been sustained. (3.42)**

Achieved. There had been no self-inflicted deaths since our last inspection and only one death arising from natural causes. Action plans from all deaths in Wales and the south west were discussed at quarterly meetings. There had been regular updates at safer prisons meetings about the one outstanding inquest.

2.29 **Investigations should take place into all serious and near-fatal incidents of self-harm, and learning from these disseminated to improve practice. They should also acknowledge where good practice was evident. (3.43)**

Achieved. There was now a clear definition of serious and near-fatal incidents. One investigation in 2010 was reasonably comprehensive and included an action plan. There was evidence that a further investigation had been completed in 2011, but details were not available. This incident of self-harm had been discussed at the safer prisons meeting in October 2011.

2.30 **Assessment, care in custody and teamwork (ACCT) reviews should be multidisciplinary, have continuity of case manager and include the prisoner's personal officer. (3.44)**

Not achieved. Only officers were present at most reviews. At one review, only the senior officer and the prisoner were present. At the safer prisons meeting, health care staff had raised concerns that there was not always sufficient notice of reviews. There was no personal officer scheme.
We repeat the recommendation.

2.31 **Care maps should be improved. The initial reasons for the ACCT being opened and any subsequent issues that have heightened risks should be followed through and documented. (3.45)**

Not achieved. There was little evidence that ACCT reviews considered issues identified at previous reviews so that discussions could take place about their relevance for how the prisoner was feeling and what progress had been made.
We repeat the recommendation.

2.32 **Care maps should be in place for all women at risk of suicide and self-harm. (3.46)**

Achieved. We found no ACCT documents without care maps.

2.33 **Safer cells should be available in appropriate locations. (3.47)**

Partially achieved. One safer cell had been installed on Residential 4 and some remedial work was being done to make it fully compliant with the most recent specifications.

2.34 **A sufficient number of Listeners should be trained and their transfer or release better anticipated. (3.48)**

Achieved. There were five Listeners and further training was planned. Despite concerns about the small number of Listeners, the scheme had not been suspended as it had been at the previous inspection.

2.35 **A Listener suite should be provided to enable Listeners to provide 24-hour confidential support for women. (3.49)**

Not achieved. There was still no Listener suite.
We repeat the recommendation.

2.36 **Informal access to Listeners for women new to the prison should be improved. (3.50)**

Not achieved. There was no Listener working in reception and none on K and B wings, which received new prisoners. Listeners had no role in the induction.
We repeat the recommendation.

2.37 **Direct dial telephones providing free 24-hour confidential access to the Samaritans should be provided. (3.51)**

Achieved. These were available on each wing and those we tried were working.

2.38 **Training for staff working at night should be improved and night procedures and equipment should be checked regularly and overhauled where necessary. (3.52)**

Achieved. Training records indicated that seven permanent night staff had received up to date training in first aid and fire procedures. We did not conduct a night visit during this short follow-up inspection.

2.39 **The cell call alarm system on D and E wings should be audible from the landings. (3.53)**

Not achieved. The cell call alarm could still only be heard in the office.
We repeat the recommendation.

2.40 **The members of the senior management team should review the quality of ACCT procedures weekly. (3.54)**

Partially achieved. Senior management checks had been reinstated. These were not recorded in the ACCT document, but on a separate sheet. Most did not comment on the quality of the ACCT document and simply stated 'No concerns'.

Security

2.41 **A data management system should be put in place to monitor target searching and mandatory drug tests arising from security information reports. (6.15)**

Not achieved. Logs detailing such information had been maintained, but there was an absence of management oversight. As a result, managers were unaware that officers consistently failed to carry out all required target drug tests and, to a lesser extent, target cell searching.
We repeat the recommendation.

2.42 **There should be a trained analyst in the security department. (6.16)**

Not achieved. No-one in the department had received such training.
We repeat the recommendation.

2.43 **Rules should be displayed on all residential wings. (6.17)**

Achieved. Rules were displayed on at least one notice board on each wing.

Incentives and earned privileges

2.44 **An accurate central register should be maintained of those prisoners on the basic level of the incentives and earned privileges (IEP) scheme. (6.50)**

Achieved. The register accurately reflected the C-NOMIS system when it came to identifying the women who were on the basic level of the scheme.

2.45 **Progress to the enhanced level of the scheme should take into account participation in activity for convicted women. (6.51)**

Achieved. The IEP policy now stipulated that women had to engage positively with the prison regime in order to progress to the enhanced level.

2.46 **Women on the basic level should not be deprived of in-cell electricity. (6.52)**

Not achieved. Although not outlined in the IEP policy, staff reported that if a woman remained at the basic level after her first review, her electricity would be turned off completely until she had progressed to the standard level. This appeared to be an ineffective punishment.
We repeat the recommendation.

Disciplinary procedures

2.47 **Adjudication hearings should always include a record of the hearing and evidence of a full enquiry. (6.35)**

Partially achieved. All adjudications now included a record of the hearing. There was evidence that many adjudications failed to carry out an adequate level of enquiry before reaching a verdict.
We repeat the recommendation.

The use of force

2.48 **Use of force should be examined regularly by managers for trends, the background to the incident and any learning points. (6.36)**

Not achieved. A use of force meeting was held quarterly, and, while data was collated and monitored, it only ever covered the preceding three months and focused only on the total number of incidents. Senior operational managers did not attend the meeting nor did they scrutinise any use of force records or records of planned incidents.
We repeat the recommendation.

2.49 **The person certifying the use of force should not be the same person who authorised it. (6.37).**

Achieved.

Segregation

2.50 **Women segregated under rule 53 should be seen by medical staff to ascertain whether they are medically fit to be segregated. (6.38)**

Achieved. All women who were subject to rule 53, had to be placed in their own unit in the absence of a segregation unit. This was now only carried out on the authority of an operational manager and subject to a safety algorithm completed by a member of staff from the health care department.

2.51 **Women held under rule 53 should be given information about how long they are to be segregated and details of their entitlements. (6.39)**

Achieved. Women subject to rule 53 were provided with a pro-forma explaining that they would be segregated until an initial adjudication hearing took place. It also outlined what their entitlements were while they were segregated.

2.52 **Women on K wing who do not wish to take part in the planned regime should not be locked up unless they are disruptive. (6.40)**

Partially achieved. The regime on K wing had now changed; all women had had their risks and needs assessed and were unlocked for as long as possible. Instead of requiring every woman to follow a set regime, the regime was tailored to the needs of the individual. However, adjudications were still held on K wing in the mornings, which meant that all women on the wing had to remain in their cells while they took place.

Further recommendation

2.53 Adjudications should not be held on K wing.

2.54 **Care maps for women on K wing should be coordinated so that all relevant disciplines are responsible for target-setting and monitoring as part of a multi-disciplinary process. (6.41)**

Not achieved. Care and support for women on K wing was excellent. Few women remained in the unit for long periods, as staff achieved the unit's stated aim in the majority of cases of providing a safe haven for women who were struggling in the mainstream units. Staff did this by providing appropriate multidisciplinary support that allowed them to return better equipped to deal with their custodial situation. That said, this work was not reflected in the care plans we were shown. These appeared to provide little more than updates on behaviour that were considered at a weekly multidisciplinary meeting, which discussed all women on the wing. There were few action points arising from the discussion.
We repeat the recommendation.

Substance misuse

2.55 **Women on B wing should receive learning and skills input from the education department. (3.161)**

Achieved. Women on B wing were able to access education and learning and skills. Alcohol and drug awareness and dependency support was available and there were victim awareness courses. Access to other departments such as the gym, were also accessible where appropriate.

2.56 **The supervision and management of women administered controlled drugs on E wing should be improved. (3.16)**

Partly achieved. The behaviour of women collecting medication had improved since the last inspection. However discipline staff were not always at the treatment hatch to ensure that medicines were safely administered. Although officers were in the area they were not necessarily concentrating on what was happening at the hatch during the administration of controlled drugs.
We repeat the recommendation.

2.57 **Women on E wing should have direct access to the integrated drug treatment system (IDTS) team for care reviews. (3.163)**

Achieved. A multiagency meeting was held every week to ensure that there were discussions relating to every woman under the IDTS programme and to decide on their future care. Women were invited to the meetings and care plans were reviewed.

2.58 **The mandatory drug testing (MDT) programme should be adequately resourced for the required level of target testing within identified timescales. (3.164)**

Not achieved. The log maintained in the security department indicated that many tests were not carried out; managers confirmed that this was primarily due to the redeployment of MDT staff.
We repeat the recommendation.

Residential units

2.59 **Communal areas should be repainted on a more regular basis. (2.21)**

Achieved. Communal areas were generally well presented.

2.60 **A programme allowing prisoners to paint cells should be introduced. (2.22)**

Achieved. However, the programme was overly dependent on one member of staff, and many cells still needed urgent attention.

2.61 **Action should be taken to remove graffiti and prevent its recurrence. (2.23)**

Not achieved. There was a large amount of graffiti on the walls on B wing. In other parts of the prison the walls were cleaner, but many items of furniture had been defaced. Some graffiti was evident in the new Kinnon unit.
We repeat the recommendation.

2.62 **The temperature of residential areas should be properly regulated. (2.24)**

Not achieved. B wing and Residential 4 were still too hot. Some prisoners on D and E wings (formerly known as Residential 2) complained about being cold, especially at night.
We repeat the recommendation.

2.63 **The ventilation on Residential 1 should be improved. (2.25)**

Not achieved. Residential 1 formerly comprised A, B and C wings. A and C wings had been mothballed (see paragraph 1.21). B wing was now the first night and induction unit. No remedial work had been done to improve ventilation.
We repeat the recommendation.

2.64 **All cells should be furnished with tables, chairs and lockable cupboards, sufficient for the number of people expected to live there. (2.26)**

Not achieved. Most cells had a lockable safe, but few were in working order. This was noted particularly on B and Kinnon wings, where women were placed during their first few days in custody, when they were most vulnerable to having items stolen. It was inappropriate that women had to pay a £5 deposit for a key to operate the few safes that worked. Double cells on D and E wings were too small, making it impossible for two women to sit at a table. Toilets were unscreened and few had lockable cupboards.
We repeat the recommendation.

Further recommendation

2.65 A lockable cupboard should be provided and the use of safes should be free of charge.

2.66 **Young adults should be located together, where there is specific regime provision and staff dedicated to them. (2.27)**

Not achieved. All young adults were now placed in the same accommodation as adult women, but they did not share cells with adults. There was no separate regime or staffing group to cater for their specific needs. The prison management and some prisoners felt that the challenges of managing young adults had been reduced by mixing them with adults. However, we were concerned that there was no strategic oversight or provision for the specific needs of young women (see recommendation 2.27).

Further recommendation

2.67 The prison should have a strategic oversight of young adults, and ensure their specific needs are met.

2.68 **Women on Residential 1 should be allowed to associate in their rooms as well as in the large association room, facilitating access to showers and telephones, as on the other units. (2.28)**

Partially achieved. Residential 1 now comprised only B wing, as A and C wings had been closed. Officers reported that the unit had now been staffed in such a way that full association facilities should have been possible two evenings a week for prisoners on the standard regime. However, prisoners and staff explained that staff shortages sometimes restricted the availability of this provision, which meant that access to the association room, and the telephones which are located within it, was available only on request, and for limited time periods.
We repeat the recommendation.

2.69 **Prisoners should have clothes for outside wear. (2.29)**

Partially achieved. Women were allowed to have their own coats and some wings had a supply of waterproof coats. All wings should have this facility (see recommendation 2.152).
We repeat the recommendation.

2.70 **There should be sufficient prison issue bed linen. (2.30)**

Achieved. No shortages of bed linen were reported or observed.

2.71 **Arrangements for regularly replacing mattresses should be improved. (2.31)**

Achieved. No problems with mattress supply were reported or observed.

2.72 **Curtains should be provided in all cells. (2.32)**

Not achieved. Many cells had either no curtains or improvised curtains.
We repeat the recommendation.

2.73 **Telephones in busy areas should be placed in booths. (2.33)**

Not achieved. There was no privacy for prisoners using telephones, particularly those in the B wing association area.
We repeat the recommendation.

2.74 **A central register should be kept of those young adults who have been authorised to move to adult status. (2.34)**

No longer relevant. There was no longer any specific provision for young adults, so this process was redundant (see paragraph 2.66).

Mother and baby unit

2.75 **Childcare professionals should be involved in the daily running of the unit. (2.48)**

Achieved. The mother and baby unit continued to be managed by Prison Service staff, although nursery staff and the health visitor were involved in running the unit and making decisions.

2.76 **Mother and baby unit (MBU) staff should not wear prison uniforms. (2.49)**

Not achieved. Although the uniforms were different from those worn by wing staff, officers continued to wear them.
We repeat the recommendation.

2.77 **Mattresses should be clean and more suitable for pregnant women and women who have recently given birth. (2.50)**

Achieved. Mattresses were clean and suitable.

2.78 **The MBU should usually operate nearer to its capacity of 12 women. (2.51)**

Not achieved. The unit rarely ran at full capacity. Statistics produced the week before the inspection showed that all MBUs nationally were operating at approximately 55% of capacity.

2.79 **There should be one coherent MBU policy document. (2.52)**

Achieved. There was one comprehensive policy.

2.80 **Women whose applications to the unit fail should automatically receive support and have a separation plan. (2.53)**

Achieved. A pertinent separation plan was produced for women whose applications to the MBU had failed. These included an outline of the reason for the separation, planned care of the baby, contact details of the baby's carer and arrangements for contact between the mother and baby post separation. A hard copy was placed in the prisoner's wing file and information was entered on C-NOMIS, the prison computer system, to which other prison staff had access. A member of the MBU staff and the woman concerned reviewed the plan on a monthly basis.

2.81 **Multidisciplinary care plans for pregnant women should be developed as soon as the prison is aware a woman is pregnant, and these should be regularly reviewed. (2.54)**

Not achieved. Pregnant women were seen regularly by a midwife and could apply to talk to an officer from the MBU, but there continued to be no multidisciplinary plans. Several of the pregnant women had questions about their care and situation and would have benefited from planned meetings.
We repeat the recommendation.

2.82 **There should be opportunities for co-parents to be fully involved in antenatal care and preparation with pregnant women. (2.55)**

Partially achieved. Co-parents could not attend antenatal and midwifery appointments in the prison, but they could go to routine hospital appointments if they gave advance notice.

2.83 **Women should be able to cook all meals for their babies and eat with them. (2.56)**

Not achieved. The main kitchen continued to provide meals for the women, while a caterer prepared meals for the babies. Mothers could prepare snacks for their child and were encouraged to work alongside the caterer, but were unable to take full responsibility for their child.
We repeat the recommendation.

2.84 **Women should be able to walk up and down stairs with their babies if they choose to. (2.57)**

Achieved. Women were able to walk up and down stairs with their babies.

2.85 **During all day children's visits the carer should be able to join in with the visit if the mother chooses. (2.58)**

Achieved. Carers were able to join visits on the unit.

2.86 **Emergency admission procedures for mothers and babies should be more flexible, speedy and responsive to need. (2.59)**

Not achieved. MBU officers tracked and pursued all requests from the prison for reports from social services regarding the suitability of women to live on the MBU.
However, although emergency admissions could be completed quickly, some applications continued to be delayed as a result of slow response to requests for reports.
We repeat the recommendation.

2.87 **Mothers being separated from their children should have detailed support and separation plans, with action points to ensure continuing support after they leave the MBU. (2.60)**

Achieved. Detailed separation plans included details of timescales, the named carer, any legal issues and information sharing arrangements. Plans included an outline of support for the mother after leaving the MBU, such as contact arrangements and follow-up meetings. A copy of the plan was included in wing files and information recorded on C-NOMIS.

Staff-prisoner relationships

2.88 **Personal officer allocation should not be cell-based, to avoid regular changes of personal officers for individual prisoners. (2.73)**

Not achieved. There was no personal officer scheme and prisoners were not allocated a nominated officer.
We repeat the recommendation.

2.89 **The personal officer scheme should be further developed so that personal officers engage their prisoners in progress against custody plans. (2.74)**

Not achieved. Custody planning was no longer carried out. This should be re-introduced and supported by nominated officers for prisoners.
We repeat the recommendation.

2.90 **Important personal information which emerges about individual prisoners should be noted in their wing history files to ensure all staff have access. (2.75)**

Not achieved. There were many instances where entries in observation books or reports from diversity incident investigation interviews were not duplicated in C-NOMIS.
We repeat the recommendation.

Equality and diversity

Strategic management

2.91 **There should be a published diversity policy outlining the arrangements for meeting the needs of all minority groups. It should include an action plan to meet identified targets and be based on a needs analysis. (3.68)**

Not achieved. Although a policy was in place, it did not describe the arrangements for meeting the needs of all minority groups and was not based on a needs analysis.
We repeat the recommendation.

2.92 **Designated liaison officers should receive appropriate training and sufficient time to meet the needs of all minority groups. (3.69)**

Not achieved. There were no longer any designated liaison officers other than the disability liaison officer.
We repeat the recommendation.

2.93 **The disability liaison officer should receive appropriate training and have sufficient time to meet the needs of prisoners with disabilities. (3.70)**

Partially achieved. The disability liaison officer was appropriately trained, but was not always allocated the time designated for carrying out this work.
We repeat the recommendation.

2.94 **There should be adapted cells and reasonable adjustments for prisoners with disabilities. (3.71)**

Achieved. There was a fully equipped hospital-style cell with a large wet room facility, an electric bed and several cell call bells that were positioned appropriately. It was unfortunate that this excellent facility was in Kinnon unit, the drug detoxification and maintenance unit, instead of in a mainstream unit. There were four cells with grab rails in the bathroom areas in

other parts of the prison, but these were not suitable for wheelchair users. All cells on Residential 4 could be used for wheelchair users. There was evidence that specific needs were being met for example, through the provision of Tempur mattresses.

2.95 **All prisoners with disabilities and older women should be consulted about their individual needs and care. (3.72)**

Achieved. These women were seen by the equalities officer and prisoner peer worker on reception, and regularly thereafter, although this was not always recorded in C-NOMIS.

2.96 **Monitoring should be introduced to ensure that prisoners from minority groups are not being victimised or excluded from any activity. (3.73)**

Not achieved. Monitoring to ensure fair access to regime activities was still focused exclusively on ethnicity rather than extended to include other protected characteristics.
We repeat the recommendation.

2.97 **Care plans should be developed for those with disabilities and reviewed regularly by a multidisciplinary team. (3.74)**

Achieved. A weekly multidisciplinary team, led by health care staff, reviewed care plans.

2.98 **The race equality action team (REAT) should meet monthly and include all members or their representatives. (3.94)**

Achieved. Bimonthly arrangements for the REAT, now known as the diversity and race equality action team (DREAT) were in place and these were appropriate.

2.99 **The race equality officer (REO) should be fully trained and have sufficient time for his work. (3.95)**

Achieved. The REO was full time and had received appropriate training.

2.100 **All staff should receive training that enables them to understand and respond appropriately to race and cultural issues. (3.96)**

Partially achieved. All staff had received 'Challenge it, change it' diversity training, but we were not satisfied that this had equipped staff with sufficient understanding of race and cultural issues. There was a marked tendency among staff to refer inspectors to the equalities officer rather than answering questions we posed themselves.
We repeat the recommendation.

2.101 **The REO should regularly attend the safer custody meetings. (3.97)**

Not achieved. The REO did not attend these meetings.
We repeat the recommendation.

2.102 **The results of ethnic monitoring and other action taken should be publicised and displayed in an easy to understand format for prisoners. (3.98)**

Partly achieved. Ethnic monitoring data was publicised among prisoners. However, this had been presented in a format that prisoners and staff might have found difficult to understand. The data should have been interpreted and information provided about the actions taken as a

result of the analysis.
We repeat the recommendation.

2.103 **Black and minority ethnic women should be able to meet regularly and their views reported to the REAT. (3.99)**

Not achieved. Black and minority ethnic prisoners had little opportunity to meet regularly other than during the periodic equalities focus groups, to which some of the women were invited. Only a dedicated opportunity would have given this group of prisoners the privacy they needed to speak freely.
We repeat the recommendation.

2.104 **The published membership of the REAT should include prisoner representatives. (3.100)**

Achieved. Prisoner representatives had attended the last six meetings.

2.105 **The foreign national policy should be informed by a local needs analysis and contain an action plan against agreed targets. (3.118)**

Not achieved. The prison's policy on foreign nationals had been drawn up in 2008, and appeared to have been unchanged since then. However, the race equality action plan included action planning for foreign nationals.
We repeat the recommendation.

2.106 **Prisoners should have access to accredited translation and interpreting services wherever matters of accuracy and/or confidentiality are a factor. (3.119)**

Achieved. The Applied Language Solutions telephone interpretation system was used on a daily basis across the prison, and staff and prisoners across the prison were familiar with it.

2.107 **There should be an accurate record of staff and prisoners able and willing to speak other languages, and support provided by prisoners should be appropriately rewarded. (3.120)**

Achieved. Prisoners who were willing to speak other languages were paid bonuses and were used to provide company and comfort in periods of distress, or during routine events. The telephone interpretation service was used for all official or personal matters.

2.108 **Areas of concern raised at foreign national meetings or with the diversity representatives should be fed back to senior managers. (3.121)**

Partially achieved. The senior management team was well represented at the DREAT meeting, but diversity and equality issues were not routinely discussed at monthly senior management meetings. Some parts of the race equality action plan had not been updated for many months, which suggested that it was not given enough attention.
We repeat the recommendation.

Protected characteristics

2.109 **All staff should be aware of the distinct needs of foreign national women. (3.122)**

Not achieved. When prompted, some staff knew about the provisions for foreign national women, but this work was generally viewed as the work of the equalities officer. There was little evidence of any widespread engagement with the issues.
We repeat the recommendation.

Faith and religious activity

2.110 **There should be faith leaders for Muslim and Buddhist women. (5.41)**

Achieved. These vacancies had been filled, but there had been a vacancy for a Salvation Army chaplain for several months.

Complaints

2.111 **The promptness of replies to applications should be recorded. (3.132)**

Not achieved. There was no tracking system and some wings could not produce a log of the applications made.
We repeat the recommendation.

2.112 **The formal complaints process should be used for complaints against staff. (3.133)**

Achieved. Prisoners regularly used the formal process for complaints about staff.

2.113 **The nature and location of complaints about staff should be analysed and monitored closely by the governor and action taken where appropriate. (3.134)**

Partially achieved. Monthly monitoring took place and results were presented and considered at the operational management meeting every month. Complaints against staff were referred to managers responsible for specific areas, but were sometimes answered by senior officers. This meant that the procedure was unlikely to instil confidence in prisoners.

Legal rights

2.114 **Bail and legal services officers should all have up to date training. (3.141)**

Partially achieved. They had received bail training, but none relating to legal services.

2.115 **Recalled women should have written information describing the recall process. (3.142)**

Achieved. Recalled women were given a leaflet which described the recall procedures in general and the opportunities to make representations.

2.116 **Solicitors' visits should be easy to arrange and accommodate. (3.143)**

Achieved. The provision for solicitors' visits was adequate – they took place every morning and afternoon, except on Wednesdays and Fridays. A dedicated booking line was available and visits could also be arranged by fax.

Health services

Governance arrangements

2.117 **All health care staff should complete annual cardiopulmonary resuscitation (CPR) training, and evidence of such training should be documented. (4.43)**

Achieved. All staff completed annual training in CPR. One of the registered nurses was an accredited CPR trainer and was responsible for ensuring that training, including the emergency first aid in prisons course and updates, was delivered. All training was documented on staff members' individual records. Resuscitation equipment, including defibrillators, was available on all wings and was checked regularly.

2.118 **A dedicated prisoner health forum should be instigated to allow wing representatives to meet with senior health managers to discuss general health issues, and for health care to advise prisoners of changes in health services. (4.44)**

Achieved. Prisoners were encouraged to participate in health service developments through meetings and health fairs. A patient and public involvement group had been set up to discuss ideas for increasing health promotion throughout the prison; a prisoners' representative participated in the group. A health care assistant identified initiatives to develop health promotion activities. There were notice boards throughout the prison advertising various aspects of health, and there were plans to hold another fair in June 2012.

Delivery of care (physical health)

2.119 **Secondary screening should be completed within 72 hours of arrival in prison. (4.45)**

Achieved. All new arrivals had a comprehensive first and secondary health screening on their admission. They were offered an appointment the next day with the GP to discuss their health concerns. The GP service provided excellent support to women throughout their stay in prison. There were no significant delays in accessing the GP.

2.120 **Chronic disease management and health promotion should be further developed using existing staff and community nurse specialists. (4.46)**

Achieved. Chronic disease management was well structured and effective. Nursing staff within the prison managed women with chronic chest conditions, such as asthma, and community specialists came into the prison regularly to monitor women with other long-term illnesses.

2.121 **Health care professionals should be made aware of the courses available at the prison for parents so that they can recommend them.**

Achieved. Health staff and visiting community midwives were aware of the parenting classes available for the women; they informed pregnant women of all relevant courses, where appropriate.

2.122 **The practice manager should, with prisoners' consent, contact community GP services so that contemporaneous records can be maintained for prisoners. (4.50)**

Achieved. Where practicable women's GPs were contacted and asked to send copies of the patient's health record. However many women came into the prison without having registered with a GP in the community.

2.123 **The practice manager should review the reasons why prisoners fail to attend health care appointments and seek to reduce non-attendance. (4.51)**

Achieved. The 'did not attend' rate was within reasonable limits. Prisoners failing to attend health care appointments received a letter. They were offered another appointment, and if the prisoner did not attend again, they were removed from the waiting list.

2.124 **The governor should provide escorting staff to allow clinicians more time with patients. (4.52)**

Achieved. Prison officers escorted prisoners to clinics. This allowed clinical staff to concentrate on clinical issues and improve care for prisoners.

2.125 **The treatment room on Residential 2 should be refurbished to provide additional storage space to remove clutter from the floor. Computer equipment and electric cables should be properly housed. (4.53)**

Not achieved. Residential 2 was now referred to as D and E wings. There had been no improvements to the structure, layout and fittings in the treatment room located in the entrance area to the wings which was used for medicines administration. There was a lack of electronic clinical information system (SystmOne) computers, and storage facilities were extremely poor. In addition, the fire door was obstructed by equipment. The room was not fit for purpose and should be completely refurbished as a matter of urgency. In particular, efforts should have been made to ensure that nurses' line of vision was not obstructed when they were giving out medication. The clinical services manager should take the lead on any new design for the treatment room.
We repeat the recommendation.

2.126 **The role of a lead clinician for older women and those with disability needs should be developed in line with national guidelines. (4.54)**

Achieved. A dedicated nurse was responsible for older women. Women over 50 underwent a dedicated health screen when they arrived at the prison, and any additional health requirements were identified and addressed. Women were offered annual health checks.

Pharmacy

2.127 **A full time pharmacy technician should be based at Eastwood Park to oversee medicine stock management and to ensure the large quantities of controlled drugs in use are managed appropriately. (4.55)**

Achieved. Lloyds Pharmacy managed all medicine products. The pharmacy technician was not based at the prison, but did visit every day on weekdays to address any issues and check medicine stocks. In addition, the pharmacist visited twice a week to review all pharmacy matters and check all controlled drugs.

2.128 **Medicine charts should clearly indicate whether medication should be taken in possession or under supervision. (4.56)**

Achieved. A sample of prescription charts was seen and all were written correctly and included details of the route of administration.

2.129 **The prison controlled drug stock register should comply with the February 2008 regulations and the transfer of controlled drugs around the prison should be clearly documented. (4.57)**

Achieved. The controlled drug stock register complied with current regulations.

2.130 **All staff administering methadone should be trained to use the pump system so that electronic controlled drug registers are maintained accurately. (4.58)**

Not achieved. There were insufficient methadone pumps in the prison. This meant that not all methadone administration could be carried out using the pumps.
We repeat the recommendation.

2.131 **The use of general stock should be audited so that stock supplied can be reconciled against prescriptions issued. (4.59)**

Achieved. There was a comprehensive stock list and levels were regularly audited and reconciled against prescriptions.

2.132 **Secondary dispensing should be stopped. (4.60)**

Achieved. There was no evidence that secondary dispensing took place. Pharmacy support was very effective and prescriptions were dealt with very promptly, ensuring that patients did not have to experience lengthy waits to receive their medication.

2.133 **The in possession risk assessments of each drug and patient should be documented and the reasons for a decision recorded. (4.61)**

Partially achieved. Risk assessments were completed by the pharmacy nurses. However the current risk assessment template did not meet the needs of the patient or the service. The risk assessment should be reviewed with the involvement of all stakeholders to ensure its usefulness and purpose.
We repeat the recommendation.

2.134 **The current prescription and administration charts should be reviewed to ensure clarity of prescriptions is maintained. (4.62)**

Not achieved. The prescription chart was computer generated and allowed prescriptions to be recorded for up to 28 days. However, the format of the form was potentially unsafe as its design was poor and could have led to drug errors. The format of prescription charts should be reviewed as a matter of urgency by all health professionals using the form to ensure its efficacy and fitness for purpose.
We repeat the recommendation.

2.135 **The pharmacist should develop pharmacy-led clinics and medication reviews. (4.63)**

Not achieved. There were no pharmacy-led clinics or medication reviews. Nursing staff managed all pharmacy requirements and administered all medicines to patients. A pharmacist visited the prison regularly, but had no remit to provide professional support to patients. There

was no opportunity for patients to see a pharmacist or technician.
We repeat the recommendation.

2.136 **Standard medicine procedures and policies should be reviewed to ensure they cover all aspects of the pharmacy service. They should be formally agreed through the medicines and treatment committee and all staff should sign the agreed procedures. (4.64)**

Achieved. The pharmacy service was provided by the local Lloyds Pharmacy and a pharmacist visited the prison. Serco provided registered nurses to manage the pharmacy area in the prison, as well as to administer all pharmaceutical products to patients. Lloyds Pharmacy and Serco agreed on and produced the standard operating procedures.

2.137 **Named patient medication should be used in favour of stock, which should only be used exceptionally. (4.65)**

Partially achieved. Stock medicines were only used in the absence of access to prescribed medication and to start treatment promptly. As soon as the prescription was filled, the patient received their named medication.

Dentistry

2.138 **The dental contract should include the provision of a hygienist or a dental health educator. (4.48)**

Achieved. The contract included provision for a dental nurse, who assisted the dentist and promoted oral health to the patient. In addition an oral health promotion team visited the prison twice a year to endorse the need for positive oral health.

2.139 **Additional dental sessions should be put in place to keep the waiting list at a manageable level. (4.49)**

Achieved. There were now five sessions a week to address prisoners' needs for dental care. The waiting list was at an acceptable level and patients were seen as soon as possible.

Catering

2.140 **Breakfast should be served on the morning it is eaten. (7.13)**

Achieved. Cereals, toast, jam and UHT milk were served each morning.

2.141 **There should be a greater promotion of cultural diversity through more ethnically diverse food choices. (7.14)**

Not achieved. The promotion of diversity in the prison's catering service was still limited to occasional themed meals. The chaplaincy department had liaised with the catering manager about arrangements for Ramadan, but there had been no wider collaboration with the education department or through the diversity and race equality action team to promote diversity. Minutes of prisoner representative meetings routinely discussed catering, but there was little reference to cultural diversity. In a survey in June 2011 women had indicated that there were insufficient cultural choices on the menu. There was no strategy to ensure

prisoners from a range of cultures were employed in the kitchen.
We repeat the recommendation.

2.142 **Halal cooking and serving utensils should be clearly identified in the main kitchen and on wing serveries. (7.15)**

Achieved. Utensils used in the preparation and serving of Halal food could be identified in serveries and in the main kitchen, and were stored separately.

2.143 **Improved incentives through more rewarding work, improved training and qualifications should be offered in the kitchen. (7.16)**

Not achieved. Due to the high churn of prison kitchen workers, their main tasks were mainly restricted to sandwich and vegetable preparation. All had completed a basic food hygiene qualification. There was still no formal accredited training, which could have been introduced for the small number of women working in the kitchen for longer periods.
We repeat the recommendation.

2.144 **Supervision and monitoring of hygiene standards on wing serveries should be improved. (7.17)**

Partially achieved. Forms used for recording food temperature at the point of serving were not routinely completed in all wings. An induction pack, providing guidance to officers responsible for overseeing serveries, was in draft form. An induction pack for kitchen workers had been introduced, and one was also being developed for servery workers. Catering staff completed periodic checks of serveries, as did the duty governor.

2.145 **Food comments books should be more accessible and their constructive use encouraged by staff. (7.18)**

Not achieved. Food comments books were available, but at some serveries prisoners had to ask staff for them. Some comments sheets were held in loose-leaf folders and it appeared that some pages were missing. There were many derogatory comments about the food which, in most cases, the catering manager had responded to.

The women we spoke to did not like the food – particularly the sandwich packs used for weekend evening meals. The catering manager attended prisoner consultation meetings where many complaints about the food were raised. Six monthly surveys had been conducted, but few survey forms had been returned.
We repeat the recommendation.

Further recommendation

2.146 An action plan should be developed to address prisoners' apparent dissatisfaction with the quality of food.

Purchases

2.147 **Managers from the prison and the canteen contractor should be invited to attend prisoner representatives meetings. (7.29)**

Achieved. The canteen worked well. Few complaints were raised about this at the prisoner consultation meetings. A manager or representative from the finance department attended the meeting. There had been specific requests for the contractor to attend.

2.148 **Catalogue shopping should be introduced. (7.30)**

Not achieved. Limited catalogue shopping had been introduced for women on the enhanced regime; they could now buy products from a cosmetics catalogue. Access should be extended to more women. Although most women were not held in the prison for long periods, there was still no provision for the few who had no family or community support; these women needed to have access to catalogue shopping.
We repeat the recommendation.

2.149 **Arrangements should be made for prisoners to order newspapers and other authorised publications. (7.31)**

Not achieved. The prison supplied daily newspapers to wings, and prisoners could arrange for families or friends to send in newspapers and publications through a local newsagent. Those without this kind of support could not make personal orders. Given the short time most stayed in the prison, we accept this affected relatively few.
We repeat the recommendation.

Time out of cell

2.150 **Women should be offered an hour of exercise in the open air. (5.50)**

Not achieved. Women were only offered a maximum of half an hour in the open air.
We repeat the recommendation.

2.151 **The numbers taking part in outside exercise should be accurately recorded. (5.51)**

Not achieved. There was no log, either on units or centrally, to record the number of women taking part in outside exercise.
We repeat the recommendation.

2.152 **The prison should provide suitable clothing to take part in outside exercise. (5.52)**

Partially achieved. One wing manager had procured outdoor clothing, but this had not been replicated across all units (see recommendation 2.69).
We repeat the recommendation.

2.153 **Prisoners should spend at least 10 hours a day unlocked during the week. (5.53)**

Partially achieved. Most employed women could spend 10 hours a day unlocked, except for women on the standard level on E wing, who only received two periods of weekday evening association; women on the standard level in all other units received four nights of association. Additionally, unemployed women who at the last inspection had been unlocked during the day were now locked up in some units.

Further recommendation

2.154 All standard level women should receive the same association provision.

Learning and skills and work activities

2.155 The curriculum should be reviewed to ensure there is sufficient relevant provision, and provision that will attract hard to reach learners. Particular attention should be paid to motivating and supporting women to complete courses. (5.15)

Achieved. The average length of stay for the majority of women was about 30 days, and the learning and skills managers had reviewed the curriculum and introduced a wide variety of accredited two-week programmes aiming to meet the needs of those women in the prison for short periods. They were subsequently more able to attend and complete programmes before they were transferred or released. This was much appreciated by the women. The number of women completing programmes and achieving accredited qualifications had significantly increased from 60% at the last inspection to between 85% and 95%.

Financial rewards were offered when prisoners achieved qualifications. Tutors had increased the range of individual education sessions on wings, in health care and in the mother and baby unit. This aimed to encourage prisoners to participate in education, particularly those who were unable to take part in formal education classes. While around 65% of women accessed structured learning and skills sessions (similar figures to the last inspection), approximately 50 women were able to access education through successful outreach work, a significant increase since the last inspection.

2.156 Time tables should be organised to avoid clashes of activities. (5.16)

Achieved. The short two-week programmes provided a structure that enabled activities to be organised so that timetable clashes were kept to a minimum. Most women received a satisfactory education induction within one week of entering the prison. The allocation system was centrally and effectively managed and ensured that women predominantly received their first choice. There was little evidence that prisoners were being taken out of activities at short notice to attend other appointments. There were sufficient employment places for approximately 80% of the population. About 78% of available employment opportunities were generally occupied. On average about 75% of learning and skills sessions were occupied. Most unscheduled absences were due to doctors' appointments.

Provision of activities

2.157 There should be more vocational qualifications relevant to employment opportunities on release. (5.17)

Partially achieved. Additional vocational training opportunities had been offered since the last inspection, when only industrial cleaning was available. Approximately 40 women were working as peer mentors on the Toe by Toe programme. Several of them were following peer mentoring qualifications. Library orderlies were undertaking a qualification in library and information skills. Qualifications in radio production were also offered. Accredited painting and decorating programmes had ceased in the last few months due to staff leaving the prison, but were due to start again in March. Work needed to be done to provide vocational training and qualifications for those in the prison for longer periods, for example, in kitchen and hairdressing

skills.
We repeat the recommendation

Quality of provision

2.158 **The curriculum should be developed to include higher level courses. (5.19)**

Partially achieved. There remained little provision above level 2. A few women had been supported to undertake A level and degree courses, higher level learning in information and communications technology and a peer mentoring qualification. More work needed to be done to support prisoners wishing to do GCSEs and higher level learning programmes. Many women wanted to attend discrete English and maths programmes. At the time of the inspection there were no such programmes offered. The only formal literacy and numeracy provision was embedded and provided in a range of practical environments such as art, ceramics and cookery.
We repeat the recommendation.

2.159 **Reliance on worksheets in lessons should be reduced. (5.20)**

Achieved. At the last inspection too much teaching and learning relied on the use of worksheets to engage women in learning. At the time of this inspection, staff used interactive boards and practical demonstration to support teaching and learning. Worksheets were generally limited to the completion of documents for portfolios of evidence. However, the quality of some evidence sheets was poor and on occasion illegible.

2.160 **The targets in individual learning plans should be more detailed and focus on what individuals need to do to progress. (5.21)**

Partially achieved. The prison had recognised this as an area for development and was in the process of reviewing the content and use of individual learning plans. Some staff had developed an effective process of target setting through daily journals and diaries. Good practice was observed by inspectors – learning plans had clear targets that identified the steps the women needed to take in order to progress and improve. In some areas individual learning plans were less well developed. More work was needed to develop and share best practice.
We repeat the recommendation.

Educational and vocational achievements

2.161 **The reasons behind the significant attrition rate for courses should be researched and action taken to reduce it. (5.18)**

Achieved. The number of women leaving programmes early and not completing their learning aims was extremely high at the last inspection at approximately 40%. The prison identified this as an area for improvement in its self-assessment and quality improvement plan. Since the last inspection, senior managers had thoroughly reviewed and reorganised the curriculum and provided short two-week accredited programmes. This had significantly improved 'staying on' rates, which at the time of inspection were between 85% and 95%.

Library

2.162 **Library opening hours should be increased to allow greater flexibility and availability of access to services. (5.22)**

Not achieved. Since the last inspection the library opening hours had been reduced. The library opened for three and a half days compared to four and a half at the last inspection. The library remained closed in the evenings and at weekends due to staff shortages. The library assistant had worked extremely hard to maintain library access, but for some women this was hampered by wing staff failing to escort them to the library. A limited support service was provided by visiting library staff from other nearby prisons, but staff levels at Eastwood Park were inadequate. A part-time librarian, who had been recruited, was awaiting security clearance to begin work in the prison, after which library opening hours would increase.
We repeat the recommendation.

Physical education and health promotion

2.163 **Women should not wait more than a week for PE induction and these sessions should be offered before offenders have made all their education and training choices. (5.30)**

Achieved. Women did not have to wait more than one week as there were two PE inductions each week. Women were able to attend PE sessions before making education and training choices.

Strategic management of resettlement

2.164 **The reducing reoffending strategy should address all requirements highlighted by the needs analysis, including gambling and fire-setting, and the needs of all groups, including older women and lifers. (8.5)**

Achieved. The reducing reoffending strategy included action plans to address needs highlighted in the 2011 needs analysis, including those of older women and lifers.

Offender management and planning

2.165 **Offender assessment system (OASys) assessments should be up to date. (8.18)**

Not achieved. On average 25 new women arrived each month with a sentence of 12 months or longer making them eligible for the OASys. Ninety-six women were serving sentences of 12 months or more. Of these, 33 did not have an initial OASys and 27 did not have an up to date assessment.
We repeat the recommendation.

2.166 **Where it is in the woman's best interests, she should not be transferred while an OASys assessment is in progress. (8.19)**

Achieved. Women were not transferred while an assessment was in progress.

2.167 **OASys assessments should have targets that reflect need and should stretch into the community, especially where release is approaching. A named member of staff should be responsible for supporting each target and timescales should be given. (8.20)**

Partially achieved. Targets were suitable and included timescales, but most did not specifically name the staff responsible.

2.168 **Custody plans should be up to date and have targets relating to an individual's specific needs. Women should be aware of what their targets are. (8.21)**

No longer relevant. See recommendation 2.5.

2.169 **Women should have an opportunity to have a multidisciplinary progress review, at least annually. (8.22)**

Not achieved. Multidisciplinary sentence planning boards were generally held only for 'in scope' women and those serving over four years.
We repeat the recommendation.

2.170 **The video link facility should be used to enable offender managers based further away to participate in reviews. (8.23)**

Achieved. The facility was used for meetings with offender managers.

2.171 **All recalled women should have a sentence plan promptly. (8.25)**

Achieved. Recalled women were promptly allocated to an offender supervisor and sentence plans were produced.

2.172 **Delays in the recall process should be routinely chased up and reasons for delays sought. (8.26)**

Achieved. Case administrators proactively pursued the necessary recall paperwork, and records showed a minimum delay in most cases.

Public protection

2.173 **Wing staff should be aware of the women subject to risk management procedures. (8.24)**

Partially achieved. Most wing staff, but not all, were aware of women subject to risk management procedures.

Categorisation

2.174 **Categorisation decisions should be communicated to women in person and avenues for appeal should be made clear, verbally and in writing. (6.18)**

Not achieved. Women received categorisation decisions in writing without information on how to appeal. Staff in the observation, classification and allocation department did not know how a woman could appeal such a decision.
We repeat the recommendation.

2.175 **Notifications of transfer should have an appeals process which is discussed verbally and given in writing. (6.19)**

Partially achieved. Only women who were not subject to overcrowding drafts were given enough notice of their transfer to be able to appeal. Although not discussed verbally, information was provided in writing and included details of how to appeal.

2.176 **Women should not be repeatedly targeted for transfer. Transfers should be based on assessed need and/or closeness to home. (6.20)**

Partially achieved. Overcrowding drafts were at least a weekly occurrence. Women were selected for transfer based on their sentence length, for example, those serving the longest sentences were transferred first. There was no needs assessment, and closeness to home was not a consideration. However, women were no longer repeatedly targeted for transfer.
We repeat the recommendation.

Indeterminate-sentence prisoners

2.177 **Lifers and IPP-sentenced prisoners should receive written information about the life sentence/IPP systems. (8.27)**

Achieved. Published information was available to all women serving indeterminate sentences.

2.178 **There should be individual support in place for lifers when there are only one or two in the prison, and lifer groups when there are more women. (8.28)**

Achieved. Women on indeterminate sentences were supported by their offender supervisor and were seen regularly. They were moved promptly, and there were no women with an IPP or lifers during the inspection; one lifer from another establishment was at Eastwood Park on an accumulated visit.

Reintegration planning

2.179 **The resettlement unit should be fully utilised. (8.50)**

No longer relevant. There was no longer a resettlement unit.

2.180 **Women eligible for end of custody licence (ECL) should be subject to the same checks as they would be on other early release schemes. (8.51)**

No longer relevant.

Health care

2.181 **There should be a health care pre-release clinic. (8.52)**

Partially achieved. Not all women were seen before their release. Only those on medication or with a long-term condition were seen by health care staff. However, all of them received written health care information before they were released as part of the general discharge procedure.
We repeat the recommendation.

Drugs and alcohol

2.182 **The drug strategy team should ensure that the support needs of young adults are identified and met. (8.71)**

Achieved. The counselling, assessment, referral, advice and throughcare (CARAT) service provided support for all women, including young adults. The young adults were thoroughly assessed by a CARAT worker and care plans, which included long-term interventions, were produced. The prison's drug strategy did not identify young adults as a distinct group with specific needs and issues, and managers reported that all women were dealt with on a case by case basis (see recommendation 2.66). There were good links with community drug agencies, particularly where a young person was about to be released.

2.183 **The CARAT team should be resourced to offer longer-term interventions to women and young adults with drug and/or alcohol problems who require support. (8.72)**

Achieved. CARAT services were delivered through the Avon and Wiltshire Partnership (AWP) Trust. Resource levels had improved since our last inspection and the team consisted of a vacant band 7 CARAT worker post, three band 6 CARAT workers and seven band 5 CARAT workers. The increase in the number of workers meant that it was possible to introduce long-term interventions.

2.184 **There should be a testing suite for voluntary and compliance testing. (8.73)**

Not achieved. There was no appropriate testing suite and women still had to provide a urine sample in their unit when required.
We repeat the recommendation.

2.185 **The short duration programme should be adapted to meet the specific needs of women.**

No longer relevant. The short duration programme was obsolete; the CARAT team provided group sessions instead. This included a week-long drug addiction course for women, which was continually being reviewed to ensure that it was relevant to the women and that they benefited from it. In addition, a four-day alcohol course had been introduced to support women using alcohol. Women and young adults, who failed to attend CARAT courses or one-to-one sessions were seen by their CARAT worker. If they decided they no longer wished to participate in CARAT programmes, they signed a form confirming this. They were also told that if they wished to rejoin the programme, they would be welcome.

Finance, benefit and debt

2.186 **There should be a debt management service. (8.53)**

Achieved. A Citizens Advice Bureau (CAB) worker based in the prison provided a debt management service one day a week. The number of women assisted, type of debt and actual debt reduction was monitored, and, if necessary, women were referred to a CAB worker in their home area so that they could receive continuing support on their release. Women also had access to the national debt telephone helpline free of charge.

2.187 **There should be services for women with gambling issues. (8.54)**

Achieved. Not enough women were identified to make a Gamblers Anonymous (GA) group in the prison viable, but women could access support from GA and GamCare telephone helplines free of charge.

Children, families and contact with the outside world

2.188 **Eligibility for inter-prison visits, and the use of the video link for them, should not be dependent on IEP status. (8.100)**

Partially achieved. Women on the enhanced level could apply monthly for prison visits to relatives or partners in other prisons; other women could apply every three months.

2.189 **The procedure for obtaining additional children's letters should be better promoted and reinforced as part of the induction programme. (8.101)**

Achieved. Most women were aware that they could receive children's letters.

2.190 **Plans for a community bus service should be expedited. (8.102)**

Not achieved. There continued to be no community bus service.
We repeat the recommendation.

2.191 **Visit times should be extended to allow a longer visit at weekends. (8.103)**

Not achieved. Unchanged from 2008, visit sessions lasted one hour during the week and two hours on Sundays.
We repeat the recommendation.

2.192 **Visitors who have booked a double visit should not have to leave the visits room unless they choose to do so. (8.104)**

Not achieved. Visitors continued to have to leave halfway through a double visit.
We repeat the recommendation.

2.193 **An alternative to bibs, such as wristbands for either prisoners or visitors, should be introduced. (8.105)**

Achieved. Women now wore wrist bands.

2.194 **Funding should be procured for a proper visitors centre. (8.106)**

Not achieved. There continued to be no proper visitors centre.
We repeat the recommendation.

2.195 **Children over the age of 10 should not be classified as adults. (8.107)**

Achieved. Children aged 10 and over were no longer classified as adults.

2.196 **The resettlement pathway group should evaluate the need for a relationship course and, if relevant, obtain the resources to deliver one. (8.108)**

Partially achieved. There had been no specific evaluation of the need for a relationship course, but YMCA workers delivered a three-session 'emotional wellbeing' course, which

included an 'interpersonal relationships' session. Although it did not look specifically at intimate relationships, the session was designed to help women better understand and empathise with others, and to develop assertiveness, negotiation and communication skills.

2.197 **There should be alternative arrangements put in place for women who are not able to participate in all day family visits on the mother and baby unit. (8.109)**

Partially achieved. Women on all wings could now apply to have a visit with their child or children in the MBU, although this was not possible for all women (see recommendation 2.198).

2.198 **All day visits should be held in the main visits room to allow carers to bring children to participate in the day. (8.110)**

Partially achieved. Children's days now took place in the main visits room. However, the only women who could participate in the children's days were those who had completed the two-day 'Time to connect' course, which focused on the impact of imprisonment on children and families.

Attitudes, thinking and behaviour

2.199 **An offending behaviour needs analysis should be completed. (8.116)**

Partially achieved. There had been no specific offending behaviour needs analysis, but 'attitude, thinking and behaviour' had been part of the overall 2011 needs analysis.

2.200 **There should be support for women who have experienced domestic violence. (8.117)**

Achieved. Women could refer themselves or be referred by offender supervisors or other staff to one of the several female officers who had received awareness training to help prisoners with experience of physical, mental, sexual abuse and/or sex work. They gave out information and could refer women to a variety of support workers who visited the prison. This support was available after their release. Rape Crisis and Women's Aid telephone helplines were available.

A four-session pilot reading group, facilitated by an offender supervisor and based on a book about domestic abuse and alcoholism, had been successful. Regular 'Support for you' fairs allowed women to talk directly to support workers or simply to collect literature from the agencies attending the event. Unfortunately funding for the 'Freedom' domestic violence programme had ceased in September 2011.

2.201 **Links with voluntary and community sector groups to assist with the development of provision for women who have experienced sexual abuse or domestic violence should be formalised, and all women should have access to support linked to their home area. (8.118)**

Achieved. The prison had partnership agreements with various community women's groups, and women were signposted to services in their home area, irrespective of where they were returning to.

2.202 **The number of women receiving support for sexual abuse or domestic violence should be monitored to give feedback on how far needs are being addressed. (8.119)**

Achieved. All referrals were recorded and monitored for timeliness. Action was taken at each quarterly pathway meeting, which was chaired by a senior manager.

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 NOMS

3.1 There should be additional provision for women offenders in the West Midlands. (2.1)

3.2 Staff should be trained in the use of care mapping and action planning for women on K wing, and other vulnerable prisoners, such as those at risk of suicide and self-harm or bullying. (2.2)

3.3 All women should have a sentence or custody plan that reflects individual need and is followed up by offender supervisors or personal officers. (2.5)

Recommendations — To the governor

Courts, escorts and transfers

3.4 Women should be held in court cells for the minimum possible period. (2.6)

3.5 Prisoners should arrive before 7pm and should receive essential first night procedures, irrespective of their time of arrival. (2.7)

3.6 Women should have breakfast on the morning they go to court. (2.8)

3.7 Escort vans should be comfortable. (2.9)

3.8 Female and male prisoners should be transported separately. (2.10)

3.9 Prisoners should be given information at court about the prison. (2.11)

Early days in custody

3.10 Prisoners should be held in reception for as short a time as possible. (2.12)

3.11 Sentenced women should not share cells with unsentenced women. (2.13)

3.12 The one-to-one interviews in reception should not be disturbed by noise. (2.16)

3.13 The video shown in induction about the reception process should be used in reception. (2.17)

Bullying and violence reduction

3.14 There should be more opportunities to consult prisoners about safety. Particular attention should be given to those who are new to the prison and to young adults. (2.20)

3.15 All staff in contact with prisoners should receive training in the violence reduction strategy. Principles of mediation should be included in this training. (2.21)

3.16 An action plan should be developed in response to the prison's own survey of bullying and violence, which should include more active supervision of women when they are congregated together. (2.22)

3.17 The governance of the violence prevention protocol should be improved to ensure that appropriate authorisation is obtained and recorded if a prisoner is locked in cell after an incident. (2.23)

3.18 An evaluation should be completed of the seven-day antisocial behaviour programme. (2.25)

3.19 Senior managers should quality check the monitoring of prisoners subject to the violence reduction strategy. (2.26)

3.20 Violence reduction statistics for juveniles, young adults and adults should be disaggregated so that the prison can track trends in each of these groups. (2.27)

Self-harm and suicide prevention

3.21 Assessment, care in custody and teamwork (ACCT) reviews should be multidisciplinary, have continuity of case manager and include the prisoner's personal officer. (2.30)

3.22 Care maps should be improved. The initial reasons for the ACCT being opened and any subsequent issues that have heightened risks should be followed through and documented. (2.31)

3.23 A Listener suite should be provided to enable Listeners to provide 24-hour confidential support for women. (2.35)

3.24 Informal access to Listeners for women new to the prison should be improved. (2.36)

3.25 The cell call alarm system on D and E wings should be audible from the landings. (2.39)

Security

3.26 There should be a trained analyst in the security department. (2.42)

Incentives and earned privileges

3.27 Women on the basic level should not be deprived of in-cell electricity. (2.46)

Disciplinary procedures

3.28 Adjudication hearings should always include a record of the hearing and evidence of a full enquiry. (2.47)

The use of force

3.29 Use of force should be examined regularly by managers for trends, the background to the incident and any learning points. (2.48)

Segregation

3.30 Adjudications should not be held on K wing. (2.53)

3.31 Care maps for women on K wing should be coordinated so that all relevant disciplines are responsible for target-setting and monitoring as part of a multi-disciplinary process. (2.54)

Substance misuse

3.32 The supervision and management of women administered controlled drugs on E wing should be improved. (2.56)

3.33 The mandatory drug testing (MDT) programme should be adequately resourced for the required level of target testing within identified timescales. (2.58)

Residential units

3.34 Action should be taken to remove graffiti and prevent its recurrence. (2.61)

3.35 The temperature of residential areas should be properly regulated. (2.62)

3.36 The ventilation on Residential 1 should be improved. (2.63)

3.37 All cells should be furnished with tables, chairs and lockable cupboards, sufficient for the number of people expected to live there. (2.64)

3.38 A lockable cupboard should be provided and the use of safes should be free of charge. (2.65)

3.39 Young adults should be located together, where there is specific regime provision and staff dedicated to them. (2.66)

3.40 The prison should have a strategic oversight of young adults, and ensure their specific needs are met. (2.67)

3.41 Women on Residential 1 should be allowed to associate in their rooms as well as in the large association room, facilitating access to showers and telephones, as on the other units. (2.68)

3.42 Prisoners should have clothes for outside wear. (2.69)

3.43 Curtains should be provided in all cells. (2.72)

3.44 Telephones in busy areas should be placed in booths. (2.73)

3.45 Mother and baby unit (MBU) staff should not wear prison uniforms. (2.76)

3.46 Multidisciplinary care plans for pregnant women should be developed as soon as the prison is aware a woman is pregnant, and these should be regularly reviewed. (2.81)

3.47 Women should be able to cook all meals for their babies and eat with them. (2.83)

3.48 Emergency admission procedures for mothers and babies should be more flexible, speedy and responsive to need. (2.86)

Staff-prisoner relationships

3.49 Personal officer allocation should not be cell-based, to avoid regular changes of personal officers for individual prisoners. (2.88)

3.50 The personal officer scheme should be further developed so that personal officers engage their prisoners in progress against custody plans. (2.89)

3.51 Important personal information which emerges about individual prisoners should be noted in their wing history files to ensure all staff have access. (2.90)

Equality and diversity

Strategic management

3.52 There should be a published diversity policy outlining the arrangements for meeting the needs of all minority groups. It should include an action plan to meet identified targets and be based on a needs analysis. (2.91)

3.53 Designated liaison officers should receive appropriate training and sufficient time to meet the needs of all minority groups. (2.92)

3.54 The disability liaison officer should receive appropriate training and have sufficient time to meet the needs of prisoners with disabilities. (2.93)

3.55 Monitoring should be introduced to ensure that prisoners from minority groups are not being victimised or excluded from any activity. (2.96)

3.56 All staff should receive training that enables them to understand and respond appropriately to race and cultural issues. (2.100)

3.57 The REO should regularly attend the safer custody meetings. (2.101)

3.58 The results of ethnic monitoring and other action taken should be publicised and displayed in an easy to understand format for prisoners. (2.102)

3.59 Black and minority ethnic women should be able to meet regularly and their views reported to the REAT. (2.103)

3.60 The foreign national policy should be informed by a local needs analysis and contain an action plan against agreed targets. (2.105)

3.61 Areas of concern raised at foreign national meetings or with the diversity representatives should be fed back to senior managers. (2.108)

Protected characteristics

3.62 All staff should be aware of the distinct needs of foreign national women. (2.109)

Complaints

3.63 The promptness of replies to applications should be recorded. (2.111)

Health services

Delivery of care (physical health)

3.64 The treatment room on Residential 2 should be refurbished to provide additional storage space to remove clutter from the floor. Computer equipment and electric cables should be properly housed. (2.125)

Pharmacy

3.65 All staff administering methadone should be trained to use the pump system so that electronic controlled drug registers are maintained accurately. (2.130)

3.66 The in possession risk assessments of each drug and patient should be documented and the reasons for a decision recorded. (2.133)

3.67 The current prescription and administration charts should be reviewed to ensure clarity of prescriptions is maintained. (2.134)

3.68 The pharmacist should develop pharmacy-led clinics and medication reviews. (2.135)

Catering

3.69 There should be a greater promotion of cultural diversity through more ethnically diverse food choices. (2.141)

3.70 Food comments books should be more accessible and their constructive use encouraged by staff. (2.145)

3.71 An action plan should be developed to address prisoners' apparent dissatisfaction with the quality of food. (2.146)

Purchases

3.72 Catalogue shopping should be introduced. (2.148)

3.73 Arrangements should be made for prisoners to order newspapers and other authorised publications. (2.149)

Time out of cell

3.74 Women should be offered an hour of exercise in the open air. (2.150)

3.75 The numbers taking part in outside exercise should be accurately recorded. (2.151)

3.76 The prison should provide suitable clothing to take part in outside exercise. (2.152)

3.77 Prisoners should spend at least 10 hours a day unlocked during the week. (2.153)

3.78 All standard level women should receive the same association provision. (2.154)

Provision of activities

3.79 There should be more vocational qualifications relevant to employment opportunities on release. (2.157)

Quality of provision

3.80 The curriculum should be developed to include higher level courses. (2.158)

3.81 The targets in individual learning plans should be more detailed and focus on what individuals need to do to progress. (2.160)

Library

3.82 Library opening hours should be increased to allow greater flexibility and availability of access to services. (2.162)

Offender management and planning

3.83 Offender assessment system (OASys) assessments should be up to date. (2.165)

3.84 Women should have an opportunity to have a multidisciplinary progress review, at least annually. (2.169)

Categorisation

3.85 Women should not be repeatedly targeted for transfer. Transfers should be based on assessed need and/or closeness to home. (2.176)

Health care

3.86 There should be a health care pre-release clinic. (2.181)

Drugs and alcohol

3.87 There should be a testing suite for voluntary and compliance testing. (2.184)

Children, families and contact with the outside world

3.88 Plans for a community bus service should be expedited. (2.190)

3.89 Visit times should be extended to allow a longer visit at weekends. (2.191)

3.90 Visitors who have booked a double visit should not have to leave the visits room unless they choose to do so. (2.192)

3.91 Funding should be procured for a proper visitors centre. (2.194)

Appendix I: Inspection team

Paul Fenning	Inspector
Joss Crosbie	Inspector
Jeanette Hall	Inspector
Martin Owens	Inspector

Specialist inspectors

Bob Cowdrey	Ofsted
Bridget McEvilly	Health care inspector

Appendix II: Prison population profile

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

Population breakdown by:

Status	18–20 yr olds	21 and over	%
Sentenced	28	161	63
Recall	1	12	4.3
Convicted unsentenced	3	22	8.3
Other	7	64	23.7
Civil prisoners	0	1	0.3
Detainees	0	1	0.3
Total	**39**	**261**	**100**

Sentence	18–20 yr olds	21 and over	%
Unsentenced	10	92	34
Less than 6 months	7	56	21
6 months to less than 12 months	6	17	7.7
12 months to less than 2 years	7	37	14.7
2 years to less than 4 years	3	27	10
4 years to less than 10 years	2	17	7
10 years and over (not life)	0	13	5
ISPP	0	0	0
Life	0	2	0.7
Total	**39**	**261**	**100**

Age	Number of prisoners	%
Please state minimum age	18	
Under 21 years	39	13
21 years	102	34
30 years to 39 years	100	33.3

40 years to 49 years	47	15.7
50 years to 59 years	9	3
60 years to 69 years	3	1
70 plus years	0	0
Please state maximum age	69	
Total	**300**	**100**

Nationality	18–20 yr olds	21 and over	%
British	38	241	93
Foreign nationals	1	20	7
Not stated	0	0	0
Total	**39**	**261**	**100**

Security category	18–20 yr olds	21 and over	%
Uncategorised unsentenced			
Uncategorised sentenced			
Cat A			
Cat B			
Cat C			
Cat D			
Other- Female Closed	39	261	100
Total	**39**	**261**	**100**

Ethnicity	18–20 yr olds	21 and over	%
White			
British	35	222	85.7
Irish	0	2	0.7
Other white	0	10	3.3
Mixed			
White and black Caribbean	0	1	0.3
White and black African	0	0	0.0

White and Asian	1	0	0.3
Other mixed	0	1	0.3
Asian or Asian British			
Indian	0	1	0.3
Pakistani	0	4	1.3
Bangladeshi	0	0	0.0
Other Asian	0	4	1.3
Black or black British			
Caribbean	3	1	1.3
African	0	4	1.3
Other black	0	4	1.3
Chinese or other ethnic group			
Chinese	0	1	0.3
Other ethnic group	0	3	1.0
Not stated	0	3	1.0
Total	**39**	**261**	**100**

Religion	18–20 yr olds	21 and over	%
Baptist	0	0	0.0
Church of England	0	43	14.3
Roman Catholic	5	31	10.3
Other Christian denominations	5	35	11.7
Muslim	0	8	2.7
Sikh	0	1	0.3
Hindu	0	0	0.0
Buddhist	0	8	2.7
Jewish	0	1	0.3
Other	0	5	1.7
No religion	29	139	56
Total	**39**	**261**	**100**

Sentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month	7	2.3	61	20.3
1 month to 3 months	12	4	42	14
3 months to 6 months	5	1.7	34	11.3
6 months to 1 year	4	1.3	20	6.7
1 year to 2 years	1	0.3	3	1.0
2 years to 4 years	0	0	0	0
4 years or more	0	0	0	0
Total	**29**	**9.7**	**160**	**53.3**

Main offence	18–20 yr olds	21 and over	%
Violence against the person	4	22	8.7
Sexual offences	1	7	2.6
Burglary	4	22	8.7
Robbery	7	17	8
Theft and handling	3	64	22.3
Fraud and forgery	0	1	0.3
Drugs offences	5	34	13
Other offences	19	89	36
Civil offences	0	1	0.3
Offence not recorded/holding warrant	0	0	0
Total	**43**	**257**	**100**