

Report on an unannounced short follow-  
up inspection of

## **HMP Foston Hall**

19–22 November 2012

by HM Chief Inspector of Prisons

## Glossary of terms

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# Contents

	<b>Introduction</b>	5
	<b>Fact page</b>	7
<b>1</b>	Summary	9
<b>2</b>	Progress since the last report	15
<b>3</b>	Summary of recommendations	39
	<b>Appendices</b>	
	I Inspection team	44
	II Prison population profile	45

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# Introduction

Foston Hall women's prison remained a multi-purpose prison, holding a complicated mix of remanded prisoners, those awaiting sentence, and those serving short, long and indeterminate sentences. The small separate juvenile unit had closed. A short follow-up inspection such as this focuses only 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 establishment as a whole.

First night and induction arrangements had improved and there was good use of peer workers, during the early days and in a range of other areas, but interviews still did not take place in private. Substance misuse services were also much improved and now covered both alcohol and drugs.

The physical environment remained generally good, although D wing continued to offer poorer accommodation. Personal officer work and health services were both improved. However, there were ongoing weaknesses in the management of equality and diversity and not all the protected groups were well supported. Outcomes for the small number of foreign nationals were improving but consultation with them needed to be better.

The number of activities available had increased in line with the rise in the prison's population, and most women had an activity to attend. However, there were still insufficient full-time opportunities for everyone and better use could have been made of what was available. In addition, the frequent interruptions to learning had not been addressed, although there was now equality of opportunities for remand and convicted prisoners. Both the library and PE services were in need of improvement.

Resettlement remained the weakest area and, despite some improvements, most of the key problems raised at the previous inspection remained. Strategic thinking about the resettlement needs of the population was underdeveloped and leadership was weak. While offender management arrangements were good, provision in some key reducing reoffending pathways was poor, and there was only limited custody planning with remand and short-term prisoners. We continued to be disappointed with the unimaginative and somewhat limited support provided to women in maintaining links with their families and friends. This was a particular omission in a women's prison.

In summary, sufficient progress had been made in implementing our previous recommendations in the areas of safety, respect and providing an active environment for the women held but, as with the previous inspection findings, more needed to be done to ensure that women were able to benefit from resettlement opportunities.

**Nick Hardwick**  
HM Chief Inspector of Prisons

**January 2013**



# Fact page

## **Task of the establishment**

HMP Foston Hall is a female closed prison for local, training and life-sentenced prisoners.

## **Prison status**

Public

## **Region**

East Midlands

## **Number held**

288

## **Certified normal accommodation**

290

## **Operational capacity**

310

## **Date of last full inspection**

28 September – 2 October 2009

## **Brief history**

In December 1996, the prison was a redundant site. After extensive rebuilding and refurbishment, it opened in July 1997 as an establishment for 125 prisoners. Since then, additional residential wings have been opened, to bring it up to its current capacity.

## **Short description of residential units**

Accommodation comprises a remand wing and residential wings (A, B, C and F), with D wing providing accommodation for short-term prisoners and E and T wings providing a level of independent living for women who have enhanced status.

## **Name of governor/director**

Ken Kan

## **Escort contractor**

GeoAmey

## **Health service commissioner and provider**

Derbyshire Health United

## **Learning and skills providers**

Milton Keynes College

## **Independent Monitoring Board chair**

Gordon Thornhill





# Section 1: Summary

## Introduction

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- 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 short follow-up inspection was to follow up the recommendations made in our last full inspection of 2009 and assess the progress achieved<sup>1</sup>. 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:

<b>Safety</b>	prisoners, particularly the most vulnerable, are held safely
<b>Respect</b>	prisoners are treated with respect for their human dignity
<b>Purposeful activity</b>	prisoners are able, and expected, to engage in activity that is likely to benefit them
<b>Resettlement</b>	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.

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<sup>1</sup> Short follow-up inspections focus on recommendations made at the last full inspection and do not provide an assessment of the prison as a whole.

## Safety

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- 1.5 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 36 recommendations in this area, of which 17 had been achieved, six partially achieved and 13 had not been achieved. We have made no further recommendations.
- 1.6 Prisoners were allocated to Foston Hall appropriately but not all were given sufficient notice of moves. All relevant documentation arrived with them. Reception and first night interviews were not conducted in private. Peer workers provided good support, and induction had improved, but written materials were inaccurate. Initial needs were assessed and most issues were dealt with immediately.
- 1.7 The safer custody safeguarding meeting provided good oversight. There was a prisoner exit safety questionnaire, which was analysed for trends. Levels of violence appeared to be low. The management of violence reduction processes was reasonable but prisoners were not set challenging behavioural targets. A central log was kept of all violence and anti-social behaviour investigations. Insufficient staff had received violence reduction training.
- 1.8 There was a suicide and self-harm policy but it did not cover all aspects. Assessment, care in custody and teamwork (ACCT) self-harm monitoring procedures were underdeveloped. Relatively few staff had attended ACCT refresher training. Risk assessments for activities were not sufficiently individualised. The overall quality of case management for those on the ACCT process remained insufficient.
- 1.9 Few prisoners were on closed visits. Strip-searches were intelligence led but were not adequately monitored for trends.
- 1.10 Incentives and earned privileges (IEP) processes were generally appropriate, although prisoners complained that too few were on the enhanced level. Data about IEP were not collated or reviewed.
- 1.11 Adjudication data were monitored and the number of cases dismissed had decreased. The adjudications room remained inappropriate. Use of force was proportionate and well managed. The segregation unit continued, occasionally, to be used as a place of respite. There were good care plans for those in segregation for over 14 days but daily entries by staff lacked detail.
- 1.12 Clinical and psychosocial substance misuse services were much improved.
- 1.13 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

## Respect

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- 1.14 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 62 recommendations in this area, of which 29 had been achieved, 14 partially achieved and 19 had not been achieved. We have made one further recommendation.

- 1.15 Units generally looked clean and tidy but D wing remained in need of refurbishment. Opportunities for prisoners to cater for themselves were limited. Applications were not recorded or quality assured.
- 1.16 A prisoner forum had been introduced. Personal officer guidance had improved and case records showed some good examples of interactions, although links to sentence planning remained in need of improvement.
- 1.17 The equality and diversity policy covered all the relevant areas. Governance structures were in the process of being re-established and were not yet adequate. Action was taken against prisoners who demonstrated racist behaviour, although there were no specific interventions to address this. A list of racist incidents was maintained. Regular diversity events were run. There had been no consultation with Muslim prisoners to explore their perceptions of victimisation. Disability work was reasonable but not sufficiently individualised. Work with foreign national prisoners was improving, but consultation with them and other diverse groups was underdeveloped. Telephone translation services were not always used when needed.
- 1.18 The monitoring of complaints was reasonable, although we found one serious matter which had been dealt with inappropriately.
- 1.19 Health services had improved. The facilities were reasonable but some issues remained. Staffing levels were improving. The care provided was good. Prisoners were no longer allowed to keep tradable medication in possession, although this policy was being reviewed. Pharmacy and mental health services were good.
- 1.20 Women were still unable to purchase from the shop within 24 hours of arrival but consultation about the goods available had improved.
- 1.21 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

## **Purposeful activity**

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- 1.22 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 19 recommendations in this area, of which nine had been achieved, one partially achieved and eight had not been achieved. One recommendation was no longer applicable. We have made one further recommendation.
- 1.23 The regime still had a negative impact on attendance at education classes. The number of activity places had increased but many opportunities were part time and some were not sufficiently meaningful. This, in addition to the underutilisation of the activity places available, resulted in some women not being fully occupied. The pay system did not incentivise those working a full week.
- 1.24 There was equity in access to activities and the regime for remand and convicted prisoners. Prisoners were given written reasons about outcomes of applications for activities. Use of data had improved.
- 1.25 The breadth of provision in some areas remained limited but those working in the main servery and kitchens were completing relevant qualifications.

- 1.26 The work of peer supporters was not fully recognised by the pay system. Staff had benefited from training to support those with specific learning issues but feedback provided to improve prisoners' progress was limited in some areas. There was some good provision in literacy, numeracy and English for speakers of other languages.
- 1.27 Education staff reported to sentence planning boards and some good targets were set. Computers for distance learning were only available within the education core day. The library service had not moved on since the previous inspection.
- 1.28 Staffing in the gym had further reduced and the range of accredited courses leading to employment remained poor. A healthy living course was now offered.
- 1.29 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

## Resettlement

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- 1.30 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were not sufficiently good. We made 33 recommendations in this area, of which 12 had been achieved, six partially achieved and 14 had not been achieved. One recommendation was no longer applicable. It was notable that, of the three main recommendations made in this area, only one had been partially achieved and two had not been achieved. We have made no further recommendations.
- 1.31 The resettlement strategy remained inadequate and not based on a needs analysis of the population. There were no reducing reoffending pathway action plans, and leadership in this area was inadequate. No resettlement meetings had been run for several months.
- 1.32 The quality of offender assessment system (OASys) assessments was good. All prisoners had an offender supervisor, including remand prisoners.
- 1.33 Most public protection and child protection arrangements appeared reasonable but some information was out of date.
- 1.34 Prisoner needs were assessed on arrival and again pre-release, although we were not assured that all issues were dealt with. There were no custody plans for short-term and remand prisoners.
- 1.35 There were no specialist accommodation services. All prisoners had access to information, advice and guidance workers. Resettlement drug and alcohol services were good.
- 1.36 There was poor coordination of work in the children, families and contact with the outside world pathway. The procedures for inter-prison telephone calls were unclear. The visitors centre was often closed. There had been no visitors' survey, and visits capacity remained inadequate. Mothers still could not have telephone calls from their children but this was mitigated by staff taking a considerate approach. There was no family support worker or parenting course.
- 1.37 A needs analysis had not been completed to identify which offending behaviour programmes were needed or the support required for women who had been abused, raped or subject to domestic violence.

1.38 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient 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)

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- 2.1 **The distinction between the two sides of the prison should be reduced, so that, unless there are overriding security reasons, all women are able to participate in the same activities and regime services. (HP40)**

**Achieved.** Unless there were overriding security reasons or their length of stay was too short for them to complete the qualification successfully, all women had the opportunity to participate in the education and training activities available. The small number of young offenders also had the same opportunities to participate in the full range of activities.

- 2.2 **A first night strategy should be introduced which ensures that the immediate needs and anxieties of newly arrived women are properly identified and addressed before they are locked up for the night. (HP41)**

**Partially achieved.** First night officers interviewed new prisoners using a revised 'passport' questionnaire, based on the resettlement pathways. Some issues identified were addressed during induction, and others subsequently by the offender management unit (OMU). The interview could take place in a variety of locations, including the reception area and the remand unit office, neither of which provided sufficient privacy or a suitable environment in which to engage with new receptions and identify concerns. The passport interview did not focus on immediate needs or include questions about vulnerability, self-harm or any anxieties about being sent to prison. However, reception staff asked questions about substance use, self-harm and welfare issues, and responses were included in handover information. A more appropriate first night room had been developed but was not yet in use. A first night orderly provided good support which included preparing cells and completing a range of compacts with new receptions. These included standards of behaviour, prison rules and details of visitors and telephone contacts which would have been more appropriately completed with staff in private. The orderly took new receptions to their cells.

- 2.3 **All prisoners should have a consistent comprehensive induction beginning the day after reception and completed no longer than two weeks after arrival, subject to the needs of women withdrawing from drugs or alcohol. (HP42)**

**Achieved.** The induction programme had improved and was overseen by the education department. This was a rolling programme which prisoners started within 48 hours of arrival and took place over five days. It included input from a range of departments and peer mentors, and a tour of the prison. Women withdrawing from substances were required to attend but could be absented by health services staff. A record was kept of the induction sessions that prisoners completed, which were overseen by the induction tutor. The dining room on C wing was used for induction, which was unsuitable, but there were reasonably advanced plans to develop former classrooms on the remand unit for this purpose.

- 2.4 **A distinct foreign national policy should be introduced to ensure, in consultation with foreign national women, that all their specific needs are met. Implementation of the**

**policy should be overseen by a senior manager and a dedicated multidisciplinary team. (HP43)**

**Partially achieved.** A foreign nationals policy had been implemented in December 2010, but this had not been based on a needs analysis and was in need of review. Foreign national needs were discussed at equality action team (EAT) meetings but there was no specific consultation with women in this group.

**We repeat the recommendation.**

**2.5 The frequent interruptions to learning should be significantly reduced. (HP44)**

**Not achieved.** Regime activities continued to cause frequent interruptions to learning sessions, for example, to attend appointments and receive medication.

**We repeat the recommendation.**

**2.6 The offender management and reducing reoffending strategy should be informed by an annual needs analysis and should detail how resettlement provision, including interventions, meets the needs of different groups of women. (HP45)**

**Not achieved.** There was a reducing reoffending strategy but it was not known to staff, even in the OMU. Although a limited needs assessment had taken place in 2012, drawing on basic offender assessment system (OASys) data and the results of a prisoner survey, the findings were not clearly reflected in the strategy. Some strategic directions were listed but these were largely aspirational, and there was no evidence of action planning to remedy any perceived gaps in provision. The strategy did not contain any detail on provision for distinct prisoner groups such as young women or those serving indeterminate sentences.

**We repeat the recommendation.**

**2.7 All prisoners, including unconvicted women and those serving sentences less than 12 months, should have their resettlement needs assessed and incorporated into a custody plan which is regularly reviewed. (HP46)**

**Partially achieved.** The 'passport' process (see recommendation 2.2) helped staff to meet prisoners' needs during induction, and facilitated signposting to other services. It was also used to trigger child protection processes as necessary. However, there was no review process for women who did not receive an OASys assessment.

**We repeat the recommendation.**

**2.8 A full review of provision to help women maintain contact with their children and families should be undertaken, particularly for mothers of children under 18, and a clear action plan devised to drive forward progress against this resettlement pathway. (HP47)**

**Not achieved.** We were shown an undated and unattributed document which listed the provision for promoting family contact and made four suggestions for improvement. It was not clear how these suggestions had been generated or if there had been any prisoner consultation, and there was no action plan. The current pathway lead was unaware of the existence of the document (see also recommendation 2.151).

**We repeat the recommendation.**



## Recommendations – safety

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### Courts, escorts and transfers

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2.9 Escort vans should be comfortable. (1.6)

**Achieved.** A new contract for the movement of prisoners around the prison estate had been introduced since the previous inspection and this had included a fleet of new escort vans. We heard no concerns from women about comfort levels. Some we spoke to complained about a lack of comfort breaks and about being escorted with men.

2.10 All relevant information should travel with prisoners. (1.7)

**Achieved.** We found no examples of prisoners arriving without relevant information, and a reception manager told us that this rarely happened.

2.11 Women should not be required to lodge at other prisons en route to Foston Hall. (1.8)

**Achieved.** Occasionally, women had overnight stays at the establishment en route from prisons in the North East to those in the South. We found no evidence that women allocated to Foston Hall had lodged at other prisons before their arrival at the establishment.

2.12 The suitability and individual needs of prisoners transferring to Foston Hall should be assessed before transfer and they should be given at least 24 hours' notice of their move. (1.9)

**Partially achieved.** Many prisoners arriving at the establishment had not been given at least 24 hours' notice of their transfer there. However, most had been appropriately allocated to complete courses. Fewer than at the time of the previous inspection arrived as a result of overcrowding at other establishments.

**We repeat the following part of the recommendation: Prisoners transferring to Foston Hall should be given at least 24 hours' notice of their move.**

### Early days in custody

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2.13 Reception interviews should take place in private. (1.28)

**Not achieved.** The layout of reception had not changed, and there were very limited facilities for private interviews. Staff said that when reception was not busy, interviews could be held in a holding room or a small room used by health services staff. However, many interviews still took place in the main reception area, which did not provide privacy.

**We repeat the recommendation.**

2.14 Reception and first night staff should have the contact details of local social services and emergency duty teams. (1.29)

**Achieved.** Emergency contact numbers for social services and emergency duty teams were displayed in reception. A directory was also held in the OMU.

2.15 Information given to women should be properly and accurately produced and should also be provided in media other than writing. (1.30)

**Not achieved.** The induction booklet given to all new receptions contained some inaccurate information about visits and rules about property. Reception information was not available in video format, although there were plans to produce a DVD. The quality of the photocopies of written material given to new receptions had improved.

**We repeat the recommendation.**

**2.16 Prisoners' resettlement needs should be formally assessed and identified during induction and referrals made to relevant agencies. (1.31)**

**Achieved.** The passport interview (see recommendation 2.2) covered the resettlement pathways and the completed form was forwarded to the OMU. This, in addition to the contributions from a range of agencies during induction which subsequently took referrals, enabled resettlement needs to be identified.

**2.17 Prisoners should be interviewed individually during induction to address any feelings about imprisonment and any self-harm issues. (1.32)**

**Not achieved.** The induction programme did not include a private interview to ask women about feelings of self-harm.

**We repeat the recommendation.**

**2.18 Staff should receive training in interview skills. (1.33)**

**Not achieved.** Five officers had completed training in reception procedures but this did not focus specifically on interview skills.

### **Bullying and violence reduction**

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**2.19 A member of the senior management team should routinely chair the safer custody meeting. (3.13)**

**Achieved.** This meeting was now routinely chaired by the head of residence, who was a member of the senior management team.

**2.20 Findings from exit surveys relating to prisoners' experiences of bullying should be routinely collated and analysed. (3.14)**

**Achieved.** The outcomes of exit surveys were analysed each month at the safer custody meeting to identify any trends, but levels of violence appeared to be low. However, only around 50% of women being discharged completed the voluntary exit survey.

**2.21 Non-accidental injuries should be reported and investigated and outcomes included in the monthly safer custody report. (3.15)**

**Not achieved.** There had been only one report of a non-accidental injury over the previous year. The safer custody manager agreed that such a low incidence suggested under-reporting. The need to report such incidents had been brought to the attention of staff.

**We repeat the recommendation.**

**2.22 Prisoners should be involved in discussions to develop strategies to help identify and defuse potential problems that arise from personal relationships and community living. (3.16)**

**Partially achieved.** Listeners and prisoner violence reduction representatives met the safer custody team regularly, and representatives also attended the safer custody meeting, which provided the opportunity to discuss emerging tensions. There was little evidence of wing staff proactively addressing relationship difficulties through unit meetings to defuse potential problems.

- 2.23 **If women are placed on the formal violence and anti-social behaviour strategy, review boards should be convened to set targets, review progress and monitor any sanctions imposed to avoid unofficial punishments. (3.17)**

**Not achieved.** Decisions on the progress of women placed on the anti-social behaviour strategy were overseen by a good weekly multidisciplinary safeguarding committee. There were regular entries that evidenced monitoring of those placed on the violence reduction strategy. They often included routine observational comments and there was little evidence of direct engagement with individual prisoners about relevant targets or challenges to their behaviour.

**We repeat the recommendation.**

- 2.24 **An accurate central log should be maintained of all investigations under the violence and anti-social behaviour strategy and their outcomes. (3.18)**

**Achieved.** A central electronic log was kept which identified women who had been involved in investigations, either as perpetrators or victims. This also included outcomes and dates, and relevant information was sent to other departments.

- 2.25 **All staff in contact with prisoners should receive training in the violence and anti-social behaviour strategy. (3.19)**

**Not achieved.** An aide mémoire about the completion of violence reduction paperwork had been circulated to all staff but there had been no training in the strategy. Concerns had been expressed by the Prisons and Probation Ombudsman about staff's knowledge of the violence reduction strategy following the investigation of the most recent self-inflicted death.

**We repeat the recommendation.**

### **Self-harm and suicide prevention**

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- 2.26 **The suicide prevention policy document should be reviewed to ensure it includes all relevant areas, including procedures for the use of closed-circuit television in monitoring women at risk and appropriate staffing of constant watches. (3.35)**

**Partially achieved.** The suicide prevention policy had recently been reviewed (August 2012) but still did not include all relevant areas, such as the need to learn from investigations of serious near-fatal incidents. There was no reference to the role that families could potentially play in support plans. Some reference was made to the use of closed-circuit television when monitoring women at risk of self-harm and there was a separate, comprehensive, but undated document on the management of women subject to 'constant observation'.

**We repeat the following part of the recommendation: The suicide prevention policy document should be reviewed to ensure that it includes all relevant areas.**

- 2.27 **Women at risk of self-harm should not be transferred to other prisons without a clear assessment and agreement that this is appropriate. (3.36)**

**Not achieved.** During the inspection, a woman arrived at the establishment from HMP

Eastwood Park via a Birmingham Court. She was considered to be at high risk of self-harm and was subject to an open assessment, care in custody and teamwork (ACCT) self-harm monitoring document. She was facing a serious charge and was on medication. There had been no prior contact from Eastwood Park. Only on being alerted by the escort contractor was Foston Hall able to contact the sending prison to ask for relevant information.  
**We repeat the recommendation.**

- 2.28 **Assessment, care in custody and teamwork procedures should be improved and include more consistent case management and involve a range of disciplines. (3.37)**

**Not achieved.** We reviewed a small sample of ACCT documents. Few involved any staff other than officers. Some reviews were attended by only a senior officer and the prisoner. Most did not have a consistent case manager.

**We repeat the recommendation.**

- 2.29 **The range of telephone help lines should be publicised and all should be available free of charge. (3.38)**

**Not achieved.** Telephone help lines were not advertised on all the wings and not all were free.  
**We repeat the recommendation.**

- 2.30 **All staff should receive refresher training in assessment, care in custody and teamwork procedures. (3.39)**

**Not achieved.** Around 30% of officers and 40% of all staff had not received refresher training in the previous three years.

**We repeat the recommendation.**

## **Security**

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- 2.31 **Security risk assessments for activity allocation should be based on clear criteria, specific to the activity and to the individual woman. (7.14)**

**Not achieved.** The work allocation risk assessment process was not sufficiently individualised. Women were restricted to activities suitable to their assessed risk, with no consideration of individual circumstances.

**We repeat the recommendation.**

- 2.32 **The criteria to place women on closed visits should be unambiguous, proportional to risk and linked directly to inappropriate actions or strong security intelligence associated with visiting arrangements. (7.15)**

**Achieved.** At the time of the inspection two women were subject to closed visits, which had been applied only in conjunction with supporting security intelligence evidence associated with visiting arrangements.

- 2.33 **All strip-searches should be logged and monitored by senior managers. (7.16)**

**Not achieved.** Strip-searches were only carried out if intelligence indicated the need, but they were logged in numerous areas, including the reception diary, on the wings and in visits documentation, and were not collated centrally or monitored by senior managers.

**We repeat the recommendation.**

## **Incentives and earned privileges**

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- 2.34 **The points-based incentives and earned privileges system should be abandoned in favour of a system more suited to adult women. (7.53)**

**Achieved.** The previous points-based approach had been abandoned in favour of a more conventional scheme where progression and regression were based on an assessment of behaviour by staff over a period of time. Warnings were issued for poor behaviour and three could result in prisoners being moved down one level of the scheme; consistent positive behaviour could result in progressive moves. There was a comprehensive incentives and earned privileges (IEP) policy.

- 2.35 **Each woman's progression or regression between levels should be based on patterns of behaviour over time and take into account clearly defined criteria applied by staff and evidenced by entries in wing files. (7.54)**

**Achieved.** Electronic case notes showed that the IEP scheme was applied in accordance with the written policy document. The number of prisoners on the enhanced level of the scheme had increased since the previous inspection, from 27% to 36% of the population, but this still seemed relatively low for a stable and well-controlled prison. Some prisoners complained that staff were inconsistent in using their discretion to decide on progressive moves on the scheme and this was not effectively monitored across the prison to ensure fairness (see also recommendations 2.34 and 2.37).

- 2.36 **Loss of the facility to eat out of cell and loss of association should not be incurred without following formal disciplinary procedures. (7.55)**

**Achieved.** The points-based warning system which could result in immediate loss of evening association was no longer operating.

- 2.37 **Data relating to the incentives and earned privileges scheme should be collated and regularly reviewed to identify and, if necessary, address emerging patterns and trends and ensure fairness. (7.56)**

**Not achieved.** There was no prison-wide analysis of the IEP scheme to ensure that staff discretionary decision making was consistent and that there was no adverse impact for particular groups of prisoners (see recommendation 2.35).

## **Disciplinary procedures**

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- 2.38 **The adjudication standardisation meeting should monitor a wide enough range of data to detect emerging patterns and trends. (7.36)**

**Achieved.** Adjudication standardisation meetings monitored sufficient data to identify emerging patterns and trends.

- 2.39 **The high number of adjudications dismissed or not proceeded with should be analysed and appropriate action taken. (7.37)**

**Achieved.** The number of adjudications dismissed or not proceeded with had reduced considerably, from 44% to 18%, and was monitored at adjudication standardisation meetings.

2.40 **Adjudications should be conducted in a suitable, less intimidating environment. (7.38)**

**Partially achieved.** Although some adjudicators chose to use the association area in D wing, some continued to use the small, cramped room on the reflection (segregation) unit.

2.41 **Enquiries into all disciplinary charges should be sufficiently detailed to ensure fair outcomes for all prisoners involved. (7.39)**

**Achieved.** Enquiries into disciplinary charges appeared generally reasonable.

### **The use of force**

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2.42 **Force should be used only if necessary and not solely to gain a woman's compliance. (7.40)**

**Achieved.** Force was used only when necessary and not to gain compliance.

2.43 **Senior managers should monitor data on use of force to identify any trends and carry out regular quality assurance checks of the records to satisfy themselves that all force used is justified. (7.41)**

**Achieved.** There had been 77 uses of force in the year to date, which was comparable to the levels in 2010 and 2011. All such incidents were quality checked by a senior officer and monitored at quarterly use of force meetings.

### **Segregation**

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2.44 **The segregation unit should not be used as a place of respite. (7.42)**

**Not achieved.** Some women with mental health issues spent time in segregation because of difficulties in living on ordinary location. Although staff were caring and supportive, the environment was not designed to provide respite care and there was no suitable alternative. **We repeat the recommendation.**

2.45 **Care plans should be implemented for all women held in the segregation unit for more than 14 days and these should be reviewed and updated regularly. (7.43)**

**Achieved.** Care plans were in place for women held for more than 14 days; these were thorough and reviewed regularly.

2.46 **Comprehensive history sheet records should be maintained for all women held in the segregation unit, with daily entries from segregation unit staff and visitors that record interaction and comment on the women's well being. (7.44)**

**Partially achieved.** History sheets for women held in segregation, either on the reflection unit or in cellular confinement on the wings, required a written comment every hour. Comments were frequent but most of those we sampled showed little meaningful interaction – for example, simply stating 'states OK' or 'no issues'.

**We repeat the following part of the recommendation:** History sheet records for women held in the segregation unit should record interaction and comment on the women's well-being.

## **Substance misuse**

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- 2.47 The prison and the health services provider should ensure that women receive first night medication promptly. (3.72)

**Achieved.** First night prescribing was well managed and the on-call facility was used regularly to ensure that patients were seen and treated promptly.

- 2.48 The prison should provide a more suitable environment for women who attend the health services department for methadone administration. (3.73)

**Partially achieved.** The provider Trust had funded considerable changes to the waiting facilities in the health care centre and on the remand wing. The work was due to be completed by April 2013 and would provide a much more suitable environment.

- 2.49 Target testing should be conducted appropriately and effectively. (3.74)

**Achieved.** Target testing was much improved and was more effective, in terms of timeliness and results.

- 2.50 Drug testing figures should be monitored by location to provide effective management information. (3.75)

**Achieved.** The data for drug testing were analysed by wing and discussed at the monthly strategy meetings.

## **Recommendations – respect**

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### **Residential units**

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- 2.51 D wing should be refurbished and the number of women held there reduced. (2.13)

**Not achieved.** Units generally looked clean and tidy but D wing had not been refurbished or the population reduced.

**We repeat the recommendation.**

- 2.52 Prisoners on E wing should be given the opportunity to cook for themselves. (2.14)

**Not achieved.** Women on E wing could still not fully self-cater. Enhanced prisoners living on T wing (previously the Toscana girls unit) were similarly unable to self-cater fully.

**We repeat the recommendation.**

- 2.53 Prisoners should have better access to hot water to make drinks. (2.15)

**Not achieved.** Most prisoners did not have kettles in their rooms and continued to rely on inefficient flasks.

**We repeat the recommendation.**

- 2.54 Toasters and microwaves should be provided on the wings for use during association. (2.16)

**Not achieved.** Only enhanced women on E and T wings had access to toasters and microwaves during association.

**2.55 Managers should monitor response times and quality of replies to applications. (3.46)**

**Not achieved.** There was no management monitoring of response times or quality of replies to applications.

**We repeat the recommendation.**

**Staff–prisoner relationships**

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**2.56 A prisoner forum or council should be established to allow women to raise issues of concern in a formal and constructive way. (2.22)**

**Achieved.** Wing prisoner representatives attended monthly prisoner council meetings. Minutes showed that action was often taken in response to issues raised.

**2.57 Guidance for personal officers should include the need to get to know women’s personal circumstances with a specific aim of helping maintain links with children and families. (2.29)**

**Achieved.** Guidance in the personal officer policy included the need for officers to know prisoners’ personal circumstances, ‘be open to contact with families’ and encourage prisoners to maintain contact with their next of kin.

**2.58 Senior officers should ensure that all personal officers make regular, good quality entries in wing files, which should cover progress with sentence plans, resettlement issues and any relevant family matters. (2.30)**

**Partially achieved.** Comments by officers on electronic case notes were monitored by managers. They reflected good levels of interaction and support with family issues, but there was little evidence that women were supported with resettlement issues or that officers were aware of women’s sentence planning targets.

**We repeat the recommendation.**

**2.59 Personal officers should attend sentence planning boards and reviews. (2.31)**

**Partially achieved.** Personal officers attended sentence planning boards and reviews when possible but this was often prevented by operational requirements.

**Equality and diversity**

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**2.60 The diversity policy for prisoners should include sexuality, disability and age. (4.5)**

**Achieved.** The diversity policy had been reviewed and included sexuality, disability and age.

**2.61 Racist incident report forms should be scrutinised by an external body and feedback provided to the diversity and race equality action team. (4.14)**

**Not achieved.** Discrimination incident report forms were discussed at EAT meetings but there was no external scrutiny of them.

**We repeat the recommendation.**



- 2.62 **Racist incidents that involve abusive derogatory name calling should be dealt with through prison disciplinary procedures unless there are mitigating mental health factors. (4.15)**
- Achieved.** Women were placed on report for incidents involving derogatory name calling.
- 2.63 **There should be regular events to promote racial and cultural diversity. (4.16)**
- Achieved.** Several events had been held since January 2012, including special meals, and faith-based festivals in the chapel and education department.
- 2.64 **Interventions to challenge racist bullying and protect the victims of racist bullying should be put in place, with mediation used in appropriate cases. (4.17)**
- Partially achieved.** There were no specific interventions to deal with racist behaviour. Perpetrators of racist bullying were placed on the local violence and anti-social behaviour procedures (VAS). The weekly multidisciplinary safeguarding team discussed the progress of women subject to VAS, and cell sharing risk assessments were reviewed. Mediation was used appropriately. Victim needs were assessed on a case-by-case basis.
- 2.65 **The prison should maintain a list of those involved in racist incidents, which should be shared with key staff. (4.18)**
- Achieved.** The safeguarding team maintained a list of prisoners who had been involved in racist incidents. Cases were discussed at the weekly safeguarding meetings, and the minutes were published for staff.
- 2.66 **Discussions should take place with Muslim prisoners about their perceptions of victimisation by staff. (4.22)**
- Partially achieved.** The Muslim chaplain provided forums for Muslim women to raise any concerns, but there had been no specific consultation with this group about victimisation.
- 2.67 **A trained foreign national liaison officer directly accessible to prisoners should be appointed. (4.33)**
- Achieved.** There was a foreign national liaison officer, who had completed diversity training. She had recently started attending prisoner induction sessions, to talk to foreign national prisoners.
- 2.68 **Staff should receive awareness training about the needs of foreign national prisoners. (4.34)**
- Not achieved.** There had been no foreign national prisoner awareness training for staff. **We repeat the recommendation.**
- 2.69 **Forums for all foreign national women should be held to focus on their distinct needs. (4.35)**
- Not achieved.** There were no distinct forums for foreign national women. **We repeat the recommendation.**

- 2.70 **The remit of the designated foreign national prisoner representative should be expanded and she should be given full access to the areas where women are located and opportunity to use translation services to support foreign national women and feed back concerns to managers. (4.36)**

**Partially achieved.** There was a prisoner foreign national representative, who was allowed access to all parts of the prison. She did not have access to translation services but tried to link women with others who spoke their language. She attended the establishment EAT meeting.

- 2.71 **All foreign national women should have their language needs assessed. Those who require interpreting services should have this noted on the wing files and staff should use telephone interpreting services whenever necessary. (4.37)**

**Partially achieved.** Foreign national prisoners were asked in reception about their ability to speak and understand English. In spite of this, some told us of their frustration that staff did not routinely use translation services. Many had experienced problems in understanding induction information, which was only given verbally, and in English. However, staff in the OMU, at adjudications and in the health care department routinely arranged translation services. **We repeat the following part of the recommendation: Staff should use telephone interpreting services whenever necessary.**

- 2.72 **Official letters about immigration status and deportation should be provided in a language the prisoner understands. (4.38)**

**Achieved.** Staff in the OMU interviewed women to assess their understanding of spoken and written English, before giving them letters about their immigration status and deportation. Telephone translation services had been used for such women, and in one recent case a letter had been sent for translation.

- 2.73 **All foreign national prisoners with immediate family living overseas should receive at least one free international telephone call a month, regardless of whether they have received a social visit. (4.39)**

**Not achieved.** Only nine of the 22 foreign national prisoners being held received a free monthly five-minute telephone call. The remainder had not been allowed these telephone calls because they received domestic visits. **We repeat the recommendation.**

- 2.74 **Women prisoners should be able to receive independent legal advice on immigration matters. (4.40)**

**Not achieved.** Foreign national prisoners were not aware of any provision for independent legal advice on immigration matters. Staff were generally unaware of the need for foreign national prisoners to have access to independent legal advice on immigration matters. **We repeat the recommendation.**

- 2.75 **Regular consultation forums for women with disabilities should be held. (4.50)**

**Not achieved.** There were no forums for women who considered themselves to have a disability. **We repeat the recommendation.**

- 2.76 **Women with disabilities should have an individualised and multidisciplinary care plan into which they have had an input. (4.51)**

**Partially achieved.** Assessments had been carried out by the disability liaison officer (DLO), to identify the needs of women who had declared disabilities. Plans detailed the reasonable adjustments that had been made but did not outline the practical support that might have been needed; this was acknowledged by the DLO.

**We repeat the recommendation.**

- 2.77 **Equality of treatment should be monitored through the diversity and race equality action team and analysed by disability, and appropriate action taken to rectify any inequalities. (4.52)**

**Not achieved.** The first EAT meeting in 2012 had taken place in September. The number of prisoners with a disability was collected but there was no other monitoring of disability.

**We repeat the recommendation.**

- 2.78 **The draft buddy scheme should be fully implemented and include suitable training and rewards. (4.53)**

**Partially achieved.** A 'buddy' scheme had been implemented but formal training was not yet in place, and prisoners worked on a voluntary basis.

**We repeat the following part of the recommendation: The buddy scheme should include suitable training and rewards.**

- 2.79 **The action plan for older prisoners should be implemented. (4.57)**

**Not achieved.** There was only one action point for older prisoners on the equalities action plan. There was no older prisoner champion, and services for older prisoners were underdeveloped.

**We repeat the recommendation.**

- 2.80 **The prison should introduce an action plan to support and meet the needs of women who are gay or bisexual, including referral to external networks. (4.61)**

**Not achieved.** There were no support groups available to meet the needs of women who were gay or bisexual. There was no appointed staff champion, and work with this group of women was underdeveloped.

**We repeat the recommendation.**

## **Complaints**

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- 2.81 **The subject matter of complaints should be tracked over time to monitor progress and highlight any emerging problems. (3.47)**

**Achieved.** The subject matter of complaints was tracked over time and issues were discussed at senior management team meetings. All complaints were quality assessed each month by the performance manager and overseen by the governor or deputy governor. Action taken in response to identified shortfalls was recorded. A serious allegation against a member of staff had been dealt with through the violence reduction process rather than as a complaint. The investigation had been carried out by a senior officer, which was inappropriate for such a matter.

## Further recommendation

- 2.82 All allegations about staff misconduct should be referred to, and investigated by, a senior manager.

## Health services

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- 2.83 **Health care information should be available in languages appropriate to the prison population. (5.50)**

**Achieved.** Health care information in reception and in the health care waiting areas included guidance about access to services, in a range of languages. Data were also available via the Trust intranet in languages other than English when required.

- 2.84 **Health care reception screening interviews should be carried out in an appropriate and confidential environment. (5.51)**

**Not achieved.** The room designated for the initial health care reception screening was very small, did not provide sufficient levels of privacy and remained unfit for purpose.

**We repeat the recommendation.**

- 2.85 **All vacant nursing posts should be filled quickly. (5.52)**

**Achieved.** Following the previous inspection the vacant nursing posts had been filled. Subsequent to further changes in the health care provider contract, a number of new vacancies had been created. At the time of the inspection there remained four unfilled vacancies and the provider had employed a consultant to manage recruiting issues.

- 2.86 **A representative patient forum should be established. (5.53)**

**Not achieved.** Prisoners had access to a general forum in which health care was an agenda item but they had no access to a dedicated health care forum and there were no health care representatives on the wings.

**We repeat the recommendation.**

- 2.87 **Barrier protection should be made freely available. (5.54)**

**Not achieved.** Apart from issuing dental dams on release, there was no opportunity for prisoners to be provided with barrier protection during their time in the prison.

**We repeat the recommendation.**

- 2.88 **Day care facilities should be established for women who need therapeutic support for emotional, behavioural and mental health problems. (5.55)**

**Partially achieved.** Prisoners had access to a range of therapeutic support based on individual needs, including art therapies and healthy fitness programmes via the gym. Funding had been awarded for the development of new day care facilities, to be constructed by the end of 2013.

- 2.89 **Care should be taken to make full and complete records of administration of medicines. This should include records of all occasions where the patient refuses medication or**

**fails to attend and issues relating to drug compliance should be followed up where appropriate. (5.56)**

**Achieved.** Full and complete records of medicine administration were maintained and a new matrix of data collected assisted in the identification of patients who had not received their medication. Pharmacy technicians followed up patients who had failed to attend or had not been compliant with their course of medicines.

**2.90 The medicines and therapeutics committee should review the use of general stock, with named patient medication used wherever possible. (5.57)**

**Achieved.** The practice meeting was held monthly, and prescribing regimes and the formulary were standing items on the agenda. At the time of the inspection, general stock was being reviewed in readiness for the change of location of the pharmacy that was due to be completed by April 2013.

**2.91 The pharmacist should be supported to develop pharmacy-led clinics and medicine use reviews. (5.58)**

**Achieved.** The pharmacist visited the prison each week and was available to provide clinics for prisoners and carry out medicine use reviews.

**2.92 Appropriate waiting facilities should be provided for patients waiting for medicine administration. (5.59)**

**Partially achieved.** The provider Trust had funded significant changes to the waiting facilities in the health care centre and on the remand wing. The work was due to be completed by April 2013 and would provide patients with much more acceptable waiting areas inside the buildings.

**2.93 Subject to risk assessment, where possible in-possession medication should be supplied for 28 rather than seven days. (5.60)**

**Partially achieved.** This recommendation had been achieved but events occurring one month before the inspection regarding the sharing and trading of medication had resulted in all medications being observed rather than in-possession. A new risk assessment policy was being progressed before the resumption of the administration of medicines in-possession.

**2.94 The controlled drugs register for schedule two drugs should comply with current legislation. (5.61)**

**Achieved.** Registers for schedule two controlled drugs complied with current legislation.

**2.95 A system should be introduced to audit stock usage against medication supplied. (5.62)**

**Achieved.** A system had been introduced to audit stock usage. This was carried out by the pharmacist.

**2.96 The medicines and therapeutics committee should ensure that prescribing data are used to demonstrate value for money and to promote effective medicines management. (5.63)**

**Achieved.** Reports were provided regularly by a community pharmacist, were reviewed at the practice meeting and demonstrated value for money.

**2.97 Patients with mental health needs should be held in the segregation unit only in exceptional circumstances. (5.64)**

**Achieved.** Two safer custody rooms had been created at the end of the reflection unit, enabling patients with mental health needs to be cared for in more appropriate conditions. All were seen regularly by mental health nurses, and patients were only segregated in exceptional circumstances.

**2.98 The dental suite should be equipped with an amalgam separator and washer/disinfector. (5.65)**

**Achieved.** All equipment in the dental suite was well maintained and included a new dental chair, amalgam separator and washer/disinfector.

**2.99 Prisoners should have access to an appropriate dental waiting area that provides information and seating and maintains privacy for those receiving treatment. (5.66)**

**Partially achieved.** The provider Trust had funded the construction of a new area attached to the dental suite, for use as a dirty utility. This allowed reorganisation of the suite, to include a new waiting area. At the same time, a new waiting area was to be created, attached to the suite. The work was due to be completed in April 2013.

**2.100 Measures should be taken to reduce the length of waiting time for routine dental treatment. (5.67)**

**Achieved.** The waiting time for routine dental treatment had significantly improved. At the time of the inspection there were only 23 patients waiting to be seen, with the longest wait being three weeks.

**2.101 Transfers to secure mental health units should be managed expeditiously. (5.68)**

**Achieved.** During the six months before the inspection, four patients had been transferred to secure mental health units. Waiting times from referral to transfer were much quicker than at the time of the previous inspection and relationships with outside units were generally good.

## **Purchases**

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**2.102 Women should be able to make a shop purchase within 24 hours of arrival and advanced funds of up to one week's pay if necessary. (8.10)**

**Not achieved.** Women were unable to purchase from the shop within 24 hours of arrival and did not receive any advanced pay.  
**We repeat the recommendation.**

**2.103 Black and minority ethnic women should be separately consulted about what goods should be added to the shop list to meet their specific needs. (8.11)**

**Achieved.** Shop provision was a standing agenda item at monthly prisoner council meetings, attended by prisoner wing representatives. Black and minority ethnic women were not separately consulted but were represented at meetings by the diversity and foreign national

representative. Representatives also had the opportunity to change items available in the shop at quarterly 'additional and deletions' meetings.

**2.104 Surveys should be conducted every quarter to determine what items should be added to the shop list. (8.12)**

**Achieved.** An annual survey took place and wing representatives were able to comment on shop issues through regular meetings (see recommendation 2.103).

## **Recommendations – purposeful activity**

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### **Learning and skills and work activities**

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**2.105 More use should be made of appropriately qualified prisoners to provide peer support and rewards for peer supporters improved. (6.33)**

**Not achieved.** Use was made of peer workers to support other prisoners but the pay policy had not yet addressed the need to recognise or reward prisoners in positions of responsibility such as mentors, advisers and internal verifiers.

**We repeat the recommendation.**

**2.106 The links between learning plans and sentence/resettlement plans should be improved. (6.34)**

**Achieved.** Education staff attended sentence planning boards or sent a report on the learner's educational progress for consideration by the board. Most sentence plans listed educational targets that informed the prisoner's learning and skills activity choices.

**2.107 Staff working in learning and skills areas should be trained to gain skills and knowledge about how to reinforce equality and diversity topics and better support prisoners with dyslexia and English for speakers of other languages needs. (6.35)**

**Achieved.** Education staff had benefited from a range of training to increase their understanding and enable them to identify and support effectively women with learning difficulties and/or disabilities and those for whom English was not their first language.

**2.108 The analysis and use of the wide range of data should be improved to inform the development of learning and skills. (6.36)**

**Achieved.** A wide range of data was routinely shared by the education contractor with the prison. Data were used to inform curriculum planning and to set overall and course improvement targets.

**2.109 There should be sufficient activity places for the operational capacity of the prison. (6.37)**

**Not achieved.** The number of activity places had increased slightly since the previous inspection, but so had the population and many of the places available were part time or provided low quality work. However, of the 282 activity places, only 73% were being used. Women could attend up to five education sessions a week and be allocated work for the remaining time but many chose to do either education or work, not both. Too few women had a full timetable of activities to occupy them fully during the core day and to help them develop a

good work ethic.  
We repeat the recommendation.

- 2.110 **Women should be given written reasons why their applications to education, training and work have been unsuccessful. (6.38)**

**Achieved.** Women applying for vocational training and work were given written responses detailing the outcome of their applications.

- 2.111 **The number of women achieving qualifications from work in the gardens should be increased. (6.39)**

**Not achieved.** Too few women undertook horticulture qualifications.  
We repeat the recommendation.

- 2.112 **Prisoners working in the main prison kitchen and the serveries should take qualifications relating to the skills they use at work. (6.40)**

**Achieved.** All women took a level 2 food safety and a level 1 health and safety at work qualification as part of their induction during their first two weeks at the prison. Those working in the prison kitchen could take a level 1 accredited catering qualification.

- 2.113 **All prisoners working in the kitchens and serveries should have basic food hygiene awards. (6.41)**

**Achieved.** See recommendation 2.112.

- 2.114 **The monitoring of prisoners' progress on education courses and the detail of feedback on their work should be improved. (6.42)**

**Partially achieved.** Prisoners' progress in class was monitored and recorded. Some tutors corrected learners' spelling and grammatical errors, helping them to improve their English skills. In art classes, the teacher gave helpful written feedback on how learners could progress their skills, but in other subject areas tutors did not provide prisoners with detailed information on how they could improve.

- 2.115 **The take-up of literacy, numeracy and English for speakers of other languages support by prisoners with abilities assessed at below level 1 should be monitored. (6.43)**

**Achieved.** At induction, literacy and numeracy skill levels were assessed and those with skills below level 2 were encouraged to attend education classes. Education staff routinely recorded and reviewed assessment scores and managed the curriculum appropriately to ensure that there were sufficient courses to meet need.

- 2.116 **Prisoners on distance learning courses should have study facilities with access to computers in the evenings and at weekends. (6.44)**

**Not achieved.** No additional study facilities had been provided in the evenings or at weekends to support those on distance learning courses. However, they were allowed access to the virtual campus computer facilities for one session during the day each week, and those who attended education classes were allowed to use the computer facilities to type up their work.  
We repeat the recommendation.



## **Library**

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- 2.117 The library should provide some evening and weekend sessions. (6.45)

**Not achieved.** The opening hours of the library had not been extended. However, the library had recruited more staff and planned to open the facilities on a Saturday morning.  
**We repeat the recommendation.**

## **Physical education and health promotion**

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- 2.118 The number of PE staff should be increased. (6.51)

**Not achieved.** Since the previous inspection, staffing levels had further decreased from three to two PE staff; this severely limited the opportunity to offer accredited courses, as recreational gym took priority.

- 2.119 Accredited courses that lead to employment should be re-introduced. (6.52)

**Not achieved.** Achievement rates of existing qualifications had improved but the range of accredited courses that lead to employment remained poor.  
**We repeat the recommendation.**

- 2.120 PE, fitness and healthy lifestyle activities should be better promoted to increase participation. (6.53)

**Achieved.** PE and education staff jointly delivered a healthy living course. PE activities were advertised on accommodation units. Specific sessions were available for women who had been referred by the substance misuse team and for those with mental health issues.

- 2.121 The PE activities offered in the evening should be published in advance. (6.54)

**No longer relevant.** As a result of limited staffing, no evening sessions were run.

## **Recommendations – resettlement**

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### **Strategic management of resettlement**

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- 2.122 All representatives should attend the offender management and resettlement liaison committee meetings and progress against each pathway should be reviewed at each meeting. (9.11)

**Not achieved.** The offender management and resettlement liaison committee had not met since March 2012. Attendance up to that point had not regularly included a representative from the residential function. There were no reducing reoffending pathway action plans.  
**We repeat the recommendation.**

- 2.123 The prison should involve voluntary and community sector groups providing services to prisoners in periodic meetings to inform them of the reducing reoffending strategy and their contribution towards its development. (9.12)

**Not achieved.** Guest speakers from voluntary and community sector groups had sometimes attended the resettlement liaison committee meeting. However, this process was primarily intended as a briefing for other staff rather than as a routine opportunity for voluntary and community sector groups to contribute to the reducing reoffending strategy.  
**We repeat the recommendation.**

**2.124 Analysis from sources such as OASys reviews and first night interviews should be used to inform resettlement services. (9.13)**

**Partially achieved.** Some basic OASys information had been used to produce a needs analysis in March 2012, but data collected during first night interviews had not been included.  
**We repeat the recommendation.**

### **Offender management and planning**

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**2.125 Sentence plans should contain outcome-focused objectives. (9.39)**

**Achieved.** Most sentence planning objectives were outcome focused.

**2.126 A quality assurance system should be introduced to monitor the quality of sentence planning assessments. (9.40)**

**Achieved.** The standard National Offender Management Service (NOMS) quality assurance process was in regular use.

**2.127 Offender managers should be better engaged and involved with prisoners in line with the required expectations. (9.41)**

**Partially achieved.** Levels of attendance by offender managers at sentence planning boards were still low. However, staff in the OMU promoted communication by routinely providing offender managers with a note of each meeting with the prisoner, briefing them on the telephone about key or urgent matters, and arranging video-link or telephone conferences.  
**We repeat the recommendation.**

**2.128 All prisoners should meet their offender supervisor regularly to monitor and review sentence plans. (9.42)**

**Achieved.** All prisoners had an offender supervisor and the frequency of contact with them, including for prisoners on remand, was impressive. Even lower risk prisoners were generally seen bimonthly.

**2.129 Offender management unit staff should receive training in child safeguarding issues. (9.43)**

**Achieved.** All the offender supervisors were probation staff, and received regular training in child safeguarding matters.

**2.130 The quality of risk of harm assessments and risk management plans should be improved. (9.44)**

**Achieved.** The risk of harm assessments and risk management plans in our sample were of an acceptable standard.

**2.131 Risk of harm assessments and risk management plans should be integrated into sentence plans. (9.45)**

**Achieved.** In our sample of sentence planning assessments, actions identified in risk management plans were reflected in the sentence planning objectives.

**2.132 Public protection work with women identified as high risk of harm should be effectively managed. (9.46)**

**Not achieved.** A weekly list of women subject to public protection restrictions was circulated and available both to visits staff and in the correspondence unit. However, the list in the correspondence office was one week out of date, although staff spoke confidently about how it should be used. In visits, the list was up to date but other information available was out of date and staff had a limited understanding of the information provided, relying on a system of red dots. This system was unknown to managers and conflicted with the information on the weekly list. There was no longer any case supervision of high and very high risk of harm cases. **We repeat the recommendation.**

### **Reintegration planning**

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**2.133 Accommodation and finance services should be well advertised on the wings and promoted to women. (9.61)**

**Partially achieved.** The services which existed were reasonably well advertised to prisoners (however, see recommendation 2.134).

**2.134 The accommodation pathway should be effectively led and pathway meetings introduced to monitor and develop services. (9.62)**

**Not achieved.** The identity of the accommodation pathway lead was unclear. There was no longer any dedicated resource to help women to find accommodation at the end of their sentence, although the process for managing tenancies and benefits on their arrival at the establishment seemed robust. Previously existing resources had been lost, and, although Citizens Advice provided some information on accommodation providers, they did not have clear responsibility for this work. We were told that accommodation on release was now the responsibility of the OMU team, but these staff did not feel that they had the resources to meet the level of need.

**We repeat the recommendation.**

**2.135 Remanded women should be able to receive support from information, advice and guidance workers. (9.63)**

**Achieved.** Women on remand received the same service from the National Careers Service staff as those who were sentenced.

**2.136 The life skills course recruitment should ensure that prisoners most in need of the skills it offers are targeted and the aims of the course are clear to the prisoners to encourage full attendance. (9.64)**

**No longer relevant.** This course was no longer offered.

**2.137 A pre-release course should be provided for all women before discharge. (9.65)**

**Achieved.** Women who were reaching the end of their sentence were targeted for the pre-release course. Four sessions, run over four weeks, included topics of presenting personal information, interview preparation, financial capability and forming relationships. In addition, Jobcentre Plus provided support for job search through the virtual campus, which was well used in the prison. National Careers Service staff also supported job search and interview preparation.

**2.138 The information, advice and guidance services should be better promoted to ensure prisoners are more aware of relevant education, training and employment opportunities available to them. (9.66)**

**Achieved.** All women had an introduction to the National Careers Service staff and the service they offered during their prison induction, and all received an offer of an individual interview to discuss their opportunities to improve their education and skill level during their time in custody.

**2.139 Pathway meetings should be held to coordinate the work of the different individuals and agencies providing support and advice on finance, benefit and debt. (9.67)**

**Not achieved.** There were no pathway meetings, and the identity of the finance, benefit and debt pathway lead was unclear.

**We repeat the recommendation.**

**2.140 The drug strategy policy should include alcohol services and be informed by a comprehensive needs assessment. (9.78)**

**Achieved.** A needs assessment had been carried out to inform the drug strategy policy. The policy had been updated at least annually and included the more recent development of alcohol services.

**2.141 Women should have access to accredited drug and alcohol treatment programmes. (9.79)**

**Achieved.** Substance misuse services were provided by Phoenix Futures, with a range of drug and alcohol programmes built into the service provision. All target groups were included, including prisoners on remand.

**2.142 The frequency of compact-based drug testing should be determined by individual risk assessments. (9.80)**

**Achieved.** All compact-based drug testing was determined by individual risk assessment and focused on the resettlement outcomes for prisoners.

**2.143 A visitors' centre should be provided. (9.98)**

**Not achieved.** Although a pleasant facility existed, it was regularly closed. In the eight weeks preceding the inspection, it had been closed on at least 17 occasions, 15 of which had been at weekends. It was staffed by prisoners from HMP Sudbury, who were welcoming, but they found it difficult to communicate with the prison and were often short of supplies, such as toilet paper and milk, to make drinks for visitors. We were told that the television in the centre had been out of order for several months, despite their requests for it to be replaced. The visits booking line was open for only two hours a day and was often unobtainable.

**We repeat the recommendation.**

- 2.144 **Women should be encouraged and helped to maintain telephone contact with partners and family members in other establishments. The procedures for inter-prison telephone calls should be clarified and widely advertised. (9.99)**

**Partially achieved.** A policy on inter-prison telephone calls, dating from 2009, was available on the wings. It stated that calls could be given every four weeks but, in practice, calls were allowed only every eight weeks. There was evidence of successful applications, but prisoners told us that they had often spent most of their credit before they got through to their family member because switchboard procedures took too long at receiving prisons. However, prisoners could have video link 'visits' with family members who were in custody elsewhere. **We repeat the recommendation.**

- 2.145 **The prison should carry out a review including a visitors' survey to establish the visits capacity necessary to meet the needs of the population and provide sufficient places. (9.100)**

**Not achieved.** There was no evidence of any review. Managers said that the capacity in visits was insufficient. **We repeat the recommendation.**

- 2.146 **Parenting courses should be introduced as part of the new life skills programme. (9.101)**

**Not achieved.** There was no parenting course. However, women on the REACH programme (which aimed to build confidence and self-esteem) received some parenting input. **We repeat the recommendation.**

- 2.147 **Mothers should be able to receive incoming telephone calls from children and to deal with arrangements for them. (9.102)**

**Partially achieved.** There was no formal system for women to receive incoming telephone calls. However, we saw and heard that women were often supported to make arrangements for their children. **We repeat the recommendation.**

- 2.148 **The prison should employ a family support worker. (9.103)**

**Not achieved.** There was no family support worker. **We repeat the recommendation.**

- 2.149 **A log should be kept of requests for inter-prison and accumulated visits to enable any unmet need to be identified and acted on. (9.104)**

**Not achieved.** It was not possible to establish how many applications had been made or their outcome. **We repeat the recommendation.**

- 2.150 **The type and range of interventions and programmes to address offending behaviour should be based on an up-to-date assessment of the needs of all groups of prisoners using all available data, including OASys assessments and first night interviews. (9.108)**

**Not achieved.** Although a limited needs assessment had taken place in 2012 (see recommendation 2.6), it had not been sufficiently detailed to meet this recommendation. **We repeat the recommendation.**

2.151 The pathways for women who have been abused, raped or have experienced domestic violence and for women who have been involved in prostitution should be suitably developed and support services introduced informed by a needs analysis. (9.114)

**Not achieved.** Although an enthusiastic officer led the children, families and contact with the outside world pathway, and the existing provision was valued, there had been no detailed needs analysis for this pathway, and there was no time allocated for this task (see also recommendation 2.8).

**We repeat the recommendation.**

## Section 3: Summary of recommendations

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

	<b>Recommendation</b>	<b>To NOMS</b>
3.1	Women at risk of self-harm should not be transferred to other prisons without a clear assessment and agreement that this is appropriate. (2.27)	

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	<b>Recommendations</b>	<b>To the governor</b>
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### **Courts, escorts and transfers**

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|-----|---|--|
| 3.2 | Prisoners transferring to Foston Hall should be given at least 24 hours' notice of their move. (2.12) |  |
|-----|---|--|

### **Early days in custody**

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- |     |   |  |
|-----|---|--|
| 3.3 | Reception interviews should take place in private. (2.13)   |  |
| 3.4 | Information given to women should be properly and accurately produced and should also be provided in media other than writing. (2.15)     |  |
| 3.5 | Prisoners should be interviewed individually during induction to address any feelings about imprisonment and any self-harm issues. (2.17) |  |

### **Bullying and violence reduction**

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- |     |   |  |
|-----|---|--|
| 3.6 | Non-accidental injuries should be reported and investigated and outcomes included in the monthly safer custody report. (2.21)   |  |
| 3.7 | If women are placed on the formal violence and anti-social behaviour strategy, review boards should be convened to set targets, review progress and monitor any sanctions imposed to avoid unofficial punishments. (2.23) |  |
| 3.8 | All staff in contact with prisoners should receive training in the violence and anti-social behaviour strategy. (2.25)  |  |

### **Self-harm and suicide prevention**

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- |      |   |  |
|------|---|--|
| 3.9  | The suicide prevention policy document should be reviewed to ensure that it includes all relevant areas. (2.26)   |  |
| 3.10 | Assessment, care in custody and teamwork procedures should be improved and include more consistent case management and involve a range of disciplines. (2.28) |  |

- 3.11 The range of telephone help lines should be publicised and all should be available free of charge. (2.29)
- 3.12 All staff should receive refresher training in assessment, care in custody and teamwork procedures. (2.30)

### **Security**

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- 3.13 Security risk assessments for activity allocation should be based on clear criteria, specific to the activity and to the individual woman. (2.31)
- 3.14 All strip-searches should be logged and monitored by senior managers. (2.33)

### **Segregation**

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- 3.15 The segregation unit should not be used as a place of respite. (2.44)
- 3.16 History sheet records for women held in the segregation unit should record interaction and comment on the women's well-being. (2.46)

### **Residential units**

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- 3.17 D wing should be refurbished and the number of women held there reduced. (2.51)
- 3.18 Prisoners on E wing should be given the opportunity to cook for themselves. (2.52)
- 3.19 Prisoners should have better access to hot water to make drinks. (2.53)
- 3.20 Managers should monitor response times and quality of replies to applications. (2.55)

### **Staff–prisoner relationships**

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- 3.21 Senior officers should ensure that all personal officers make regular, good quality entries in wing files, which should cover progress with sentence plans, resettlement issues and any relevant family matters. (2.58)

### **Equality and diversity**

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- 3.22 Racist incident report forms should be scrutinised by an external body and feedback provided to the diversity and race equality action team. (2.61)
- 3.23 A distinct foreign national policy should be introduced to ensure, in consultation with foreign national women, that all their specific needs are met. Implementation of the policy should be overseen by a senior manager and a dedicated multidisciplinary team. (2.4)
- 3.24 Staff should receive awareness training about the needs of foreign national prisoners. (2.68)
- 3.25 Forums for all foreign national women should be held to focus on their distinct needs. (2.69)
- 3.26 Staff should use telephone interpreting services whenever necessary. (2.71)



- 3.27 All foreign national prisoners with immediate family living overseas should receive at least one free international telephone call a month, regardless of whether they have received a social visit. (2.73)
- 3.28 Women prisoners should be able to receive independent legal advice on immigration matters. (2.74)
- 3.29 Regular consultation forums for women with disabilities should be held. (2.75)
- 3.30 Women with disabilities should have an individualised and multidisciplinary care plan into which they have had an input. (2.76)
- 3.31 Equality of treatment should be monitored through the diversity and race equality action team and analysed by disability, and appropriate action taken to rectify any inequalities. (2.77)
- 3.32 The buddy scheme should include suitable training and rewards. (2.78)
- 3.33 The action plan for older prisoners should be implemented. (2.79)
- 3.34 The prison should introduce an action plan to support and meet the needs of women who are gay or bisexual, including referral to external networks. (2.80)

### **Complaints**

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- 3.35 All allegations about staff misconduct should be referred to, and investigated by, a senior manager. (2.82)

### **Health services**

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- 3.36 Health care reception screening interviews should be carried out in an appropriate and confidential environment. (2.84)
- 3.37 A representative patient forum should be established. (2.86).
- 3.38 Barrier protection should be made freely available. (2.87)

### **Purchases**

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- 3.39 Women should be able to make a shop purchase within 24 hours of arrival and advanced funds of up to one week's pay if necessary. (2.102)

### **Learning and skills and work activities**

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- 3.40 The frequent interruptions to learning should be significantly reduced. (2.5)
- 3.41 More use should be made of appropriately qualified prisoners to provide peer support and rewards for peer supporters improved. (2.105)
- 3.42 There should be sufficient activity places for the operational capacity of the prison.

- 3.43 The number of women achieving qualifications from work in the gardens should be increased. (2.112)
- 3.44 Prisoners on distance learning courses should have study facilities with access to computers in the evenings and at weekends. (2.117)

### **Library**

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- 3.45 The library should provide some evening and weekend sessions. (2.118)

### **Physical education and health promotion**

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- 3.46 Accredited courses that lead to employment should be re-introduced. (2.120)

### **Strategic management of resettlement**

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- 3.47 The offender management and reducing reoffending strategy should be informed by an annual needs analysis and should detail how resettlement provision, including interventions, meets the needs of different groups of women. (2.6)
- 3.48 All representatives should attend the offender management and resettlement liaison committee meetings and progress against each pathway should be reviewed at each meeting. (2.123)
- 3.49 The prison should involve voluntary and community sector groups providing services to prisoners in periodic meetings to inform them of the reducing reoffending strategy and their contribution towards its development. (2.124)
- 3.50 Analysis from sources such as OASys reviews and first night interviews should be used to inform resettlement services. (2.125)

### **Offender management and planning**

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- 3.51 All prisoners, including unconvicted women and those serving sentences less than 12 months, should have their resettlement needs assessed and incorporated into a custody plan which is regularly reviewed. (2.7)
- 3.52 Offender managers should be better engaged and involved with prisoners in line with the required expectations. (2.128)
- 3.53 Public protection work with women identified as high risk of harm should be effectively managed. (2.133)

### **Reintegration planning**

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- 3.54 A full review of provision to help women maintain contact with their children and families should be undertaken, particularly for mothers of children under 18, and a clear action plan devised to drive forward progress against this resettlement pathway. (2.8)
- 3.55 The accommodation pathway should be effectively led and pathway meetings introduced to monitor and develop services. (2.135)

- 3.56 Pathway meetings should be held to coordinate the work of the different individuals and agencies providing support and advice on finance, benefit and debt. (2.140)
- 3.57 A visitors' centre should be provided. (2.144)
- 3.58 Women should be encouraged and helped to maintain telephone contact with partners and family members in other establishments. The procedures for inter-prison telephone calls should be clarified and widely advertised. (2.145)
- 3.59 The prison should carry out a review including a visitors' survey to establish the visits capacity necessary to meet the needs of the population and provide sufficient places. (2.146)
- 3.60 Parenting courses should be introduced as part of the new life skills programme. (2.147)
- 3.61 Mothers should be able to receive incoming telephone calls from children and to deal with arrangements for them. (2.148)
- 3.62 The prison should employ a family support worker. (2.149)
- 3.63 A log should be kept of requests for inter-prison and accumulated visits to enable any unmet need to be identified and acted on. (2.150)
- 3.64 The type and range of interventions and programmes to address offending behaviour should be based on an up-to-date assessment of the needs of all groups of prisoners using all available data, including OASys assessments and first night interviews. (2.151)
- 3.65 The pathways for women who have been abused, raped or have experienced domestic violence and for women who have been involved in prostitution should be suitably developed and support services introduced informed by a needs analysis. (2.152)

## Appendix I: Inspection team

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Sean Sullivan	Team leader
Rosemarie Bugdale	Inspector
Joss Crosbie	Inspector
Paul Fenning	Inspector
Jeanette Hall	Inspector

### **Specialist inspectors**

Mick Bowen	Substance misuse/health services inspector
Sheila Willis	Ofsted inspector

## Appendix II: Prison population profile

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

Status	18-20-year-olds	21 and over	%
Sentenced	18	195	74
Recall	0	17	5.9
Convicted unsentenced	3	21	8.3
Remand	1	32	11.5
Civil prisoners	0	1	0.3
Detainees	0	0	0
<b>Total</b>	<b>22</b>	<b>266</b>	<b>100</b>

Sentence	18-20-year-olds	21 and over	%
Unsentenced	5	60	22.6
Less than 6 months	4	37	14.2
6 months to less than 12 months	3	11	4.9
12 months to less than 2 years	3	21	8.3
2 years to less than 4 years	2	41	15
4 years to less than 10 years	4	26	10.4
10 years and over (not life)	0	6	2.1
ISPP	0	13	5
Life	1	51	18
<b>Total</b>	<b>22</b>	<b>266</b>	<b>100</b>

Age	Number of prisoners	%
Please state minimum age 18		
Under 21 years	22	7.6
21 years to 29 years	81	28.1
30 years to 39 years	88	30.6
40 years to 49 years	67	23.3
50 years to 59 years	26	9
60 years to 69 years	4	1.4
70 plus years	0	0
Please state maximum age 66		
<b>Total</b>	<b>288</b>	<b>100</b>

Nationality	18-20-year-olds	21 and over	%
British	20	245	92
Foreign nationals	2	20	7.6
Not stated	0	1	0.3
<b>Total</b>	<b>22</b>	<b>266</b>	<b>100</b>

Security category	18-20-year-olds	21 and over	%
Uncategorised unsentenced	1	26	9.4
Uncategorised sentenced	12	97	37.8
Category: female closed	6	141	51
Category: female open	0	2	0.7
Category: YOI closed	13	0	1.0
Category D	NA		
Other: open YOI	NA		

<b>Total</b>	<b>22</b>	<b>266</b>	<b>100</b>
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<b>Ethnicity</b>	<b>18-20-year-olds</b>	<b>21 and over</b>	<b>%</b>
White			
British	14	213	78.8
Irish	1	1	0.7
Other white	2	5	2.4
Mixed			
White and black Caribbean	2	7	3.1
White and black African	0	1	0.3
White and Asian	0	1	0.3
Other mixed	1	4	1.7
Asian or Asian British			
Indian	0	3	1.0
Pakistani	0	2	0.7
Bangladeshi	0	0	0.0
Other Asian	0	5	1.7
Black or black British			
Caribbean	1	10	3.8
African	0	3	1.0
Other black	1	5	2.1
Chinese or other ethnic group			
Chinese	0	1	0.3
Arab	0	0	0
Other ethnic group	0	5	1.7
Not stated			
<b>Total</b>	<b>22</b>	<b>266</b>	<b>100</b>

<b>Religion</b>	<b>18-20-year-olds</b>	<b>21 and over</b>	<b>%</b>
Baptist	0	0	0
Church of England	3	77	27.8
Roman Catholic	4	41	15.6
Other Christian denominations	2	23	8.7
Muslim	0	22	7.6
Sikh	0	4	1.4
Hindu	0	2	0.7
Buddhist	0	9	3.1
Jewish	0	0	0
Other	0	5	1.7
No religion	13	83	33.3
<b>Total</b>	<b>22</b>	<b>266</b>	<b>100</b>

<b>Other demographics</b>	<b>18-20-year-olds</b>	<b>21 and over</b>	<b>%</b>
Gypsy/Romany/Traveller	1	0	0.3
<b>Total</b>	<b>1</b>	<b>0</b>	<b>0.3</b>

Other demographics	18-20 yr olds	21 and over	%
Veteran (ex-armed services)	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>

#### Sentenced prisoners only

Length of stay	18-20-year-olds		21 and over	
	Number	%	Number	%
Less than 1 month	4	1.4	46	16
1 month to 3 months	6	2.1	44	15.3
3 months to 6 months	3	1.0	32	11.1
6 months to 1 year	3	1.0	26	9
1 year to 2 years	1	0.3	28	9.7
2 years to 4 years	0	0	20	6.9
4 years or more	0	0	10	4
<b>Total</b>	<b>17</b>	<b>5.8</b>	<b>206</b>	<b>72</b>

#### Sentenced prisoners only

	18-20-year-olds	21 and over	%
Foreign nationals detained post sentence expiry	0	0	0
Public protection cases	2	30	12
<b>Total</b>	<b>2</b>	<b>30</b>	<b>12</b>

#### Unsentenced prisoners only

Length of stay	18-20-year-olds		21 and over	
	Number	%	Number	%
Less than 1 month	4	1.4	26	9
1 month to 3 months	0	0	16	5.6
3 months to 6 months	1	0.3	13	4.5
6 months to 1 year	0	0	5	1.7
1 year to 2 years	0	0	0	0
2 years to 4 years	0	0	0	0
4 years or more	0	0	0	0
<b>Total</b>	<b>5</b>	<b>1.7</b>	<b>60</b>	<b>20.8</b>

Main offence	18-20-year-olds	21 and over	%
Violence against the person	7	86	32
Sexual offences	1	7	2.7
Burglary	3	14	5.9
Robbery	4	18	7.6
Theft and handling	3	53	19.4
Fraud and forgery	0	12	4.1
Drugs offences	1	16	5.9
Other offences	3	58	21.1
Civil offences	0	2	0.6
Offence not recorded/holding warrant			
<b>Total</b>	<b>22</b>	<b>266</b>	<b>100</b>