Report on an unannounced short follow-up inspection of

HMP Kingston

3–5 November 2008

by HM Chief Inspector of Prisons

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Introduction

Kingston is a small specialist prison, holding only indeterminate-sentenced prisoners. The last inspection found that it was a safe prison, with a generally positive environment and approach, but that the provision of activities, for prisoners who would spend long periods marking time in their lengthy sentences, was underdeveloped.

This inspection confirmed that Kingston remained, in general, safe. Support for prisoners in their early days, and measures to deal with bullying and prevent suicide, were well developed. Safety was also supported by extremely good staff-prisoner relationships: staff knew, and engaged constructively with, prisoners. However, it was disappointing that the overprescription of opiate-based drugs, which could lead to bullying, which had been identified at the time of the last inspection, had not yet properly been tackled three years later. The recently appointed modern matron was beginning to deal with this issue, along with other prescribing problems and the deficiencies in mental health provision.

The quantity and quality of activity had improved noticeably since the last inspection. Almost all prisoners were involved in activity, and over half accessed education, with a wide-ranging curriculum. However, there were still too many prisoners in menial contract services work, or without the opportunity to gain employment skills. Nevertheless, we judged that the prison was now performing reasonably well in this area.

The majority of the population at Kingston were serving mandatory life sentences, though a few were serving discretionary life, or indeterminate public protection, sentences. The internal sentence planning processes in the prison were effective, though there had been no recent needs analysis to ensure that the interventions and support available matched the needs and risks of prisoners.

The main problem, as at the time of the last inspection, was the weakness of the external systems for managing indeterminate-sentenced prisoners. There was still no clear national operational strategy that could ensure that recategorised prisoners were able to move on quickly, or that probation support was available to ensure the timely production of parole reports. Nor was it clear whether Kingston was a regional or national resource. This dislocation was most evident in the regional decision to withdraw the CALM offending behaviour programme, despite the fact that prisoners had been moved to Kingston from other parts of the country specifically to undertake it.

Kingston continues to be a well-managed and safe prison, with good and appropriate staff-prisoner relationships. It has addressed some of the weaknesses in activity, and is now in a position to tackle the prescribing and mental health deficits that remain. It suffers, however, from the weakness of national management of the growing number of indeterminate-sentenced prisoners, who need to have a clear progression route through the prison and parole systems. This is something that the National Offender Management Service should urgently address.

Anne Owers
HM Chief Inspector of Prisons

February 2009

Fact page

Task of the establishment
Second-stage category B male lifer prison with a discrete category C unit for 24 life-sentenced prisoners.

Area organisation
South Central

Number held
3 November 2008: 173 (category C unit closed for refurbishment).

Certified normal accommodation
199

Operational capacity
175 (200 including category C unit)

Last inspection
28 November – 2 December 2005

Brief history
The prison was built between 1874 and 1876 by French prisoners of war and is a listed building with many original Victorian architectural features. Originally a city jail holding men, women and children, it has fulfilled its current role since 1968.

Description of residential units

A wing	69 single cells
C wing	56 single cells
D wing	50 single cells
E wing	category C unit holding 24 prisoners in shared rooms

Section 1: Healthy prison assessment

Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2005 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

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

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

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

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

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable

inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

Safety

HP4 In 2005, we assessed the prison as performing well against this healthy prison test and made 15 recommendations. In this short follow-up inspection, we found that 11 of these recommendations had been achieved and four partially achieved.

HP5 The throughput of prisoners at Kingston was very low, at about two or three planned transfers a week, and reception and induction processes were individualised. The reception area was small and untidy, but staff were respectful and some information was provided in the one holding room. New arrivals were not unduly delayed by reception processes, and were given considerable useful induction material as well as appropriate risk assessments.

HP6 All new arrivals were initially placed in one of three induction cells on D wing. They had good access to telephones and showers, but the presence of a new arrival was not recorded in night handover books unless other risk factors had been identified. New arrivals received individual induction from personal officers and wing staff, and progress was recorded on an induction checklist. This approach was thorough, and new arrivals appreciated the attention they received.

HP7 Anti-bullying and violence reduction processes were managed through the monthly safer custody meetings and by the violence reduction coordinator. Information provided to safer custody meetings was reasonable, and some evaluation was evident. However, information collated by the coordinator was not comprehensive. For example, work on the illicit use of prescription medication, a principal concern of the prison, was underdeveloped. There was a three-stage anti-bullying protocol, but suspected bullies rarely advanced beyond stage one, which only involved limited supervision and ongoing observation. Interventions for bullies or victims were limited, although prisoner violence reduction representatives provided some informal support to victims.

HP8 Suicide and self-harm prevention measures were also managed through the safer custody meeting, but coordinated by a residential senior officer. In 2008 to date, 22 assessment, care in custody and teamwork (ACCT) self-harm monitoring documents had been opened. The quality of ACCT documents was reasonable and reviews multidisciplinary, but the evaluation of some recent near-death incidents was weaker.

HP9 There had been about 1,100 security information reports during 2008, with most concerning drugs and bullying. There had been 24 reportable incidents recorded, but most related to self-harm. A monthly security and intelligence report was produced, but analysis and discussion recorded in the minutes of the security committee was thin. The prison had good support from a police liaison officer and had two trained intelligence analysts. The application of security and rules did not needlessly impede the delivery of the regime.

HP10 The segregation unit was small, with three normal cells. Use was very low – there had been just one resident in recent months. Daily access to showers, telephones and exercise was available, but the exercise yard was very small. There was no rehabilitative regime to reintegrate prisoners back to the wings.

HP11 There was a low number of adjudications. Adjudication records suggested hearings were managed fairly, and there was additional healthcare involvement to ensure the competence and wellbeing of prisoners before the adjudication process.

HP12 There had been only five uses of force in 2008, and no use of the special cell. Planned control and restraint removals were videoed if necessary. Records of incidents suggested that documentation was well maintained and governance arrangements were satisfactory.

HP13 The prison reported a random mandatory drug testing positive figure of 5.4% in 2008. Ten of these 12 positive tests were due to diverted prescribed medication, possibly linked to bullying. As at the last inspection, widespread prescription of opiate-based medication was a problem, but this was being addressed through better supervision, and there were recent plans to reduce in-possession opiate-based analgesia.

HP14 Vulnerable prisoners were fully integrated into the prison and had no separate accommodation. Prisoners were informed about this before their transfer to Kingston. There was no system to inform or identify to staff those prisoners potentially vulnerable due to the nature of their offence. Concerns about prisoners were managed through the personal officer or violence reduction procedures.

HP15 Kingston continued to perform well against this healthy prison test.

Respect

HP16 At our last inspection in 2005, we assessed the prison as performing reasonably well against this healthy prison test. We made 39 recommendations, of which 17 were achieved, 10 partially achieved and 11 were not achieved. One recommendation was no longer relevant.

HP17 Communal areas and cells were clean, and cells were reasonably well equipped. Shower facilities were satisfactory, and a few tables permitted some prisoners to dine in association. Prisoners could wear their own clothes, and laundry arrangements appeared to work satisfactorily. Access to telephones was reasonable, but recreational equipment was limited.

HP18 The majority of prisoners, 162, were on enhanced regime status. Only 11 prisoners were on standard and none on basic. Incentives and earned privileges procedures had recently been revised and incorporated adequate review mechanisms. Application of basic level was rare, and appropriate reviews, when necessary, ensured that improvement targets were clear and that the time spent on basic was minimal.

HP19 Staff-prisoner relationships were good. We observed frequent and constructive staff engagement with prisoners, and they showed good knowledge of their prisoners. The atmosphere on the residential units was relaxed.

HP20 The personal officer policy document outlined significant expectations from personal officer work, such as a requirement to engage with case management as well as familiarisation with the prisoner's case. Some wing files reflected this knowledge, but others focused on a more observational assessment of the prisoner. Personal officers wrote reports for some sentence planning boards, but their attendance at these, as at ACCT and anti-bullying reviews, was variable. Quality assurance of personal officer work required further improvement.

HP21 We received no significant complaints from prisoners about the food. The three-week menu cycle offered an acceptable variety and diversity of dishes. Food was discussed in prisoner forums, and a survey had been completed at the beginning of 2008. The kitchen was adequate, but some appliances required repair. The servery was correctly supervised. Food complaints books were available and used. The opportunities to dine in association were limited. The prison canteen had a reasonable range of products, including those aimed at black and minority ethnic prisoners, and there was a wide range of catalogues. However, the canteen was only available once a week, which delayed access for some new arrivals.

HP22 There was no written diversity policy. However, a diversity orderly was employed to support prisoners with mobility needs, and currently assisted three prisoners by collecting their meals, cleaning their cells and helping with kit change. The fire officer had a list of prisoners with mobility needs, and the prison provided an accessible cell and accessible toilets and shower facilities. Other elements of diversity were less well developed – for example, there was no policy relating to older prisoners, although over 27% of the population were over 50.

HP23 Black and minority ethnic prisoners made up almost a quarter of the population. Procedures were effective. The race equality action team (REAT) was attended by prisoner representatives and also supported by a prisoner race equality action group, which facilitated further consultation. A prisoner race representative provided a race equality induction to all new black and minority ethnic arrivals. There were few racist incident complaints, but investigations were thorough.

HP24 The coordination of foreign nationals work was undertaken by the REO in the long-term absence of the foreign nationals coordinator. A foreign national prisoner policy covered issues relevant to the 18 foreign nationals in the prison. There was some liaison with the local immigration service. Basic requirements were met, but there was little peer support and work in this area needed renewal.

HP25 The application system was reasonable. Applications were responded to properly, but there was no quality assurance scheme to monitor responses and track the speed of replies. There had been 343 formal complaints in 2008, a reduction on 2007. The quality of responses varied, with some curt and perfunctory, and not all were easy to read. There were no quality assurance arrangements. One legal services officer was available for advice, but he had not received refresher training for 10 years.

HP26 There was one full-time coordinating chaplain, supported by sessional chaplains. Chaplaincy facilities were reasonable, but there was limited prisoner engagement in services and activities. The service provided to Muslim prisoners was poor.

HP27 The recent appointment of a modern matron had begun to make a positive impact on the management of health services, despite some shortages of nursing cover. Access to primary care through the three GPs was reasonable, although there was a lack of

nurse-led clinics for chronic disease management. Mental health provision was inadequate and under-resourced, with poor communication with other healthcare staff. Waiting times for dentistry and the optician were not unreasonable, but the management of the pharmacy was poor. As we identified in our last report, there was too much prescribing of opiate-based medication.

HP28 We concluded that Kingston continued to perform reasonably well against this healthy prison test.

Purposeful activity

HP29 At our last inspection in 2005, we assessed that Kingston was not performing sufficiently well against this test and made 13 recommendations. At this inspection, we found that six of these recommendations had been achieved, four partially achieved and three were not achieved.

HP30 The education provider was Milton Keynes College, with whom the prison had good and effective relationships. The quality improvement group had been reconstituted and there was evidence that this had led to improvements, such as the integration of learning plans with sentence plans, but more remained to be done. About 54% of prisoners were in full- or part-time education, and there was a reasonable breadth of curriculum, which was applied flexibly. Progression was also available and 12 prisoners were undertaking distance learning and Open University courses. Education was properly promoted through information, advice and guidance (IAG) at induction, and there were good systems to track and monitor punctuality and attendance.

HP31 There was near to full access to activity, with only seven prisoners recorded as unemployed. There were 135 prisoners employed across a range of activities, and 43 learners in vocational training. Pay was equitable, and skills acquisition was reasonable, but about a tenth of prisoners were still engaged in menial contract services work. Opportunities included a print shop, drawing office and light assembly shop. Access to key skills and accredited learning was, however, limited, and opportunities to develop vocational training further had been missed.

HP32 The library was larger and improved since our last visit, and was usefully embedded in education. Open seven days a week, access was reasonable and stock levels were good.

HP33 The physical education facility was adequate and was attended by 64% of prisoners, but the PE team remained too small. There was good use of the limited space available, and a good range of provision that addressed the diversity of the population. The cardiovascular equipment was adequate, although old and in poor condition. Good links were maintained with the local community, and the broader work of the prison was supported through health promotion and links to the counselling, assessment, referral, advice and throughcare service (CARATs) and healthcare. A few accredited PE courses were also available.

HP34 The published core day indicated that time unlocked for a normal prisoner was 9.5 hours a day from Mondays to Thursdays, just short of our expectation of 10 hours. There were few delays in the unlocking of prisoners, and weekday access to evening

association was good. Daily access to time in the open air was reasonable, although take-up appeared limited.

HP35 At this short inspection, we judged that there had been sufficient improvement to conclude that Kingston was now performing reasonably well against this healthy prison test.

Resettlement

HP36 At our last inspection in 2005, we described Kingston as performing reasonably well against this healthy prison test and made 27 recommendations. On this short follow-up inspection, we found that six of these recommendations had been achieved and six partially achieved, but that 15 remained unachieved.

HP37 The published reducing reoffending strategy included an overview of the seven resettlement pathways, as well as a description of current work and development proposals. Oversight was provided by a reducing reoffending committee that met bi-monthly. However, the strategy was not underpinned by a recent analysis of prisoner need. Its emphasis was on assessment of risk, addressing offending behaviour and exercising responsibility in a custodial setting. More recently, there had also been a focus on raising staff and prisoner awareness of offender management work in the prison and the opportunities available under the resettlement pathways.

HP38 An offender management structure had been introduced in April 2008. There was a multidisciplinary team of five full-time equivalent offender supervisors who each carried a manageable caseload of about 40, which included all life- and indeterminate-sentenced prisoners. Sentence management boards were chaired by one of three managers dedicated for this task, and all prisoners were initially inducted into the process the week after their arrival. Offender supervisors updated all offender assessment system (OASys) assessments and maintained records of contacts, although the quality of these was mixed. Recategorisation was managed through the sentence planning process.

HP39 Accommodation needs on resettlement were managed on a case-by-case basis, normally in the context of public protection measures. Only three prisoners had been discharged from Kingston in 2008.

HP40 Work on the education, training and employment resettlement pathway was similarly limited. There was little opportunity for vocational skills. The education department provided an Open College Network-accredited course in budgeting and money management, and there was some help to assist prisoners to open bank accounts.

HP41 Healthcare staff saw all prisoners before their release or transfer and gave them a summary of the care received, as well as details of outstanding or ongoing outpatient appointments and a week's supply of medication where appropriate. The palliative care policy worked well, but the care programme approach was not applied.

HP42 There were links with community drugs teams for the few prisoners released with drug problems. CARATs had only one staff member, with a caseload of 53, and there was no groupwork. The P-ASRO (prison addressing substance related offending) drug intervention programme was available, and there were good links between CARATs and the mental health nurse. The prison had no alcohol strategy, although

Alcoholics Anonymous and some awareness training through education were on offer.

HP43 An adequate visits facility could cater for 15 visits at a time on four days a week. There was no visitors' centre, but there was a small waiting room in the gate complex. There had been some attempts to develop and improve extended family visits, including opportunities for prisoners to lunch with family members. Family attendance at offending behaviour course reviews and involvement in the sentence planning process were encouraged.

HP44 Two accredited programmes, P-ASRO and controlling anger and learning to manage it (CALM) were available, although the prison was due to withdraw CALM and introduce the healthy relationships programme (HRP).

HP45 The prison continued to perform reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

To the National Offender Management Service

2.1 The National Offender Management Service should agree the role of Kingston within the regional and national strategy for managing life-sentenced prisoners, and ensure effective probation support. (HP41)

Not achieved. The prison continued to function as a national resource for second-stage life-sentenced prisoners and so did not align easily with the regional reducing reoffending strategy. However, the aims of Kingston's reducing reoffending strategy reflected the regional strategy, and it had established some local community links to develop resettlement pathway work (for example, with Sure Start). We were told the recent decision to withdraw the CALM (controlling anger and learning to manage it) programme and introduce the high intensity healthy relationships programme (HRP) (see paragraph 2.274) was taken at regional level in consultation with the prison's head of offender management. However, this decision had national implications, as some prisoners had transferred to Kingston specifically to undertake the CALM programme and would need to be transferred elsewhere (see recommendation 2.275).

We repeat the recommendation.

Additional information

2.2 Although the prison held only 14 prisoners in scope of phase three of the NOMS offender management model for indeterminate-sentenced prisoners (IPP), implemented in January 2008, it had decided to case manage all prisoners under this model through the introduction of an offender management unit (OMU). These arrangements appeared to be working reasonably well, and ensured a consistent approach to sentence planning. However, strategic links with external probation services were not consistently effective. Resource pressures meant that contact with community-based offender managers was variable (see paragraph 2.212). Offender managers attended sentence planning boards for IPP prisoners, who were generally positive about the level of contact and communication with their community offender manager. However, many life-sentenced prisoners felt they did not have access to effective support from their offender managers. One prisoner told us he had received four letters informing him of a change to his allocated offender manager, but he had not met any of them. The prison's video-conferencing facilities had been used on only seven occasions since July 2008.

2.3 The National Offender Management Service should put in place effective arrangements to ensure that life-sentenced prisoners are able to make appropriate progress in their sentence without undue delay. (HP45)

Not achieved. There were 58 category C prisoners at the time of the inspection, and 78 category C prisoners had been transferred on to other prisons in 2008. However, some prisoners were frustrated about the length of time they had to wait before securing a transfer.

Staff also said they had sometimes experienced difficulty in securing suitable places for category C lifers, and that some prisons had allocation criteria that further limited the availability of suitable places. For example, one prison that had previously accepted prisoners on progressive transfers from Kingston now only took those who came from its region. We repeat the recommendation.

Main recommendations (from the previous report)

To the governor

2.4 Kingston's specific role should be set out in a statement of purpose, and the task of assessing and reducing the risk posed by life-sentenced prisoners should inform the work of all staff in the prison. (HP42)

Partially achieved. Kingston's role as a second-stage prison for life-sentenced prisoners was outlined in its delivery plan and reducing reoffending strategy, which had appropriate emphasis on the need for prisoners to participate in offending behaviour work to reduce identified risk factors and progress. The introduction of the OMU approach and the consistent attendance by some key workers at sentence planning boards had begun to ensure that staff across the prison understood how their work contributed to this process. However, we were not sufficiently assured that all staff recognised this as an essential and integral part of their work. For example, although personal officers could access offender management records electronically and received copies of completed sentence planning reviews, prisoners' wing files did not always show that they had used this information to engage with prisoners. Personal officers did not consistently attend or contribute to annual reviews (see recommendation 2.218).

Further recommendation

2.5 The task of assessing and reducing the risk posed by life-sentenced prisoners should inform the work of all staff in the prison.

2.6 Personal officers should take a more active role in the case management of life-sentenced prisoners at Kingston, checking progress against life sentence plan targets, encouraging and supporting prisoners to address their risk factors and attending life sentence planning and review boards. (HP43)

Partially achieved. Since the prison had introduced the offender management model, all prisoners were allocated an offender supervisor, who now undertook much of the role previously identified for personal officers. Nonetheless, the distinction between the two roles remained unclear and there was considerable crossover.

Further recommendation

2.7 The role of the personal officer, and its distinction from that of the offender supervisor, should be clarified.

2.8 Low quality contract work should be replaced by work that allows prisoners to obtain relevant accredited employment skills. (HP44)

Partially achieved. Some of the previous low quality contract work had been replaced by

lighting assembly work, which required more complex skills. However, more than 10% of prisoners were still engaged in low quality menial contract work, and they were not given enough encouragement to extend their learning.

Further recommendation

2.9 Additional learning opportunities should be available and encouraged for the small proportion of prisoners engaged in low quality contract work.

2.10 A full staffing and skill mix review should be undertaken to ensure that sufficient appropriately qualified nursing staff are available to provide a range of services to meet the healthcare needs of long-sentenced prisoners, particularly mental health needs. (HP46)

Partially achieved. There had been a health needs assessment in July 2008, which had included a staffing skill mix review. A modern matron, who was a band 8a registered general nurse (RGN), was the head of healthcare. Appointed in September 2008, she devoted 30% of her time to clinical duties and her qualifications included nurse prescribing, diabetes, asthma and sexual health. She was supported by an experienced clinical nurse lead who was a band 6 dual-qualified RGN and registered mental nurse (RMN) who had been in post for one year. The healthcare team also included a further two band 5 RGNs who had been on extended leave for the previous three months. A full-time RMN gateway worker provided primary and in-reach mental healthcare, but this provision needed to be developed further to meet the needs of prisoners with primary mental health needs. There were no nurse-led clinics to support prisoners with long-term conditions. Healthcare staff had not received substance misuse training to improve the care of prisoners with these problems (see recommendation 2.107). We repeat the recommendation.

2.11 The incentives and earned privileges scheme should be made more relevant to Kingston's lifer population, or should be abandoned. (HP47)

Achieved. The incentives and earned privileges scheme had been updated in March 2008, with key privileges oriented to extra visits and access to private cash, as well as increased earning capacity, access to game machines and increased gym access. The scheme offered sufficient incentives for prisoners to work towards enhanced status, even for those without private cash or visitors. At the time of the inspection, 162 (94%) of prisoners were enhanced, 11 (6%) were on standard and none were on basic.

2.12 A needs analysis should be undertaken to inform the development of the prison's resettlement policy and the provision of suitable offending behaviour programmes. (HP48)

Not achieved. The psychology department had conducted a needs analysis in October 2006. This had been a self-report questionnaire focused on the seven resettlement pathways. It was not clear if an action plan was produced as a result. There was no up-to-date needs analysis to underpin the prison's reducing reoffending strategy, the development of pathway provision or to assess the suitability of offending behaviour programmes. This was particularly significant given the recent decision to withdraw the CALM programme.

Further recommendation

2.13 There should be a formal annual needs analysis and this should inform the development of the reducing reoffending strategy and the provision of suitable offending behaviour programmes.

Recommendations

First days in custody

2.14 All newly arrived prisoners should be offered a reception pack. (1.19)

Partially achieved. We were told that all new arrivals were given a reception pack, but we were only shown a stock of smoker's packs.

Further recommendation

2.15 All new arrivals should be offered a reception pack suitable for their needs.

2.16 Prisoners should be able to take their in-possession property to their cell on the day of arrival. (1.20)

Partially achieved. Most transfers to the prison were planned and arrival times predictable. We were assured that every effort was made to ensure that new arrivals could access their property on the day of their arrival, and that this was normally achieved. However, because only two staff worked in reception and the facility closed at 5pm, it was not always possible to process all property on the day if there were multiple or late arrivals. In these cases, prisoners were given what they requested for the evening and the process was completed the following day.

2.17 Initial information should reinforce Kingston's role as a prison for life-sentenced prisoners and check that prisoners understand the implication of their sentence in advance of the formal lifer reception board. (1.21)

Achieved. All new arrivals were given a comprehensive 79-page prisoner information booklet that described in detail what they could expect at Kingston. The document included a detailed section on all aspects of offender management, under which all life-sentenced prisoners were managed. On the first Wednesday after their arrival, all prisoners were invited to a collective and informal multidisciplinary reception board, which described aspects of offender management and the services they could expect. This took place in advance of the formal initial sentence planning board, which was held at the three-month stage.

Additional information

2.18 There was a low throughput of prisoners, with usually two or three new arrivals a week. All new arrivals were planned and relationships with escort contractors were described as good. Late arrivals were rare.

2.19 The reception facility was cramped, dingy and untidy, but due to be refurbished. The one holding room lacked natural light, but was reasonably clean and had some limited written and

video information. Searching took place in a private room, but there were no private interview facilities for the meeting with healthcare staff or risk assessment. Reception staff dealt with prisoners in a respectful and friendly manner, and with an appropriate focus on identifying and addressing potential risk factors. The reception process was normally completed within 90 minutes.

2.20 New arrivals were initially located in one of three induction cells on D wing, which was a normal wing. They were allowed to associate and could use the telephones and showers. An induction checklist initiated in reception, including the risk assessment, was handed over to residential staff. Any identified risk factors for a prisoner on his first night were highlighted in the night officers' handover book, although there was no standard notification of prisoners spending their first night on the wing, as a risk in itself.

2.21 Induction was provided on an individual basis. As well as the excellent information booklet provided in reception, new arrivals were given comprehensive information on other aspects of the establishment. Further information was provided by reception staff, the wing senior officer, peer supporters and the prisoner's personal officer, who introduced themselves at the earliest opportunity. Aspects of the process were recorded on a simple checklist, and evidence in prisoners' wing files confirmed that induction took place. The new arrivals we spoke to were very positive about the quality of information and individual attention they had received.

Further recommendations

2.22 The reception area should be refurbished.

2.23 There should be private interview facilities in reception.

2.24 All newly arrived prisoners should be highlighted in the night officers' handover book and all night staff should be briefed.

Residential units

2.25 Facilities should be provided to enable prisoners to retain or develop independent living skills such as washing their own clothes and cooking simple meals. (2.21)

Not achieved. There were no facilities for prisoners to wash their clothes or cook their own food. Prisoners could have their clothes washed weekly in the prison laundry, which was managed by two orderlies. This arrangement appeared to be appropriate, and prisoners said that damage and loss were rare. Some prisoners washed their clothes in sinks in the annex of A wing and the bath house, but there was only limited space for drying.

Further recommendation

2.26 There should be facilities to enable prisoners to cook simple meals.

2.27 Prisoners should have the opportunity to eat together and this should be encouraged. (2.22)

Partially achieved. The prison had a few tables on each wing where prisoners could eat together, and we saw some prisoners doing so. However, there were not enough to enable a

large number of prisoners to eat out of cell at a time. The area around the servery did not have sufficient space for dining tables.

Further recommendation

2.28 Dining facilities should be extended to enable more prisoners to eat together.

2.29 D wing annex (the bath house) should be refurbished. (2.23)

Achieved. The bath house in the basement of D wing had been refurbished. The area had 13 shower cubicles, two baths, three sinks and a toilet. It was clean and well maintained. There were also two showers at the end of each wing, and four further showers in the A wing annex, which were also used by prisoners from other wings. Although E wing was closed at the time of the inspection, its disabled-access shower and washing facilities were still used. The general standard of shower facilities was good.

2.30 Some beds should be removed from rooms in E wing to provide a less cramped environment. (2.24)

No longer relevant. E wing was closed and due to be refurbished in 2009.

Additional information

2.31 There were four wings radiating from a central area with the main office. Although E wing was closed, the other three wings, A, C and D, were not separated and prisoners had free movement between them during unlocked periods. The general standard of accommodation was good, and there was no overcrowding. The communal areas were very clean and maintained by wing cleaners to a high standard. All cells were single and generally of a good standard. Cells included integral sanitation with screens around toilets. The offensive displays policy had been updated in 2007 and a notice issued to prisoners in July 2008. Pictures displayed in cells were appropriately within this policy. Information boards on the wings were well maintained with up-to-date information about key policies. Prisoners who were on standard or enhanced level of the incentives and earned privileges (IEP) scheme could wear their own clothes. Those who chose not to, or who were on a basic regime, could exchange prison clothing weekly.

Staff-prisoner relationships

2.32 Staff should actively engage with prisoners, encourage them through example and challenge them to address their life sentence plan targets. (2.31)

Achieved. Our observations confirmed many examples of positive engagement between staff and prisoners. Staff knew their prisoners and appeared to show an interest in their concerns. There was evidence in wing files that staff asked prisoners about matters relating to their sentence. The personal officer scheme was the principal structure through which staff could contribute to a prisoner's progress.

Additional information

2.33 Staff-prisoner relationships appeared respectful and positive. The use of preferred names or titles was well embedded and prisoners seemed confident in approaching staff. We observed friendly engagement, as well as informal discussions about substantive issues. The prison's most recent measuring the quality of prison life (MQPL) survey had been in 2006 and, although there were some negative comments about prisoners' perceptions of staff, responses ranged from the typical to the positive.

Personal officers

2.34 Personal officers should be given time to familiarise themselves with the full background of all new prisoners so that they can operate more effectively as caseworkers as set out in Kingston's document on the role and responsibilities of personal officers. (2.38)

Achieved. Personal officers were expected to interview new arrivals and to be familiar with their case. Prisoner wing files showed this largely happened, but there remained a lack of clarity about the role of the personal officer and that of the offender supervisor (see paragraph 2.6 and recommendation 2.7).

2.35 Entries in wing history sheets should comment on progress on life sentence plan targets and matters relevant to risk factors. (2.39)

Partially achieved. The personal officer policy document outlined the need for personal officers to familiarise themselves with prisoners' cases, risk factors and sentence management targets. Some wing files reflected this knowledge, along with offender assessment system (OASys) information and scores. Sentence planning targets were not included in files, although they were available on the intranet. Generally, the level of personal officer knowledge indicated in wing files was good, although engagement with prisoners was variable. Wing files included management checks, but this monitoring focused primarily on frequency of contact rather than on quality.

Further recommendation

2.36 There should be a more comprehensive quality assurance system for personal officers that focuses on the quality as well as frequency of engagement.

Additional information

2.37 Personal officers completed comprehensive template reports on prisoners every three years, which included details of their offending behaviour and assessment of risk factors. These reports were kept by the OMU and were generally of a reasonable standard. Annual reports for sentence planning tended to be written by wing managers rather than personal officers.

Bullying and violence reduction

2.38 Members of the anti-bullying committee identified in the policy and strategy document should attend the safer custody meeting regularly. Prisoner representatives, such as

Listeners, should be invited to attend part of the safer custody meeting to contribute to the violence reduction strategy. (3.15)

Achieved. The safer custody meeting was held monthly and attendance was generally good. Safer custody work incorporated violence reduction, anti-bullying, and suicide and self-harm prevention. Representatives of all these areas attended each meeting. Two violence reduction prisoner representatives also attended the monthly strategy meeting.

2.39 The anti-bullying policy document should be updated and include a concise description of the strategy, and an effective second stage should be developed. (3.16)

Partially achieved. The anti-bullying strategy had been subsumed into the violence reduction strategy. The policy had been reviewed and updated in July 2008 and detailed the management of unacceptable behaviour, which usually meant bullying. The policy still incorporated three stages, although in practice stage three was unlikely to be reached, as prisoners would usually have been transferred from Kingston by this point. In the first 10 months of 2008, 16 stage one monitoring logs had been opened and no stage two, compared with 27 stage one and two stage two documents for the whole of 2007. Options for managing prisoners on stage two were still limited, with no specific interventions. The introduction of offender management offered further options for monitoring and managing inappropriate behaviour through sentence planning and offender supervisors. Personal officers were not routinely involved with the anti-bullying management of their prisoners on stage two.

Further recommendation

2.40 There should be interventions for prisoners on stage two of anti-bullying monitoring, and their personal officers should be involved in their management.

2.41 A more thorough confidential survey of bullying should be completed. (3.17)

Partially achieved. The safer custody coordinator had carried out anti-bullying surveys in July 2007 and July 2008. The response rates to both were low (22% in 2007 and 18% in 2008), but the reasons for this were not clear. Despite the poor response, the prison had developed an action plan to respond to some key findings, although this had not yet been implemented.

Further recommendations

2.42 The annual safer custody surveys should include further ways of gathering prisoner views, including focus groups.

2.43 Objectives identified through safer custody reviews should be implemented and monitored.

2.44 Staff should be more vigilant when prisoners are unlocked, challenge prisoners' behaviour and be alert to areas of the prison where bullying is more likely to occur. (3.18)

Partially achieved. The violence reduction group and recent bullying survey had identified some potential bullying hot spots, including the bath house and food queues. There had been no specific action to address these, although they were included in the post-survey action plan (see above).

Further recommendation

2.45 There should be continuous monitoring of potential bullying hot spots and action taken to address these.

Additional information

2.46 The violence reduction coordinator collated information from security, healthcare and wing observation books each month and maintained a database of actual or potential bullies or victims. The log had included 121 prisoners in 2008 to date, of whom 12 were currently live. This information was reviewed at safer custody meetings. However, there were some concerns about the general collation of information on and management of bullying behaviour. In 2008 to date, 20 complaints from prisoners indicated a bullying aspect, yet not all of these had been picked up by the violence reduction coordinator for investigation. The violence reduction log also did not include details of a security department review of prisoner misuse of prescribed medication (see following).

2.47 Ten of the 12 prisoners who had tested positive through mandatory drug testing in 2008 had misused prescribed medication. In July 2008, the security department had reviewed the management and misuse of such medication by prisoners, but the violence reduction group had taken little action on this. The subject was not included in the continuous improvement log, which was reviewed monthly, and minutes of group meetings indicated minimal discussion of it.

Further recommendations

2.48 The violence reduction coordinator should log all information on inappropriate prisoner behaviour.

2.49 The violence reduction coordinator should always investigate complaints by prisoners that indicate potential bullying.

2.50 The violence reduction committee should continuously monitor and effectively manage prisoner misuse of prescribed medication.

Self-harm and suicide

2.51 All members of the suicide prevention team should attend the team meetings regularly. (3.35)

Achieved. The suicide prevention team had been subsumed into the monthly safer custody meeting. Attendance was reasonable, and included representation from the seven Listeners.

2.52 A formal agreement or protocol should be developed with HMP Winchester to set out the circumstances in which it would be appropriate for prisoners at high risk of self-harm to be transferred there. (3.36)

Achieved. Under an agreed area protocol, prisoners with significant medical issues or in need of constant supervision could be transferred temporarily to Winchester, Highdown or Bullingdon prisons. At the time of the inspection, one prisoner was on an open assessment,

care in custody and teamwork (ACCT) self-harm monitoring document. He had been transferred to Winchester for 10 days immediately after his attempted suicide, and told us that staff had handled this with sensitivity and care.

2.53 The planned actions in response to the recommendations made in the death in custody investigation should state clearly what action will be taken, by whom and with a time target for each. (3.37)

Achieved. There had been a further death in custody since the last inspection, in September 2006. An action plan had been compiled based on the recommendations from the Prisons and Probation Ombudsman's report. At the time of the inspection, each of the recommendations identified had been implemented.

2.54 The work detail should always ensure that there is a member of staff on duty who is first aid trained and night patrols know where that member of staff is working. (3.38)

Achieved. All senior officers were trained in first aid, and there were always first aid trained staff on duty, including at night. Most senior officers had also been trained in using the defibrillator. The violence reduction committee monitored completion of this training.

Additional information

2.55 The suicide and self-harm policy had been reviewed and updated in March 2008. The document was comprehensive and gave detailed guidance to staff on ACCT procedures and advice on appropriate support and engagement. A range of new procedures had been introduced in the previous six months, including a log of all new arrivals with a history of self-harm. This enabled appropriate active monitoring and support. There had been 22 ACCT documents opened in 2008 to date, with one currently open.

2.56 ACCT procedures were generally reasonable, although further quality assurance systems were required. Assessments were generally good and most case reviews were appropriately multidisciplinary. However, the quality of staff engagement was variable, and care maps were rarely updated appropriately after each review. Although there were regular management checks, they did not always lead to appropriate changes. The suicide and self-harm coordinator prepared a monthly report for the safer custody strategy group identifying necessary improvements, but the implementation of changes was slow.

2.57 There was no system to investigate and report on near-deaths to develop staff awareness and understanding of appropriate issues. There was also no analysis of trends and patterns in data.

Further recommendations

2.58 The quality assurance and management checks of assessment, care in custody and teamwork (ACCT) documents should be strengthened as a matter of urgency.

2.59 Near-deaths should be thoroughly investigated and lessons learned should be widely publicised.

2.60 There should be regular analysis and evaluation of trends and patterns in self-harm and suicide data to inform staff awareness.

Diversity

2.61 There should be more active promotion of diversity. (3.57)

Not achieved. The prison focused on prisoners with visible disabilities, such as mobility or sight impairment, but was less attuned to prisoners with less apparent disabilities. There was also little attention to the needs of older prisoners or those who were gay, bisexual or transgender (see paragraph 2.66). The race equality officer had recently taken on the role of diversity officer and was aware of the areas that required further development.
We repeat the recommendation.

2.62 One telephone should be set at a level for wheelchair users. (3.93)

Achieved. One telephone, on A wing, had been adapted for use by wheelchair users. There were two prisoners who used wheelchairs at the time of the inspection, and no reported problems with access to telephones.

Additional information

2.63 The prison had an equal opportunities policy, but this applied primarily to staff. A diversity training plan was being developed to enhance staff understanding in managing diversity issues effectively. There was no diversity policy. The prison was responding operationally to the needs of several prisoners with restricted mobility and one with visual impairment. The fire officer had been involved in the development of evacuation procedures for these prisoners.

2.64 New arrivals completed a disability assessment form, which alerted staff to any specific needs. A disability orderly was responsible for supporting prisoners with mobility problems, such as collecting their meals, cell cleaning and kit change. He held a supply of information on disability, which he used to advise prisoners. He worked for seven days a week without back-up assistance, which meant he had no rest days.

2.65 There was one cell adapted for a disabled prisoner with integral sanitation and a shower. There were facilities for disabled prisoners on E wing, including showers and a toilet, but no contingency plans for when E wing was inaccessible due to refurbishment. Prisoners complained about the lack of a disabled-access toilet in the workshops. We were told that hearing loops had been installed in the chapel and in the visits hall.

2.66 Although 27% of prisoners were over 50, there was insufficient attention to the needs of older prisoners. There were a few retired prisoners based on the wings who could have undertaken work in cell or low level activity, but there was no formal recognition of the specific needs of this group.

Further recommendations

2.67 There should be a comprehensive diversity policy that addresses the needs of older prisoners, disability and sexual orientation.

2.68 There should be back-up support for disability orderlies.

2.69 There should be contingency plans to sustain access to disabled-access toilets and showers on E wing.

2.70 Disabled access toilets should be installed in the workshops.

2.71 There should be more active support for minority groups.

Race equality

2.72 The perceptions of black and minority ethnic prisoners about their treatment should be explored with them in more depth. (3.55)

Not achieved. There was no opportunity for groups of black and minority ethnic prisoners to meet key staff. Following our previous inspection, when survey evidence had suggested that black and minority ethnic prisoners felt unsafe in the prison, staff had apparently canvassed them on whether they wished to meet as a group, but there was little interest in taking this forward (see below).

2.73 A group open to all black and minority ethnic prisoners should meet regularly to inform the work of the race relations advisory group and the race relations management team. (3.56)

Not achieved. Although the prison had made efforts to encourage black and minority ethnic prisoners to meet together periodically to contribute views to the race equality action group (REAG) and race equality action team (REAT) meetings, there had been little interest in such a forum. However, a committee had recently formed to contribute to black history month, with a level of interest from black and minority ethnic prisoners, and the race equality officer (REO) believed that this might be a more successful forum.
We repeat the recommendation.

Additional information

2.74 While 24% of prisoners were from black and minority ethnic backgrounds, only 3% of staff were. The REO post was now full time, and the post holder was also about to take on diversity work. Recruitment for a part-time assistant REO post was under way.

2.75 The governor had recently started to chair the REAT meeting, which had increased the profile of race equality. Meetings were bi-monthly and were well attended. A race equality action group of eight prisoners continued to meet to inform the REAT meeting, but notes of this meeting indicated that it lacked direction and purpose. Prisoner representatives attended the REAT. They displayed meeting notes in the prison and acted as a reference point for prisoners. Posters and photographs of key personnel from the REAT and REAG were circulated around the prison.

2.76 Since the beginning of 2008, 23 racist incident forms (RIFs) had been submitted. The quality of investigations was high and complainants received an individual response with the outcome of the investigation. RIFs were submitted from a variety of sources. Outcomes included staff referral to diversity training.

2.77 A race equality prison community coordinator was employed across several prisons in the area and had had some success in recruiting local black and minority ethnic representatives to attend REAT meetings. These representatives had recently undertaken a quality assurance exercise on a sample of RIFs. A separate black and minority ethnic community engagement strategy had also been developed.

2.78 A separate element of the induction for black and minority ethnic prisoners outlined the purpose of the REAT and REAG. The induction also covered how to make a complaint using the RIF procedures, and introduced new arrivals to REAG representatives. This was evidenced in many wing files and was a positive initiative.

Further recommendations

2.79 The race equality action group meeting should develop a programme of work to raise its profile and develop race equality work in Kingston.

2.80 There should be a formal quality assurance scheme for racist incident forms.

Foreign national prisoners

2.81 More information should be provided in languages other than English. (3.70)

Not achieved. There was little evidence that information was provided in other languages, apart from the handbook for foreign national prisoners available in the library. Staff were aware of the telephone translating service, although this had not been used for some time.
We repeat the recommendation.

2.82 The foreign nationals policy should be informed by a needs analysis, and an action plan developed. (3.71)

Not achieved. The foreign national prisoner policy had been updated, but there was no evidence of a comprehensive needs analysis of foreign national prisoners. A survey of foreign national prisoners was due to take place, but this was limited in scope and did not address a sufficiently broad range of areas to assist developing services for foreign national prisoners.

Further recommendation

2.83 The foreign nationals policy should be based on a comprehensive analysis of the needs of foreign national prisoners.

2.84 Foreign national prisoners should be helped to maintain contact with their family abroad through a monthly free 10-minute telephone call irrespective of whether they have received a visit. (3.72)

Partially achieved. Foreign national prisoners could now make an application for a free five-minute telephone call per month, regardless of whether they received domestic visits. However, they felt this was not long enough to have a meaningful conversation.
We repeat the recommendation.

2.85 Foreign national prisoners should meet periodically as a group with an identified liaison officer. (3.73)

Not achieved. The designated foreign national liaison officer had been absent for some months and work with foreign national prisoners had stalled. Responsibility for these prisoners was managed jointly by the OMU and the REO, but there had been some loss of momentum

with this work. We were told that foreign national prisoners had been consulted about holding regular meetings, but had declined this option.

Further recommendation

2.86 There should be more efforts to encourage foreign national prisoners to hold regular meetings to raise their concerns.

2.87 Foreign national issues should be a standing agenda item at the race relations management team meetings. (3.74)

Achieved. Foreign national issues were a standing item at the race equality action team meetings.

Additional information

2.88 There were 15 foreign national prisoners at the time of our inspection. The legal services officer had helped several prisoners to obtain legal representation to challenge deportation orders, but said this process had been difficult at times. There appeared to be good contact with Portsmouth Immigration Service, whose staff attended the prison monthly. Foreign national prisoners said they received good quality information from the immigration service.

2.89 All the current foreign national prisoners spoke English. A list of prisoners and staff who spoke other languages was updated and published.

2.90 The library held a range of information for foreign national prisoners, but no foreign language newspapers or magazines.

Further recommendation

2.91 The library should meet the needs of prisoners who do not speak English, and stock foreign language publications.

Applications and complaints

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

Additional information

2.92 The application system was reasonably comprehensive. A triplicate application form was available on wings, and prisoners kept one copy for their reference. Applications were logged daily when they were handed in, and prisoners were supposed to receive an answer within five days. There was no system to track responses or follow them up, and we saw some applications that had been outstanding for several weeks. No quality assurance system was in place.

2.93 Since January 2008, 343 complaints had been submitted, considerably fewer than the 724 for 2007. There was an electronic system to log and track responses, but no quality assurance scheme to ensure consistent and appropriate responses. Some of the responses we saw were curt, others did not answer the complaint and a number were difficult to read.

2.94 Although there had been an analysis of complaints by type at the end of 2007, there was no ongoing analysis. There had been a survey of prisoners about the complaints system in August 2008, but the response rate was low (12%) and it had not yet been analysed.

2.95 Complaints that indicated bullying or racism were forwarded to the violence reduction coordinator or race equality officer, although not all that raised bullying were forwarded (see paragraph 2.46). There had been 20 each of such complaints in 2008 to date.

Further recommendations

2.96 A quality assurance system for applications should be introduced.

2.97 A quality assurance system for complaints should be introduced.

2.98 There should be ongoing analysis of patterns and trends in complaints to identify key concerns.

2.99 The complaints survey of prisoners should be analysed and fed into ongoing analysis to identify areas of prisoner concern.

Legal rights

2.100 Additional private interview rooms for legal visits should be provided. (3.119)

Not achieved. There was still just one booth for legal visits, which was insufficient. Legal visits took place four times a week, and the private booth was usually allocated on a first come, first served basis. As the main visits hall was relatively small, conversations could be overheard if legal visits took place in the main visits hall.
We repeat the recommendation.

Additional information

2.101 There was one trained legal services officer, but he had been trained over 10 years ago and had not had any refresher training. He had had difficulties in accessing profiled time for this work, which had reduced his availability for prisoners.

2.102 New arrivals were asked to report if they were appealing against sentence or conviction and could also request a meeting with the legal services officer. The legal services officer maintained an appellants' register. He said that his main work was linked to appeals, but prisoners also asked for information on family law, including divorce proceedings and access to children. He was attempting to get access to a laptop computer for a small group of prisoners under the Access to Justice project, as the previous laptop was defunct.

2.103 The library stocked up-to-date Prison Service orders and a reasonably broad range of legal texts and reference books.

Further recommendations

2.104 The legal services officer should have regular profiled time for this work, with back-up provision available.

2.105 The legal services officer should have refresher training.

2.106 A laptop computer should be provided for the Access to Justice prisoners' group.

Substance use

2.107 Healthcare staff should receive training in the clinical management of opiate-dependent prisoners. (8.59)

Not achieved. No members of the healthcare team had received specialist training in the clinical management of prisoners with substance misuse problems.
We repeat the recommendation.

2.108 Comprehensive clinical protocols should be developed in consultation with external substance misuse specialists. (8.60)

Not achieved. There had been initial links with the community drug and alcohol team, but there were no comprehensive clinical protocols to manage prisoners with substance misuse problems.
We repeat the recommendation.

2.109 Individual care plans and reviews should be introduced. (8.61)

Achieved. The counselling, assessment, referral, advice and throughcare service (CARATs) saw all new arrivals, whether or not they had a substance misuse problem, and drew up care plans for identified cases. CARATs care plans were reviewed after every six sessions, or six months, even if the files were suspended. The CARATs administrator sent letters to all prisoners on the database to check whether their cases needed to be reopened.

Additional information

2.110 There had been 222 mandatory drug tests in the year to date, of which 12 were positive (5.4%). Of these positive tests, 10 (4.5%) were due to illicit use of dihydrocodeine and benzodiazepines (diverted prescribed medication), and only two due to cannabis or cocaine (0.9%) – which had been the source of most positive tests at our previous inspection. There had been seven suspicion tests in the year to date, of which two were positive, and 1,915 voluntary drug tests, of which 30 were positive. There were an additional 117 positive tests, which were consistent with prescribed medication.

Vulnerable prisoners

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

Additional information

2.111 The policy of the prison was to integrate sex offenders and other vulnerable prisoners with the general population. All prisoners were informed of this policy before their transfer to Kingston. While there was no formal procedure to make staff aware of these prisoners, the policy appeared to be effective.

2.112 We were told that any concerns about vulnerable prisoners were identified and addressed through the violence reduction measures. We were given an example of one such case, which involved the use of the safer custody representatives.

Health services

2.113 Nursing cover should be extended until later in the evening to provide a more flexible service to prisoners. (4.44)

Achieved. The healthcare department still opened 8am to 5pm Monday to Friday and 8am to 12.30pm on weekends, but drop-in sessions had been introduced at 11am and 2pm, which had improved access to healthcare. Most of the prisoners we spoke to were satisfied with their access to health services.

2.114 The lead clinical nurse should receive professional updating to develop chronic disease management and health promotion services. (4.45)

Partially achieved. The clinical lead nurse was an experienced dual-qualified registered general nurse (RGN) and a registered mental nurse (RMN) who had been in post for one year. She had recently completed a minor injuries course and a community upskilling programme. There were health promotion displays on topics such as diabetes, weight, smoking cessation and skin cancer awareness in the healthcare corridor. Although the clinical lead nurse and the modern matron had the clinical skills to run chronic disease and health promotion clinics, these had been hampered by the lack of the full complement of nursing staff. There needed to be stronger links with the PE department and the kitchen to improve health promotion.

Further recommendations

2.115 There should be regular chronic disease and health promotion clinics.

2.116 The healthcare department should work with the PE department and the kitchen to improve health promotion.

2.117 The prison core day should be revised to accommodate additional medication dispensing times. (4.46)

Achieved. Medication administration had been increased to three times per day, at 8am, noon and 4.30pm. At weekends, medications were administered twice daily, at 8am and 12.30pm.

2.118 Officers should supervise prisoners carefully during medication distribution and challenge any inappropriate behaviour. (4.47)

Achieved. Prisoner queues for medication were supervised by at least one officer. Prisoners were kept behind the gated door near the dispensary and went to the medication hatch one at a time. The medication sessions we observed were quiet and orderly, and prisoners had an opportunity to discuss medication in confidence with the nursing staff.

2.119 A full review of prescribing practices should be undertaken to reduce the levels of opiate medications in use. (4.48)

Not achieved. There had been a recent review of opiate prescribing by the head of the

medicine management committee. We were told that the findings showed that the majority of prisoners prescribed opiate-based medication were already on this when they arrived at Kingston. However, this should have addressed the underlying issue of the overprescribing of opiate-based medication, which had been our concern at the previous investigation. The newly appointed modern matron was a fully qualified nurse prescriber and planned to address the prescribing practices to decrease the prescription of opiate-based medication, which had been linked to bullying and intimidation (see also recommendation 2.50).

2.120 Additional qualified counsellors should be provided to improve support for prisoners. (4.49)

Partially achieved. The provision of qualified counsellors had greatly improved, but there was still a need to improve counselling services for prisoners with minor mental health needs, such as for anxieties, phobias, loss and bereavement, and mild depression.

Further recommendation

2.121 A member of the healthcare team should receive training in cognitive behaviour therapy to meet the needs of prisoners with primary mental health problems.

2.122 The primary care trust, the pharmacy and the healthcare manager should amend the current service level agreement for pharmacy services to establish clear responsibilities for the professional and supply aspects of the service and appropriate lines of communication. (4.50)

Not achieved. The September 2008 meeting of the bi-monthly medicines management committee (see paragraph 2.126) had discussed issues concerning non-adherence to the service level agreement (SLA). Shortcomings identified included irregular pharmacist attendance at the prison, delays in medications arriving on time and sometimes not at all, insufficient checking of dispensed medication, leading to some labelling inaccuracies, and supply of wrong dosages. An audit of these inaccuracies showed that there had been 32 errors in the period from 15 October to 2 November 2008. Prisoners had no direct contact with the pharmacist.

Further recommendation

2.123 There should be an urgent review of pharmacy services to determine the required level of input from the pharmacist, provide pharmacist-led clinics, and introduce clinical audit, quality control and medication reviews.

2.124 Stock lists and levels of medicines held should be established, records should be kept in a logbook and the use of medication reconciled against the drug chart. Pharmacy staff should visit the prison regularly to check and reconcile medicines stocks. (4.51)

Achieved. A pharmacy technician had been appointed in August 2008 and attended the prison every afternoon. Stock lists and levels were maintained and records kept.

2.125 All medicines supplied to patients should be labelled in accordance with the Medicines Act. (4.52)

Not achieved. Pre-packed medicines supplied by the pharmacy were not dual-labelled to

enable one label to be fixed to the prescription chart at the point of supply to inform the pharmacist that the correct item had been supplied.
We repeat the recommendation.

2.126 The medicine management committee should involve representatives of the healthcare team and a representative from the PCT, and develop and formally adopt a medicine policy to include in possession and special sick directives. (4.53)

Partially achieved. A medicines management committee meeting took place every two months and was attended by the modern matron, GP, contracted pharmacist, and PCT head of pharmacy. An in-possession policy had been developed incorporating a three-way risk assessment, which included assessing the prisoner, the medication and security issues. The policy included a list of medications to be issued in possession with caution, but this did not seem to be followed rigorously. There were no patient group directives to enable nurses to prescribe medications.

Further recommendations

2.127 The in-possession medication policy should be adhered to.

2.128 There should be patient group directives to enable nurse prescribing.

2.129 An evidence-based drug formulary should be established. (4.54)

Partially achieved. A formulary used by all GPs across the district had been adopted. However, this formulary did not take into account the special circumstances of a prison, and the additional cautions needed to reduce the potential for possession of certain medication to give rise to bullying and intimidation.

Further recommendation

2.130 The medicines management committee should write a prison-specific addendum to the drug formulary highlighting those medications with the potential for abuse.

2.131 The dental x-ray machine should be replaced. (4.55)

Achieved. The dental suite was refurbished in July 2008 and a new X-ray machine installed.

2.132 Clinical policies and protocols should be introduced. (4.56)

Achieved. Several policies and protocols had been written and introduced. These covered palliative care, infection control, information sharing, in-possession medication and a condom policy. Further policies and protocols were not prison-specific, but shared with the PCT.

Additional information

2.133 Portsmouth Primary Care Trust had been responsible for the commissioning and provision of health services at Kingston since 2006. The modern matron (head of healthcare) took up the post in October 2008, three weeks before the inspection. She had inherited significant staffing problems that had left the department with only two qualified RGNs, which had affected the

delivery of service. There were plans to overcome this shortfall through temporary use of agency nurses. Three GPs from a local practice held surgeries three times a week, but were on site daily if needed. They provided continuity of care, and access to their clinics was usually within 24–48 hours.

2.134 The mental health provision consisted of one full-time RMN, a psychiatrist who provided one session a week and a clinical psychologist who held two sessions a week. During the inspection, the RMN was on sick leave and other members of the healthcare team were uncertain about her responsibilities. There seemed to be little communication between the RMN and the rest of the healthcare team, and information about her workload needed to be more transparent. Prisoners with primary mental health, needs such as anxiety, phobias, loss and bereavement issues and mild depression, did not appear to be adequately supported. We saw no evidence that multidisciplinary care programme approach reviews were carried out for patients with severe and enduring mental illness. Healthcare and relevant prison staff did not receive annual mental health awareness training. The RMN reviewed and conducted mental health assessments on all prisoners who had self-harmed, which was good practice. The psychiatrist conducted mental state examinations and medication reviews of prisoners with more serious mental health needs. The psychologist spent most of his time helping prisoners with post-traumatic stress disorders or personality disorders.

2.135 There was liberal prescribing of opiate-based analgesia, which could result in intimidation, bullying and diversion of medication to others not prescribed it. This area was beginning to be addressed, and the newly appointed modern matron had already started to rectify this situation. No member of the healthcare team had received training in substance misuse, which would have helped the management of prisoners with drug abuse problems (see recommendation 2.107). The pharmacy provision needed scrutiny to ensure safer practices.

Further recommendations

2.136 There should be yearly mental health awareness training for all healthcare and relevant prison staff.

2.137 Prisoners with severe and enduring mental illness should be subject to the safeguards of regular multidisciplinary care programme approach reviews.

Learning and skills and work activities

2.138 Punctuality and attendance in education classes should be improved. (5.13)

Achieved. Monitoring of attendance and punctuality in education classes had improved since the last inspection. Milton Keynes College had thorough processes to track attendance and punctuality in education, and electronic registers were used to record this. Attendance and punctuality were discussed at staff meetings and the quarterly quality improvement group (QIG) meetings. Late starts to lessons due to regime issues were bought to the attention of senior prison staff, and improvements had been made. Attendance during the last six months averaged over 90%, an improvement from around 80% in the previous year. Most absences were fully explained and clearly recorded.

2.139 Education and training should be better promoted to make good use of capacity. (5.14)

Achieved. Education and training were now better advertised on the wings and well promoted

through the information, advice and guidance (IAG) service at induction, which used clearly presented leaflets on the courses available. Prominently displayed notices advertised course dates and times. Four education representatives helped to further promote the provision among prisoners.

2.140 Effective quality assurance procedures should be fully implemented in education and training. (5.15)

Partially achieved. The QIG had been re-established following the previous inspection and had the full backing and support of the governor. The quarterly QIG meetings were well attended by senior staff from all key departments. There had been actions to ensure that individual learning plans (ILPs) were fully integrated into sentence planning. The education department had well-established quality improvement procedures. However, many aspects of quality assurance – such as observations of teaching and learning, and learner feedback – were not fully implemented in vocational areas and had not led to significant improvements. The self-assessment process was inclusive and had led to useful action planning for learning and skills provision. Attempts were made to ensure appropriate courses were available and data was used adequately to influence the curriculum.

2.141 The library should increase its materials to support literacy, numeracy, English for speakers of other languages [ESOL] and accredited training. (5.16)

Achieved. The library had been extended in the previous 18 months and the range of learning materials had been increased for literacy and numeracy and accredited training courses. Although the materials for ESOL were limited, the library could obtain requests promptly.

2.142 The library should better promote its services to prisoners. (5.17)

Achieved. The library service was now advertised on notice boards around the prison, and the education representatives promoted the service directly to prisoners on the wings. Prisoners said that there was greater use of the service by those not attending education courses following the introduction of loan DVDs and CDs, as well as the development of appropriate reading challenges, and an active book club, which was attended by prisoners and officers. However, data on attendance at the library was limited and not used to inform improvements to the service.

2.143 Opportunities should be taken to accredit all skills acquired at work to reflect industrial practice and needs for employment. (5.23)

Not achieved. There were few opportunities for prisoners to gain accreditation for the skills they developed. Some qualifications had not been relevant for prisoners on long sentences. National qualifications had been stopped in the kitchen and gardens since the last inspection, with nothing appropriate to replace them.
We repeat the recommendation.

2.144 A wider range of accredited training opportunities should be offered, providing useful skills to aid eventual resettlement. (5.24)

Partially achieved. Some training opportunities had improved since the last inspection, including more advanced colour printing. However, there were missed opportunities to develop training (see below). The prison's self-assessment recognised that little had been done to ensure work skills were appropriately accredited.

Additional information

2.145 There had been actions to improve the education provision, and the percentage of prisoners on education courses had improved slightly to 54%, from 51% at the previous inspection. This included 12 prisoners on distance learning and Open University courses, as well as others on GCSE and A level courses.

2.146 Learning and skills provision was well led, and managers had a clear understanding of the strengths and areas for improvement. There were good working relationships between senior staff from the prison and college managers to ensure an adequate range of courses was available. This included entry level one and two in literacy and numeracy; GCSEs in English, maths, sociology and history; art and design; and a range of information and communication technology (ICT) courses.

2.147 Quality improvement was good in education, although not fully implemented across the learning and skills provision. Observations of teaching and learning in education had helped to identify action points for teaching staff, although there had been few observations in vocational training areas. Quality monitoring in education also included well-recorded peer observations. The acting head of learning and skills had been active in ensuring a more cohesive approach to education and training across the prison, and had encouraged active and full participation at the QIG, with support from the governor. There were plans to develop the learning and skills provision further.

2.148 There were 135 prisoners employed across a range of activities and 43 in vocational training, although most were on short courses. Prisoners were encouraged to work and there were sufficient work spaces, with only seven unemployed. Pay was equitable, and all prisoners had an opportunity to participate in part-time education. There was acquisition of skills in some areas, although over 10% of prisoners were still engaged in low quality contract work (see paragraph 2.8). Some prisoners gained useful skills in areas such as computer-aided design, technical drawing, gardening and in the kitchens. Those working in the print shop could use a wide range of equipment, including a newly installed two-colour print machine. However, although the range of vocational training opportunities had improved, there was still insufficient recognition of skills learned in many of these areas. In the kitchens, for example, there was no opportunity to gain recognised qualifications in food preparation, and only five out of the 15 prisoners working there were on a food hygiene course. The skills learned in the gardens were similarly not accredited. There were missed opportunities to develop vocational training in the works department, where only one prisoner was employed as a painter and decorator with no accreditation.

2.149 The library service was operated by Portsmouth Library Service and was run by a part-time librarian supported by two prison orderlies. The training received by the prison orderlies was not accredited. The librarian's hours had increased from 14 to 20 hours per week since the last inspection. The library was in the education department and was bright, well laid out and spacious, having been extended since the last inspection. It had a good range of books, periodicals, DVDs and other learning materials, although prisoners had no access to computers.

2.150 The library was well used by those attending education courses. Prisoners who did not attend education had adequate access for half an hour a day including weekends, although the library was not open in the evenings. Stock levels were well maintained, although book loss was not monitored. Library use was poorly recorded, and the little data that was available gave insufficient information to help improve the service.

Further recommendations

2.151 There should be more vocational training and accredited learning in the workplace.

2.152 Library usage and book loss should be better recorded, and the information used to help improve the service.

Physical education and health promotion

2.153 The quality and availability of outdoor sports facilities should be improved. (5.32)

Not achieved. There had been no improvements to the outdoors sports facilities since the previous inspection. The outdoor football pitch was in good condition, but was underused by most prisoners. The external AstroTurf area had deteriorated beyond economical repair. A tarmac-surface yard near the perimeter wall was only suitable for a limited range of sporting activity.
We repeat the recommendation.

2.154 Access to information technology in the physical education department should be increased to enable more prisoners to work towards national vocational qualifications, trainer and assessor awards and internal verifier qualifications. (5.33)

Achieved. A room had been converted to a PE course study area, and new computers and software had been installed.

2.155 Staff numbers should be increased to meet the growing needs for vocational training and recreational physical education. (5.34)

Not achieved. The number of staff remained low, with one senior officer and two full-time PE staff. Staff were experienced and continued to offer a comprehensive range of provision. However, as at the last inspection, there were too few staff, which affected the availability of the full range of activities.
We repeat the recommendation.

Additional information

2.156 The PE facility was adequate and was attended by 64% of prisoners. Prisoners had access to at least two hours of PE sessions a week, and there was a PE programme during the week, at weekends and in the evenings. The PE staff made good use of the limited space available and offered a good range of provision; including training sessions aimed at the over 40s. Few prisoners took accredited sports awards, and only five were currently on courses. The cardiovascular and weights rooms were small and difficult to monitor, and the cardiovascular equipment, although adequate, was old and in poor condition. The sports hall was well maintained. Clean towels and gym kit were available to all prisoners, and could be changed once a week. Showers in the PE department were in good condition, although most prisoners showered on the wings.

2.157 The PE department continued to have good links with the local community. The prison football team played in a local league, and held regular away and home matches. Links with a local school for children with learning difficulties had been maintained, and children came into the prison once a week to receive training from those on PE courses.

2.158 There were good links with healthcare and CARATs staff to provide a programme of remedial sport. Healthy living was generally well promoted to prisoners who went to PE, and three trained prisoners with responsibility for this area helped other prisoners with weight management and health-related issues.

Faith and religious activity

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

Additional information

2.159 The small chaplaincy team comprised one full-time coordinating chaplain supported by sessional chaplains representing major faiths. There was a programme of regular religious services and meetings, some supported by external community input, including a local Baptist church, the Quakers and the Prison Fellowship. Attendance at Christian services was, however, limited to about five for Catholic services and between eight and 13 for the weekly Church of England service.

2.160 The prison held 21 Muslim prisoners, of whom about 10 were regular attendees at Friday prayers. A Muslim chaplain had been appointed to provide five sessional hours per week, but we were told that his attendance was erratic and he rarely took Friday prayers, which were left to a prisoner to organise. His involvement in the recent successful Ramadan observance was also marginal. The issue had been raised through the REAT.

2.161 Chaplaincy facilities comprised a chapel, including a flexible meeting space, and a world faith room that was also used for prisoner boards. Both the chapel and the world faith room were appropriate, but were untidy. The chapel was due to be refurbished.

2.162 The coordinating chaplain discharged statutory responsibilities, and all new arrivals were seen within 72 hours, if not sooner. The chaplain was invited to attend the senior management team, and did so occasionally, but was more routinely engaged with the REAT and the drug strategy committee. The chaplain was particularly focused on supporting sentence planning work.

Further recommendation

2.163 The Muslim chaplain should attend the prison for the required number of sessional hours.

Time out of cell

2.164 Staff should check periodically on those staying in their cells during association and record the reasons in the prisoner's wing file. (5.50)

Partially achieved. We were told that staff were aware if prisoners chose to remain in their cells during association, particularly if this represented a change in behaviour. The quality of notes in wing files provided further assurance of staff knowledge of prisoners and their behaviour. However, not every instance where prisoners chose to opt out of association was recorded.

2.165 Prisoners of retirement age who choose not to work should be allowed to remain unlocked during the working day and suitable activities should be provided for them. (5.51)

Achieved. Several staff confirmed that prisoners of retirement age were not locked up during the working day if they chose not to work. However, all nine prisoners of retirement age had opted to work and were engaged in various activities. If a prisoner decided not to work, his activity needs were addressed on an individual basis. E wing, which was now closed, had held several older prisoners who did not work and who had been offered various on-wing and recreational educational activity.

Additional information

2.166 The prison reported a time unlocked figure of 10 hours a day against a target of 9.7 hours. This was accurate, but included data from the recently closed E wing, which inflated the overall figure, as the prisoners were never locked in on that wing. The published core day indicated that, for a normal prisoner, actual unlocked time was 9.5 hours from Mondays to Thursdays, just short of our expectation of 10 hours. Our observations suggested that the application of the core day was reasonably disciplined, and that prisoners were unlocked on time and were not locked up early.

2.167 Access to association was good, with 2.25 hours available each evening, Monday to Thursday, as well as Friday afternoons and throughout the day at weekends. Access to time in the open air was limited to 30 minutes every morning, but was also available throughout Friday afternoons for standard and enhanced prisoners. On weekend afternoons, an additional two hours in the open air was available for enhanced prisoners. However, there was poor take-up of time in the open air.

Further recommendations

2.168 All prisoners should have access to at least 10 hours a day unlocked.

2.169 Standard-level prisoners should have access to additional time in the open air at weekends.

Security and rules

2.170 Security intelligence should be analysed each month to indicate trends and provide a basis for risk management. (6.13)

Achieved. In addition to notes for the security meeting, a security briefing report was prepared to provide a more in-depth analysis of key security incidents. This report enabled a more detailed perspective on emerging security trends. The prison also responded to specific concerns, such as the management of prescribed prescription drugs, and prepared specific, detailed reports based on a number of sources, including security information reports (SIRs), dynamic security and staff observations.

2.171 Restrictions on prisoners should be imposed only when there is evidence to demonstrate that this is a proportionate response to an identified risk. (6.14)

Achieved. Only one prisoner was currently subject to closed visits, for reasons that appeared

proportionate. In recent months, there had been few prisoners on closed visits, and there was no evidence that the prison imposed significant restrictions on prisoners without supporting intelligence.

Additional information

2.172 Between January and October 2008, 1,242 SIRs had been submitted. Most indicated instances of drugs, bullying and threats from prisoners. The main security concerns for the prison were mobile telephones and drugs. The location of the prison in the town centre made it vulnerable to packages thrown in over the wall.

2.173 There had been 24 incident reporting system (IRS) incidents since January 2008, of which nine related to incidents of self-harm.

2.174 Security committee meetings took place monthly and were well attended. The police liaison officer was usually present. Notes of the meeting were brief, but a separate intelligence report contained more detailed information. Two staff had been trained in intelligence analysis.

2.175 Fewer than 10 prisoners were subject to telephone monitoring, and there were no developing or prominent nominal prisoners (individuals targeted for legitimate security reasons).

Categorisation

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

Additional information

2.176 The recategorisation process was administered by the offender management unit (OMU) and appeared to be effective. The prisoner's category was discussed at his annual sentence planning review board. If the board felt recategorisation was appropriate, the prisoner was referred to a recategorisation board.

2.177 Recategorisation boards were held during the last week of the month and were chaired by the governor and informed by a report from the personal officer, offender supervisor and security department. Prisoners attended these boards and discussed their categorisation and appropriate allocation. Once a decision was made, the OMU was responsible for submitting transfer requests to the allocated prison and liaising with the population management section.

2.178 Some prisoners were dissatisfied with the allocation system because of the lengthy delays in moving on, as well as management of the system. It was unclear how OMU staff ensured the system operated equitably.

2.179 E wing, which had held 24 category C prisoners in shared accommodation, was closed for refurbishment. Some prisoners had been transferred out to new accommodation in HMP Coldingley. The prison needed to ensure that its remaining C prisoners were sufficiently supported and encouraged by staff, and that their regime focused on their progression and preparation for open conditions.

Further recommendations

2.180 The allocation waiting lists should be appropriately managed.

2.181 Category C prisoners should be provided with a regime that focuses on and supports their progression to open conditions.

Discipline

2.182 Healthcare staff and managers should ensure that the section in the algorithm concerning healthcare issues is completed accurately. (6.30)

Achieved. We reviewed a broad sample of cases from the segregation unit since 2007 and noted that that healthcare algorithm section was completed in all cases. Segregation unit staff reported a closer working relationship with staff from the healthcare department, which had improved practice.

2.183 There should be a register to indicate each prisoner who has been segregated, the reason for it and its duration. (6.31)

Achieved. A segregation register had been introduced, which indicated the name of the prisoner, the aspects of the regime he had participated in, staff on duty and the reason for the segregation. Managers could use this register to determine the duration of stays in the segregation unit for individual prisoners.

Additional information

2.184 There were no adjudications during the inspection. Adjudications were held in the segregation unit wing office, which appeared small for the number of potential participants. Adjudication records were well completed and there was evidence of consistency for punishments. In almost all adjudication files, healthcare staff reported on the fitness of the prisoner to participate in adjudication processes and cellular confinement.

2.185 Since January 2008, there had been five uses of force. Paperwork was completed well. A planned removal had been video recorded.

2.186 At the time of our inspection, there was only one prisoner in the segregation unit, who was there for his own protection. Since the last inspection, the segregation unit had relocated to B wing. The unit had three cells plus one special cell. Staff said that the special cell had not been used for more than a year. The unit, which was dark, had a telephone, two showers and a toilet. A small, clean exercise yard was also available, but there were no outdoor seats. The segregation unit regime included daily showers, one hour's exercise and access to the telephone. In-cell education was included on the timetable, but staff said it rarely took place. A small library was available. In-cell electricity was about to be installed, and wind-up radios were provided in the interim.

Further recommendations

2.187 Adjudication hearings should be conducted in a suitable environment.

2.188 Outdoor seating should be provided in the segregation unit exercise area.

2.189 In-cell education should be provided in the segregation unit for those prisoners who request it.

Incentives and earned privileges

2.190 The prison should confirm a prisoner's incentives and earned privileges status on reception. (6.41)

Achieved. New arrivals could maintain their previous privilege level. All prisoners were assessed again after three months to ensure that they were adhering to the standard appropriate to their level at Kingston.

2.191 Decisions to demote a prisoner should not be unduly delayed. (6.42)

Achieved. Prisoners on enhanced level were reviewed annually. If they were demoted, there was a review after three months and, thereafter, as frequently as deemed appropriate, but at least at three-monthly intervals. Documentation from the recent boards that we reviewed did not indicate that decisions to demote were unduly delayed.

2.192 An individual case work approach should be adopted for the few prisoners who do not reach enhanced and prisoners should not be allowed to remain on basic for long periods without progress. (6.43)

Achieved. Only two prisoners had been on the basic level in the previous 12 months. In both cases, the prisoner was reviewed after seven days and was set clear objectives in order to progress. History sheets were maintained during any period on basic to ensure there was appropriate information to inform decisions.

Additional information

2.193 An identified senior officer was the incentives and earned privileges (IEP) coordinator. The system for managing prisoners under the IEP scheme was generally good. Information about the process was displayed on wing notice boards. IEP board decisions were relayed to prisoners within 24 hours, and usually at the board itself.

2.194 Personal officers were expected to complete assessments for the boards, based on a template. Although such reports were expected to indicate the work undertaken on offending behaviour, our review suggested this was not always the case. Prisoners who denied their offence and, therefore, did not attend identified programmes and courses, could still achieve enhanced status.

Catering

2.195 Meals should be served on a rota to avoid undue congestion and queuing. (7.11)

Achieved. Meals were served in the dining hall. A controlled unlock meant there was a steady flow of prisoners to the servery. The disability orderly attended first to collect meals for prisoners he was supporting before other prisoners were unlocked. The meal queue was supervised by staff and we did not see any congestion; the queue moved swiftly and was well managed.

2.196 Facilities should be provided to allow all prisoners the opportunity to eat out of their cells. (7.12)

Not achieved. There had been no change in the facilities available. A few chairs and tables were available on each wing for prisoners who wished to dine in association, but these were not enough for the number of prisoners who would have liked to dine together (see also paragraph 2.27 and recommendation 2.28).

Additional information

2.197 Most prisoners were satisfied with the quality of the food. A three-week rolling menu offered a range of choices, including healthy options, halal and vegetarian dishes. Fresh fruit was offered daily. Breakfast packs were issued the day before consumption and contained longlife rather than fresh milk. There had been a prisoner food survey earlier in 2008, and catering was a standing item on the bi-monthly amenities meeting.

2.198 Fifteen prisoners worked in the kitchen. Several complained that they did not receive clean kitchen whites each day. The kitchen was reasonably large with a range of storage areas, but many large electrical items, including the blast chiller, several freezers, fridges and ovens, were out of commission.

Further recommendation

2.199 Breakfast should be served on the day it is to be eaten.

Housekeeping points

2.200 Clean whites should be available to kitchen workers each day.

2.201 Electrical items in the kitchen that are out of commission should be repaired as soon as possible.

Prison canteen

2.202 Prisoners should have access to the canteen within 24 hours of arrival. (7.20)

Not achieved. Prisoners were unable to use the prison canteen on their first day of arrival. Canteen order sheets were collected by Wednesday, and orders distributed on Saturday mornings. Prisoners transferred from prisons in the region could have their canteen order transferred to Kingston by Aramark, but only if all the electronic transfers were made on time. Some prisoners transferred in without their shop order and could wait for over a week to buy items from the canteen.
We repeat the recommendation.

2.203 A wider range of products including fresh fruit should be available from the canteen. (7.21)

Achieved. The canteen list had been extended and now included over 300 items, with evidence that new goods were added regularly, and prisoners could now buy packs of oranges and apples. There appeared to be a reasonable range of goods for black and minority ethnic prisoners and those who followed specific diets. Prices appeared to be broadly comparable to high street prices. Prisoners could also buy clothes, footwear, music, games and craft materials from a range of catalogues.

Strategic management of resettlement

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

Additional information

2.204 The published reducing reoffending strategy had been revised in July 2008 to reflect the introduction of the offender management unit (OMU). The strategy incorporated an overview of each resettlement pathway, including details of the interventions available to support their delivery and the key partners involved. The strategy was largely descriptive, and was not underpinned by a current needs analysis (see recommendation 2.13). The sections on pathways did not include action plans or target dates to develop delivery.

2.205 Pathway provision was well advertised throughout the prison. Posters in departments such as education and CARATs outlined their contribution to specific pathways and the interventions available.

2.206 The head of offender management chaired a bi-monthly reducing reoffending meeting, which was attended appropriately by strategic lead staff.

2.207 Few prisoners were released from Kingston to the community – there had been just three releases in 2008 but these were very ill prisoners released on compassionate grounds. Category C prisoners could have three accompanied community visits in a 12-month period.

Further recommendation

2.208 The reducing reoffending strategy should include clear and specific objectives with identified lead staff and achievement milestones.

Offender management and planning

2.209 Supervising probation officers should complete their contribution to prisoner progress reports on time. (8.19)

Not achieved. OMU staff said it was difficult to obtain reports from community-based offender managers in a timely manner. They always requested reports for parole board reviews well in advance of board dates, but parole dossiers often had to be submitted incomplete. In one case, the prison had requested a report from external probation services in January 2008 for an oral hearing scheduled for July 2008. The report was subsequently received in October 2008 and, at the time of the inspection, the hearing had yet to take place.

Further recommendation

2.210 Community-based offender managers should complete their contribution to prisoner progress reports on time.

2.211 Supervising probation officers should attend the annual review boards. (8.20)

No longer relevant. See below.

Additional information

2.212 Designated prison service managers (DPSMs) and the OMU were now responsible for the sentence plan process for life-sentenced prisoners other than those on indeterminate sentence for public protection (IPPs). Offender supervisors routinely informed the community-based offender manager of a prisoner's arrival at Kingston, gave them information about the prison's role and the dates of any planned boards, and invited them to attend or submit contribution reports. From the OMU records and contact logs it appeared that contact and liaison between community offender managers and offender supervisors was not regular. There was little evidence of discussions about a prisoner's progress or developments in sentence plans. In one offender manager file that we viewed the offender supervisor had logged a query to the offender manager in July 2008, but an entry in September showed that a response had not yet been received. Community-based offender managers for IPP prisoners in scope of phase three usually attended review boards, but did not consistently chair them. The prison supported offender managers to take on this role, but dealt with a large number of different probation services and offender managers, which made it difficult to establish positive, effective relationships.

Further recommendation

2.213 There should be regular contact between community-based offender managers and offender supervisors to discuss prisoners' progress and developments in their sentence plan.

2.214 Sending prisons should ensure that all offence analysis and risk assessment work is completed before transferring prisoners to a second stage prison. (8.21)

Not achieved. OMU staff expressed frustration that prisoners continued to be transferred to Kingston without completion of risk assessment work. For example, at the time of inspection they were completing three offender assessment system (OASys) assessments for prisoners who had arrived at the prison without them. Although all transfers to Kingston were planned, key documentation often did not accompany the prisoner. This affected the effectiveness of reception and initial sentence plan review meetings.

Further recommendations

2.215 Sending prisons should ensure that prisoners have an up-to-date offender assessment system (OASys) assessment before transferring them to a second-stage lifer prison.

2.216 All appropriate life sentence documentation should be forwarded to the receiving prison in a timely manner when a prisoner is transferred.

2.217 All annual review boards should be informed by a personal officer and seconded probation officers. (8.22)

Partially achieved. There had been a recent re-profiling exercise to ensure that there was sufficient facility time for personal officers to attend boards. OMU staff said that personal officers provided reports and attended sentence planning reviews (SPRs). Our examination of OMU files and completed SPR documentation showed that offender supervisors consistently attended and contributed to boards. However, personal officers did not consistently attend or provide written contributions. The board we observed was not attended by the prisoner's

personal officer. We saw evidence that residential staff made contributions to three-year reviews for lifer prisoners, but these were often completed by residential managers rather than personal officers.

Further recommendation

2.218 Personal officers should attend their prisoners' annual review boards and/or provide written contributions.

2.219 The public protection committee should meet quarterly as published and all identified members should attend. (8.39)

Partially achieved. The public protection committee had met quarterly throughout 2008. The meeting was chaired by a designated prison service manager (DPSM) who was also the public protection manager. The membership was limited. Although the police liaison officer and security department staff attended, representation from other departments was not consistent. The meeting largely focused on procedural arrangements, but there was some discussion of individual cases.

Further recommendation

2.220 All appropriate departments should be represented at the public protection committee, and identified members should attend its quarterly meetings.

2.221 All prisoners subject to public protection measures should have their risk re-assessed as part of their annual lifer review. (8.40)

Achieved. The SPR documentation had been adapted to include reference to any public protection measures that applied to the prisoner to ensure these were discussed during annual reviews. The minutes of the public protection meeting showed that annual reviews had taken place.

Additional information

2.222 The public protection policy was under review at the time of the inspection. The prison continued to operate effective procedures to ensure that all prisoners subject to public protection measures were identified in reception initially, and the public protection manager examined all reception paperwork to ensure that key information and risks had not been missed. Communication with other relevant departments was effective. Staff in visits were well informed about safeguarding children arrangements and the prisoners to whom the procedures applied. Telephone and mail monitoring was carried out by an administrative member of the security team. The public protection manager had recently attended an external multi-agency public protection meeting for a prisoner who was subsequently released from Kingston.

2.223 A minimum of two days each year should be held for life-sentenced prisoners to have events that will enable them to develop their understanding and engagement with risk reduction and eventual reintegration. (8.23)

Partially achieved. Lifer surgeries no longer took place following the introduction of the OMU. The head of offender management gave examples of several events and activities throughout

the year, such as the international sports day, but these were not focused on developing prisoners' understanding and engagement with identified risk factors. OMU staff had conducted a recent survey to establish how well prisoners understood the offender management arrangements and the indeterminate sentence structure. Completed surveys had not been collated and analysed, but in a significant number of the responses we examined prisoners said they were clear about their identified risk factors and offending behaviour work they needed to complete. OMU staff had also developed an offender management awareness package for prisoners, which outlined the role of the offender supervisor, the sentence planning process and the resettlement pathways. This had been delivered on five occasions in 2008, but staff felt it did not positively engage prisoners, and intended to revise its content.

Further recommendation

2.224 There should be a range of specific activities aimed at life-sentenced prisoners to develop their understanding and engagement with risk reduction and eventual reintegration.

Additional information

2.225 At the time of the inspection, there were 159 life-sentenced prisoners, most serving mandatory life sentences. There were two prisoners serving automatic life sentences and 22 prisoners on discretionary life sentences. There were also 14 IPP prisoners. All prisoners were case managed by the OMU, introduced in April 2008.

2.226 The OMU consisted of three designated prison service managers (DPSMs) who chaired all sentence planning boards for life-sentenced prisoners. There were six offender supervisors, two of whom worked part time. DPSMs and offender supervisors were drawn from uniformed prison staff and probation service officers. Each full-time offender supervisor carried a caseload of 40 prisoners. Cases were allocated on the basis of numbers rather than by type, and each offender supervisor carried a mix of IPPs, mandatory, discretionary and automatic life-sentenced prisoners. When transfers into the prison were confirmed, one of the DPSMs allocated each prisoner an offender supervisor and a personal officer. This information was circulated to all relevant staff before the prisoner's arrival.

2.227 Offender supervisors completed OASys assessments and reviews for the majority of prisoners. Reviews were carried out before the annual sentence plan review board. DPSMs were responsible for quality assuring a sample of completed assessments. In addition to OASys, the prison continued to use documentation from the life sentence plan to identify a prisoner's risk factors. This appeared to be out of step with national offender management arrangements.

2.228 All prisoners attended a reception board within the first week of their arrival, for an introduction to the various departments in the prison. An initial sentence plan meeting was held, usually within their first three months of arrival, and annually thereafter. Life-sentenced prisoners also had a comprehensive three-year review. Reviews took place each Wednesday morning. The sentence planning review (SPR) records we examined showed that boards were consistently well attended by offender supervisors, and education and chaplaincy staff. Personal officers and community-based offender managers did not regularly attend boards or provide written contributions. Families were always invited to contribute to SPRs.

2.229 The sentence planning board we observed focused appropriately on identified risk factors and risk reduction. The prisoner was engaged in the discussion, and his understanding of the process was checked. During the inspection, there was a board for an IPP prisoner to which

the offender manager contributed through the video-conferencing facility. The board was chaired by the DPSM, as the offender manager had been reluctant to do so. Targets set as a result of SPRs were appropriately oriented to reducing identified risk factors.

2.230 While DPSMs quality assured completed OASys assessments, there were no quality assurance systems for evaluating the level of engagement with prisoners. The content of the offender supervisor contact logs and the frequency of entries were variable. The frequency of contact also varied. Some files contained clear evidence that offender supervisors worked actively with prisoners to focus on risk reduction and progression against sentence plan targets. Other contacts were oriented towards practical issues, liaising with other agencies and general support and encouragement. In some contact files that we saw, the offender supervisor had observed that the prisoner was refusing to engage with his sentence plan, but there was no evidence that the offender supervisor had explored or challenged this.

Further recommendations

2.231 There should be an effective quality assurance scheme to cover all work undertaken by the offender management unit.

2.232 Offender supervisors should demonstrate engagement with the prisoner to address identified risk factors, and this should be recorded in the records of contact.

Resettlement pathways

Reintegration planning

Accommodation

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

Additional information

2.233 The majority of prisoners progressed to other establishments and very few were released into the community. The accommodation provision, therefore, focused appropriately on public protection and liaison between the offender supervisor and offender manager on a case-by-case basis. This was to ensure that there was a release plan that included accommodation for those prisoners with the possibility of release, and that sentence plan reviews and parole board reports referred to this.

Education, training and employment

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

Additional information

2.234 Education provision included courses in citizenship, personal development, and budgeting and money management. There was also a good range of courses to support those with additional learning needs, from entry level one to level two in literacy and numeracy. These courses were well promoted.

2.235 There were employment spaces for all prisoners, and seven prisoners were currently unemployed. However, prisoners received insufficient information from the labour board to be able to improve if they were rejected from employment. Good quality work skills were developed in areas such as printing, information and communications technology (ICT), food preparation and gardening. However, too much of this work was not accredited, and there were missed opportunities for prisoners to gain accreditation from working with highly skilled crafts people in the works department (see recommendation 2.143). There was a useful information, advice and guidance service.

Finance, benefit and debt

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

Additional information

2.236 Although there were no partnerships with relevant community and voluntary sector organisations to support this work, there was a reasonable range of provision, predominantly delivered through the education department. This included an Open College Network (OCN) budgeting and money management course at entry level and level two, and 14 prisoners had obtained a level two qualification in the previous 12 months. A financial training resource for prisoners developed by UNLOCK (UNLOCKing financial capability) had been mapped into this course to focus specifically on managing finances on release. Prisoners could also complete a Firmstart business studies qualification.

2.237 Prisoners could open a savings account, facilitated through a bank, to allow them to learn and demonstrate effective budgeting skills. However, this provision was not referred to in the resettlement strategy.

Further recommendations

2.238 The labour board should provide more detailed information to prisoners rejected from employment.

2.239 The strategic pathway document should include reference to the savings account scheme.

Mental and physical health

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

Additional information

2.240 Healthcare staff saw all prisoners before their release or transfer and gave them a summary of the care received. Prisoners with an outstanding or ongoing outpatient appointment were given a clearly written document outlining the specialism, hospital, consultant and date of their next appointment. All prisoners on medication were given at least a week's supply.

2.241 The palliative care policy worked well. A terminally ill prisoner had recently been released home with a fully integrated care package to support his needs.

2.242 We saw no evidence of multidisciplinary care programme approach (CPA) reviews to support the throughcare of prisoners with severe and enduring mental illness.

Further recommendation

2.243 Prisoners with severe and enduring mental illness should be subject to the care programme approach (CPA).

Drugs and alcohol

2.244 An alcohol strategy should be developed. (8.58)

Not achieved. The overall drug strategy did not include an alcohol strategy. The only support for prisoners with sole alcohol problems was an alcohol awareness course offered by the education department. This was a once weekly 10-week OCN-accredited course covering the psychological, physical and social effects of alcohol. Prisoners who completed this were awarded a certificate. Access to the course was mostly by self-referral, and referrals from the substance misuse service or healthcare were rare. Alcoholics Anonymous (AA) also held weekly group sessions.
We repeat the recommendation.

2.245 Additional CARAT resources should be provided and group work introduced. (8.62)

Not achieved. There was still only one full-time CARAT worker and a part-time administrative officer. This shortfall in provision was highlighted during the inspection as the CARATs department was closed because the CARAT worker was on leave and the administrative officer had been off sick for several weeks. The CARAT worker was unable to accommodate groupwork due to the volume of her one-to-one work.
We repeat the recommendation.

2.246 Structured post-programme support should be introduced and a peer support scheme developed. (8.63)

Achieved. The CARAT worker attended all post-programme reviews after prisoners completed the P-ASRO (prison addressing substance related offending) course, offered in-cell support packs and arranged to follow up each prisoner individually for three sessions. The auricular acupuncture offered during the P-ASRO course could also be continued for as long as the prisoner felt it was useful. Past attendees provided peer support for the new recruits before, during and after the course, but this arrangement was ad hoc. A more formalised evening peer support group had been set up after the last inspection, but was discontinued due to lack of interest.

2.247 Prisoners should have access to a professional counselling service. (8.64)

Achieved. Prisoners could be referred directly to the RMN at any time through CARATs or P-ASRO. There was also a monthly interdisciplinary management meeting attended by staff from P-ASRO, probation, CARATs and the RMN and chaplain. Emerging mental health issues were taken forward by the RMN in liaison with the clinical psychologist. The psychologist offered counselling and support for prisoners with a variety of problems, including sexual abuse, neglect, and loss and bereavement. Referrals were also made to the psychiatrist if indicated.

Additional information

2.248 A drug strategy policy document had been produced in November 2007, but this was not informed by an updated needs analysis.

2.249 CARAT services were provided by RAPt (Rehabilitation of Addicted Prisoners trust). The sole CARAT worker saw all new arrivals, whether or not they had a drug problem. Her active caseload was 53, with a further 80 inactive cases. All sessions were one to one, and there was no groupwork. There were cross-referrals between healthcare and CARATs, but healthcare links with the wider substance misuse team needed to be strengthened.

2.250 The P-ASRO (prison addressing substance related offending) programme was in its fourth year. There were two courses a year, with 20 2.5-hour sessions over six weeks, attended by 12 prisoners at a time. The completion rate was very good. At the end of each module and at the end of the course, participants completed a standard questionnaire and psychometric tests, which were used to inform course development. There was a post-programme review that was generally well attended, except by healthcare staff.

2.251 CARATs made links with community drug and alcohol teams for those prisoners released into the community. Prisoners who had engaged with AA while in prison could continue with this in the community. When prisoners were transferred to another prison, CARATs liaised with the CARAT service in the forwarding establishment to ensure the transfer of care to their team.

Further recommendations

2.252 There should be an updated needs analysis to inform the drug strategy policy.

2.253 The healthcare department should take a more active role in the drug strategy programme.

Children and families of offenders

2.254 Closed visits should not be imposed solely on a drug dog indication without further intelligence. (3.94)

Achieved. Following a positive drug dog indication, the duty manager was informed to implement appropriate action. We were told the duty manager would consider all available intelligence. Visits records indicated that there had been only one positive drug dog indication in the previous six months, which had resulted in the visitor being offered a closed visit. The supporting intelligence indicated that this decision was proportionate.

2.255 Prisoners on the basic level of the incentives and earned privileges scheme should have visits of a minimum of one hour. (3.95)

Achieved. There were currently no prisoners on the basic level, but the published IEP policy document clearly specified that basic-level prisoners could receive two visits a month of at least one-hour duration. A maximum of 15 visits were booked for each session and visits were allowed to run for the duration of each session, irrespective of the prisoner's IEP status.

2.256 Prisoners should not have to wear a sash during visits. (3.96)

Not achieved. Prisoners still had to wear sashes during visits, and those on closed visits had to wear an orange bib. Staff viewed these arrangements as a secondary security precaution, as most prisoners wore their own clothes. However, the arrangements were unnecessary, as prisoners were required to sit in a designated seat and all male visitors had their hand stamped with ultraviolet light.
We repeat the recommendation.

2.257 Improved, more imaginative family visits arrangements should be provided for prisoners on all status levels to promote better contact between fathers and their children and help develop their relationships. (3.97)

Partially achieved. Monthly all-day visits were still offered to prisoners on the enhanced level of the IEP scheme. More imaginative family visits had been developed. In the most recent event, in October 2008, which ran from 10am to 4pm, families could eat a lunch provided by the prison with the prisoner in the visits hall. There were no seating restrictions for the duration of the day. The Mothers' Union staffed the play area, and the PE department supervised minor games and a session in the gymnasium. Results from feedback sheets given to the seven families who took part in the day were to be used to inform and develop future visits. However, as at the previous inspection, prisoners had to be on the enhanced level to participate.

Further recommendation

2.258 Family visits should be available to all prisoners.

2.259 Visits room furniture should be reorganised to improve comfort and contact between prisoners and visitors. (3.98)

Not achieved. The fixed furniture remained in place. This was unnecessary, and limited privacy for prisoners and their visitors.
We repeat the recommendation.

2.260 The closed visits booth should be screened and prisoners subject to closed visits should be able to receive refreshments bought by visitors. (3.99)

Not achieved. Although the number of prisoners on closed visits was low – one at the time of the inspection – the closed visits booth was not screened and prisoners on closed visits could not receive refreshments bought by visitors.
We repeat the recommendation.

2.261 The play area should be supervised. (3.100)

Partially achieved. The small play area in the visits hall was not supervised by trained staff during each visits session. The Mothers' Union provided volunteers to supervise the area, subject to the number of children scheduled to visit and their ages. The prison had arranged a meeting with Sure Start to discuss future development, and Kids VIP was due to visit to advise on improving the visits provision for children.

Further recommendation

2.262 The play area should be supervised by trained staff at each visits session.

Additional information

2.263 We were unable to observe a visits session during the inspection. Sessions were held four times a week, on Wednesday, Thursday, Saturday and Sunday afternoons. The visits hall was small, with capacity for 15 open and one closed visit each session. Visits could only be booked through the telephone booking line, but the opening hours of the line had been extended to include weekends.

2.264 There was no visitors' centre. There was a small waiting area in the gate complex. This area was clean, had lockers and toilets, and displayed appropriate information, but there was no comments book or feedback forms.

2.265 The visits room was clean. The play area flooring was badly scuffed and required cleaning. Only a limited range of refreshments was available from vending machines. Detailed records of visits were kept in a visits log. A recent visit had been allowed to take place in the chapel, supervised by the chaplain, to ensure privacy for a family in a sensitive situation.

2.266 The education department offered an accredited family relationships and parentcraft course, with prisoner participation linked to identified sentence planning targets. The learning and skills department had also recently introduced Storybook Dads.

Further recommendations

2.267 There should be a visitors' centre.

2.268 Visitors should be able to book a visit while they are at the prison.

2.269 A visitor comments book should be available.

Housekeeping point

2.270 The play area floor should be regularly cleaned.

Attitudes, thinking and behaviour

2.271 Prisoners unable or unsuited to participate in group work should have the opportunity to address offending behaviour issues through individual casework. (8.30)

Not achieved. The psychology department did not offer individual casework for prisoners identified as unable or unsuitable to participate in groupwork. The clinical psychologist who visited the prison carried out some individual work, but offending behaviour needs were not its primary focus.
We repeat the recommendation.

Additional information

2.272 The prison delivered the controlling anger and learning to manage it (CALM) accredited offending behaviour programme, in addition to P-ASRO (see paragraph 2.251). The education department offered an OCN-accredited alcohol and awareness course. Programme work

appeared to be well managed, and was delivered by a multidisciplinary team of prison officers and psychologists.

2.273 Family attendance at post-course reviews was good, and the DPSM, who was the resettlement manager for the programme, ensured families understood the indeterminate sentence structure and the risk assessment and reduction process.

2.274 Approximately three months before the inspection, and largely as a result of a regional decision, it had been agreed that the CALM programme would be withdrawn from Kingston to be replaced by the high intensity healthy relationships programme (HRP) in April 2009. Four staff had been identified for training in the delivery of HRP. The prison continued to assess prisoners for their suitability to complete the programme. DPSMs who chaired the majority of sentence plan boards felt that HRP would meet the offending behaviour needs of a significant number of current prisoners. We were also told that it was very difficult for prisoners to access this course elsewhere, and that the current waiting time to secure a place could be up to two years. Although the waiting list for CALM was only approximately 20 prisoners, the decision to withdraw the programme affected prisoners who had transferred to Kingston to complete it, and alternative arrangements were needed to allow these prisoners to address their identified risks.

Further recommendation

2.275 There should be alternative arrangements for prisoners assessed as requiring the controlling anger and learning to manage it (CALM) programme.

Section 3: Summary of recommendations

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

Recommendations — To NOMS

3.1 The National Offender Management Service should agree the role of Kingston within the regional and national strategy for managing life-sentenced prisoners, and ensure effective probation support. (2.1)

3.2 The National Offender Management Service should put in place effective arrangements to ensure that life-sentenced prisoners are able to make appropriate progress in their sentence without undue delay. (2.3)

3.3 Foreign national prisoners should be helped to maintain contact with their family abroad through a monthly free 10-minute telephone call irrespective of whether they have received a visit. (2.84)

3.4 Community-based offender managers should complete their contribution to prisoner progress reports on time. (2.210)

3.5 There should be regular contact between community-based offender managers and offender supervisors to discuss prisoners' progress and developments in their sentence plan. (2.213)

3.6 Sending prisons should ensure that prisoners have an up-to-date offender assessment system (OASys) assessment before transferring them to a second-stage lifer prison. (2.215)

3.7 All appropriate life sentence documentation should be forwarded to the receiving prison in a timely manner when a prisoner is transferred. (2.216)

Recommendations — To the governor

First days in custody

3.8 All new arrivals should be offered a reception pack suitable for their needs. (2.15)

3.9 The reception area should be refurbished. (2.22)

3.10 There should be private interview facilities in reception. (2.23)

3.11 All newly arrived prisoners should be highlighted in the night officers' handover book and all night staff should be briefed. (2.24)

Residential units

3.12 There should be facilities to enable prisoners to cook simple meals. (2.26)

3.13 Dining facilities should be extended to enable more prisoners to eat together. (2.28)

Staff-prisoner relationships

3.14 The task of assessing and reducing the risk posed by life-sentenced prisoners should inform the work of all staff in the prison. (2.5)

Personal officers

3.15 The role of the personal officer, and its distinction from that of the offender supervisor, should be clarified. (2.7)

3.16 There should be a more comprehensive quality assurance system for personal officers that focuses on the quality as well as frequency of engagement. (2.36)

Bullying and violence reduction

3.17 There should be interventions for prisoners on stage two of anti-bullying monitoring, and their personal officers should be involved in their management. (2.40)

3.18 The annual safer custody surveys should include further ways of gathering prisoner views, including focus groups. (2.42)

3.19 Objectives identified through safer custody reviews should be implemented and monitored. (2.43)

3.20 There should be continuous monitoring of potential bullying hot spots and action taken to address these. (2.45)

3.21 The violence reduction coordinator should log all information on inappropriate prisoner behaviour. (2.48)

3.22 The violence reduction coordinator should always investigate complaints by prisoners that indicate potential bullying. (2.49)

3.23 The violence reduction committee should continuously monitor and effectively manage prisoner misuse of prescribed medication. (2.50)

Self-harm and suicide

3.24 The quality assurance and management checks of assessment, care in custody and teamwork (ACCT) documents should be strengthened as a matter of urgency. (2.58)

3.25 Near-deaths should be thoroughly investigated and lessons learned should be widely publicised. (2.59)

3.26 There should be regular analysis and evaluation of trends and patterns in self-harm and suicide data to inform staff awareness. (2.60)

Diversity

3.27 There should be more active promotion of diversity. (2.61)

3.28 There should be a comprehensive diversity policy that addresses the needs of older prisoners, disability and sexual orientation. (2.67)

3.29 There should be back-up support for disability orderlies. (2.68)

3.30 There should be contingency plans to sustain access to disabled-access toilets and showers on E wing. (2.69)

3.31 Disabled-access toilets should be installed in the workshops. (2.70)

3.32 There should be more active support for minority groups. (2.71)

Race equality

3.33 A group open to all black and minority ethnic prisoners should meet regularly to inform the work of the race relations advisory group and the race relations management team. (2.73)

3.34 The race equality action group meeting should develop a programme of work to raise its profile and develop race equality work in Kingston. (2.79)

3.35 There should be a formal quality assurance scheme for racist incident forms. (2.80)

Foreign national prisoners

3.36 More information should be provided in languages other than English. (2.81)

3.37 The foreign nationals policy should be based on a comprehensive analysis of the needs of foreign national prisoners. (2.83)

3.38 There should be more efforts to encourage foreign national prisoners to hold regular meetings to raise their concerns. (2.86)

3.39 The library should meet the needs of prisoners who do not speak English, and stock foreign language publications. (2.91)

Applications and complaints

3.40 A quality assurance system for applications should be introduced. (2.96)

3.41 A quality assurance system for complaints should be introduced. (2.97)

3.42 There should be ongoing analysis of patterns and trends in complaints to identify key concerns. (2.98)

3.43 The complaints survey of prisoners should be analysed and fed into ongoing analysis to identify areas of prisoner concern. (2.99)

Legal rights

3.44 Additional private interview rooms for legal visits should be provided. (2.100)

3.45 The legal services officer should have regular profiled time for this work, with back-up provision available. (2.104)

3.46 The legal services officer should have refresher training. (2.105)

3.47 A laptop computer should be provided for the Access to Justice prisoners' group. (2.106)

Substance use

3.48 Healthcare staff should receive training in the clinical management of opiate-dependent prisoners. (2.107)

3.49 Comprehensive clinical protocols should be developed in consultation with external substance misuse specialists. (2.108)

Health services

3.50 A full staffing and skill mix review should be undertaken to ensure that sufficient appropriately qualified nursing staff are available to provide a range of services to meet the healthcare needs of long-sentenced prisoners, particularly mental health needs. (2.10)

3.51 There should be regular chronic disease and health promotion clinics. (2.115)

3.52 The healthcare department should work with the PE department and the kitchen to improve health promotion. (2.116)

3.53 A member of the healthcare team should receive training in cognitive behaviour therapy to meet the needs of prisoners with primary mental health problems. (2.121)

3.54 There should be an urgent review of pharmacy services to determine the required level of input from the pharmacist, provide pharmacist-led clinics, and introduce clinical audit, quality control and medication reviews. (2.123)

3.55 All medicines supplied to patients should be labelled in accordance with the Medicines Act. (2.125)

3.56 The in-possession medication policy should be adhered to. (2.127)

3.57 There should be patient group directives to enable nurse prescribing. (2.128)

3.58 The medicines management committee should write a prison-specific addendum to the drug formulary highlighting those medications with the potential for abuse. (2.130)

3.59 There should be yearly mental health awareness training for all healthcare and relevant prison staff. (2.136)

3.60 Prisoners with severe and enduring mental illness should be subject to the safeguards of regular multidisciplinary care programme approach reviews. (2.137)

Learning and skills and work activities

3.61 Additional learning opportunities should be available and encouraged for the small proportion of prisoners engaged in low quality contract work. (2.9)

3.62 Opportunities should be taken to accredit all skills acquired at work to reflect industrial practice and needs for employment. (2.143)

3.63 There should be more vocational training and accredited learning in the workplace. (2.151)

3.64 Library usage and book loss should be better recorded, and the information used to help improve the service. (2.152)

Physical education and health promotion

3.65 The quality and availability of outdoor sports facilities should be improved. (2.153)

3.66 Staff numbers should be increased to meet the growing needs for vocational training and recreational physical education. (2.155)

Faith and religious activity

3.67 The Muslim chaplain should attend the prison for the required number of sessional hours. (2.163)

Time out of cell

3.68 All prisoners should have access to at least 10 hours a day unlocked. (2.168)

3.69 Standard-level prisoners should have access to additional time in the open air at weekends. (2.169)

Security and rules

3.70 The allocation waiting lists should be appropriately managed. (2.180)

3.71 Category C prisoners should be provided with a regime that focuses on and supports their progression to open conditions. (2.181)

Discipline

3.72 Adjudication hearings should be conducted in a suitable environment. (2.187)

3.73 Outdoor seating should be provided in the segregation unit exercise area. (2.188)

3.74 In-cell education should be provided in the segregation unit for those prisoners who request it. (2.189)

Catering

3.75 Breakfast should be served on the day it is to be eaten. (2.199)

Prison canteen

3.76 Prisoners should have access to the canteen within 24 hours of arrival. (2.202)

Strategic management of resettlement

3.77 There should be a formal annual needs analysis and this should inform the development of the reducing reoffending strategy and the provision of suitable offending behaviour programmes. (2.13)

3.78 The reducing reoffending strategy should include clear and specific objectives with identified lead staff and achievement milestones. (2.208)

Offender management and planning

3.79 Personal officers should attend their prisoners' annual review boards and/or provide written contributions. (2.218)

3.80 All appropriate departments should be represented at the public protection committee, and identified members should attend its quarterly meetings. (2.220)

3.81 There should be a range of specific activities aimed at life-sentenced prisoners to develop their understanding and engagement with risk reduction and eventual reintegration. (2.224)

3.82 There should be an effective quality assurance scheme to cover all work undertaken by the offender management unit. (2.231)

3.83 Offender supervisors should demonstrate engagement with the prisoner to address identified risk factors, and this should be recorded in the records of contact. (2.232)

Resettlement pathways

3.84 The labour board should provide more detailed information to prisoners rejected from employment. (2.238)

3.85 The strategic pathway document should include reference to the savings account scheme. (2.239)

3.86 Prisoners with severe and enduring mental illness should be subject to the care programme approach (CPA). (2.243)

3.87 An alcohol strategy should be developed. (2.244)

3.88 Additional CARAT resources should be provided and group work introduced. (2.245)

3.89 There should be an updated needs analysis to inform the drug strategy policy. (2.252)

3.90 The healthcare department should take a more active role in the drug strategy programme. (2.253)

3.91 Prisoners should not have to wear a sash during visits. (2.256)

3.92 Family visits should be available to all prisoners. (2.258)

3.93 Visits room furniture should be reorganised to improve comfort and contact between prisoners and visitors. (2.259)

3.94 The closed visits booth should be screened and prisoners subject to closed visits should be able to receive refreshments bought by visitors. (2.260)

3.95 The play area should be supervised by trained staff at each visits session. (2.262)

3.96 There should be a visitors' centre. (2.267)

3.97 Visitors should be able to book a visit while they are at the prison. (2.268)

3.98 A visitor comments book should be available. (2.269)

3.99 Prisoners unable or unsuited to participate in group work should have the opportunity to address offending behaviour issues through individual casework. (2.271)

3.100 There should be alternative arrangements for prisoners assessed as requiring the controlling anger and learning to manage it (CALM) programme. (2.275)

Housekeeping points

3.101 Clean whites should be available to kitchen workers each day. (2.200)

3.102 Electrical items in the kitchen that are out of commission should be repaired as soon as possible. (2.201)

3.103 The play area floor should be regularly cleaned. (2.270)

Appendix I: Inspection team

Martin Lomas	Team leader
Keith McInnis	Inspector
Marie Orrell	Inspector
Margot Nelson-Owen	Healthcare inspector
Neil Edwards	Ofsted inspector

Appendix II: Prison population profile

(i) Status	Number of prisoners	%
Sentenced	173	*100*
Total	173	100

(ii) Sentence	Number of prisoners	%
Life	173	*100*
Total	173	100

(iii) Length of stay	Number of prisoners	%
Less than 1 month	8	*5*
1 month to 3 months	12	*7*
3 months to 6 months	17	*10*
6 months to 1 year	25	*14*
1 year to 2 years	46	*26*
2 years to 4 years	29	*17*
4 years or more	36	*21*
Total	173	100

(iv) Main offence	Number of prisoners	%
Violence against the person	148	*85.5*
Sexual offences	11	*6.5*
Burglary	1	*0.5*
Robbery	8	*4.5*
Other offences	5	*3*
Total	173	100

(v) Age	Number of prisoners	%
21 years to 29 years	39	*22.5*
30 years to 39 years	45	*26*
40 years to 49 years	42	*24*
50 years to 59 years	25	*14.5*
60 years to 69 years	18	*10.5*
70 plus years: *maximum age - 77*	4	*2.5*
Total	173	100

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	20	*11.5*
Between 50 and 100 miles of the prison	56	*32.5*
Over 100 miles from the prison	82	*47*
Overseas	15	*9*
Total	173	100

(vii) Nationality	Number of prisoners	%
British	158	*91*
Foreign nationals	15	*9*
Total	173	100

(viii) Ethnicity	Number of prisoners	%
White:		
British	116	*67.5*
Irish	6	*3.5*
Other White	11	*6.4*

Mixed:		
White and Black Caribbean	3	*1.7*
White and Black African	1	*0.6*
Other Mixed	2	*1.2*
Asian or Asian British:		
Indian	2	*1.2*
Pakistani	5	*2.9*
Bangladeshi	1	*0.6*
Other Asian	5	*2.9*
Black or Black British:		
Caribbean	8	*4.7*
African	6	*3.5*
Other Black	6	*3.5*
Chinese or other ethnic group:		
Other ethnic group	1	*0.6*
Total	173	100.8

(ix) Religion	Number of prisoners	%
Baptist	1	*0.6*
Church of England	51	*29.7*
Roman Catholic	30	*17.4*
Other Christian denominations	14	*8.3*
Muslim	21	*12.2*
Sikh	1	*0.6*
Hindu	2	*1.2*
Buddhist	15	*8.7*
Jewish	2	*1.2*
Other	5	*2.8*
No religion	31	*18.1*
Total	173	100.8