Report on an unannounced short follow-up inspection of

HMP Nottingham

15 – 18 October 2007

by HM Chief Inspector of Prisons

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Introduction

HMP Nottingham is a busy local prison dating back to Victorian times. When we last visited we praised a number of areas, but were critical of some very dilapidated accommodation. On our return, for this unannounced short follow up inspection, the previous poor accommodation had been taken out of commission and a range of new buildings had improved the environment considerably. This, together with examples of sustained good work, meant that Nottingham was now an effective local prison able to rise to many of the challenges it faced.

Nottingham remained a generally safe prison, despite a transient population with multiple needs. However, the reception area was unchanged and unsuitable for its task. We also considered aspects of security and searching to be disproportionate. However, first night and induction arrangements were improved, and the new accommodation was easier to supervise. Bullying was effectively confronted and the relatively low levels of self-harm were responded to appropriately. The new segregation unit was a considerable advance on its predecessor, although it was being used inappropriately as an overflow facility for vulnerable prisoners.

Progress had been made in combating the supply of illicit drugs into the prison, but managers needed to assure themselves that the relevant restrictions and punishments remained proportionate to risk. Both detoxification and drug treatment arrangements had improved with the introduction of the integrated drug treatment system.

We were pleased to see that the most unacceptable accommodation, B wing, had closed – and remained closed despite the population pressures. Ironically, some new cells were overcrowded and unsanitary, and some were inadequately heated. There was also an inexcusable lack of pillows. Staff-prisoner relations remained generally positive. Food was now served at more reasonable times and access to the chapel had improved. Race relations management was adequate, but could be further developed as could provision for foreign nationals. An excellent new healthcare facility had opened.

It was commendable, particularly for a busy local prison, that time out of cell had improved for those allocated activities, and evening association - although not daily - was now regular. The quantity and quality of education had improved with the opening of an excellent new education building and improved relations between the prison and the education provider. Access to the gym was good. However, prisoners without jobs or education classes to attend still spent too long locked up and the quality of work remained poor, particularly for vulnerable prisoners.

Nottingham continued to provide reasonable resettlement provision, although there was scope for improvement. Effective sentence and custody planning was in place, and public protection arrangements were sound. There had been some improvements to visiting arrangements, but further work was required to improve liaison with families.

As we have found in other local prisons, Nottingham faced the national problem of not being able to manage adequately the burgeoning population of prisoners serving indeterminate sentence for public protection. Large numbers of them, together with those on mandatory life sentences, were stranded in Nottingham because there were insufficient places to move them on to in training prisons. The National Offender Management Service (NOMS) is aware of the need for a strategic response, but little action is yet visible on the ground to address what is becoming a serious rehabilitative and control issue involving some very challenging prisoners.

Nottingham has progressed since our last visit. This is due both to the opening of new accommodation and facilities, and to the prison successfully sustaining the generally safe and

decent atmosphere we commended previously. Despite the current pressures, Nottingham has also managed to improve the quantity and quality of education, as well as maintaining a focus on resettlement. The challenge for managers and staff will be to sustain this progress, particularly as Nottingham will have almost doubled in size by the end of the current development programme.

Anne Owers January 2008
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Nottingham is a category B local prison holding adult male remand and sentenced prisoners.

Area organisation
East Midlands

Number held
538

Certified normal accommodation
385

Operational capacity
550

Last inspection
Full inspection: 2005
Short unannounced inspection: 20 September 2000

Brief history
HMP Nottingham was opened in 1890. It was remodelled in 1912 and served as a closed training establishment for adult men. In 1997, it re-roled as a category B local prison and now serves the courts of Nottinghamshire and Derbyshire.

Description of residential units
B wing is an old Victorian-style building that has been closed pending demolition. D and E wings were built 10 years ago and can accommodate 150 prisoners in much improved conditions. E wing provides one landing for 50 vulnerable prisoners. F and G wings were opened in 2005 and accommodate the first night and induction centre. The segregation unit has a capacity of 17. There is no in-patient facility. A major new building programme due to be completed over the next three years will see a new chapel and residential wing and new administrative accommodation.

Section 1: Healthy prison assessment

Introduction

HP1 All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

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

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

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

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

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

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

Safety

HP4 In February 2005, we found that the prison was generally safe, although reception, induction and anti-bullying procedures needed improvement, as did the monitoring of the use of special accommodation. Safer custody procedures were reasonable, but more focus on individual care was needed. Detoxification arrangements were basically safe. We concluded that the prison was performing reasonably well against this healthy prison test. At this inspection, we found that there had been some progress in overall safer custody management and the new accommodation was a considerable improvement, but other important areas, particularly reception, were little changed.

HP5 Many prisoners still had unnecessarily long stays at court, even though they did not usually travel long distances, and too many vans arrived late. A number of prisoners had spent some days in police cells because of prison overcrowding and some had been displaced a long way from their home areas. Prisoners still had to wait in vans to be processed individually in reception and continued to be handcuffed from vans. Cell-sharing risk assessments took into account only information supplied by the prisoner rather than using other available sources. Prisoners were not given an information leaflet about what to expect until they arrived at the prison and this was out of date.

HP6 The reception building remained essentially unchanged and was not a suitable environment for new arrivals. There was still no private interview area and some prisoners spent too long there. The room where strip searches took place did not provided adequate privacy. All men were routinely required to lift their genitals as part of the strip-searching procedures, which was contrary to the Prison Service's own guidance and unnecessarily degrading. First night support was much improved, helped by its location in a decent new building, but movement from reception to the first night centre was often delayed. Induction was more comprehensive, but some prisoners did not complete all sessions as they were moved from the induction wing before they were ready; others remained there for some weeks.

HP7 The replacement of the old Victorian accommodation with well-designed new wings and the appointment of two full-time coordinators had helped improve safety. Prisoners agreed that Nottingham was generally a safe place and this was reflected in a survey carried out by the prison and published in January 2007. Most prisoners believed staff did not tolerate bullying. The anti-bullying procedures were sound and investigations into alleged bullying were mostly thorough, but not all who needed to know were always informed which prisoners were being monitored under the strategy.

HP8 Levels of self-harm were not high. Most staff had been trained in assessment, care in custody and teamwork (ACCT), but the standard of completion of much of the documentation was poor. The new buildings allowed reviews to take place in appropriate locations, but few were multidisciplinary. Listeners were well used and

mostly felt supported by staff, but needed to be more involved in the early days of custody procedures. Listener suites were stark and unwelcoming.

HP9 Security processes were well managed and intelligence was dealt with efficiently. Too many prisoners were placed on closed visits for three months without adequate reviews in the interim.

HP10 Adjudications appeared properly handled and were well scrutinised by senior managers. Levels of use of force had increased significantly over the previous year. While the documentation gave little cause for concern and monitoring was reasonable, there was little attention paid at senior management level as to why numbers had increased or to identify trends. Some of the records for use of special accommodation were poorly completed and not always properly authorised. One use of the body belt had not been appropriately authorised by the governor in charge and the records did not fully support the need for the use of this extreme form of restraint. Compliant prisoners were sometimes kept in unfurnished accommodation longer than necessary.

HP11 A new segregation unit provided a much improved environment, but some cells were used simply as an overflow for the vulnerable prisoner landing. The segregation unit regime was particularly ill-suited for these prisoners and needed to be enhanced.

HP12 With the introduction of the integrated drug treatment system (IDTS), the detoxification service had developed well. Prisoners had appropriate maintenance programmes backed up by good support from the counselling, assessment, referral, advice and throughcare (CARAT) service. The mandatory drug testing (MDT) rate fluctuated significantly, but the current year-to-date positive MDT rate was just under target and had been low in recent months. New measures to combat drug use had just been introduced, but some seemed disproportionate in response to the scale of the problem.

HP13 Of the 51 recommendations we made under the area of safety at our last inspection, 32 had been achieved in whole or in part, 18 had not been achieved and one was no longer relevant. We have made 27 further recommendations.

HP14 On the basis of this short follow up inspection, we considered that the prison continued to perform reasonably well against this healthy prison test.

Respect

HP15 In 2005, we found that the prison was performing reasonably well against this healthy prison test. Relationships were positive, but some of the older accommodation was unfit for purpose. The food was satisfactory. Race relations were reasonable and some good work with foreign nationals was beginning to take place. Applications could not be tracked. Health services were developing well. At this inspection, we found some major improvements had been made with the provision of new accommodation, although most prisoners had to share cramped cells with unscreened toilets. Other areas were little changed and it was disappointing that some services for foreign national prisoners, particularly for those who did not speak English, had not developed as expected.

HP16 Relations between staff and prisoners appeared relatively positive and the interactions we observed were good. Most men knew they had a personal officer, but few said they had a pro-active relationship with them or that personal officers had introduced themselves. This was supported by wing files, few of which evidenced that the personal officer introduced themselves personally. Personal officer entries in wing files were mostly simple observations about wing behaviour.

HP17 The original outdated accommodation on B wing had closed and new replacement wings had opened. The prison was clean. Many cells designed for single use were doubled, with unscreened toilets, insufficient furniture for two men and nowhere to keep private possessions safe. Cells in some parts of the wings were cold. Remand prisoners were not usually given the opportunity to wear their own clothes. There was a recurring problem with ensuring an adequate supply of pillows and some new arrivals had to do without.

HP18 Prisoners were reasonably positive about the quality of food. Meal times were better than previously, although lunch was served a little early and small breakfast packs continued to be supplied the evening before use. Not all new arrivals could use the shop within 24 hours.

HP19 Regime clashes for those wishing to attend the chapel had reduced, with a wide range of services and a good range of faith provision. Although there was still a limit on how many prisoners could attend services, staff said those who wanted to go could do so, but it was not clear that this was always the case. The Muslim chaplain's hours had increased significantly. The multi-faith room was improved and the imminent redevelopment of older parts of the prison would enhance facilities considerably. The community chaplain initiative to provide mentoring in the community had developed well.

HP20 Prisoners could now progress more quickly to the enhanced level of the incentives and earned privileges scheme. Some additional differentials had been added between standard and enhanced levels. Prisoners on the basic level were reviewed regularly, but staff comments in monitoring books did not demonstrate much meaningful engagement.

HP21 Many prisoners complained about not getting replies to applications and having to repeat them. There was a system to log applications, but it was not used to record when responses were received so could not be checked. Not all replies to complaints properly answered the points made, suggesting a need for monitoring. The legal services officer had received no up-to-date training.

HP22 Black and minority ethnic prisoners reported little racist behaviour or discrimination. The race equality action team meetings were well attended, followed up identified action from previous meetings and encouraged appropriately challenging discussions. Ethnic monitoring was discussed in detail and disparities investigated, but monitoring results and other race equality information were not made available to all prisoners. Racist incident investigations were not sufficiently thorough and there was no independent external scrutiny.

HP23 Foreign national prisoners said they had a range of specific difficulties, including problems with immigration, language and understanding prison procedures and rules. There was good identification of potential immigration detainees, good links with local immigration workers and regular immigration surgeries. Prisoners were able to get

international telephone cards each month to help maintain family contact. The foreign national coordinator was on restricted duties and unable to do front line work so there was limited individual ongoing formal support to prisoners.

HP24 An excellent new healthcare centre provided good facilities that fostered a more respectful and calm environment. The centre contained a day care room, but this was not yet used except for some CARAT groups. An innovative decision had been taken not to have in-patient beds in a traditional healthcare centre. Instead, some prisoners were looked after by healthcare staff on part of a residential wing known as the enhanced care unit and this appeared to be working well. The standard of service and the skill mix was good, but prisoners said it was difficult to get pain relief at night. Primary mental health provision was good and there were quick transfers to hospital in most cases. The dentist service was much improved.

HP25 Of the 56 recommendations we made under the area of safety at our last inspection, 28 had been achieved in whole or in part, 28 had not been achieved and one was no longer relevant. We have made 28 further recommendations.

HP26 On the basis of this short follow up inspection, we considered that the prison continued to perform reasonably well against this healthy prison test.

Purposeful activity

HP27 In 2005, we found that Nottingham was not performing sufficiently well against this healthy prison test. Although prisoners had the opportunity to work, part-time jobs were poor quality with no accreditation of skills. The education curriculum was very narrow and at a low level. Time out of cell was poor and staffing difficulties meant that association and gym sessions were frequently cancelled. At this inspection, we found that time out of cell had improved and evening association, although not daily, was regular. An excellent new education building provided a broader range of courses, but the quality of work was still very poor. There was now good access to the gym.

HP28 The prison's performance data indicated that time out of cell had improved considerably and frequent cancellation of association was no longer an issue. However, some prisoners with no allocated activity were still out of their cells for only brief periods. At any one time during an activity period, it appeared that between 30% and 40% of prisoners were locked in their cells.

HP29 Relationships between the prison and the new education provider were much better. A new education building was a very good facility with a reasonable library. Although there had been some improvements in the range of education and opportunities to get accredited vocational qualifications, progress was difficult because of the number of prisoners at Nottingham for just a short time. The pay structure had been revised and was no longer a disincentive to education.

HP30 Allocation to activities continued not to take account of the men's individual preferences. Much of the work was repetitive and undemanding and there were relatively few opportunities to acquire useful skills for employment in the community. This was a particular problem for vulnerable prisoners, some of whom had high educational levels and stayed longer, yet the only workshop activity for them was putting together breakfast packs.

HP31 Physical education staff were no longer routinely deployed to other duties. Opportunities to gain some basic qualifications had been introduced in the gym, but courses had been disrupted in recent months because of the lack of a dedicated classroom.

HP32 Of the 18 recommendations we made under the area of purposeful activity at our last inspection, 15 had been achieved in whole or in part and three not achieved. We have made five further recommendations.

HP33 On the basis of this short follow up inspection, although there was a need to provide more and better quality work, we considered that the prison was now performing reasonably well against this healthy prison test.

Resettlement

HP34 In 2005, we judged that the prison was performing well against this healthy prison test. The resettlement policy committee needed better strategic direction, but services to prisoners, including drug work, were good and few left without accommodation. Work with lifers needed some development. Good offender assessment system (OASys) assessments were completed and public protection work was sound. At this inspection, we found that for a local prison, Nottingham continued to deliver some reasonably effective services, but movements of lifers and other indeterminate-sentenced prisoners was taking too long.

HP35 Some resettlement needs analysis had been completed, but this has not yet been incorporated into the strategy to inform its development. Work along each of the resettlement pathways was identified with a focus on an action plan, but the resettlement strategy needed to be updated to tie together various elements that appeared not to be integrated. The resettlement policy committee had been renamed the reducing reoffending strategy group and had a better strategic focus. Prisoners we spoke to had a poor awareness of resettlement services, although there was a reasonable range of provision and satisfactory outcomes.

HP36 Most OASys assessments were up to date for prisoners for whom they were required and were completed within eight weeks. Most determinate-sentenced men moved quickly to training prisons before that point. A resettlement passport system still operated and men were seen at an early stage to assess their needs.

HP37 There were only limited interventions to help prisoners address offending behaviour and other resettlement needs, but a reasonable range of resettlement services was provided. Public protection arrangements were good, with monitoring by a multidisciplinary team. There was good awareness among staff about public protection issues, although there was a need to improve formal training about what to look out for and how to respond.

HP38 There were 68 men sentenced to life and other indeterminate sentences, and good arrangements to identify prisoners who might potentially receive a life sentence. Staff made good initial contact with such prisoners, but once initial documentation was completed, contact with lifer-trained staff was more limited. There was a national problem of moving on lifers and indeterminate sentences for public protection (IPP) prisoners to training prisons with most, even those with very short tariffs, waiting up to a year and some considerably longer. Lifers and IPPs formed a large part of the

vulnerable prisoner population. The prison was successfully managing some difficult and troubled men on the vulnerable prisoner landing, but there was a real need to move them to more suitable prisons more quickly. Some were waiting years.

HP39 Prisoners complained about difficulties their families had with the visits booking line and there was a particular problem during the inspection as the booking clerks had been temporarily moved from the visitors' centre while it was refurbished. There was a temporary new number, but not all potential visitors were aware of this. Some improvements had been made by the introduction of queuing software to let callers know how long they might wait, but a computerised booking system had proved ineffective. The visits areas had been refurbished, but there was currently no children's play area.

HP40 The drug strategy had been reviewed and last updated in 2006, but needed further revision to take into account a recent prisoner survey and to reflect the changed services following the introduction of IDTS. With the advent of IDTS, the CARAT service had expanded and there was good, although not formalised, communication with healthcare. Links with a number of local drug intervention programmes were also good.

HP41 Of the 24 recommendations we made under the area of resettlement at our last inspection, 18 had been achieved in whole or in part and six not achieved. We have made 13 further recommendations.

HP42 On the basis of this short follow up inspection, we considered that the prison was still performing well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations to the Governor

2.1 Improvements should be made to reception to help arriving prisoners feel safe and respected, with adequate holding rooms and appropriate searching and changing areas. (HP44)

Not achieved. There had been no significant changes to reception. Holding rooms were small and bare, and some had graffiti on the walls. There were no televisions to occupy prisoners or to provide useful reception information and there was little information on display. The searching area had not changed. Prisoners had to stand on a mat to be searched and there were no screens or cubicles to provide privacy. Other staff entered the room during searches. (see also paragraph 2.27). A new reception building was planned.
We repeat the recommendation.

2.2 New prisoners should be held together for a longer period and managed by a new staff group, trained in suicide prevention, drug awareness and mental health, responsible for prisoners' early days in custody and with an improved and longer induction programme. (HP45)

Achieved. Staff from G wing were responsible for the first night centre and induction. Most had completed some training in suicide, drug and mental health awareness. The induction programme had improved and now lasted five days, including two half-days when prisoners could complete any missed sessions. Despite this, not all prisoners completed the full programme (see paragraph 2.38).

2.3 B wing should be closed for refurbishment so that prisoners are not held in unacceptably cold cells. (HP46)

Achieved. B wing had closed in November 2005 and was about to be demolished.

2.4 The overall management of safer custody should be improved to ensure effective assessment, review, interventions and monitoring. (HP47)

Partially achieved. A new safer custody management structure included two full-time coordinators for suicide prevention and violence reduction including anti-bullying. These appointments had raised the profile of safer custody across the prison. Wing violence reduction liaison officers had been identified and their role was reflected in their appraisal and development reviews. There were no similar liaison officers for suicide prevention. There was still some way to go to develop effective reviews, interventions and monitoring (see also sections on bulling and violence reduction and self-harm and suicide).

2.5 The amount of time prisoners spend out of their cells should be increased and all prisoners should be offered daily association. (HP48)

Partially achieved. The amount of recorded time out of cell had increased from seven to just over eight hours a day, although many prisoners said this was more than they actually

received. Key workers received the most time out of cell, frequently 8.5 hours a day. When we checked on two separate days, between 30% and 40% of prisoners were locked up during activity periods. Prisoners did not always get daily association and those on basic regime were restricted to one association period a week.

Further recommendation

2.6 All prisoners should be offered daily association.

2.7 A wider range of education courses and accredited vocational qualifications should be provided to meet the needs of prisoners at Nottingham. (HP49)

Partially achieved. A new education building had been built and a new education provider now offered a wider range of courses and accredited vocational qualifications, including industrial cleaning (British Institute of Cleaning Sciences) training. Basic literacy and numeracy support had increased, with over 100 qualifications compared to 35 the year before. Almost 100 prisoners were involved in the workright basic qualification that had been introduced in the workshops. However, provision for prisoners wanting to achieve higher-level qualifications was insufficient and it was difficult to meet the needs of the large proportion of prisoners who spent only a short time at Nottingham (see also paragraph 2.177).

Recommendations

to the Area Manager

Discipline

2.8 Cells in the segregation unit should not be certified as normal accommodation. (6.47)

Achieved. A new cell certificate had been drawn up following the closure of B wing and the opening of the new segregation unit. Segregation cells were no longer part of the certified normal accommodation.

Health services

2.9 Resources to increase the GP hours for clinical detoxification should be approved. (8.65)

Achieved. Twelve hours a week of GP time was allocated from Monday to Saturday for treatment of substance or alcohol misuse. On weekdays, prisoners were treated on the evening of admission. Additional time to review progress was also set aside during the morning GP surgeries.

Additional information

2.10 GPs had specialist qualifications in substance misuse. Prisoners often arrived after 7pm (see paragraph 2.12) and uncertain arrangements in reception meant they might not be seen by substance misuse staff until late evening. Treatment delay was putting the health of some prisoners at risk.

Further recommendation

2.11 New arrivals with substance or alcohol misuse problems should be identified promptly and receive appropriate medication without delay.

Recommendations to the Governor

Courts, escorts and transfers

2.12 Prison and escort managers should review the arrangements for transporting prisoners from local courts to the prison to ensure that prisoners arrive at the prison earlier. Management should oversee the length of time that prisoners are out of the prison for relatively short court appearances. (1.12)

Not achieved. Reception staff kept a log of when prisoners were booked in from the courts. This alerted them to the numbers of prisoners who had completed their court appearance and were being returned to the prison. They also recorded the time prisoners arrived at reception. The log contained several examples of prisoners appearing at local courts having to wait several hours before being transported to the prison. Too many escort vehicles arrived late in the evening.
We repeat the recommendation.

2.13 Prisoners should be given information in court outlining what will happen to them in their first 24 hours at Nottingham prison. (1.13)

Not achieved. The situation had not changed and prisoners were still given a leaflet about 'what happens next' only on arrival at reception. This was several years out of date and did not mention some essential information such as arrangements for telephone calls on the first night. All new arrivals were given a letter and envelope and information about the Listeners scheme.

Further recommendation

2.14 The welcome leaflet given to new arrivals in reception should be updated and given out in advance at local courts.

2.15 Escort and prison staff should cooperate in a single search of prisoners before they are discharged to court. (1.14)

Not achieved. Prison staff strip-searched prisoners before their discharge to court and this was sometimes observed by escort staff. However, escort staff still subsequently gave prisoners a rub-down search and used a hand-held metal detector.
We repeat the recommendation.

2.16 Suitable clothing should be provided for prisoners attending court who have insufficient personal clothing. (1.15)

Achieved. Additional clothing was available and an entry was made in the prisoner escort record if this was offered, but refused. We met one prisoner being discharged on bail who had no shoes and a new pair was provided by reception staff at short notice.

2.17 Prisoners should not be held on escort vehicles routinely waiting admission to reception and should be held in holding rooms instead. (1.16)
Not achieved. Prisoners were still taken off escort vans one at a time and it could be up to 45 minutes before they all arrived in reception, particularly when two vans arrived at the same time. Vulnerable prisoners needing protection were not identified in advance and staff felt the risk to their safety justified the protracted procedures.
We repeat the recommendation.

Further recommendation

2.18 Escort staff working at court should identify prisoners likely to need protection and alert reception staff of their impending arrival.

2.19 Prisoners should not be handcuffed to and from the escort vehicle unless there are clear security reasons for doing so. (1.17)

Not achieved. The prison had rejected this recommendation on security grounds as there were no secure compounds and some low roofs. However, there did not appear to be direct risk of escape from the area and the low roofs were adequately protected.

Further recommendation

2.20 The requirement for all prisoners to be handcuffed to and from escort vehicles should be reviewed again to ensure that it is necessary.

2.21 Managers should monitor the flow of information from courts and, through the court users group, ensure that information is available to aid initial risk and vulnerability assessments on a prisoner's reception. (1.18)

Not achieved. Managers did not monitor that all information available at court arrived with prisoners at reception. An operational support grade officer who administered the video link attended the court users group, but getting information from court to reception had not been a priority. Cell-sharing risk assessments were still completed based only on prisoners' responses to questions despite the fact that Nottingham now had access to the police national computer for information on previous convictions.
We repeat the recommendation.

Additional information

2.22 There were now two video link rooms, the second added in 2005. Video links were well used, mainly to local courts, but also for inter-prison visits, probation and legal interviews and parole hearings. Use had increased from 1,094 in 2005 and 1,453 in 2006 to 1,448 already to date in 2007. There was good awareness of safer custody issues and any prisoner sentenced over the video link was taken to see a nurse in reception following his change of status.

2.23 We met several prisoners who had been locked out from their local prisons. Some had come from courts as far away as St Albans, Basildon and Bexleyheath. Some were recently sentenced and were considerable distances from their home areas. Many had been lodged with the local police before transferring to Nottingham. On one day of the inspection, Nottingham received 21 prisoners who had been locked out from their local prisons.

First days in custody

2.24 There should be a new staff group responsible for prisoners' early days of custody to improve the continuity of care. All staff in this group should be trained in suicide prevention, drug awareness and mental health, and be confident in identifying prisoners at heightened risk and discussing this with them. (1.50)

Achieved. See previous main recommendation at paragraph 2.2.

2.25 Prisoners who are new to the prison should be processed first in reception and should be moved to the first night centre with minimum delay. (1.51)

Not achieved. The senior officer aimed to prioritise prisoners who needed more in-depth assessment by healthcare, particularly those withdrawing from drugs. However, given the limited facilities, this had to be balanced against processing men returning from court and those whose status had changed. These prisoners were health screened where necessary. Movement between reception and the first night centre was slower when only one nurse worked in reception and prisoners' arrival at the first night centre could be delayed if staff from there were not available to escort them.

Further recommendation

2.26 Managers from reception, healthcare, F (detoxification) wing and G wing should agree procedures to ensure that new arrivals and those at risk or vulnerable are prioritised and arrive at their first night location as quickly as possible.

2.27 Strip-searching procedures in reception should follow those set out in the Prison Service security manual. (1.52)

Not achieved. The room used for strip searches was unchanged (see paragraph 2.1). Officers explained the searching process. All prisoners were routinely required to lift their genitals as part of the strip search. This was not included in the local security strategy, was contrary to Prison Service guidance and was unnecessarily degrading.
We repeat the recommendation.

2.28 All prisoners should be offered a free telephone call on their first night, and staff should record this in their history sheets. (1.53)

Achieved. All prisoners were offered a free two-minute telephone call on the first night centre. The officer supervising the calls advised prisoners of key messages to give to families and told them they would be able to use the telephone the next day when their personal identification numbers had been credited. The names of prisoners who had made contact with family or friends were recorded in a log and those who were unable to get through were allowed to try again when time permitted.

2.29 New prisoners should be given a private interview with a reception officer. (1.54)

Not achieved. The arrangements for interviews remained the same, with little privacy and little incentive for prisoners to disclose any immediate concerns.
We repeat the recommendation.

2.30 Local information about the sources of help available, in a range of languages, should be given to prisoners in reception. (1.55)

Not achieved. The information given had not changed. The welcome leaflet (see paragraph 2.13) was useful, but out of date and in English only. A second leaflet explaining the work of Listeners was also in English only. More general information for new arrivals had been translated into 10 languages and was available to first night centre officers.
We repeat the recommendation.

2.31 A Listener and an Insider should be employed as prison orderlies in reception. (1.56)

Not achieved. However, an Insider now saw new receptions on the first night centre.
We repeat the recommendation.

2.32 Prisoners new to the prison, particularly those who have not been in prison before, those withdrawing from substances or those with mental health problems, should be checked throughout the night. (1.57)

Not achieved. Prisoners on assessment, care in custody and teamwork (ACCT) monitoring were identified to night staff and their names noted in the observation book and on wing office notice boards. No other potentially at-risk prisoners, such as those new to custody or withdrawing from drugs, were routinely checked.
We repeat the recommendation.

2.33 The design and installation of the new toilet screen being trialled on B wing should be improved. (1.58)

Partially achieved. Toilet screens offering more privacy were being installed on D wing. Managers hoped that toilet screens on D and E wings would be installed by mid-January 2008.

Further recommendation

2.34 All cells should have effective toilet screens.

2.35 There should be a video introducing new prisoners to Nottingham prison to help those with literacy problems on their first night and during induction. (1.59)

Partially achieved. Some audio tapes were available on the first night centre, but plans to produce a video had been delayed by long-term sickness.
We repeat the recommendation.

2.36 Information held at the establishment from previous periods of custody, particularly that relating to vulnerability, should be available to staff interviewing prisoners on the first night centre. (1.60)

Not achieved. The suicide prevention coordinator kept a database of all prisoners subject to self-harm monitoring in recent years, but this information was not available to first night officers.
We repeat the recommendation.

2.37 Cell-sharing risk assessments (CSRAs) should always be completed on all prisoners before they are allocated to a shared cell. (1.61)

Achieved. All new arrivals were interviewed in private by a first night officer. The CSRA was completed before a cell was allocated, but the assessment was based only on a prisoner's responses to questions (see paragraph 2.21). It was therefore impossible to establish whether, for example, a prisoner had been convicted of any racially-motivated crime. Where possible, officers tried to accommodate requests to share cells.

2.38 There should be an improved induction process, in a location where a single manager has control over the movement of all prisoners who require induction. Induction should be longer than 24 hours, and should include greater assessment through individual interview. (1.62)

Partially achieved. The induction programme was more comprehensive (see paragraph 2.2). It included brief interviews with the counselling, assessment, referral, advice and throughcare (CARAT), resettlement and chaplaincy departments, longer sessions with education and physical education staff, and two sessions with induction officers. Prisoners who had been in custody recently were not required to complete all sessions and those lodged on the wing overnight before transferring elsewhere did not have induction. There was a register of all prisoners on the first night centre and the sessions they had completed, but it was incomplete. Of the 306 prisoners who appeared eligible for a full induction between 17 September and 14 October, 131 (43%) had not completed all sessions. Difficulties in finding suitable follow-on accommodation for prisoners who required a single cell or were at risk from prisoners on other wings, but not considered suitable for the vulnerable prisoner, landing meant that staff were under pressure to move less problematic prisoners on before they had completed the full induction to make space for new arrivals.

Further recommendations

2.39 The induction record should be kept up to date and the number of prisoners not completing the full induction should be monitored.

2.40 Wing managers should cooperate to ensure that there are no unnecessary impediments to progress prisoners appropriately from the induction wing.

2.41 Prisoners should be given the opportunity to retrieve telephone numbers from their mobile telephones before these are stored in their property. (1.63)

Achieved. Prisoners were allowed to retrieve up to four numbers from their mobile telephones before their property was stored and were given paper and a pen to write these down.

Additional information

2.42 Prisoners going through reception were asked if they wanted a shower, but staff said this was not always possible if there were too many late receptions.

2.43 First night arrangements had improved considerably since being moved from B to G wing. Prisoners who went from reception to F wing (detoxification) or segregation were identified by first night officers and their progress through induction was logged. Prisoners recalled on licence were also identified, but were not automatically offered the useful information sheet

about the recall process. All prisoners new to the prison shared a cell. If there was an odd number of prisoners, an Insider agreed to share for at least the first night.

2.44 First night staff and those interviewing prisoners the following day used a checklist of key questions and a prompt sheet to ensure consistency of information provided. All new prisoners were also seen by an Insider, who followed a checklist of subjects to be covered, including signing a wing compact and completing a disability questionnaire. Prisoners were also given useful information to send out to family and friends.

2.45 The cells used for new prisoners were clean and reasonably prepared, but many did not have pillows. Staff said this was a recurring difficulty. A comprehensive information booklet was provided on each bed along with plastic cutlery, cup, plate and bowl and toiletries.

Further recommendations

2.46 All prisoners should be offered a shower on their first night either in reception or on their first night wing.

2.47 All prisoners identified as licence revokees should be given information about the recall process.

2.48 All cells should have pillows.

Residential units

2.49 All cells should be maintained at an adequate temperature at all times. (2.31)

Not achieved. Prisoners complained about the temperature in some cells. On D wing, cells and the office on one side were heated, but those on the other side were not. Prisoners on E wing said it was cold at night, while prisoners on F and G wings said the window vents let cold air in. A number of prisoners had tried to block the vents.
We repeat the recommendation.

2.50 Cells designed for single occupancy should not be shared. (2.32)

Not achieved. Single cells were still used for two prisoners.
We repeat the recommendation.

2.51 There should be at least one telephone for every 20 prisoners on all wings. (2.33)

Not achieved. The ratio varied, with 1:25 on D wing, 1:19 on E wing, 1:14 on F wing and 1:24 on G wing.
We repeat the recommendation.

2.52 The regime for vulnerable prisoners on E4 should be improved, with more work and unlock time and alternative gym sessions when scheduled sessions are cancelled. (2.34)

Achieved. Thirty workspaces were provided every morning and afternoon for prisoners on E4, along with wing work and 10 education places. Gym sessions could not be rescheduled as the timetable was too full, but sessions were rarely cancelled now that the gym was fully staffed.

2.53 The prisoner council should meet regularly with representatives elected by prisoners. (2.35)

Partially achieved. D and E wings held regular monthly meetings, but meetings on F and G wings were less predictable. Prisoner representatives on E4 were elected by other prisoners, but all the others were selected by staff. G wing did not have any regular nominated representatives. Minutes were displayed only on D and E wings, but were out of date.

Further recommendations

2.54 Up-to-date prisoner council meeting minutes should be displayed on wing notice boards.

2.55 It should be made clear to remand prisoners that they have the right to wear their own clothes, unless they choose otherwise. (2.36)

Not achieved. All prisoners, including those on remand, were given a set of prison clothing and their status was confirmed only once they had changed into it. Remand prisoners were allowed to wear their own clothes in principle, but in practice the rules said they had to have three sets of clothes to qualify, a requirement that newly-remanded prisoners were unlikely to meet.
We repeat the recommendation.

2.56 All prisoners should be able to shower every day. (2.37)

Not achieved. Prisoners on the basic regime could have only three showers a week, although some officers allowed more. Prisoners on the standard and enhanced regimes should have had daily showers, but said it was usually possible to shower only on alternate days.

2.57 All showers should be functional and cubicles, benches and hooks should be provided. (2.38)

Partially achieved. All the showers we saw were working and had benches, but none had hooks and there were no cubicles on D and E wings.

Further recommendation

2.58 Showers should be placed in cubicles with hooks or other facilities for prisoners to store clothes while showering.

2.59 Prisoners should be provided with a lockable cupboard in their cell. (2.39)

Not achieved. Only prisoners on D and E wings had lockable cupboards and many of these were broken. Most, but not all, prisoners had their own cell key, which offered some protection and privacy for personal possessions, but only for those in single cells.
We repeat the recommendation.

Additional information

2.60 A number of cells had material displayed that could be regarded as offensive, but this did not appear to be challenged by staff.

Further recommendation

2.61 The rules preventing the display of offensive material should be clarified and enforced.

Staff-prisoner relationships

2.62 Staff should address prisoners by their first name or title and surname. (2.44)

Not achieved. We heard some staff addressing prisoners they knew well by their nicknames, but almost all staff, including senior managers, addressed and referred to prisoners by surnames alone.
We repeat the recommendation.

Personal officers

2.63 Personal officers should identify themselves to prisoners. They should make regular meaningful entries in wing records, which managers should check. (2.51)

Not achieved. Personal officers were allocated by cell and their names were clearly displayed on individual cells. Most prisoners knew who their personal officer was, but few said personal officers had introduced themselves or made active efforts to speak to them and there was little evidence of this in wing records. Personal officers usually made monthly entries in wing history sheets, but most were simple observations of wing behaviour rather than demonstrating individual knowledge of the prisoner, his background or resettlement needs. Management checks were usually confined to the frequency of entries rather than the quality.
We repeat the recommendation.

Bullying and violence reduction

2.64 Staff should report all incidents of suspected bullying to the anti-bullying coordinator for investigation. (3.13)

Achieved. There was no evidence that suspected bullying incidents were not reported to the violence reduction coordinator (VRC). In the year to the end of September, 194 incidents had been investigated resulting in 44 prisoners put on initial monitoring, 34 on stage two of the anti-bullying strategy and 10 on stage three. Prisoners said staff were quick to respond to bullying.

2.65 The list of prisoners subject to anti-bullying measures should be made available to wing staff and those working with prisoners in other departments and appropriate monitoring should take place. (3.14)

Not achieved. The names of prisoners on the anti-bullying strategy were listed on the VRC's impressive database of bullying incidents, but were not published daily to all staff. Most closed monitoring booklets had daily entries, but some did not. In one case, the senior officer had recorded 'out of the 14 days Mr P was on this book, only 7 days of entries. Therefore insufficient evidence to continue observations'. In another, the VRC had written 'stage 1 booklet not completed for 7 days. Issue addressed with management'.
We repeat the recommendation.

2.66 Bullying prisoners should be helped to change their behaviour. (3.15)

Partially achieved. Closed anti-bullying booklets showed that bullies were actively managed through reviews of their behaviour, but not through any constructive intervention programmes to address the underlying causes of that behaviour. Plans to involve the psychology department in such programmes had not materialised.

Further recommendation

2.67 Specific interventions to address underlying causes of bullying behaviour should be developed.

2.68 The time that bullying prisoners spend on restrictive regimes should be decided individually for each prisoner, regularly reviewed and kept to the minimum. (3.16)

Not achieved. According to the strategy, the time spent on the basic regime could be reduced from 28 to 21 days if the prisoner completed an anti-bullying workbook and cooperated with proposed intervention sessions delivered by the psychology department. However, none of these interventions were in place (see paragraph 2.66).
We repeat the recommendation.

2.69 The anti-bullying survey should cover the locations and times when bullying occurs to target responses to reduce it. (3.17)

Achieved. In the last anti-bullying survey (November 2006, published January 2007), prisoners were asked about their feelings of safety in various areas. This had generated 269 responses, representing just over half the total population. Seventy-two per cent said Nottingham was a safe prison and 67% said they felt safe from harm or injury by other prisoners. Prisoners felt most unsafe in the showers and during association. The survey results were discussed in detail at a meeting in May 2007, where it was recommended that shower cubicles and closed-circuit television be installed to improve supervision.

Additional information

2.70 The safer prison committee met monthly and was reasonably well attended, although there had been apologies from about 10 members at each of the previous three meetings. The VRC provided a comprehensive report and analysis of violent incidents. The violence reduction strategy (June 2006) was fairly recent, but the anti-bullying strategy (November 2005) referred to interventions that did not exist and was out of date. A safer custody database recorded information on many indicators of safety across the prison.

2.71 Anti-bullying and safer custody issues were well publicised. There was a safer custody email address for people to contact the prison with any concerns and a confidential report line.

2.72 Vulnerable prisoners were identified and separated in reception, but were all initially located on the first night centre. Anyone applying for protection when the vulnerable prisoner landing (E4) was full was held in the segregation unit while waiting for a place. This could take over four weeks (see paragraph 2.218). Vulnerable prisoners on E4 said they mostly felt safe apart from at visits (see paragraph 2.142). Vulnerable prisoners had a separate workshop (see paragraph 2.177). Those who were Muslim shared Friday prayers with other Muslim prisoners, but Christians had separate services.

Further recommendations

2.73 There should be better and more consistent attendance at the safer prison meeting.

2.74 The anti-bullying strategy should be updated to reflect current practice.

Self-harm and suicide

2.75 Self-harm reviews should be held in suitable, quiet locations and staff from all disciplines should have adequate notice to attend, with relevant background information available and key workers identified. (3.41)

Partially achieved. Assessment, care in custody and teamwork (ACCT) reviews now took place in quiet rooms off the main landings with minimal interruption. They were attended usually by only the senior officer and landing officer, even though some departments, such as probation, could hold important background information. This lack of a multidisciplinary review team had been raised at a recent safer prison meeting and wider attendance was being promoted. Case managers did not consistently chair reviews and key workers were not identified.

Further recommendation

2.76 Assessment, care in custody and teamwork (ACCT) reviews should be multidisciplinary and consistently chaired by the same case manager, and key workers should be identified.

2.77 Managers should comment on the quality of care offered to prisoners when they complete checks of open F2052SHs (self-harm monitoring forms). (3.42)

Not achieved. Many ACCT (formerly F2052SH) documents indicated that managers checked that reviews and regular entries were completed, but few contained any comment on the quality of care offered.
We repeat the recommendation.

2.78 The F2052SH register should be kept up to date. (3.43)

Achieved. The safer custody administrative officer played a key role in supporting coordinators.

2.79 Action plans developed following recent investigations into self-inflicted deaths should be reviewed to establish that agreed recommendations were still being implemented. (3.44)

Achieved. Death in custody action plans were a standing agenda item at the safer prison meeting. Action plans from previous deaths in custody were reviewed annually and the recommendations reconsidered for their relevance to current practice. This was a requirement of the local suicide and self-harm policy. An action plan had been developed following the last self-inflicted death in July 2005.

2.80 The suicide prevention policy document should be reviewed to ensure that it includes all important aspects of practice, such as the post-self-harm interviews conducted by the suicide prevention coordinator (SPC), the investigation of near fatal self-harm incidents, the role of the high risk assessment team and its integration with the F2052SH (self-harm monitoring) process. (3.45)

Achieved. The suicide and self-harm policy (January 2007) was very comprehensive. Since the introduction of ACCT, post-self-harm interviews no longer took place as it was felt that the initial ACCT assessment completed within 24 hours of a document being opened fulfilled a similar purpose. The high-risk assessment team had also been disbanded and a new protocol (September 2007) introduced to investigate near-fatal incidents. One such investigation had taken place and had identified some lessons to improve practice.

2.81 The suicide prevention coordinator (SPC) should not be deployed to other duties. (3.48)

Achieved. The SPC was not deployed elsewhere and had developed a high profile.

2.82 A deputy safer custody officer and safer custody wing liaison officers should be appointed. (3.49)

Achieved. The VRC deputised for the SPC and vice versa. The arrangement worked well.

2.83 More Listeners should be recruited, there should be a Listener resident on E4 (vulnerable prisoners) and the rooms used by Listeners should be improved and heated. (3.50)

Partially achieved. The number of Listeners had nearly doubled to nine and dates for more training had been agreed. They were supported through a weekly meeting with the Samaritans. The number of Listeners and calls responded to was monitored at the monthly safer prison meeting. There was still no Listener on E4, although there were fewer concerns and calls from the landing were adequately covered by Listeners on other locations. The poorly-heated room on B wing was no longer used. The Listener rooms on D and E wings were stark and poorly decorated; the E wing room contained only two chairs while the D wing room was completely empty.

Further recommendation

2.84 Listener rooms should be improved to create a suitable environment where Listeners can support vulnerable and at-risk prisoners.

2.85 The targets for suicide prevention training should be achieved. (3.51)

Achieved. New ACCT procedures had been introduced and most staff had received foundation training. Seventeen staff had been trained as assessors and 38 as case managers, but most assessors were officers. Training records were well kept and new staff were targeted for training.

Further recommendation

2.86 Assessment, care in custody and teamwork (ACCT) assessors should be drawn from a wider range of disciplines.

2.87 Staff handover procedures should ensure that all staff are briefed about potentially vulnerable prisoners and those on open F2052SHs (self-harm monitoring forms). More staff should be trained in first aid to ensure sufficient first aid trained staff are on duty at night. (3.52)

Partially achieved. The names of prisoners on open ACCT documents were highlighted to staff at handover briefings, in wing observation books and on wing notice boards. However, the names of other high-risk prisoners, including those new to prison, withdrawing from drugs and with mental health issues, were not mentioned at handover (see also paragraph 2.32). Fifty-six staff from a range of areas had up-to-date First Aid training and two were permanent night orderly officers.

Further recommendation

2.88 Staff handovers should highlight any prisoners who may be vulnerable, but may not be on an open assessment, care in custody and teamwork (ACCT) form.

2.89 Prisoners should be able to make free confidential calls to the Samaritans from the landing telephones. The direct cordless telephone lines should be advertised to prisoners and their use recorded. (3.53)

Partially achieved. The dedicated number to make a free call to the Samaritans from landing telephones had been published to all prisoners and was well used. The availability of cordless Samaritans telephones for use during lock up was advertised on posters and displayed on notice boards, but use of these did not appear to be logged. The telephone on E wing was missing and staff said it was being repaired.

Further recommendation

2.90 A log should be kept of the use of the cordless telephones providing a direct line to the Samaritans.

2.91 All cell bells should be in working order. (3.54)

Achieved. Cell bells were tested every day and all appeared to be working.

Additional information

2.92 The SPC presented a comprehensive monthly report on the extent of self-harm and the operation of the ACCT system to the safer prison meeting. Levels of self-harm were not high, with an average of 16 incidents a month between April and September 2007 and around eight of these involving actual self-harm. The safer custody meeting discussed each case in detail. On average, 27 ACCT forms were opened each month and 11 were open during the inspection. Most were opened as a preventative measure.

2.93 ACCT forms were not well completed. One case had been open nearly three weeks and there was no care plan. Apart from those by mental health in-reach nurses, few entries demonstrated any interaction with the prisoner. The SPC monitored the quality of ACCT forms and included his findings in his monthly report.

2.94 A safer prison physical education session had been introduced to encourage prisoners on open ACCT forms to participate in activity.

2.95 Two gated cells on F3 were used for prisoners considered at high risk of self-harm. Two prisoners had been placed in these cells a number of times in 2007. A constant observation policy (February 2007) had been agreed between the Prison Service and Nottingham City Primary Care Trust. Despite its title, the policy emphasised the need for interaction between the member of staff and the distressed prisoner.

2.96 The body belt had been used once for around four hours to prevent a prisoner from self-harming. Strip clothing had been used only a few times. No separate record was kept of the use of these extreme measures.

2.97 Insiders, Listeners and Samaritans provided a monthly report to the safer prison meeting. Listeners felt supported by most officers, but were not involved in induction.

Further recommendations

2.98 Assessment, care in custody and teamwork (ACCT) documents should be better completed and report positive interaction with prisoners at risk.

2.99 The use of extreme measures such as the body belt and strip clothing for prisoners at risk of self-harm should be recorded and monitored by the safer prison committee.

2.100 Listeners should be involved in induction to explain the scheme to new prisoners.

Race equality

2.101 The race relations action plan should be time-bound. (3.67)

Achieved. The race equality action plan included deadlines for achievement of specific targets, a number of which had been carried over. Minutes of race equality action team (REAT) meetings suggested little systematic discussion or oversight of the action plan.

Further recommendation

2.102 The race equality action team should actively monitor the progress of the race equality action plan.

2.103 Racial diversity should be promoted through more cultural events and engagement with the local community. (3.68)

Not achieved. There was little evidence of any recent promotion of race equality and diversity through community engagement or celebrations of cultural events inside the prison.
We repeat the recommendation.

2.104 Ethnic monitoring should be in accordance with the Prison Service guidelines. The race relations management team (RRMT) should act on the outcomes, which should be published to prisoners and staff. (3.69)

Partially achieved. Range-setting ethnic monitoring was completed by the psychology department. The results were presented at REAT meetings, discussed in detail and persistent or concerning disparities further investigated. The REO had recently reviewed a sample of adjudications during a month when substantial disparities were highlighted in the figures and had presented a written report to the REAT. The results of investigations were presented to the REAT, but were not made more widely available.

Further recommendation

2.105 Ethnic monitoring, the results of any investigations and other relevant race equality information should be published to prisoners.

2.106 All racist incidents should be fully investigated, even when the complainant has been transferred or discharged, and they should be told the outcome in writing. (3.70)

Not achieved. We found several examples of inadequate investigations and not all complainants were given the outcome in writing. A number of racist incident report forms (RIRFs) submitted by staff were unnecessary and inappropriate, for example when they needed to communicate with other departments or when prisoners had accused them of racism. One member of staff accused as racist by a prisoner had submitted a defensive RIRF and the prisoner had been treated as a perpetrator rather than asked about the substance of his allegation. RIRFs usually included summaries of discussions, but none contained records of interviews. One officer had submitted a RIRF when a prisoner with an offensive tattoo and a history of involvement in the BNP had asked to share a cell with an Asian prisoner. The prisoner had been transferred before the REO could interview him. Although the officer was told in writing that the receiving prison had been contacted, there was no evidence of any such communication in the file. The REO presented a detailed report of every investigation to the REAT and each case was discussed individually. We attended one REAT meeting, where there was appropriate and challenging debate about some questionable actions taken relating to investigations, resulting in a direction from the chair to investigate further and act on a previously closed case. A representative of the Nottingham Black Partnership provided a useful perspective on the processes and activities, but there was no external scrutiny of completed RIRFs.
We repeat the recommendation.

Further recommendation

2.107 A sample of racist incident report forms should be quality-checked by an independent and capable external body.

Additional information

2.108 Black and minority ethnic prisoners reported little racist behaviour or discrimination and there was little evidence of significant racial tensions. Despite some weaknesses in race relations structures, race equality was generally taken seriously by managers. REAT meetings were well attended by staff from a wide range of disciplines and included prisoners and outside

representatives. Discussions were detailed and there was a commitment to making progress, encouraged by the governor and deputy, who usually attended along with other senior managers. Relevant issues were followed up from meeting to meeting.

2.109 The REO had not applied for the role and did not feel that he had all the necessary skills for it. He was leaving the post after six months and a temporary REO was about to take his place. Two wing assistant race relations officers had little formal responsibility and the REO did not believe they were able to support his role effectively. Only two prisoner representatives out of the planned nine were in place, inevitably limiting the flow of communication between prisoners and staff, and as a result prisoner race representative meetings were not meaningful. Other black and minority ethnic prisoners were not invited to the meetings with race representatives and in any event no such meetings had taken place in the previous few months. Black and minority ethnic prisoners said they would have appreciated opportunities for direct communication with staff.

2.110 The prison had completed some impact assessments, which were considered poor by the area diversity coordinator. Staff felt the process was burdensome and disheartening, although some important issues, including the lack of support plans for victims of racism, had been identified.

2.111 Only 9% of staff had received any form of diversity training in the previous three years. Most of the REAT, but not the REO, had received the 'managing and promoting race equality in prisons' training.

Further recommendations

2.112 The new race equality officer should have a specific interest in and motivation to do the job and be prepared to make a long-term commitment to the post.

2.113 All prisoner representative positions should be filled.

2.114 Wing assistant race relations officers should be given specific and formal responsibilities and time to support the work of the race equality officer.

2.115 Prisoner consultation meetings should take place monthly and attendance should not be limited to the appointed representatives.

2.116 All staff, and particularly the race equality officer, should receive regular and effective race equality training.

Foreign nationals

2.117 There should be a brief information guide for foreign national prisoners explaining their entitlements and the support available in the prison, including the name and role of the foreign national liaison officer. (3.82)

Not achieved. A shortened version of the induction booklet had been translated into nine, mostly European, languages using either a software translation programme or a professional translation service. Prisoners had checked the quality of some, but not all, of these translations. The booklet contained some useful information about visits, the telephone and postal systems, but other information, such as on applications and complaints, had been

missed out. None of the foreign national prisoners we spoke to had been given a copy of this or the nationally available translated prisoner information books. Vietnamese prisoners made up the largest foreign national group, but the local information had not been translated into Vietnamese. Only one of the 11 Vietnamese prisoners spoke reasonable English and was usually used to interpret for others (see also paragraph 2.30).

2.118 Written information in languages other than English should be given out, as required, as part of the induction interview. (3.83)

Not achieved. See paragraph 2.117.

2.119 Foreign national prisoners meetings should be open to all foreign national prisoners, rather than representatives, so that they all have an opportunity to contribute and obtain support. (3.84)

Not achieved. No foreign national meetings were held. The foreign national coordinator had been on restricted duties since a period on sick leave and was temporarily not allowed to have prisoner contact alone. No other arrangements had been made for prisoner groups.
We repeat the recommendation.

2.120 Family and friends visiting from abroad should be allowed to have extended or accumulated visits and prisoners should be informed of this. (3.85)

Not achieved. Although the foreign national coordinator said that extended visits would be allowed for prisoners with families abroad, this was not outlined in the foreign national policy or the induction booklet. None of the foreign nationals we spoke to knew of this facility.
We repeat the recommendation.

Additional information

2.121 The foreign national coordinator was not due to return to full duties for at least another few months. He received support for some aspects of his work, particularly immigration-related issues, but had no formal cover. None of the foreign national prisoners we spoke to knew about him, and some of the assistance that could be provided, such as translations, had not adequately filtered down. All those we spoke to did, however, know about the free monthly five-minute telephone call to distant family or friends and many used it to maintain essential family contact.

2.122 The foreign national policy had recently been revised, but some of it was out of date, particularly the information on immigration issues, which was based on old documents and had not been checked by a qualified immigration adviser or official. There was no action plan to guide and monitor progress. The foreign national coordinator provided a report to the race equality action team, but there was little further discussion of foreign national issues. The 51 current foreign national prisoners reported a range of difficulties, including problems with immigration, language and understanding prison procedures and rules.

2.123 The foreign national coordinator generated a list of all foreign national prisoners, their earliest release dates and languages spoken. This was sent to Border and Immigration Agency (BIA) staff at the East Midlands Enforcement Unit, enabling them to identify and act on cases of prisoners who might be detained. BIA staff usually attended the prison twice a month. There were five detainees, four of whom had been detained for about two months. One Chinese national had been detained for around 18 months, mainly due to a lack of travel documents. There was too little independent immigration advice. The prison had some links with an

independent advice service, but had not referred anyone to it in over a year and none of its advisers had attended the prison during a period when people were regularly detained under immigration powers. The service had no knowledge of the man detained for 18 months, and none of the foreign national prisoners asked had been advised of this service.

Further recommendations

2.124 The post of foreign nationals coordinator should have one or more designated assistants to ensure that provision can be continued when he or she is unavailable.

2.125 The foreign national policy should include an action plan to guide and monitor progress, overseen by a specific foreign national committee.

2.126 Links with the independent immigration advice service should be strengthened and all foreign national prisoners should be told about the service and helped to contact it when necessary.

Contact with the outside world

2.127 A computerised visits booking system should be introduced. (3.105)

Not achieved. Software had been developed to allow more use of IT in booking visits, but it had never worked well and the three booking clerks had been supplied with only two terminals so had quickly reverted to using paper systems. Many prisoners complained that their families found it difficult to get through to the booking line. The booking clerks and managers believed that the system had improved. Queuing software had been introduced to let callers know where they were in the system, but we could not check how well this was working as the visitors' centre was being refurbished and temporary telephone numbers were being used. Not all visitors were aware of these numbers.

Further recommendation

2.128 A visits booking system should be introduced that allows families and friends to book visits without undue delay.

2.129 Facilities in the visitors' area at the main gate should be improved. (3.106)

Partially achieved. The area had been refurbished and was clean and bright. Although still stark and chilly with hard bench seating, it was an improvement. Little helpful information was displayed and there were no general information books for visitors. Staff said these were normally available in the visitors' centre, but as this was closed there was nothing for new visitors and not all visitors used the centre when it was open. The information booklets were poorly produced and contained out-of-date and inaccurate information, including when the visits booking line was open.

Further recommendation

2.130 Up-to-date, accurate and well-produced information booklets for visitors should be provided in all visitor areas.

2.131 Visits for prisoners on the basic level of the incentives and earned privileges (IEP) scheme should be a minimum of 60 minutes. (3.107)

Partially achieved. The formal IEP policy allowed prisoners on the basic regime to have visits of 60 minutes, but prisoners we spoke to said this time was cut short by regular delays in getting to the visits room and staff accepted that this happened. Visits of less than an hour were contrary to the requirement of the Prison Service Order on visits and did not support the maintenance of family contacts for the purposes of resettlement and to reduce reoffending as required by Prison Rule 4. Nor did this meet the minimum requirement for unconvicted prisoners.

Further recommendations

2.132 Managers should make regular checks to ensure that prisoners on the basic regime are able to spend at least an hour with their visitors and that unconvicted prisoners on basic receive their full entitlement.

2.133 Differentials between basic and standard prisoners in the local visits and incentives and earned privileges strategies should be reviewed with a view to their removal.

2.134 A closed visit should not be given on the indication of a drug dog without supporting evidence or individual assessment. (3.108)

Not achieved. Closed visits continued to be imposed on a single drug dog indication without additional supporting evidence. The visitors' information booklet suggested that some level of discretion was applied following an indication, but the imposition of closed visits was the standard response.
We repeat the recommendation.

2.135 Facilities in the visits hall should be refurbished, and the barred gate to the playroom should be removed. (3.109)

Achieved. The visits hall had been refurbished and extended to provide additional facilities for legal visits. The barred gate to the playroom had been removed, but there was no longer any play area for children. The prison planned to create a new play area in the visits room itself rather than using a separate room where it was difficult for parents to watch their children.

Further recommendation

2.136 A children's activity area supervised by trained staff where prisoners can play with their children should be provided.

2.137 Prisoners should be able to have visits on both Saturday and Sunday, and the demand for evening visits should be evaluated. (3.110)

Partially achieved. The prison had rejected this recommendation, but had piloted evening visits and found that take-up was too low to justify the resources. The action plan stated that demand was too great for prisoners to have more than one visit at weekends, but visits staff said the Sunday morning slot was often poorly attended.

Further recommendation

2.138 The prison should offer Sunday morning visits to prisoners irrespective of whether they have had a Saturday visit.

2.139 Visitors should be able to provide feedback on their experiences. (3.111)

Partially achieved. Although a box had been placed in the visitors' area at the main gate, there were no comments cards to complete. The facility was not publicised and there was no evidence that any comments had been received or analysed. Managers did not make themselves available to visitors as the action plan suggested. However, a survey of visitors earlier in the year had reflected an overall positive experience of visits at Nottingham.

Further recommendations

2.140 Visitor comments boxes regularly stocked with comments cards should be placed in all visitor areas, including the visitors' centre and the visits room.

2.141 The facility to provide feedback should be well publicised, including in the visitors' information booklets, and publicity should contain the name and direct telephone number of a manager for those who wish to give verbal feedback.

2.142 Visits procedures for vulnerable prisoners should not enable them or their visitors to be easily identified. (3.112)

Not achieved. Arrangements for visits to vulnerable prisoners had not changed. Vulnerable prisoners did not believe that the arrangements provided suitable protection for their visitors. We repeat the recommendation.

Applications and complaints

2.143 There should be tracking system for applications and managers should monitor applications by subject and promptness of reply. (3.127)

Not achieved. A wing-based tracking system had been introduced whereby each application was logged with the date of receipt, the subject and the identified person to respond. The date of the response was supposed to be recorded, but this was not up to date and often not completed. Monitoring was prompted by prisoners chasing a response. Application boxes were emptied by the night orderly officer and complaints boxes by the request and complaints clerk daily.

Further recommendation

2.144 The applications log should be kept up to date and regularly monitored by managers.

2.145 Replies to complaints should be in legible handwriting or printed. (3.128)

Achieved. Illegible responses were returned to members of staff by the request and complaints clerk and forwarded to the head of business development to return to senior

managers. Residential managers usually produced typed responses. Not all responses were sufficiently detailed.

Further recommendation

2.146 Managers should regularly monitor the quality of responses to complaints to ensure that they fully answer the matter raised.

2.147 There should be information about applications and complaints in languages other than English. (3.129)

Not achieved. Complaint forms were available in languages other than English, but only on request. The applications and complaints systems were explained in the prisoner information booklet and at induction, but the abridged induction presentation translated into 10 languages did not cover them. Posters on the wings were in English only. We saw one English complaint form completed in Chinese where the complaint had been fully translated and responded to appropriately.
We repeat the recommendation.

Legal rights

2.148 Trained legal officers (LSOs) should be available daily to provide bail information and effective legal services advice. (3.136)

Not achieved. The legal services officer had not been trained. The officer was based on the induction unit and saw all new arrivals. Surgeries were not held on individual wings and prisoners were seen only on application.
We repeat the recommendation.

Further recommendation

2.149 Legal rights surgeries should be held on each wing to make them easily accessible to all prisoners.

Substance use

2.150 The drug strategy should be updated and informed by an up-to-date needs analysis. (8.62)

Partially achieved. The drug strategy (May 2006) had been updated in November 2006. A survey of prisoners' substance misuse problems and experiences of services had been undertaken in December 2006 and produced good information. However, services had undergone such rapid change in 2007 that numerous aspects of the strategy, including arrangements to see a doctor and admission to healthcare, were already out of date.

Further recommendation

2.151 The drug strategy, accompanying protocols and an action plan should be updated annually in line with assessed needs.

2.152 The people responsible for implementing the drug strategy targets should be specified in the action plans. (8.63)

Achieved. The most recent action plan (April 2007) set out staff responsible for actions. However, as with the drugs strategy, the action plan had been superseded (see recommendation 2.151).

2.153 There should be a dedicated location for all prisoners on clinical detoxification to ensure proper specialist supervision during the process. (8.64)

Achieved. After induction, prisoners requiring detoxification treatment were housed on F wing. A few prisoners on maintenance programmes were on D wing. Prisoners receiving treatment were seen daily by nursing staff and regularly reviewed by the lead GP.

2.154 A senior substance misuse nurse should be recruited to lead the nursing team. (8.66)

Achieved. Nursing staff had been recruited to form a substance misuse team, which was led by a nurse team leader (band 7) with specialist training.

2.155 A methadone maintenance programme to allow the management of prisoners for up to three weeks should be implemented. (8.67)

Achieved. Methadone maintenance was available to all prisoners on a community prescription who were on remand or with short sentences for up to 13 weeks.

Additional information

2.156 The prison began piloting the national integrated drug treatment system model in June 2007 and now averaged 60 to 70 patients at any one time on detoxification or maintenance programmes. Systems for administering methadone were secure using iris recognition and there were appropriate arrangements for monitoring controlled drug use. Communication between the nursing team and the counselling, assessment, referral, advice and throughcare (CARAT) service was good and there were good links with Nottingham community drugs services. The previous good communication with Derby services had been affected by a change of service provider.

2.157 The prison had met its key performance target for mandatory drug tests (15.4%) in 2006 (10.1% excluding March 2007 figures, which were missing). The 2007 year-to-date rate was 12.2%. Both figures masked a highly variable monthly rate (3.4% – 24.9% in 2007; 3.9% – 23% in 2006). Staff worked together to reduce illicit drugs supply, but some of the measures adopted were unjustified (see section on security and rules).

2.158 There should be a system to ensure that simple pain relief is available to prisoners during the night. (4.72)

Not achieved. Two nursing staff on duty overnight on F wing were able to provide simple pain relief to prisoners on all wings, but prisoners said it was difficult to get medication at night and officers would not call the nurses. Arrangements to ensure access to night time pain relief were inadequate. Prisoners could not buy paracetamol from the shop or obtain it from discipline staff.
We repeat the recommendation.

2.159 Plans for a new day care centre should be implemented as a priority to ensure patients have regular access to appropriate therapeutic services. (4.73)

Not achieved. The new health centre contained a large meeting room, which had been used for group work by CARAT staff, but not by mental health in-reach or primary care.

Further recommendation

2.160 Prisoners with mental health and allied problems should have access to appropriate therapeutic services.

2.161 The healthcare application system, including doctor's appointments, should ensure that patients can see a healthcare professional within a reasonable time. (4.74)

Achieved. A new clinical IT system made it easy to track appointments and waiting times. The only significant waiting times were for the podiatrist, where two people had been waiting four months because a clinic had been cancelled due to industrial action, and for smoking cessation, where extra nursing staff were being trained to deliver the service.

2.162 The healthcare staff skill mix should be reviewed to ensure that appropriately qualified and graded nursing staff are available to meet the clinical needs of patients. (4.75)

Achieved. The primary care team was led by a senior nurse manager (band 8a). New staff had been recruited and the primary care team had been reorganised to reflect their changing role. Four nurse team leaders (band 7) had been appointed to cover primary mental health, general nursing, long-term conditions and substance misuse. At least half the primary care nursing staff were mental health trained, providing a good resource to manage mild to moderate mental health conditions and substance misuse.

2.163 The availability of GPs should be reviewed and increased to meet the needs of patients. (4.76)

Achieved. In addition to the evening and Saturday sessions, two GPs saw up to eight patients a day each on weekday mornings for general medical and substance misuse problems. Waiting times for the GP were two to five days from original application, including seeing a nurse.

2.164 The healthcare manager should introduce prisoner focus groups to inform the further development of healthcare services. (4.77)

Not achieved. Apart from complaints, there were no regular arrangements to obtain direct feedback on health services. A local voluntary organisation had attempted to organise focus groups for minority ethnic prisoners, but these had been poorly attended. A survey of prisoners conducted by the primary care trust in early 2007 had preceded many of the service changes, but prisoners had nevertheless expressed some serious concerns about services and staff attitudes and behaviours.
We repeat the recommendation.

2.165 The healthcare department should have a dedicated session in the induction programme to ensure prisoners know how to access healthcare services. (4.78)

Not achieved. Healthcare staff were not involved in induction and information about health services was given by officers.
We repeat the recommendation.

2.166 A bath should be installed in the in-patient area. (4.79)

No longer relevant. The prison no longer had an in-patient unit.

2.167 All wing treatment rooms should have secure stable doors to prevent prisoners from entering the room. All drug cupboard keys should be securely stored when not in use. (4.80)

Partially achieved. Small key safes with combination locks were sited near drug cupboards in all treatment rooms. No staff carried drug cupboard keys. Treatment rooms on F, G and D wings were secure, but on E wing prisoners were seen at the open wooden door of the treatment room. This did not provide adequate security for staff, equipment or drugs.
We repeat the recommendation.

2.168 The medicine and therapeutics committee membership should be reviewed to include the pharmacist, who should attend all meetings. All pharmacy and medication policies should be reviewed and updated. (4.81)

Partially achieved. The primary care trust medicines manager and the pharmacist from the supplier attended the medicines and therapeutic committee meetings. Some medicines management policies and procedures were unsigned and it was unclear whether there were others in use. There was no accessible file of dated and signed policies for staff to consult.

Further recommendation

2.169 Medicines management policies should be reviewed and updated regularly, and signed and dated copies should be readily available to health staff.

2.170 Secondary dispensing should stop and alternative systems introduced for medicine administration to ensure medicines are issued in accordance with the Medicines Act. (4.82)

Not achieved. In contravention of the Medicines Act, nurses regularly broke open medicines boxes and bottles that had been assembled and dispensed by the pharmacy for 28-day supply

to a named patient in order to issue the tablets to that patient daily or weekly (secondary dispensing). Rather than requesting that a 28-day prescription be made up in several packages labelled for issue daily or weekly (according to risk assessment), we saw staff giving out a day's supply of several different tablets that prisoners took away loose in their hand. We repeat the recommendation.

2.171 Dental triage should be introduced to differentiate between the needs of short- and long-term prisoners and those in pain. (4.83)

Achieved. A dental nurse held two sessions a week where she used an agreed protocol to triage all patients asking to see the dentist.

2.172 A drugs trolley should be provided to administer medicines in the hospital. (4.84)

Achieved. A drugs trolley had been purchased and used in the hospital. However, this was no longer required as the in-patient unit had closed.

2.173 The primary care trust (PCT) dental action plan should be implemented in the specified timescale. (4.85)

Achieved. Dentistry sessions had been doubled to four a week in addition to the dental triage sessions. Waiting times to see the dentist had greatly reduced to a maximum of two weeks. Urgent cases were seen more quickly, but in the interim nurse prescribers prescribed antibiotics for dental abscesses using an agreed protocol. Dental equipment had been purchased and had reduced the number of external referrals.

Additional information

2.174 Health services had undergone huge changes in 2007. In June, health services moved to a new purpose-built prefabricated unit. The excellent facilities were appreciated by prisoners and staff and helped foster a more respectful and calm environment. Working with regional prison and health partners, health services staff had closed the in-patient unit and set up a 10-cell enhanced care unit on F wing with 24-hour nursing cover. This bold and positive move had enabled nursing staff to provide a better wing-based service, reduced misuse of nursing time with inappropriate admissions and contributed to improved access to NHS in-patient facilities, especially for people with severe mental illness.

2.175 Mental health in-reach services were working well, with good relationships between the primary care team. Waiting times were short and there was prompt access to psychiatrists. Over the previous six months, eight prisoners had waited less than six weeks between referral and transfer to outside hospitals. The exception to this was a prisoner on the segregation unit waiting for a place on a personality disorder unit. There were good links with community mental health services.

Learning and skills and work activities

2.176 Efforts should be made to improve links between the prison and the education provider. (5.14)

Achieved. Education was subcontracted to West Nottinghamshire College. The head of learning and skills and the education manager had good formal and informal links. Communications between the prison and education provider staff were effective. Working

relationships were cooperative and productive. Regular meetings between relevant parties appropriately considered operational and forward planning issues. Sharing of information for monitoring and trend analysis purposes was good.

2.177 There should be an appropriate range and number of accredited vocational qualifications. (5.15)

Partially achieved. Developments had been limited by the need to tailor courses to prisoners' relatively short average length of stay. Performing manufacturing operations (PMO) qualifications were available in workshops 1, 2 and 3, the latter being for vulnerable prisoners only. Workshop 4, the recycling workshop, offered an ASDAN (award scheme development and accreditation network) course. Activities in workshop 4 had been suspended for security reasons. Workshop 5 offered a BICS industrial cleaning programme at levels 1 and 2, but no relevant waste management qualification. An ASDAN and basic food hygiene certificate course was available in the kitchen, but no catering national vocational qualification (NVQ). A level 1 horticultural NVQ had recently been introduced. An adequate range of IT courses was run in the education department and arrangements to provide literacy and numeracy support outside the education department were satisfactory. There was an appropriate range and quantity of courses in English for speakers of other languages (ESOL). A workright course had been introduced to develop and accredit prisoners' general work skills. In physical education, there were level 1 courses in introduction to weights and introduction to fitness, as well as a first aid at work certificated course (see also paragraph 2.189). Provision for more able prisoners and those wishing to undertake open learning courses was inadequate and there were no evening or weekend classes.

Further recommendation

2.178 The range of qualifications and courses should be extended, including the provision of more higher-level education courses, open learning courses and evening and/or weekend classes.

2.179 There should be an equitable prisoner pay structure for education and work. (5.16)

Achieved. A reviewed prison pay scale had been introduced and ensured equitability between education and work.

2.180 Quality assurance arrangements for education and training should be implemented. (5.17)

Achieved. Effective quality assurance arrangements had been introduced. Provision in work and education was subject to an appropriate quality assurance process that led to improvements. The self-assessment process was part of a quality cycle that was effectively used to drive forward developments. The performance of courses and tutors was appropriately monitored.

2.181 There should be systems to identify the basic skills and educational needs of all prisoners. (5.18)

Achieved. The needs of all prisoners were appropriately identified at induction and the results of assessment widely shared with relevant staff to inform strategies. Prisoners' needs were effectively recorded on their prisoner passport. More detailed assessment of basic skills was compulsory for prisoners who wanted to start education courses, but not for those entering the workshops. Arrangements for information and advice were satisfactory.

Further recommendation

2.182 All prisoners entering the workshops should be subject to a detailed assessment of basic skills needs.

2.183 The library should improve its stock through a needs analysis involving users and relevant departments. (5.19)

Achieved. A needs analysis had been carried out through a questionnaire and the results used to improve the library stock, including on self-help, popular science and psychology topics. The range and availability of fiction books was limited.

Further recommendation

2.184 The range and availability of fiction books should be improved.

2.185 The work available to prisoners should be relevant to and useful for resettlement and should be more interesting and demanding. (5.25)

Not achieved. Much of the workshop activity was repetitive and undemanding and did not reflect the local employment needs identified by the Learning and Skills Council. Workshops were housed in modern well-maintained buildings, but the painting and decorating workshop was not in use. The only workshop activity for vulnerable prisoners was putting together breakfast packs.
We repeat the recommendation.

2.186 Allocation of work should take into account prisoners' abilities and preferences. (5.26)

Not achieved. A labour allocation board allocated prisoners to activities and prioritised prisoners who required an education course. Other than the information gained from the basic skills assessment, allocation to workshops considered prisoners' abilities, but placed too little emphasis on their preferences.
We repeat the recommendation.

2.187 Prisoner work should be better organised and reflect current industrial practice. (5.27)

Achieved. Prisoner work had been reviewed. Workshops were laid out with clear activity areas and work practices mirrored those found in industry. Appropriate health and safety procedures were displayed.

2.188 There should be opportunities for prisoners to be accredited for all skills acquired at work. (5.28)

Partially achieved. See paragraph 2.177.

Physical education and health promotion

2.189 There should be opportunities for prisoners to gain vocational qualifications in the physical education (PE) department. (5.38)

Partially achieved. There were only relatively basic level 1 courses in introduction to weights and introduction to fitness, as well as a first aid at work certificated course. Courses had been disrupted between June and early November 2007 due to classroom relocation.

Further recommendation

2.190 The range of physical education courses should be extended to include courses such as sports leadership.

2.191 All prisoners should be able to take part in gym induction. (5.39)

Not achieved. Day three of the five-day induction programme was used for gym induction, but many prisoners missed some induction sessions (see paragraph 2.38).
We repeat the recommendation.

2.192 The PE department should promote prisoner health as part of its core function. (5.40)

Achieved. There were satisfactory links with health services and appropriate referrals were made. The PE department delivered individual programmes following referrals from counselling, assessment, referral, advice and throughcare (CARAT) staff, the GP and assessment, care in custody and teamwork (ACCT) staff. A prisoner and staff health promotion day had been held and included a wide range of relevant agencies.

2.193 PE staff should not be deployed to other duties. (5.41)

Achieved. PE was part of a self-rostering pilot scheme. Staff were not deployed to other duties other than during operational emergencies.

2.194 Disabled prisoners should have full access to the gym. (5.42)

Achieved. Reasonable adjustments had been made. Following the building of two new accommodation blocks, prisoners with disabilities had satisfactory access to the gym. Prisoners with mobility difficulties could use a route through the accommodation blocks and a perimeter road to reach the weights room side door.

Faith and religious activity

2.195 All prisoners should be allowed to attend religious services of their choice to practise their faith fully, and services should not clash with other key regime activities. (5.54)

Partially achieved. The core day had been revised and there were minimal clashes with other regime activities, although there was still an overlap with the Sunday morning exercise period. In some cases, prisoners went from services to exercise and the coordinating chaplain said there were no significant issues with this.

2.196 The paid hours for the imam should be increased beyond one and half hours a week. (5.55)

Achieved. A Muslim chaplain was employed for 30 hours a week and another imam provided two hours on Fridays.

2.197 The world faith room should be big enough to comfortably accommodate the largest group of prisoners using it, should have secure, lockable cupboards, and be maintained in a respectful state. (5.56)

Achieved. The multi-faith room had been relocated to E wing. The room was large enough to hold around 30 prisoners, which was usually sufficient. The room was used by the Muslim, Hindu, Sikh and Buddhist faiths and all groups had access to secure lockable cupboards.

Additional information

2.198 There was still a limit on how many prisoners could attend services, but we were told that those who wanted to were able to do so, although we could not ascertain if this was always the case. The community chaplain initiative to provide mentoring in the community had developed well.

2.199 The chapel was due to be demolished and moved to a portacabin. The extensive building plans for the prison included a purpose-built chapel and world faith room with washing facilities, which were expected to be in place in three years. The current room had no washing facilities and there were no plans for these in the temporary facility.

Further recommendations

2.200 There should not be a limit on the number of prisoners able to attend services.

2.201 The world faith room should be equipped with washing facilities.

Time out of cell

2.202 Prisoner participation in exercise should be monitored. (5.67)

Achieved. Officers monitoring exercise kept a record of the number of prisoners participating.

Security and rules

2.203 The gate between B wing and the managers' corridor should not be double locked until the night state of the prison regime. (6.13)

No longer relevant. B wing had been closed.

2.204 Staff should be notified of prisoners identified by intelligence as posing a significant security threat. (6.14)

Achieved. There were good systems to identify prisoners who posed a security threat, including those posing a risk of escape, those with a history of arson, barricading and threats to women, and known racists. This information was accessible to all staff through the local intranet. Staff, including workshop staff, regularly used it to carry out risk assessments within their own areas.

2.205 Strip-searching of prisoners, other than on reception and cell searches, should be based on individual risk assessment. (6.15)

Partially achieved. Strip-searching was no longer routine in the segregation unit (see paragraph 2.215). However, there were other areas, including voluntary drug testing procedures, where prisoners were strip-searched without a risk assessment.
We repeat the recommendation.

2.206 The prison should have direct computer access to information about previous convictions. (6.16)

Achieved. The prison had access to the police national computer and could obtain information about previous convictions.

Additional information

2.207 Security was well managed, with good processes for dealing with intelligence. A security audit carried out in 2006 had identified weaknesses in searching processes and these were being addressed through more rigorous procedures. Security objectives were mostly focused on the prevention of drug supply and searching techniques. As a response to the proximity of D wing to the perimeter fence, the D wing exercise yard had been closed and bars were being fixed to D wing windows to prevent prisoners using hooks to pick up drug parcels. There was evidence that these actions had resulted in a reduction of the drug supply. In these circumstances, we regarded many of the actions set out in a notice to prisoners ('positive action against drug use', 5 September 2007) as disproportionate as the mandatory drug test rate had fallen considerably before its introduction.

2.208 There were 28 banned visitors and 32 prisoners on closed visits. Most prisoners placed on closed visits had this imposed due to a combination of incidents or intelligence, but this was not always the case. Some prisoners, including one found with a £5 note, were subject to three months of closed visits as a minimum term despite the lack of intelligence from other sources. Prisoners were reviewed monthly, but reviews were brief and in practice nearly all prisoners were subject to the full three months. The 'positive action against drug use' notice said that any visitor found in possession of a SIM card would be banned for a three-month period and the prisoner to be visited placed on closed visits for three months.

Further recommendations

2.209 Monthly reviews of prisoners on closed visits should fully take into account the continued risk posed by the prisoner and document the reasons for the continuation of closed visits.

2.210 The measures set out in the notice to prisoners dated 5 September 2007, 'positive action against drug use', should be reviewed to ensure that they are proportionate and justified. In particular, visitors in possession of SIM cards should not automatically be banned from visits without an appropriate review of the circumstances, prisoners should not automatically be reduced to basic as a result of one positive mandatory drug test and presumptions about the use of Class A drugs should not be made without reasonable evidence.

Discipline

2.211 Where charges of fighting are heard separately at adjudications, all the evidence should be available to both of the accused. (6.43)

Achieved. There were few incidents of fighting among prisoners, but the records showed that prisoners facing such charges were seen together by the adjudicating governor.

2.212 Mechanical restraints should be used only when authorised by an appropriate manager and the medical officer. (6.44)

Not achieved. Mechanical restraints had been used only twice since December 2006 and on one occasion use of force instead of body belt documentation had been completed. There was no authority from the governor in charge and the correct procedures had not been followed. We repeat the recommendation.

2.213 Use of force and the use of unfurnished accommodation and mechanical restraints should be fully recorded and properly monitored by managers. Unfurnished cells should not be used for compliant prisoners or to prevent a prisoner self-harming except in exceptional circumstances. (6.45)

Partially achieved. Use of force was monitored by the control and restraint coordinator and a small group of staff at quarterly meetings. Use of the special cell was not properly monitored. Unfurnished cells were not used for prisoners self-harming, but compliant prisoners were sometimes held in special accommodation (see additional information).
We repeat the recommendation.

2.214 The protocol on the use of the video unit in the segregation unit should be followed and all staff should be reminded that women should not observe male prisoners being stripped. (6.46)

Achieved. There was no evidence that women staff observed prisoners being stripped and staff we spoke to were clear about their roles and responsibilities.

2.215 Prisoners entering the segregation unit should not be routinely strip-searched unless a specific threat has been identified. (6.48)

Achieved. Prisoners were not routinely strip-searched in the segregation unit. Those located there for fighting or believed to be holding concealed weapons were strip-searched, but rules were specific that those placed there for their own protection were not to be strip-searched.

Additional information

2.216 Use of force had increased during 2007, with 123 incidents to date compared to 108 in the whole of 2006. Paperwork was mostly well completed, although some descriptions were formulaic. Seven incidents had involved one prisoner and there was little analysis of this at senior management level. The quarterly use of force meeting chaired by the head of operations had been poorly attended and there were plans to integrate it with the security committee. A full-time control and restraint coordinator analysed data by a number of factors, including prisoner status, ethnicity, location and trends, but this did not highlight the factors behind the use of force or why it was increasing.

2.217 The special cell had been used 10 times to date in 2007. Paperwork was generally inadequate, with half of forms not having a unique log number and some forms not authorised by the duty governor. In some cases, the reasons given for the use of special accommodation were insufficient. While most referred to prisoners being violent and refractory, one described a

prisoner as compliant and asking to come out of the special cell, but being refused because only one member of staff was on duty. The Independent Monitoring Board was normally contacted, but in one case this had been only by email.

2.218 The segregation unit had a capacity of 17, including four double cells. Of the nine prisoners held there, seven were vulnerable prisoners. Segregation was often used to hold vulnerable prisoners when E4 was full, which was frustrating for prisoners and staff. Some were put in double cells, which were subject to cell-sharing risk assessments, and allowed to exercise together, but the regime overall was poor and unsuitable for these longer-stay prisoners. Staff tried to move vulnerable prisoners to E4 as soon as possible, but in practice some waited several weeks for a place. The situation was exacerbated by the problems faced moving indeterminate-sentenced prisoners (60% to 70% of prisoners on E4) to other establishments. The segregation unit also held some long-term residents with mental health and behavioural problems who could not be moved to normal location. One prisoner had been waiting several months for a move to a secure unit, while several options for a life-sentenced prisoner who was difficult to place had been discounted and staff were having to manage him.

2.219 The segregation unit regime was decent and included showers, exercise and telephone calls, but the high numbers held meant that daily showers were not always possible. Association was not possible, but there was some limited in-cell education and access to books.

Further recommendations

2.220 Prisoners in the segregation unit should be offered daily showers.

2.221 Longer-term vulnerable prisoners should not be routinely held in the segregation unit. When necessary, the regime should be enhanced to meet their needs, including opportunities for association.

2.222 Special cell paperwork should be completed correctly, with log numbers assigned and detailed information given justifying the use of the special cell.

2.223 The use of mechanical restraints should be authorised by the governor in charge and authorisation should comply with national Prison Service guidelines.

2.224 Senior managers should routinely examine information relating to use of force and special accommodation.

Incentives and earned privileges

2.225 There should be greater differentials in the incentives available at the standard and enhanced levels of the incentives and earned privileges (IEP) scheme. (6.69)

Achieved. Enhanced level prisoners were now entitled to higher levels of unlock, their own clothing and some hobby items. They were also given priority for single cells, but this was not detailed on the IEP policy or the facilities list.

2.226 The incentives and earned privileges (IEP) scheme should be developed to engage those prisoners at the establishment for only a short while. (6.70)

Achieved. Prisoners were now able to apply for enhanced status after three weeks compared to two months at the last inspection.

2.227 Prisoners on the basic level should be reviewed every seven days, and there should be opportunity for improved behaviour to be rewarded with a reduction in their time on basic. (6.71)

Achieved. All prisoners on basic were reviewed after seven days and in most cases prisoners could return to standard level after 14 days if their behaviour had improved.

2.228 Staff comments in monitoring booklets should show evidence of engaging with prisoners to encourage improved behaviour. (6.72)

Not achieved. Comments were generally a report of observations rather than interaction. We repeat the recommendation.

2.229 All basic-level prisoners should have a radio. (6.73)
Achieved. Radios were not removed from prisoners demoted to basic, although those without a radio had to apply to the chaplaincy for one rather than being given one automatically.

Further recommendation

2.230 Prisoners on basic and at risk should be given a radio without having to apply for one.

Additional information

2.231 Prisoners could be demoted to basic regime for not cleaning their cells. However, once on basic, they were able to clean their cells only once a week. This gave confusing messages about expected behaviour. Prisoners on basic also had a reduced visits entitlement, which unfairly punished their families.

Further recommendations

2.232 Prisoners on basic should be encouraged to maintain normal standards of personal and environmental hygiene.

2.233 Visitors to prisoners on the basic regime level should not be penalised by reduced visits opportunities.

Catering

2.234 Prisoners, and in particular, foreign national and black and minority ethnic prisoners should be consulted about the food offered with the aim of improving satisfaction. (7.14)

Achieved. A food survey was conducted every six months, with the latest generating 141 returns. Positive and negative comments were made and changes introduced as a result, but comments were not broken down by ethnicity to allow any patterns to be identified. Prisoners also used the food comments books and were positive about the response from the catering department. The catering manager went to some prisoner consultation meetings and attended

race equality action team meetings to gather feedback from prisoner representatives. Muslim prisoners had been positive about the food provided during Ramadan.

Further recommendation

2.235 The prisoner food survey should be broken down by ethnicity to allow any patterns to be identified.

2.236 A dietician or nutritionist should advise the prison on menu planning. (7.15)

Not achieved. There had been no formal analysis of the menu.
We repeat the recommendation.

2.237 Prisoners working in the kitchen should have opportunities for accredited training. (7.16)

Partially achieved. See paragraph 2.177.

2.238 Lunch should not be served before noon and the evening meal not before 5pm. (7.17)

Partially achieved. The evening meal was served at 5.45pm, but lunch was usually at 11.45am and both meals were served earlier at weekends.

Further recommendation

2.239 Lunch should not be served before noon.

2.240 Breakfast should not be served until the morning it is to be eaten. (7.18)

Not achieved. Breakfast packs were given out the evening before use and some prisoners ate the contents before morning.
We repeat the recommendation.

2.241 Prisoners should not have to eat in cells with unscreened toilets. (7.19)

Not achieved. Most prisoners still had to eat in cells with unscreened toilets.
We repeat the recommendation.

2.242 Toasters and microwaves should be provided on wings. (7.20)

Not achieved. These were not provided on any of the wings.
We repeat the recommendation.

2.243 Catering managers should attend prisoner council meetings. (7.21)

Partially achieved. The catering manager attended some prisoner councils and responded to specific points raised in the minutes if he was absent. However, neither he nor any other member of the catering team had attended a meeting since January 2007.
We repeat the recommendation.

Prison shop

2.244 Prisoners should be able to use the shop within 24 hrs of their arrival. (7.36)

Not achieved. The prison had rejected this recommendation and the situation remained that not all new arrivals could use the shop within 24 hours.
We repeat the recommendation.

2.245 There should not be an administration fee for Argos orders. (7.37)

Achieved. The prison had rejected this recommendation on the basis that the delivery charge was passed on to prisoners by Aramark, but had subsequently decided to fund delivery charges so there were no additional costs to prisoners.

Strategic management of resettlement

2.246 A clear resettlement policy should be agreed based on the identified needs of prisoners at Nottingham. (8.11)

Partially achieved. The psychology department had undertaken a needs analysis based on offending behaviour in August 2007. The response rate had been 43%. The results had been analysed and the range of interventions evaluated against perceived need. This had not been incorporated into the resettlement strategy, which had been written in 2006 and was being updated to reflect the resettlement pathways. The strategy largely focused on what currently happened and there was insufficient identification of gaps in provision.
We repeat the recommendation.

2.247 A resettlement policy committee (RPC) with a multidisciplinary agency membership should be formed. The RPC should control the strategic direction of resettlement work and assess progress against measurable targets and maintain these monthly. (8.12)

Partially achieved. A multidisciplinary resettlement strategy meeting had been established, but had been replaced in May 2007 by a reducing reoffending strategy group. The draft terms of reference were focused on the East Midlands reducing reoffending action plan and linked to the local strategy and performance standards. There were clear links to the resettlement pathways. The meeting did not meet regularly and although we were told that two meetings had taken place since May, minutes were not available. The May meeting had been well attended and focused on attributing staff responsibilities to the pathways.

Further recommendation

2.248 The reducing reoffending strategy group should meet regularly with up-to-date records of meetings to ensure an appropriate focus on agreed action to drive forward the strategy.

2.249 Prisoners should be provided with clear information about the resettlement process at Nottingham and what help they can expect. (8.13)

Partially achieved. Prisoners were seen by the resettlement team on induction and interviewed about housing, family and financial issues. There were a number of leaflets about resettlement service provision, but the prisoner information booklet did not include resettlement information. Prisoners we spoke to had a poor awareness of resettlement services.

Further recommendation

2.250 A short clear information leaflet about resettlement services and how to access them should be provided to all prisoners during induction.

Offender management and planning

2.251 The prison should agree a protocol with the local courts to improve access to victim and witness statements. (8.21)

Partially achieved. Although no formal protocol had been agreed, liaison with the court had improved and there were no reported problems with access to official court documents.

2.252 The lifer manager and all lifer officers should be trained for their roles. (8.29)

Achieved. The lifer manager was a senior officer and was supported by six trained lifer officers.

2.253 Potential life-sentenced prisoners should be identified and supported before sentence and given particular care after sentence if convicted. (8.30)

Achieved. All prisoners on remand for charges that could result in a life sentence were identified at reception and interviewed by a trained lifer officer during induction. Potential life-sentenced prisoners were interviewed formally. Identifying prisoners likely to be given an indeterminate sentence was more difficult as the huge list of relevant offences made it impossible to predict with any certainty when the sentence would be used.

2.254 The protocol for new and potential lifer receptions should be revised in line with current guidance. (8.31)

Achieved. All life-sentenced prisoners were issued with up-to-date guidance about the establishment. The leaflet was comprehensive and covered the aspects of the Criminal Justice Act 2003 and details about indeterminate sentences.

2.255 All relevant life-sentenced prisoner reports should be completed on time. (8.32)

Achieved. All multi-agency lifer risk assessment panels were completed on time. There were some delays in getting external probation reports, but in general the system worked well.

2.256 There should be efforts to transfer convicted life-sentenced prisoners more quickly using all potential prison allocations. (8.33)

Not achieved. Although the prison made strenuous efforts to allocate indeterminate-sentenced prisoners to first stage lifer centres, there were substantial delays in achieving transfers (see additional information).

2.257 Public protection awareness training should be restarted so that staff can contribute to the intelligence and informed supervision of high-risk prisoners. (8.90)

Not achieved. There was no public awareness training for staff, although this was planned. We repeat the recommendation.

2.258 Wing managers should keep staff informed of those prisoners subject to public protection arrangements and what specific behaviour should be identified and reported. (8.91)

Not achieved. There was no formal system by which wing managers informed staff about public protection issues, although wing liaison officers were part of the monthly inter-departmental risk management meetings.
We repeat the recommendation.

Additional information

2.259 Most offender assessment system (OASys) assessments were up to date for those for whom they were required and were completed within eight weeks. Most determinate-sentenced men moved quickly to training prisons before that point. A resettlement passport system still operated and men were seen at an early stage to assess their needs.

2.260 Forty-nine of the 68 indeterminate-sentenced prisoners were serving indeterminate sentences for public protection. Of the 22 mandatory life-sentenced prisoners, eight were recalled prisoners and there were difficulties getting them transferred to a training prison. Many indeterminate-sentenced prisoners, including those serving very short tariffs, remained at Nottingham for over a year. The reasons given were problems in getting to first stage centres and restrictions in the selection criteria of some receiving establishments. The prison regularly negotiated with other establishments, but movements were hampered by the lack of a coordinated central approach.

2.261 The lack of moves had a significant impact on Nottingham. Twenty-eight of the 50 prisoners on E4 were serving indeterminate sentences, resulting in a lack of vulnerable prisoner spaces which contributed to vulnerable prisoners spending long periods in segregation. Provision for indeterminate-sentenced prisoners did not meet the needs of those who were not transferred quickly, with little involvement from lifer case officers after the initial period.

2.262 Public protection arrangements were sound. Information on high-risk prisoners was maintained on a detailed and accessible database. This was regularly accessed by staff working in telephone and mail monitoring as well as those involved in offender management and working with prisoners in residential areas. Multi-agency risk management panels were well attended and there were very good arrangements with local public protection panels. The policy was up to date and addressed all areas. Staff had a good awareness of public protection issues, but formal training on what to look out for and how to respond was lacking (see paragraph 2.258).

Further recommendations

2.263 A national strategy should be put in place to ensure that indeterminate-sentenced prisoners are transferred to the most appropriate training prison as soon as possible after sentencing.

2.264 Lifer case officers should maintain regular contact with indeterminate-sentenced prisoners throughout their stay at Nottingham.

Section 3: Summary of recommendations

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

Main recommendations to the Governor

3.1 Improvements should be made to reception to help arriving prisoners feel safe and respected, with adequate holding rooms and appropriate searching and changing areas. (2.1)

3.2 All prisoners should be offered daily association. (2.6)

Recommendation to the Chief Executive of NOMS

Offender management and planning

3.3 A national strategy should be put in place to ensure that indeterminate-sentenced prisoners are transferred to the most appropriate training prison as soon as possible after sentencing. (2.263)

Recommendation to the Area Manager

Health services

3.4 New arrivals with substance or alcohol misuse problems should be identified promptly and receive appropriate medication without delay. (2.11)

Recommendations to Prisoner Escort and Custody Services and the Governor

3.5 Prison and escort managers should review the arrangements for transporting prisoners from local courts to the prison to ensure that prisoners arrive at the prison earlier. Management should oversee the length of time that prisoners are out of the prison for relatively short court appearances. (2.12)

3.6 The welcome leaflet given to new arrivals in reception should be updated and given out in advance at local courts. (2.14)

3.7 Escort staff working at court should identify prisoners likely to need protection and alert reception staff of their impending arrival. (2.18)

Recommendations to the Governor

Courts, escorts and transfers

3.8 Escort and prison staff should cooperate in a single search of prisoners before they are discharged to court. (2.15)

3.9 Prisoners should not be held on escort vehicles routinely waiting admission to reception and should be held in holding rooms instead. (2.17)

3.10 The requirement for all prisoners to be handcuffed to and from escort vehicles should be reviewed again to ensure that it is necessary. (2.20)

3.11 Managers should monitor the flow of information from courts and, through the court users group, ensure that information is available to aid initial risk and vulnerability assessments on a prisoner's reception. (2.21)

First days in custody

3.12 Managers from reception, healthcare, F (detoxification) wing and G wing should agree procedures to ensure that new arrivals and those at risk or vulnerable are prioritised and arrive at their first night location as quickly as possible. (2.26)

3.13 Strip-searching procedures in reception should follow those set out in the Prison Service security manual. (2.27)

3.14 New prisoners should be given a private interview with a reception officer. (2.29)

3.15 Local information about the sources of help available, in a range of languages, should be given to prisoners in reception. (2.30)

3.16 A Listener and an Insider should be employed as prison orderlies in reception. (2.31)

3.17 Prisoners new to the prison, particularly those who have not been in prison before, those withdrawing from substances or those with mental health problems, should be checked throughout the night. (2.32)

3.18 All cells should have effective toilet screens. (2.34)

3.19 There should be a video introducing new prisoners to Nottingham prison to help those with literacy problems on their first night and during induction. (2.35)

3.20 Information held at the establishment from previous periods of custody, particularly that relating to vulnerability, should be available to staff interviewing prisoners on the first night centre. (2.36)

3.21 The induction record should be kept up to date and the number of prisoners not completing the full induction should be monitored. (2.39)

3.22 Wing managers should cooperate to ensure that there are no unnecessary impediments to progress prisoners appropriately from the induction wing. (2.40)

3.23 All prisoners should be offered a shower on their first night either in reception or on their first night wing. (2.46)

3.24 All prisoners identified as licence revokees should be given information about the recall process. (2.47)

3.25 All cells should have pillows. (2.48)

Residential units

3.26 All cells should be maintained at an adequate temperature at all times. (2.49)

3.27 Cells designed for single occupancy should not be shared. (2.50)

3.28 There should be at least one telephone for every 20 prisoners on all wings. (2.51)

3.29 Up-to-date prisoner council meeting minutes should be displayed on wing notice boards. (2.54)

3.30 It should be made clear to remand prisoners that they have the right to wear their own clothes, unless they choose otherwise. (2.55)

3.31 Showers should be placed in cubicles with hooks or other facilities for prisoners to store clothes while showering. (2.58)

3.32 Prisoners should be provided with a lockable cupboard in their cell. (2.59)

3.33 The rules preventing the display of offensive material should be clarified and enforced. (2.61)

Staff-prisoner relationships

3.34 Staff should address prisoners by their first name or title and surname. (2.62)

Personal officers

3.35 Personal officers should identify themselves to prisoners. They should make regular meaningful entries in wing records, which managers should check. (2.63)

Bullying and violence reduction

3.36 The list of prisoners subject to anti-bullying measures should be made available to wing staff and those working with prisoners in other departments and appropriate monitoring should take place. 2.65)

3.37 Specific interventions to address underlying causes of bullying behaviour should be developed. (2.67)

3.38 The time that bullying prisoners spend on restrictive regimes should be decided individually for each prisoner, regularly reviewed and kept to the minimum. (2.68)

3.39 There should be better and more consistent attendance at the safer prison meeting. (2.73)

3.40 The anti-bullying strategy should be updated to reflect current practice. (2.74)

Self-harm and suicide

3.41 Assessment, care in custody and teamwork (ACCT) reviews should be multidisciplinary and consistently chaired by the same case manager, and key workers should be identified. (2.76)

3.42 Managers should comment on the quality of care offered to prisoners when they complete checks of open F2052SHs (self-harm monitoring forms). (2.77)

3.43 Listener rooms should be improved to create a suitable environment where Listeners can support vulnerable and at-risk prisoners. (2.84)

3.44 Assessment, care in custody and teamwork (ACCT) assessors should be drawn from a wider range of disciplines. (2.86)

3.45 Staff handovers should highlight any prisoners who may be vulnerable, but may not be on an open assessment, care in custody and teamwork (ACCT) form. (2.88)

3.46 A log should be kept of the use of the cordless telephones providing a direct line to the Samaritans. (2.90)

3.47 Assessment, care in custody and teamwork (ACCT) documents should be better completed and report positive interaction with prisoners at risk. (2.98)

3.48 The use of extreme measures such as the body belt and strip clothing for prisoners at risk of self-harm should be recorded and monitored by the safer prison committee. (2.99)

3.49 Listeners should be involved in induction to explain the scheme to new prisoners. (2.100)

Race equality

3.50 The race equality action team should actively monitor the progress of the race equality action plan. (2.102)

3.51 Racial diversity should be promoted through more cultural events and engagement with the local community. (2.103)

3.52 Ethnic monitoring, the results of any investigations and other relevant race equality information should be published to prisoners. (2.105)

3.53 All racist incidents should be fully investigated, even when the complainant has been transferred or discharged, and they should be told the outcome in writing. (2.106)

3.54 A sample of racist incident report forms should be quality-checked by an independent and capable external body. (2.107)

3.55 The new race equality officer should have a specific interest in and motivation to do the job and be prepared to make a long-term commitment to the post. (2.112)

3.56 All prisoner representative positions should be filled. (2.113)

3.57 Wing assistant race relations officers should be given specific and formal responsibilities and time to support the work of the race equality officer. (2.114)

3.58 Prisoner consultation meetings should take place monthly and attendance should not be limited to the appointed representatives. (2.115)

3.59 All staff, and particularly the race equality officer, should receive regular and effective race equality training. (2.116)

Foreign nationals

3.60 Foreign national prisoners meetings should be open to all foreign national prisoners, rather than representatives, so that they all have an opportunity to contribute and obtain support. (2.119)

3.61 Family and friends visiting from abroad should be allowed to have extended or accumulated visits and prisoners should be informed of this. (2.120)

3.62 The post of foreign nationals coordinator should have one or more designated assistants to ensure that provision can be continued when he or she is unavailable. (2.124)

3.63 The foreign national policy should include an action plan to guide and monitor progress, overseen by a specific foreign national committee. (2.125)

3.64 Links with the independent immigration advice service should be strengthened and all foreign national prisoners should be told about the service and helped to contact it when necessary. (2.126)

Contact with the outside world

3.65 A visits booking system should be introduced that allows families and friends to book visits without undue delay. (2.128)

3.66 Up-to-date, accurate and well-produced information booklets for visitors should be provided in all visitor areas. (2.130)

3.67 Managers should make regular checks to ensure that prisoners on the basic regime are able to spend at least an hour with their visitors and that unconvicted prisoners on basic receive their full entitlement. (2.132)

3.68 Differentials between basic and standard prisoners in the local visits and incentives and earned privileges strategies should be reviewed with a view to their removal. (2.133)

3.69 A closed visit should not be given on the indication of a drug dog without supporting evidence or individual assessment. (2.134)

3.70 A children's activity area supervised by trained staff where prisoners can play with their children should be provided. (2.136)

3.71 The prison should offer Sunday morning visits to prisoners irrespective of whether they have had a Saturday visit. (2.138)

3.72 Visitor comments boxes regularly stocked with comments cards should be placed in all visitor areas, including the visitors' centre and the visits room. (2.140)

3.73 The facility to provide feedback should be well publicised, including in the visitors' information booklets, and publicity should contain the name and direct telephone number of a manager for those who wish to give verbal feedback. (2.141)

3.74 Visits procedures for vulnerable prisoners should not enable them or their visitors to be easily identified. (2.142)

Applications and complaints

3.75 The applications log should be kept up to date and regularly monitored by managers. (2.144)

3.76 Managers should regularly monitor the quality of responses to complaints to ensure that they fully answer the matter raised. (2.146)

3.77 There should be information about applications and complaints in languages other than English. (2.147)

Legal rights

3.78 Trained legal officers (LSOs) should be available daily to provide bail information and effective legal services advice. (2.148)

3.79 Legal rights surgeries should be held on each wing to make them easily accessible to all prisoners. (2.149)

Substance use

3.80 The drug strategy, accompanying protocols and an action plan should be updated annually in line with assessed needs. (2.151)

Health services

3.81 There should be a system to ensure that simple pain relief is available to prisoners during the night. (2.158)

3.82 Prisoners with mental health and allied problems should have access to appropriate therapeutic services. (2.160)

3.83 The healthcare manager should introduce prisoner focus groups to inform the further development of healthcare services. (2.164)

3.84 The healthcare department should have a dedicated session in the induction programme to ensure prisoners know how to access healthcare services. (2.165)

3.85 All wing treatment rooms should have secure stable doors to prevent prisoners from entering the room. All drug cupboard keys should be securely stored when not in use. (2.167)

3.86 Medicines management policies should be reviewed and updated regularly, and signed and dated copies should be readily available to health staff. (2.169)

3.87 Secondary dispensing should stop and alternative systems introduced for medicine administration to ensure medicines are issued in accordance with the Medicines Act. (2.170)

Learning and skills and work activities

3.88 The range of qualifications and courses should be extended, including the provision of more higher-level education courses, open learning courses and evening and/or weekend classes. (2.178)

3.89 All prisoners entering the workshops should be subject to a detailed assessment of basic skills needs. (2.182)

3.90 The range and availability of fiction books should be improved. (2.184)

3.91 The work available to prisoners should be relevant to and useful for resettlement and should be more interesting and demanding. (2.185)

3.92 Allocation of work should take into account prisoners' abilities and preferences. (2.186)

Physical education and health promotion

3.93 The range of physical education courses should be extended to include courses such as sports leadership. (2.190)

3.94 All prisoners should be able to take part in gym induction. (2.191)

Faith and religious activity

3.95 There should not be a limit on the number of prisoners able to attend services. (2.200)

3.96 The world faith room should be equipped with washing facilities. (2.201)

Security and rules

3.97 Strip-searching of prisoners, other than on reception and cell searches, should be based on individual risk assessment. (2.205)

3.98 Monthly reviews of prisoners on closed visits should fully take into account the continued risk posed by the prisoner and document the reasons for the continuation of closed visits. (2.209)

3.99 The measures set out in the notice to prisoners dated 5 September 2007, 'positive action against drug use', should be reviewed to ensure that they are proportionate and justified. In particular, visitors in possession of SIM cards should not automatically be banned from visits without an appropriate review of the circumstances, prisoners should not automatically be reduced to basic as a result of one positive mandatory drug test and presumptions about the use of Class A drugs should not be made without reasonable evidence. (2.210)

Discipline

3.100 Mechanical restraints should be used only when authorised by an appropriate manager and a doctor or registered nurse. (2.212)

3.101 Use of force and the use of unfurnished accommodation and mechanical restraints should be fully recorded and properly monitored by managers. Unfurnished cells should not be used for compliant prisoners or to prevent a prisoner self-harming except in exceptional circumstances. (2.213)

3.102 Prisoners in the segregation unit should be offered daily showers. (2.220)

3.103 Longer-term vulnerable prisoners should not be routinely held in the segregation unit. When necessary, the regime should be enhanced to meet their needs, including opportunities for association. (2.221)

3.104 Special cell paperwork should be completed correctly, with log numbers assigned and detailed information given justifying the use of the special cell. (2.222)

3.105 The use of mechanical restraints should be authorised by the governor in charge and authorisation should comply with national Prison Service guidelines. (2.223)

3.106 Senior managers should routinely examine information relating to use of force and special accommodation. (2.224)

Incentives and earned privileges

3.107 Staff comments in monitoring booklets should show evidence of engaging with prisoners to encourage improved behaviour. (2.228)

3.108 Prisoners on basic and at risk should be given a radio without having to apply for one. (2.230)

3.109 Prisoners on basic should be encouraged to maintain normal standards of personal and environmental hygiene. (2.232)

3.110 Visitors to prisoners on the basic regime level should not be penalised by reduced visits opportunities. (2.233)

Catering

3.111 The prisoner food survey should be broken down by ethnicity to allow any patterns to be identified. (2.235)

3.112 A dietician or nutritionist should advise the prison on menu planning. (2.236)

3.113 Lunch should not be served before noon. (2.239)

3.114 Breakfast should not be served until the morning it is to be eaten. (2.240)

3.115 Prisoners should not have to eat in cells with unscreened toilets. (2.241)

3.116 Toasters and microwaves should be provided on wings. (2.242)

3.117 Catering managers should attend prisoner council meetings. (2.243)

Prison shop

3.118 Prisoners should be able to use the shop within 24 hrs of their arrival. (2.244)

Strategic management of resettlement

3.119 A clear resettlement policy should be agreed based on the identified needs of prisoners at Nottingham. (2.246)

3.120 The reducing reoffending strategy group should meet regularly with up-to-date records of meetings to ensure an appropriate focus on agreed action to drive forward the strategy. (2.248)

3.121 A short clear information leaflet about resettlement services and how to access them should be provided to all prisoners during induction. (2.250)

Offender management and planning

3.122 Public protection awareness training should be restarted so that staff can contribute to the intelligence and informed supervision of high-risk prisoners. (2.257)

3.123 Wing managers should keep staff informed of those prisoners subject to public protection arrangements and what specific behaviour should be identified and reported. (2.258)

3.124 Lifer case officers should maintain regular contact with indeterminate-sentenced prisoners throughout their stay at Nottingham. (2.264)

Appendix I - Inspection team

Michael Loughlin	Team Leader
Paul Fenning	Inspector
Hayley Folland	Inspector
Hindpal Singh Bhui	Inspector
Susan Fenwick	Inspector
Sarah Corlett	Healthcare Inspector
Nigel Bragg	Ofsted

Appendix II - Prison population profile

Population breakdown by:

(i) Status	Number of prisoners	%
Sentenced	296	54
Convicted but unsentenced	97	18
Remand	149	27
Civil prisoners	3	0.5
Detainees (single power status)	5	0.5
Detainees (dual power status)		
Total	550	100

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	47	16
6 months to less than 12 months	30	10
12 months to less than 2 years	40	14
2 years to less than 4 years	51	17
4 years to less than 10 years	50	17
10 years and over (not life)	7	2
Life	70	24
Total	296	100

(iii) Length of stay	Number	%
Less than 1 month		
1 month to 3 months	NOT AVAILABLE	
3 months to 6 months		
6 months to 1 year		
1 year to 2 years		
2 years to 4 years		
4 years or more		

(iv) Main offence	Number of prisoners	%
Violence against the person	114	21
Sexual offences	50	9

Burglary	66	12
Robbery	46	8
Theft & handling	66	12
Fraud and forgery	8	1
Drugs offences	53	10
Other offences	129	24
Civil offences	5	1
Offence not recorded/holding warrant	13	2
Total	550	100

(v) Age	Number of prisoners – inc. remands	%
21 years to 29 years	258	47
30 years to 39 years	163	30
40 years to 49 years	82	15
50 years to 59 years	31	5
60 years to 69 years	11	2
70 plus years	5	1
Maximum age		
Total	550	100

(vi) Home address	Number of prisoners – inc. remands	%
Within 50 miles of the prison		
Between 50 and 100 miles of the prison	NOT AVAILABLE	
Over 100 miles from the prison		
Overseas		
NFA		
Total		

(vii) Nationality	Number of prisoners – inc. remands	%
British	516	94
Foreign nationals	34	6
Total	550	550

(viii) Ethnicity	Number of prisoners	%
White		
British	420	75
Irish		
Other White	11	2
Mixed		
White and Black Caribbean	15	3
White and Black African	1	0.5
White and Asian		
Other Mixed	3	1
Asian or Asian British		
Indian	11	2
Pakistani	5	1
Bangladeshi	1	0.5
Other Asian	13	2
Black or Black British		
Caribbean	41	7
African	9	2
Other Black	6	1
Chinese or other ethnic group		
Chinese	5	1
Other ethnic group	9	2
Total	550	550

(ix) Religion	Number of prisoners	%
Baptist		
Church of England	195	35
Roman Catholic	65	12
Other Christian denominations	9	2
Muslim	35	6
Sikh	8	1
Hindu	1	
Buddhist	10	2

Jewish	2	
Other	14	2
No religion	211	38
Total	550	100