Report on an unannounced short follow-up inspection of

HMP/YOI Peterborough (Women)

30 June – 4 July 2008

by HM Chief Inspector of Prisons

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Printed and published by:
Her Majesty's Inspectorate of Prisons
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Introduction

Peterborough is the only prison in England and Wales holding both men and women. We first inspected it in 2006, when it had been open for 18 months. This is a follow-up inspection of the women's prison.

At our last inspection, we found that the women's prison was not performing sufficiently well against any of our four tests: safety, respect, purposeful activity and resettlement. We also found that its culture and processes were based on the needs of men and not women.

This inspection found improvements in relation to safety and activity, and also found that there had been attempts to create a separate management structure and distinct procedures for the women's prison.

Arrangements for support in the early days of custody and during detoxification had improved. However, women continued to have to share escort vans, and spent their first night in the stark and unsuitable environment of the healthcare centre. Though procedures to support women at risk of suicide had improved, levels of self-harm were high and available resources were not effectively targeted. The separate policy document for women was in fact an identical copy of the policy in the men's prison. Similarly, though bullying did not appear to be a major problem, the violence reduction strategy still did not properly reflect the specific nature of bullying among women.

We continued to have concerns about a number of the areas covered in our heading of respect. Staff-prisoner relationships were not positive, with little interaction or support for women prisoners from relatively inexperienced officers, a high proportion of whom were male. Women had little confidence in applications and complaints systems, and the separate incentives scheme was little different from that in the men's prison. More progress was needed in dealing with race and diversity issues, and in particular to provide support to the 17% of women who were foreign nationals. Healthcare had improved, but there remained much to be done, and primary mental health services were under-resourced. The mother and baby unit continued to be well-run.

Since the last inspection, the quantity and quality of activity places had increased, with better allocation procedures, more part-time working and more skills training. However, there was still not enough activity for the population: on one day, we found a third of the women locked up. There was also too little accredited vocational training. Association was regular and consistent.

There had been progress in resettlement work, with the introduction of the offender management system and improved accommodation advice and support. Drug treatment work, and links with community drug services, had also improved. However, provision for short-term prisoners, lifers and young adult women was underdeveloped. There was still no short-term custody planning. Work with women in the important first stage of a life sentence was under-resourced and poorly supported, with insufficient specialist staff, leading to considerable frustration among the women. There was no consideration of the specific needs of young adults.

In two of our key areas – safety and activity – Peterborough women's prison was now performing reasonably well. Though there had been improvements in resettlement work, it had failed properly to provide for the prison's new lifer and young adult population. The prison had not improved sufficiently in the area of respect, and staff-prisoner relationships remained weak and insufficiently proactive. There had clearly been progress since the last inspection, which was commendable in such a new prison. However, there remained weaknesses in the crucial

area of staff-prisoner relationships, and insufficient focus on the specific and different needs of a diverse female population.

Anne Owers October 2008
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP/YOI Peterborough operates as a local prison for women and men. Since the last inspection, the women's side now provides one wing designated for convicted young offenders (B1). The women's side also has a lifer wing (A2). There is also a mother and baby unit.

Brief history
Peterborough is a new establishment operated under a 25-year DCMF contract awarded by the Home Office to Peterborough Prison Management Ltd, which sub-contracts to the operator, Kalyx. It opened in spring 2005.

Area organisation
East of England

Number held
362 at unlock on 30 June 2008

Certified normal accommodation
384

Operational capacity
384

Last full inspection
October 2006

Description of residential units
The women's residential unit is made up of two houseblocks. Each has five wings and each wing has two landings. All wings are self-contained, with a servery, showers, baths and association space. All cells have fitted furniture and each wing has purpose-built double cells. Other cells are single, but can be adapted for two prisoners. All have privacy locks.

Each wing has two telephones. Locked boxes for applications, outgoing mail, request/complaints, Independent Monitoring Board and canteen orders are located on each wing. In-cell televisions are provided for prisoners on the standard and enhanced regime levels. Each cell has curtains. There are laundries on each wing.

Mother and baby unit
This is a self-contained unit with 12 rooms; one room has been designed for a mother with two babies. A crèche and indoor and outdoor play areas are available. The unit has a servery, baby kitchen, showers, baths and telephones. Babies can stay with their mother up to the age of 18 months. The crèche is staffed by nursery nurses.

Healthy prison summary

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 October 2006, we found that the prison was not performing sufficiently well against this healthy prison test. We made 58 recommendations in this area, 50 of which had been achieved either in whole or in part and eight not achieved. We have made 25 further recommendations.

HP5 Female prisoners continued to travel on escort vans with men and many arrived late. The prison had produced information for distribution at courts, but few women appeared to have received it. The video link was still underused.

HP6 The reception area was bright and clean and women were dealt with quickly. Women new to custody had the process explained to them considerately. A well-produced information book was given to new prisoners and some information was in a range of languages. Help for new arrivals varied depending on the time of arrival, but immediate first night support had improved, with a more detailed interview by reception officers that included questions about children. However, there was a need to ensure that issues raised were systematically followed up, and the use of the stark and unwelcoming environment of the healthcare centre was inappropriate. Although shorter, the induction programme still did not keep women fully occupied. Induction was almost entirely computer-based and more active staff input was needed.

HP7 There was little evidence that bullying was a major problem or that many women felt unsafe, but a more comprehensive survey of perceptions of safety was needed. There was now a separate violence reduction strategy for women, but there was a need for further development to better reflect the specific nature of bullying among women. Monitoring systems had improved and nine women were being monitored under the violence reduction strategy. This included anyone involved in an incident of violence, so not all had necessarily been involved in bullying.

HP8 As in most local women's prisons, the level of self-harm was high. Procedures for those at risk of suicide and self-harm included daily interactions, regular reviews and management checks, but there was relatively little multidisciplinary involvement. The very good resources of the Bridge still needed to be more effectively targeted to support women at risk of self-harm. There were not enough Listeners, so there were none on duty at night. Although there was now a separate policy document for women, it exactly reflected that in the men's prisons and did not identify the specific needs and circumstances of women.

HP9 Security arrangements for movements had been relaxed with the introduction of a free-flow system to activities. Although women were given general guidance about the standard of behaviour expected, they were not issued with clear rules of the prison and rules were not displayed on notice boards. As a result, some were unsure about what might result in a behaviour warning or lead to a disciplinary charge. There was still a relatively high number of adjudications, many about minor matters that could have been resolved in other ways. The number of use of force incidents had decreased and incidents were well recorded. The segregation unit was clean and well ordered and record-keeping had improved. Segregation unit staff had received mental

health awareness training and there were good links to the mental health in-reach team.

HP10 The random positive mandatory drug testing rate was relatively low, at 6% over the last six months. There had been considerable improvement in clinical services for women with substance use problems and in psychosocial treatment, but the strategy would have benefited from a formal needs assessment. Clinical staff had received appropriate training and there were good clinical protocols and improved service provision.

HP11 On the basis of this short follow-up inspection, we considered that the prison was now performing reasonably well against this healthy prison test.

Respect

HP12 In 2006, we concluded that overall the prison was not performing sufficiently well against this healthy prison test. We made 97 recommendations in this area, 69 of which had been achieved either in whole or in part and 28 not achieved. We have made 39 further recommendations.

HP13 Some women in groups were positive about the support they received from staff, but most said that officers were unhelpful, often because of their lack of experience. Although we observed generally respectful relationships, a recent measuring the quality of prison life survey had also been very negative about staff. All women had allocated personal officers, but few said they were active and supportive. There was a relatively high proportion of male officers for a women's prison and not a great deal of interaction between staff and prisoners. Personal officers made regular entries in wing files, but these were mostly observations about behaviour and demonstrated little knowledge of the women, although some officers knew the women and their backgrounds well.

HP14 The general environment and communal residential areas were clean and well maintained, although some women now had to share poorly ventilated cells, not all of which had lockable cupboards. Although there were plenty of cleaning materials in stores, there were some difficulties getting them. Sanitary items had to be requested, often from male staff. Women complained about the quality and quantity of the food and said it was sometimes cold. Women believed menus were geared towards men.

HP15 Female prisoners were still required to make an application in advance of their intent to attend religious services, which continued to be disturbed by gym activities, and a lack of escorts meant prisoners frequently arrived late. A female Muslim chaplain had now been appointed.

HP16 Although there were now separate incentives and earned privileges policies, there was little real distinction in the policy for women. This had been recognised and focus groups had been held to identify appropriate changes. Warnings were often issued for petty infringements of wing rules and reviews were too infrequent.

HP17 There was a lack of confidence in both the applications and complaints systems, which reflected poor relationships with staff. The records suggested that many applications had not received a response. Managers had begun to quality check replies to complaints and had identified a need to improve standards. An unusually

large proportion of complaints were by confidential access and many involved matters that should have been resolved at wing level.

HP18 There was no overarching diversity policy. All staff received initial diversity training and a refresher training programme was about to be implemented. The local operating procedure for prisoners with disabilities was not consistently followed.

HP19 There was now a race equality scheme specific to the women's prison, which set out the demographic make up of the female population, but would have benefited from a more thorough needs assessment. Prisoner representatives attended the race equality action team meetings, but there was no external representation. Until recently, some important issues had not been covered at the meetings. The race equality officer had to cover both the men's and women's prisons and also dealt with foreign national issues, so the post was extremely stretched. Investigations into reported racist incidents were well handled and the women's deputy director provided quality assurance and helpful comments. More rigorous race equality action plans were needed.

HP20 Approximately 17% of female prisoners were foreign nationals, with three immigration detainees. Little had been done to address the needs of foreign national prisoners and few staff or prisoners were aware of the local policy. Some good translated and pictorial induction information had been produced, but there was very little use of telephone translation or interpreters, even in healthcare. Foreign national peer support groups had only just begun. A need for information about immigration issues had begun to be addressed through regular surgeries run by an immigration officer, but there was no impartial and independent advice.

HP21 The mother and baby unit continued to provide a safe and supportive environment.

HP22 Perceptions of the quality of healthcare were still very poor, but the overall service had improved. A new management structure was working effectively and, while much remained to be done, particularly to develop work with the primary care trust, some progress had been made. A better healthcare applications system was needed to ensure quicker access to appointments. The mental health in-reach team provided a good service, but resources for primary mental healthcare were stretched and there was no day care facility. There were no delays in assessing prisoners and arranging transfers to hospital.

HP23 On the basis of this short follow-up inspection, we considered that the prison was still not performing sufficiently well against this healthy prison test.

Purposeful activity

HP24 In 2006, we found that the prison was not performing sufficiently well against this healthy prison test. Of the 19 recommendations in this area, 15 had been achieved either in whole or in part and four not achieved. We have made four further recommendations.

HP25 Women in full-time activity had a good amount of time out of cell, but this was not as good for others. Too many prisoners spent too long locked up and on one day we found a third of women locked in their cells during activity periods. There was regular

and consistent association. Exercise during the day was usually limited to 45 minutes, but this was supplemented by additional evening exercise in the summer.

HP26 There was better and increased use of allocated places in education and work, with an emphasis on developing employability and work skills, but nevertheless there was little formally accredited vocational training. Overall, there were insufficient work opportunities to keep women actively employed full-time, although more participated through part-time activity.

HP27 There had been significant improvements in induction and the use of information to guide allocation to activities. Punctuality and attendance at classes and workshops had also generally improved. A satisfactory range of literacy, numeracy and personal and social development courses were run, but the English for speakers of other languages programmes did not lead to accredited qualifications. Women now had better access to the library through the free flow system to activities.

HP28 Women were positive about access to physical education (PE) and regular planned PE activities had been introduced for older women. Key skills had been integrated in PE and healthy lifestyle programmes were now run, with formal links between healthcare and gym staff.

HP29 On the basis of this short follow-up inspection, despite some concerns about the number of women locked in cells during the day, we considered that the prison was now performing reasonably well against this healthy prison test.

Resettlement

HP30 At the last inspection in 2006, the prison was not performing sufficiently well against this healthy prison test. Of the 48 recommendations in this area, 30 had been achieved either in whole or in part and 18 not achieved. We have made 19 further recommendations.

HP31 While there was no formal resettlement strategy, there were reducing re-offending plans that provided strategic direction and took into account the resettlement pathways. The two additional pathways for women were also beginning to be acknowledged. The needs analysis that informed the plans was based on information from offender assessment system (OASys) assessments and did not adequately cover the position of young adults, lifers and short-term prisoners.

HP32 The offender management system had been introduced since the last inspection and 78 women were covered by those provisions. Most had an up-to-date OASys, which were generally of a good quality. Contact between offender supervisors and prisoners was good, but the prison's wide catchment area made it difficult for some offender managers to attend the prison. Opportunities for women to move to lower category prisons had improved and more were moving to open and semi-open conditions. Although immediate needs were better identified through Connections workers and the Link resettlement services, there was still no short-term custody planning.

HP33 The number of women going out on release on temporary licence had increased, but there continued to be delays with release on home detention curfew caused principally by delays with external probation reports. There were some arrangements to meet reintegration needs, although the absence of the accommodation adviser

because of sickness was a problem. The accommodation service was generally stretched and not helped by the fact that many women were a long distance from their home areas. A pre-release course covered a wide range of areas, but at six weeks long was not suitable for many women.

HP34 The prison now operated as a first stage centre for women lifers, but this had not been well planned or resourced. There was no psychology team and only a sessional psychology service to provide individual assessments, and many of these were delayed. The provision did not reflect that found in other first stage lifer prisons. Few relevant interventions were offered other than enhanced thinking skills. The women lifers reported considerable frustrations with their position and a lack of support from specialist staff.

HP35 As previously, there were delays with prisoners' receiving their mail, despite a contractual requirement to provide this on time. The visitors' centre did not provide toilets or refreshments or any supportive services to visitors. Visits did not always start at the advertised time. There was no supervised play area in the women's prison. There were no parenting or relationship courses, but Adfam workers offered help, advice and support to families. Regular children's days were run and there was a story book mum scheme.

HP36 The counselling, assessment, referral, advice and throughcare services for drug users had significantly improved and group work, including the short duration programme, was run. There continued to be good links with local drug intervention programmes. The drug strategy was one of the few policies that still covered the men's and women's prisons and it did not adequately reflect the specific needs of the female population.

HP37 On the basis of this short follow up inspection, we found that while some reasonable progress had been made, there was still no formal custody planning for the many women who stayed for short periods. We had concerns about the lack of specific services for life-sentenced and young women. We therefore considered that the prison was still not performing sufficiently 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 recommendation

To the Regional Offender Manager

2.1 A full review of the contract should take place to ensure that outcomes for prisoners are not perversely affected by out of date or unworkable requirements in the contract. (HP40)

Achieved. Changes to the contract had been agreed for 2007/08 and a further contract refresh had taken place. The additional changes had yet to be formally ratified, but they were effective from April 2008. Many of the outdated prescriptive requirements had been removed and there was now a better focus on outcomes. The director and controller were both satisfied that this represented a substantial improvement.

Main recommendations

To the Director

2.2 All policies and procedures at Peterborough should be reviewed and changed where necessary to ensure that they appropriately take into account the specific and different needs of female prisoners. (HP41)

Partially achieved. With the appointment of a deputy director responsible for the women's prison, there was a better focus on the specific needs of female prisoners. Good efforts had been made to separate policies to take account of the different needs of women. Some policies, such as anti-bullying and violence reduction, needed further development and the drugs policy had still not been differentiated, but overall progress had been made.

2.3 Women should be supported during their first days in custody through the development of a first night policy and strategy to ensure that their immediate needs are identified and dealt with, followed by a structured, good quality induction programme which fully occupies them. (HP42)

Partially achieved. There had been general improvements in reception and first night procedures, which were described in a first night protocol, but not specifically for women. All women were interviewed by a reception officer to complete a first night checklist. They were asked if they were new to custody and about any dependants. However, this needed to be more thorough. New arrangements to hold women in the healthcare unit on their first night were inappropriate. (See also section on first days in custody.)

2.4 Services for women with substance use problems, from clinical care on arrival to resettlement support on release, should be based on a needs assessment and appropriately resourced.

Partially achieved. Substance use services had improved and women generally found them supportive and effective. However, the prison's strategic approach had not been properly informed by an adequate needs analysis. The existing analysis was based on a prisoner questionnaire rather than formal assessments. The response rate had been only 19.4% so it did not fully represent the needs of the population. The strategy document made no mention of the needs analysis questionnaire.

We repeat the recommendation.

2.5 An effective clearly defined personal officer scheme should be developed with officers given training, guidance and resources to carry out their role. (HP44)
Partially achieved. Personal officer work was now more effectively established. A written policy set out in separate local operating procedures (LOPs) for the men's and women's prisons gave guidance to personal officers. This was narrow and principally related to process and procedures rather than encouraging personal officers to make active efforts to get to know the women they were responsible for and to understand and support them with their resettlement needs or family issues. Officers confirmed that they had been given some training and guidance about the personal officer role during their initial training and that there was further written guidance available. Most said they believed that personal officer work was best learned through experience on the job. The women we spoke to generally knew they had an allocated personal officer, but, while some were positive, many did not believe this served much purpose and said that officers were too inexperienced to help them.

2.6 Prisoners in groups were generally negative about their relationships with staff and many said that officers were unhelpful, often because of their lack of experience. Although we observed generally respectful relationships, a recent survey measuring the quality of prison life had also been very negative about staff. There was not a great deal of interaction between staff and prisoners. (See also section on personal officers.)
We repeat the recommendation.

2.7 A safer custody strategy specifically for women should be established covering all aspects of safety and involving female prisoners to help ensure a generally safe environment and improve support and care for those at risk of self-harm. (HP45)
Not achieved. Revised LOPs for suicide prevention and self-harm management had been published for men (April 2008) and women (May 2008). The title page distinguished the two documents as procedures for men or women, but the content was identical except that the word 'prisoners' was substituted for 'women' in the female version. It did not make clear the different nature and frequency of self-harm among women, with around four times as many incidents each month as in the men's prison. It made no reference to the use of the Bridge and the Link as resources to support women at risk.
We repeat the recommendation.

2.8 There should be a dedicated safer custody coordinator for the women's prison. (HP46)
Achieved. A full-time dedicated safer custody coordinator for the women's prison had been appointed about 12 months previously. Unlike in the men's prison, there was also a deputy coordinator.

2.9 The foreign nationals policy, which should include a targeted action plan, should be updated in consultation with foreign national women and publicised to staff and prisoners so that all who need to know are aware of the services and support available. (HP47)
Partially achieved. A LOP (2007) described the main problems facing foreign national women and some provisions for them. A schedule of actions had been drawn up from HM Inspectorate of Prisons Expectations and the Prison Service Order and Instruction on foreign national prisoners, but contained no target dates for implementation or review, although some of the actions had been taken. Staff were generally unsure of the content of the LOP, but knew where to find it. Prisoners had little knowledge of it and there was little evidence that they had been consulted about its content. Foreign national group meetings had only recently started. A copy of the LOP was filed with other local documents in the library, but it was not well advertised around the prison. (See also section on foreign national prisoners.)
We repeat the recommendation.

2.10 A full review of all health services should be undertaken to ensure that women at Peterborough have appropriate and safe health services based on an assessment of their needs and which match the standard of care provided in the community. The primary care trust's clinical governance strategy should be followed to provide a framework to support improved services to prisoners. (HP48)
Partially achieved. A health needs assessment had been carried out in February 2008, but much of the data related to 2007. There was no embedded clinical governance structure. The relationship with the local primary care trust appeared to be strained and the few links that did apparently work well seemed to be based on individual relationships rather than formalised arrangements. The appointment of a clinical manager meant that nursing staff were receiving clear clinical leadership and the complementary skills of the clinical managers of the men's and women's prisons provided a wide range of expertise. A lot of work was being developed as the new management arrangements had only recently been implemented, but the movement was in a positive direction.
We repeat the recommendation.

2.11 Sufficient, good quality work and education opportunities should be provided to occupy fully all prisoners and meet their training and employment needs. (HP49)
Partially achieved. There were 334 work and education places and around 275 women were involved in these activities. The remainder were awaiting induction or for the allocations board, or were on maternity leave. Good and relevant employment was provided and women were working in a diverse range of jobs. Women with existing skills helped to deliver holistic therapy programmes, while others had high levels of responsibility, such as working as receptionists in the holistic therapies department and assessors in the industrial cleaning academy. The kitchens provided a number of employment places where women gained a range of food preparation skills. Those working in the kitchen for more than two months worked towards food preparation training and food hygiene certificates. The implementation of accredited programmes had been slow and staff were undertaking professional development to deliver them. The hairdressing salon was not used effectively as a training resource and accreditation of vocational skills in horticultural had not yet been implemented.

2.12 The range of accredited literacy and numeracy programmes was satisfactory, but the English for speakers of other languages programme was not accredited. The prison had greatly increased the number and range of courses and activities in social and development programmes. A wide range of therapy activities was available in the Bridge, and the drug rehabilitation and mental health teams referred clients for therapy sessions. Other workshops included a writing group, yoga, a music workshop and Spanish. Many of the activities were run by external providers, whose work was carefully coordinated to ensure that it was appropriately targeted to meet prisoners' needs.

2.13 Overall, there were still insufficient activity places to keep all women fully occupied.

2.14 Security procedures for women should take into account the different risks and needs of the population and security systems should be re-evaluated to bring the establishment in line with other women's prisons. (HP50)
Achieved. There had been a number of changes in security procedures to bring them in line with other women's prisons. These were being developed separately based on the risks, rather than applying across the men's and women's prisons. Changes included that women were no longer strip searched on reception and the introduction of a free flow system.

2.15 The resettlement strategy should be based on a comprehensive needs analysis, including the specific needs of women and young adult women, ensuring appropriate interventions and services are provided to reduce risk and match identified resettlement

needs. (HP51)
Partially achieved. The previous resettlement policy, which had applied to the men's and women's prisons, had been replaced by a draft business plan that mapped the resettlement pathways to existing and planned provision. A needs analysis was based on an extract from sentence planning targets, so was based only on the needs of women serving more than 12 months. The specific needs of short-sentenced young adult women and life-sentenced women had not been analysed. (See also section on strategic management of resettlement.)

2.16 All prisoners, including unconvicted prisoners, should have a sentence or custody plan based on their individual risk and specific resettlement needs. Their reintegration needs should be identified during induction and they should be case managed so that progress in meeting these needs can be tracked throughout their time at Peterborough. (HP52)
Not achieved. There was no short-term custody planning for women. Their individual resettlement needs were identified on arrival by Connections workers, but these were not integrated into a custody plan and there was no case management of individual women. (See also section on offender management and planning.)
We repeat the recommendation.

Recommendation

To NOMS

2.17 Checks on addresses for home detention curfew should be carried out more quickly to allow release on the due date. (8.28)
Not achieved. Prison staff provided enough time for external probation officers to check home addresses, but these were rarely completed on time. In 22 recent home detention curfew cases, only four women had been released on time and eight had been delayed by over two weeks. This was attributed largely to pressures on external probation officers. Staff anticipated delays by sending out paperwork early.
We repeat the recommendation.

Recommendations

To the Director

Courts, escorts and transfers

2.18 Property and private cash should accompany unsentenced prisoners to court and sentenced prisoners being transferred. (1.9)
Partially achieved. Valuables and property now accompanied unsentenced prisoners to court, but prisoners still had to apply in advance to take their private cash. Those who did not apply and did not return to prison had to collect their money or ask for a cheque to be posted to them. Private cash was still forwarded to sentenced prisoners after their transfer to another prison.

Further recommendation

2.19 Private cash should accompany unsentenced prisoners to court and sentenced prisoners on transfer.

2.20 Escort vans should be clean and comfortable. (1.10)
Not achieved. Prisoners still found vans uncomfortable and the two we saw were grubby. One had cigarette buts on the floor and the other had large amounts of graffiti dated 2005 scratched

into the cubicles.
We repeat the recommendation.

2.21 Prisoners should receive comfort breaks at least every two and a half hours. Reception staff should confirm with prisoners the detail of breaks recorded in prisoner escort records and discrepancies should be recorded and raised with the escort contractor. (1.11)
Partially achieved. Some women complained that they had travelled a long way without a comfort break. Arrival times were recorded in a reception log and staff checked the information in prisoner escort records (PERs), but confirmed any comfort breaks offered only with escort staff rather than the women who had travelled.

Further recommendation

2.22 Reception staff should ask female prisoners whether they have been offered a comfort break and this should be recorded.

2.23 Male and female prisoners should be transported separately. (1.12)
Not achieved. Men and women were transported together.
We repeat the recommendation.

2.24 Prisoners should be moved from court cells to the prison within an agreed and acceptable timeframe. (1.13)
Not achieved. Many women continued to spend long days in court.
We repeat the recommendation.

2.25 Female prisoners should arrive in reception before 7pm except in exceptional circumstances. (1.14)
Not achieved. To date in 2008, 314 women had arrived after 7pm, of whom 39 had arrived after 8pm and 37 after 8.30pm.
We repeat the recommendation.

2.26 Prisoners should receive information at court about the prison and what is going to happen to them. (1.15)
Partially achieved. Information leaflets had been distributed to all local courts, but most prisoners still arrived with little or no information about what was going to happen to them on arrival.

Further recommendation

2.27 Court and escort staff should be reminded to provide prisoners with information leaflets.

2.28 More use should be made of the video link facility and this should be monitored by a manager. (1.16)
Not achieved. The video link was still under-used. To date in 2008, 713 women had left Peterborough for court appearances and the video link had been used only 129 times. Little was done to promote its use.
We repeat the recommendation.

First days in custody

2.29 Prisoners should be asked in reception if they are new to custody and officers should give a clear explanation of the initial processes, including the searching procedures and what will happen next. This should be recorded. (1.50)
Partially achieved. All new arrivals were asked if they were new to custody and, if so, given information to read in the holding room about what to expect. They were not asked whether they could read or given the opportunity to ask questions or express any anxieties. The local operating procedure did not differentiate between the different needs of men and women.

Further recommendations

2.30 New arrivals should be given clear and simple verbal information about the reception process.

2.31 The local operating procedure should refer to the specific needs of female prisoners on reception.

2.32 Information in reception holding rooms should be published in languages other than English and be available in other media. (1.51)
Partially achieved. Information about the prison in six languages was displayed in a large, comfortable holding room. All information was in written form, although staff said that there was also an information DVD for new arrivals.

2.33 A prisoner information booklet should be provided and made available in a variety of languages. (1.52)
Achieved. A well designed and attractive information booklet was provided in a range of languages. However, not all the information was correct.

Further recommendation

2.34 Reception information given to prisoners should be correct.

2.35 The individual circumstances and immediate needs, risks and anxieties of prisoners should be identified during the reception interview. All women should be asked if they have any dependants, how they are being cared for and their whereabouts. Information and action taken should be recorded in a single history file for the benefit of first night and wing staff. (1.53)
Partially achieved. All new arrivals were interviewed in private and a first night checklist was completed. This covered services offered, such as refreshments and a telephone call, and collection of information such as whether the woman was new to custody and whether she had children. Women were not asked about their children's care arrangements, legal status or contact. The first night checklist was attached to the prisoner's wing file and included a first night centre welcome interview and checklist, an immediate action plan and compacts to be signed in the first night centre. The officer gave a broad range of information clearly and simply and women were given a first 24 hours leaflet, a prisoner information booklet and a separate information pack. The pack contained information not covered in the information book, including the core day, expected standards of behaviour, the work of Connections peer supporters and the various support agencies such as Drinkwise and Adfam. It also included copies of the different application forms. Women were told they could have up to three adults

and four children under 17 to visit, but this was incorrect. They were able to ask questions or raise issues. Checklists were passed to the first night centre, but not all were fully completed. A cell-sharing risk assessment was also completed in reception and prisoners were asked about any homophobic or Schedule One offences, although terms such as these were not explained.

Further recommendation

2.36 Mothers should be asked further questions about their children, including whether their current care arrangements are satisfactory, if there are any court orders or social work involvement and if they are in contact with their children. This should be recorded.

Housekeeping point

2.37 Reception officers should ensure that prisoners are given the correct information and understand the terminology used when completing the cell-sharing risk assessment.

2.38 Reception staff should be trained and given information to enable them to take action to promote the safety of children and other dependants if they are informed or suspect that dependants may be at risk as the result of the carer's imprisonment. (1.54)
Partially achieved. The telephone numbers of local police stations and social services departments, including out-of-hours emergency teams, were displayed in the reception interview room, but not all reception staff were aware of this.

Further recommendation

2.39 Reception staff should know about the emergency telephone numbers and where to find them.

2.40 Prisoners should be able to shower on their day of arrival. (1.55)
Partially achieved. Prisoners arriving in the afternoon were offered a shower on the wing, but those arriving near to lock up had to wait until the next day. The offer of a shower was recorded, but not whether this was accepted or refused.

Further recommendation

2.41 All prisoners should be able to shower on arrival, irrespective of their time of arrival.

2.42 Prisoners should be offered a free telephone call in reception and a record of this should be kept. (1.56)
Achieved. Prisoners were offered a free call and this was usually, but not always, recorded. Recent arrivals said they had been offered a free telephone call.

2.43 Prisoners should not automatically be locked in holding rooms. (1.57)
Achieved. Women were not locked in reception holding rooms.

2.44 Some means of occupying women's time while they wait in the holding rooms should be provided. (1.58)
Achieved. The holding room contained comfortable seating, a range of information about regimes and services and a selection of magazines and newspapers.

2.45 Prisoners should be held in reception for as short a time as possible. Time spent should be recorded and monitored by managers. (1.59)
Achieved. Prisoners did not spend long in reception and this was recorded. The log was checked and signed regularly by a manager.

2.46 Before first night lock-up, all women should have their immediate needs identified and acted upon during a private interview with an officer. Their individual circumstances and any special needs should be documented. (1.60)
Not achieved. Most, but not all, women were given a first night centre welcome interview, which covered how the woman was feeling and any immediate issues that had not been addressed. There was also a separate first night centre checklist, which recorded whether the prisoner had been seen by a Connections worker, chaplain, counselling, assessment, referral, advice and throughcare (CARAT) and Adfam workers and a GP or nurse. Some, but not all, of these staff visited healthcare every evening. Some of these forms were completed the day after a woman's arrival and many were incomplete. Completed first night information indicated that some issues were not thoroughly followed up. Where problems were identified, there was little evidence of anything being done to resolve them.

Further recommendation

2.47 Reception and first night records should be fully completed and action taken on all identified needs, particularly relating to children.

2.48 A trained prison custody officer should work at night in support of the auxiliary officer. (1.61)
Partially achieved. An auxiliary officer still worked on the induction wing at night. A trained custody officer also worked nights, but worked in both the men's and women's prisons. We were told that they spent most of their time in the women's prison because more women were deemed at risk of self-harm and the auxiliary officer there needed more help to monitor and support them. Despite this, there was no guarantee that the trained officer would always be in the women's prison.

Further recommendation

2.49 A trained custody officer should be present at all times in the women's prison at night.

2.50 Prisoners undergoing detoxification should not be included in the induction programme the day after their arrival. (1.62)
Not achieved. Induction officers said women undergoing detoxification regularly attended the induction programme.
We repeat the recommendation.

Additional information

2.51 First night procedures were published in a local operations procedure (July 2007), but this did not differentiate women's needs. In a recent initiative, all new arrivals, including those withdrawing from drugs and young women on remand, went to a first night centre in healthcare. The unit was stark and an unwelcoming environment. New arrivals shared with others withdrawing from drugs and even with in-patients. Unsentenced women shared with convicted prisoners. Many women said they had been frightened on their first night.

2.52 Women moved to the induction wing the day after their arrival. Some were moved later in the day and did not start induction until their second morning. No Connections workers were based on the wing to provide peer support and information. The induction programme lasted for two half-days spread over two days and women were locked in their cells when not attending induction.

2.53 On the first morning, women had a gym induction before going to the Link for their formal induction. Induction information was delivered by a computer programme, which could be used in other languages, as audio and in different colour for those with colour blindness. Connections workers were on hand to help those with poor or no reading skills or who were not confident using a computer. An officer was based in the room, but only supervised. Each woman went through the information individually and completed a quiz at the end to show what she had learned. The session involved a lot of information, but women were not able to make notes. Women were locked in their cells for the afternoon. The second morning consisted of an education assessment and women were again locked in their cells in the afternoon.

2.54 There was no opportunity for women to engage with staff or other prisoners or to ask questions. They were not seen individually by an officer during induction to identify any issues, finish collecting information that had not been completed in reception or deal with any immediate needs.

Further recommendations

2.55 Women should feel safe on their first night and should be supported in appropriate comfortable accommodation. They should not be required to share with in-patients or prisoners withdrawing from drugs and unconvicted women should not have to share with convicted prisoners.

2.56 Female prisoners should be kept fully occupied through a comprehensive, structured and multidisciplinary induction programme.

2.57 During the induction programme, women should have the opportunity for recorded individual interviews at which their initial feelings about imprisonment are addressed, including any thoughts about suicide or self-harm.

Residential units

2.58 Cells designed for one prisoner should not be shared. (2.16)
Not achieved. Thirteen of the 17 single cells designated to be shared were in use. These were spread throughout the residential units, with the most (four cells on each) on D1 and E1. More were planned in response to the increase in the prison population and changes to the contract. We repeat the recommendation.

2.59 Prisoners should be able to have clothing handed in on visits, irrespective of how long they have spent at Peterborough. (2.17)
Achieved. Women were allowed to have clothing handed in every quarter subject to volumetric control measures and the facilities list.

2.60 Clothing for outside wear in cold weather should be issued to women on request. (2.18)
Not achieved. Some outdoor clothing had been ordered, but it was not available in the stores.

Women could have jackets posted or handed in.
We repeat the recommendation.

Additional information

2.61 The design of ligature-free windows meant cells were poorly ventilated. Staff said fans were provided in single cells used for two women, but this was not the case. Not all women in shared cells had a lockable cupboard. Cells and communal areas were very clean and women had good access to wing laundries.

Further recommendation

2.62 All single cells accommodating two women should have fans and a lockable cupboard for each prisoner.

Staff-prisoner relationships

2.63 All staff should routinely knock before entering cells and male staff should routinely knock before using observation panels. (2.26)
Achieved. We observed officers knocking on doors before they entered cells. Some women said they did not give them sufficient time before entering, but we saw no evidence of this.

2.64 Prisoner consultative meetings should have clear action points and responsibilities recorded with a report back on progress to subsequent meetings. (2.27)
Partially achieved. A good template for consultative meetings with columns for action points and the date for action was used. According to the minutes of the last four meetings, all had been chaired by the residential manager, but no senior manager had been present. While the action required and the person responsible was usually recorded, a number of action points were not followed up at subsequent meetings and not all action points from the May meeting had a date for action. The failure to report back clearly on all agreed actions risked representatives and other prisoners losing confidence in the system.

Further recommendation

2.65 All action points from consultative meetings should have target dates attached and should be followed up with a report to the next meeting as matters arising from the previous meeting.

Personal officers

2.66 Personal officers should introduce themselves to prisoners, get to know their personal circumstances and record contact in wing files to build up an accurate chronological account of a woman's time at Peterborough and any significant events affecting her. (2.36)
Partially achieved. Wing files indicated that personal officers usually recorded introducing themselves to prisoners and made regular, usually weekly, entries. However, entries were often just passive observations about behaviour and did not actively deal with any issues. There were few references to sentence plan targets, resettlement issues or families unless there was a major family crisis. In some cases, a problem had been identified, but there was no information about what, if anything, had been done to resolve the issue. It was clear from

talking to officers that they had a good knowledge of the women and their circumstances and it was unfortunate that this was not reflected in their written entries.
We repeat the recommendation.

2.67 Women with specific care needs such as prisoners with disabilities and older prisoners should have regularly monitored care plans as part of their wing files. (2.37)
Partially achieved. The files of women with identified disabilities included care plans, but not all were comprehensive (see paragraph 2.107).

2.68 Managers should make regular checks of wing files and record these on the file. (2.38)
Achieved. There were regular recorded checks by senior custody officers and other managers on the wing files. These usually identified when personal officer comments were missing. Managers also occasionally provided positive feedback, but perhaps because of the low aspirations for personal officers set out in the local operating procedure, this tended to be when officers dealt at greater length with behavioural issues rather than more in-depth comments.

Further recommendation

2.69 The guidance to personal officers should be further developed to encourage them to make active efforts to engage with prisoners, get to know their circumstances, report on their resettlement needs and help them to maintain contact with their families.

2.70 The local operating procedure should reflect the different allocation arrangements for women prisoners. (2.39)
Achieved. The separate local operating procedure for women accurately reflected the personal officer allocation arrangements in the women's prison.

Bullying and violence reduction

2.71 Minutes of the safer custody meeting should reflect an analysis of any developing trends in bullying and other indicators of violence. (3.14)
Achieved. A monthly violence reduction and anti-bullying report provided some detailed information on a good range of indicators of violence and bullying. This was compared to previous months' statistics and allowed the safer custody team to identify any developing trends. For example, information was included on the location and times of assaults and fights and whether weapons were involved. It identified perpetrators and victims and included data on adjudications.

2.72 A full survey of women's perceptions and experiences of bullying and feelings of safety should be carried out. (3.15)
Achieved. A general survey about safety that included questions about self-harm procedures and bullying had been carried out in May 2008. Sixty percent of women said they had never been bullied and 15% said they had. Twenty-six percent said they were not able to talk to staff about self-harm and bullying.

2.73 The quality of investigations into allegations of bullying should be improved, coordinated by the safer custody office and monitored by a senior manager. (3.16)
Partially achieved. Bullying incidents were reasonably well investigated. A violence reduction referral form was usually completed following a fight or assault and prisoners were placed on the first stage of the violence reduction strategy. The high number of prisoners automatically

placed on the strategy risked masking the extent and focus on bullying and did not sufficiently distinguish behaviours. Disputes between women were often associated with broken relationships and were resolved by staff more informally. Referral forms for more serious incidents were sent to the safer custody department and logged on a useful violence reduction database. The safer custody coordinator (SCC) added relevant information about the prisoners involved, such as security information, cell-sharing risk assessments or previous information from the violence reduction database. The SCC then made recommendations and forwarded these to the residential senior officer for a final decision. There were fewer delays between the incident and action taken than we found in the men's prison. Nine prisoners were being monitored through the violence reduction strategy. The quality of investigations was not checked by a senior manager.

Further recommendation

2.74 A senior manager should monitor the quality of investigations.

2.75 The anti-bullying policy and strategy should recognise the particular needs and circumstances of women. (3.17)
Partially achieved. There was very little difference between the anti-bullying policies and strategies for men and women, although the women's version recognised the specific nature of bullying among women particularly associated with fractured relationships. Bullying for medication had been raised several times at the safer custody meeting for women, but was not referred to in the strategy.
We repeat the recommendation.

Additional information

2.76 There was no evidence that bullying was a major problem or that the prison was generally unsafe. The violence reduction policy had been reviewed in June 2008 and incorporated bullying. The bully line was well advertised beside each landing telephone and to visitors. It was checked daily and any calls recorded, although there had been few with useful information about bullying. Training in the violence reduction strategy had been delivered only through a short staff briefing.

Further recommendation

2.77 All staff working directly with prisoners should receive training in the violence reduction strategy.

Self-harm and suicide

2.78 The purpose and agenda of the self-harm and suicide prevention and safer custody meetings should be clarified to improve attendance and avoid duplication of work. (3.40)
Partially achieved. The previous separate meetings on self-harm and safer custody had been brought together, but in May 2008 the decision was taken to revert to two meetings, suicide and self-harm prevention and violence reduction, each held monthly. Separate local operating procedures described the aims and objectives of each meeting, but it was too early to assess whether this would lead to duplication and poor attendance at the self-harm meeting as we found at the last inspection.

2.79 The self-harm and suicide prevention meeting should analyse and discuss the data provided on incidents of self-harm and the operation of ACCT procedures to improve the care of women at risk. More qualitative measures drawing on women's experience of the procedures should be developed. (3.41)
Partially achieved. A monthly report provided by the safer custody team's administrator included good data on assessment, care in custody and teamwork (ACCT) procedures, statistics from Listeners and levels of self-harm. Information was also provided on the number of women on open ACCT documents and their home area. Most lived a considerable distance from the prison, but the greatest number was listed as being of no fixed abode, which had led to more referrals to the chaplaincy for prison visitors. Minutes of the self-harm meeting did not reflect in-depth discussion of the relevance of statistical reports. Women who self-harmed were not routinely asked about their experiences to identify what they thought would help reduce the incidence of self-harm.

Further recommendation

2.80 Women who self-harm should routinely be asked what they think will help. This information should be collated, presented in a qualitative report to the self-harm and suicide prevention meeting and used to improve the levels of care.

2.81 Prisoners in the early days of custody should be informed of and helped to use the support available for those feeling depressed or suicidal. (3.42)
Partially achieved. Women were given the opportunity to disclose feelings of vulnerability and were given information during reception, first night and induction. Women new to the prison were interviewed in private by reception staff who explained the Listener scheme and Samaritan help. No Listener was based in reception. Women met Adfam workers and informal peer support was provided by Connections workers. Listeners visited the first night centre, but this did not happen consistently. The safer custody coordinator no longer spoke to all women new to the prison to outline the help available. What help and support had been provided was not always clear (see paragraph 2.46).

Further recommendation

2.82 The help provided to women identified as needing support in the early days should be clearly recorded.

2.83 A clear definition of serious or near fatal incidents should be developed and a formal investigation procedure instigated in order to learn from such incidents. (3.43)
Partially achieved. Serious or near-fatal incidents when women had to be resuscitated or taken to hospital as an emergency admission were described as near misses in the local operating procedure on suicide and self-harm. The safer custody coordinator was required to investigate these incidents, but none of the incidents when women had been taken to hospital as an emergency had been formally investigated.

Further recommendation

2.84 Serious and near-fatal incidents should be formally investigated in order to learn from them.

2.85 There should be improved multidisciplinary working and this should include initial assessors from a range of disciplines, and a wider range of attendance of staff from

other disciplines at suicide prevention meetings and ACCT reviews. (3.44)
Not achieved. There were 22 ACCT assessors for both prisons and usually enough were on duty in each. Twenty were prison custody officers or senior prison custody officers working in a range of departments. The other two were staff working in stores and the prison shop. The most recent self-harm and suicide prevention meeting, the first under the separate arrangements (see paragraph 2.78), had been attended by representatives of a good range of disciplines, but ACCT documents provided little evidence of good multidisciplinary working. The need for improved multidisciplinary attendance had been raised at safer custody meetings.
We repeat the recommendation.

2.86 A local operating procedure describing the operation of ACCT and offering guidance to staff should be developed. Guidance should be sought from the safer custody group to improve the operation of ACCT procedures. (3.45)
Achieved. A revised local operating procedure (May 2008) clearly outlined roles and responsibilities in ACCT procedures. Although the prison had not sought direct support from the safer custody group, good links had been developed through attending the area safer custody meetings and with the women's and young people's group at Prison Service headquarters.

2.87 There should be improved management checks of the quality of ACCT procedures and these should include talking to women at risk about their experience of their care. (3.46)
Partially achieved. Most ACCTs had frequent management checks, but contained little evidence that managers supplemented these by talking to the women concerned.
We repeat the recommendation.

2.88 ACCT forms should be opened in all cases of self-harm and closed only when a multidisciplinary team is satisfied that this is justified by the level of risk. (3.47)
Partially achieved. There was no evidence that ACCT documents were not opened in all cases of self-harm. However, representatives from other disciplines were not always present when an ACCT was closed. Many problems arose from a lack of consistency of case manager and planning for reviews.

Further recommendation

2.89 ACCT reviews for individual prisoners should be chaired by consistent case managers and ACCT documents closed only when a multidisciplinary team is satisfied that this is justified by the level of risk.

2.90 The prison should target women at risk who would benefit from the resources offered at the Bridge and the Link, and staff from these areas should be more involved in ACCT. There should be improved access for all prisoners. (3.48)
Partially achieved. Although not widely publicised, women subject to ACCT procedures were entitled to free treatments at the Bridge, including some holistic therapies. ACCT documents contained little evidence that referrals were regularly made as part of care maps. The manager of the Bridge said uptake had not significantly improved and it remained an underused resource. The manager was invited to safer custody meetings, but this had proved difficult as she had no cover. She had attended two ACCT reviews and one review had taken place in the Bridge. Overall, the facility and the staff were still not integrated as a resource for women at risk, although procedures were in place to promote more use through a recognition and reward scheme and to improve the referral process. There was similar poor integration between ACCT

procedures and the group work and counselling services provided through the Link. Women no longer had to be escorted to the Bridge.

Further recommendation

2.91 Staff from the Bridge and the Link should be better integrated in ACCT procedures to improve the use of the resources for women at risk of self-harm.

2.92 Listener recruitment and training should anticipate the release and transfer of trained Listeners to ensure a viable scheme. (3.49)
Not achieved. There were five trained Listeners, but only three working in the role. Two had temporarily withdrawn from the scheme. The low number had led to a decision not to use Listeners between midnight and 6am, when women were instead offered use of a telephone with a direct link to the Samaritans. There was no Listener in reception, but one visited healthcare, where most women spent their first night. The scheme had come close to being suspended. Thirteen women had applied to become a Listener, but training had not yet been arranged. Listeners made a good contribution to self-harm and suicide prevention meetings.
We repeat the recommendation.

2.93 There should be improved confidential telephone access to the Samaritans over 24 hours. (3.50)
Achieved. A system had been introduced whereby callers had only a headset in the cell and the telephone was left outside. This had reduced the previous level of damage to telephones. These telephones were used frequently and each call was logged. Prisoners could also call the Samaritans free of charge from landing telephones, but these did not provide much privacy (see section on contact with the outside world).

Additional information

2.94 There had been a death in the prison in January 2007 and another in March 2008. The investigation into the first had been suspended by the Prisons and Probation Ombudsman due to an ongoing investigation by the Crown Prosecution Service. The second was being investigated.

2.95 Levels of self-harm remained high, but ACCT procedures had improved. On average, 31 ACCTs were opened each month, with 92 incidents of self-harm involving 23 women. Thirty-eight ACCTs were open on one day of the inspection. There were some good monitoring systems to track when case reviews were due through the ACCT database. Since February 2008, women with complex needs, many with long histories of self-harm, had been reviewed weekly by a multidisciplinary team. In several cases, families had been invited to reviews as part of care plans.

2.96 A therapeutic music workshop was still run and offered to some women twice a year. A small number of women attended safety, awareness, futures and empowerment (SAFE) groups for survivors of abuse. There had been longstanding problems with the refurbishment of a Listener suite, which was still not available, but staff ensured that rooms were available for Listeners when callers were in double cells. Training was regularly discussed at safer custody meetings, but not all senior prison custody officers responsible for chairing ACCT reviews had been trained as case managers.

Further recommendations

2.97 All staff responsible for chairing ACCT reviews should have completed case manager training.

2.98 A Listeners suite should be available.

Diversity

2.99 A separate race equality and diversity scheme should be introduced specifically to meet the needs of female prisoners. (3.60)
Partially achieved. There was no general diversity scheme. A commitment to the elimination of all aspects of discrimination was mentioned in a race equality and diversity policy statement at the front of the race equality scheme. There was a local operating procedure for women with disabilities, last revised in October 2007, but no designated and trained disability liaison officer (see paragraph 2.107). Separate race equality schemes for men and women had been drawn up in 2007.

Further recommendation

2.100 The women's prison should have an overarching diversity policy encompassing all main minority groups.

2.101 The race equality and diversity scheme should outline how the needs of minority groups will be met and monitored to ensure that prisoners from minority groups are not victimised or excluded from any activity. (3.61)
Not achieved. There was still no recognition or monitoring of the distinct needs of young adults, older prisoners, prisoners of different faiths or lesbian and bisexual women.
We repeat the recommendation.

2.102 Action plans in the race equality and diversity scheme should be based on a needs analysis. (3.62)
Partially achieved. Although there was no general race equality and diversity scheme, a sequence of undated action plans showed clear signs of progress and followed general needs identified in Prison Service Order 2800, HM Inspectorate of Prisons Expectations, audit baselines and the Mubarek inquiry. There was some limited reflection of needs specific to Peterborough, with the addition of a section based on the recent measuring the quality of prison life (MQPL) survey and identification of the person responsible for the delivery of action points, but few specific target dates.

Further recommendation

2.103 An action plan arising from a race equality and diversity scheme should include a local needs analysis and have target dates for implementation of action points.

2.104 There should be a race equality and diversity manager specifically for female prisoners. (3.63)
Not achieved. A senior prison custody officer was the one full-time race equality officer (REO) for the establishment, and was supported by a team of AREOs. Notionally each block had an assistant, but this was not always the case and their levels of training and effectiveness varied.

Notice boards with the photographs and names of the team were displayed around the prison. One of the assistants had also recently been appointed to take a lead in the women's prison and the deputy director overseeing the women's prison was progressing the race equality action plan. There was no diversity manager.
We repeat the recommendation.

2.105 The wing race equality and diversity officers should receive enough facility time to carry out their responsibilities. (3.64)
Not achieved. Wing AREOs had a job description, but no time set aside to meet this and no training. The job description simply said 'you will be allocated time by your line manager to carry out this role'. The slow progress since the last inspection left this in some doubt.
We repeat the recommendation.

2.106 All prisoners should be assessed during reception or induction as to whether they have a physical, mental or sensory disability, or learning disabilities including dyslexia. (9.65)
Achieved. Reception processes included questions on disability and other conditions, followed by a more detailed screening questionnaire completed by healthcare staff. The health and safety officer was notified by email. (See also paragraph 2.107).

2.107 Prisoners with disabilities and older prisoners should be consulted about their individual needs and care and formal care plans should be drawn up. (3.66)
Partially achieved. Healthcare staff drew up a care plan for prisoners with extensive healthcare needs. Beyond healthcare, the process was less systematic. There was no dedicated trained disability liaison officer. A health and safety officer interviewed prisoners about additional needs and filled out a care plan, mainly recording physical adaptations or additional equipment. Some additional needs were addressed, but these were not always recorded in a formal care plan and plans did not integrate suitable provision across the prison. The gym held regular sessions for prisoners over 40, undertook individual assessments for tailored gym programmes and had special equipment for wheelchair users. The library offered a trolley service. Prisoners we spoke to with disability or age-related needs said they had been interviewed by a health and safety officer about certain needs, but their knowledge of what was available was incomplete as they had picked up information from different sources, often other prisoners. They were not always assessed promptly on arrival, which meant that they, and others, faced disruption if they were relocated. Some had not seen or did not know if they had care plans.

Further recommendation

2.108 The prison should have a designated trained disability liaison officer to undertake integrated care planning in consultation with prisoners, taking account of various provisions across the prison.

2.109 Diversity training should be given to all staff. (3.67)
Achieved. Staff received diversity training during initial training, which was generally within the last three years. Approximately 20% had received further diversity training in the previous 12 months. A number of staff were booked on relevant courses in the near future and the contractor, Kalyx, had recently announced a programme of equality and inclusion training for all its staff.

Race equality

2.110 A comprehensive race equality policy and strategy should be developed and included in the race equality and diversity scheme. This should be based on a needs analysis of the female prisoners. (3.82)
Partially achieved. Nearly a quarter of women were from black or minority ethnic backgrounds compared to 14% at the last inspection. In support of the race equality scheme, a race equality action plan set out a detailed programme of work (see paragraph 2.102), which the deputy director was driving forward. The prison had not undertaken an extensive needs analysis of the women's population. Progress on driving forward the race equality policy and strategy had been slow, but, because of changes to NOMS arrangements, the prison now had support from the Prison Service national structures and was reviewing race equality impact assessments. The race equality action team had not always discussed important indicators such as racist incident reports and ethnic monitoring, but structures had recently improved. The deputy director was now the lead for race relations in the women's prison and provided active input.
We repeat the recommendation.

2.111 Black and minority ethnic prisoner groups should be held regularly. (3.83)
Achieved. Prisoner race equality representatives from most units met periodically with the REO and AREOs and their photographs and names were displayed on the race equality action team (REAT) notice board. The REO aimed to have meetings ahead of REAT meetings. These were also attended by prisoner representatives. Matters arising from previous meetings were also discussed.

2.112 All racist incident complaints should be thoroughly investigated, including when the complainant or alleged perpetrator has been transferred or discharged, and completed forms should contain transcripts of all interviews. Copy letters sent to complainants on completion of the investigation should be included. (3.84)
Achieved. Between January and mid-June 2008, 49 racist incident complaints had been logged. All boxes, including in the visitors' centre, had a stock of racist incident report forms (RIRFs). Completed forms were collected by the REO, acknowledged promptly and a response issued within the expected timescale. The REO interviewed the complainant and witnesses and reported back in writing, with a copy on the file. Written responses were invariably respectful, addressing the complainant by her first name. In a number of cases, the complainant was given an apology. Issues were followed up even if a prisoner left. The deputy director checked all reports and made constructive comments.

2.113 Planned interventions should be available to challenge those who demonstrate racist attitudes and behaviour. (3.85)
Partially achieved. There was no formal programme of structured interventions, but on a number of racist incident reports the deputy director had referred the subject to anti-bullying procedures. The deputy director was seeking advice from the Prison Service race equality action group on structured interventions. In most cases, the REO spoke to prisoners demonstrating racist attitudes and explained the prison policy and reasons for it.
We repeat the recommendation.

2.114 An external organisation should be involved in quality checking completed racist incident complaint forms. (3.86)
Partially achieved. A member of the Independent Monitoring Board reviewed all RIRFs. He was a member of the Peterborough diversity forum and the local race equality council, so had relevant experience. He and the prison had approached other external bodies to bring a more

detached perspective, but so far without success.
We repeat the recommendation.

2.115 The race relations group should be proactive in promoting and celebrating racial and cultural diversity within the prison. (3.87)
Partially achieved. Various religious events were observed. There was some exploration of race and cultural diversity, including during black history month, and there were plans to develop understanding of different nationalities in the run up to the Olympic Games. However, promotion and celebration of diversity was occasional rather than sustained.
We repeat the recommendation.

Foreign national prisoners

2.116 A race equality and diversity manager specifically for women should be given enough time and support to develop work with foreign national prisoners. (3.99)
Partially achieved. Seventeen percent of women prisoners were foreign national prisoners. Until recently, work with foreign national prisoners had been undeveloped. Race equality prisoner representatives included some foreign nationals, and some issues of concern to foreign nationals were raised at prisoner representative meetings and REAT meetings. One of the AREOs had recently taken some responsibility for organising regular foreign nationals meetings and one had recently taken place. There was a commitment to monthly meetings to identify needs and develop relevant support. Sufficient dedicated time was still required to maintain the commitment (see paragraph 2.105).
We repeat the recommendation.

2.117 Guidance on the appropriate use of face-to-face and telephone interpreters should be re-issued to ensure that services are used when necessary. (3.100)
Not achieved. Although most staff knew how to get an interpreter, few had ever used one. Recent invoices included a substantial sum spent on translations, but little for face to face or telephone interpreting. In some cases, another bilingual prisoner assisted, but this was not usually appropriate for personal and confidential matters.
We repeat the recommendation.

2.118 Foreign national prisoners' meetings should be held at least monthly. (3.101)
Partially achieved. These had just been introduced and so far only one had been held in June. This had been attended by the women's prison's assistant REO and seven prisoners. Detailed minutes revealed intelligent discussion, exploring a number of concerns with proposals for improvements. These included English for speakers of other languages (ESOL) classes tailored to a wider range of needs and a foreign nationals buddy scheme. The inability of foreign nationals to understand the detail of day-to-day prison life emerged repeatedly. (See also paragraph 2.116).
We repeat the recommendation.

2.119 A foreign national peer support scheme should be initiated. (3.102)
Partially achieved. See paragraph 2.116. It was intended that the regular monthly meetings, to which all foreign nationals were invited, would be a first step in developing peer support for foreign nationals. The forum would give them a chance to discuss needs and how these could be addressed and to report good practice they had seen at other establishments. Plans to develop a bilingual buddy scheme had been welcomed at the group meeting.

Further recommendation

2.120 Foreign national peer supporters should be appointed.

2.121 Foreign national prisoners should be made aware of and offered independent immigration advice. (3.103)
Not achieved. Foreign national prisoners and detainees could get advice from an immigration officer (see paragraph 2.123), but getting independent legal advice was more difficult. The legal services officer had a list of just four immigration solicitors, in Peterborough, Nottingham, Birmingham and London, and was unsure whether any responded to inquiries or took on legal aid cases. The Immigration Advisory Service (IAS), an independent provider, had previously undertaken some advice surgeries, but not for some time, although some staff still thought these took place. In some documents, including the foreign nationals policy, the IAS was confused with the visiting immigration officer. The library legal reference stock did not include any books explaining immigration law and procedure.
We repeat the recommendation.

Further recommendation

2.122 The prison library should have legal reference material explaining immigration law and procedures.

2.123 The race equality and diversity officers and manager should work together with the administrative officer responsible for immigration paperwork to ensure that all potential and current detainees are identified and assisted. (3.104)
Partially achieved. An immigration officer from a UK Border Agency (UKBA) office in the region visited two or three days a week to see foreign national prisoners. He collaborated with the administrative officer responsible for immigration matters to identify foreign national prisoners, interview them about their status and act as the liaison between the prison and the UKBA during sentence and, if they became immigration detainees, following the end of custodial sentence.

2.124 Nevertheless, there were three detainees. Sometimes their offending history made them unsuitable for an immigration removal centre, but most were moved to one, although a lack of beds in the immigration detention estate was slowing transfer. The three women had been held as detainees for between five and 13 weeks following the end of their sentence. Two had been prosecuted for offences related to immigration status and, since immigration officers were involved in the decision to prosecute, it was not clear why they had not taken the opportunity to progress their immigration casework at the same time. One, from a European country, was cooperating with removal, but was still held as a detainee several weeks after expiry of her short sentence. She had not received a review justifying her continued detention, which is a legal requirement. In the other case, the UKBA's Criminal Casework Directorate had indicated that the short sentence was not within the criteria for formal deportation, but it was left to other operational staff to consider removal. Several weeks later there was no further information and, again, no mandatory review of detention to explain to the detainee why she was still detained and what was happening. Assistance for detainees to help them understand their situation was poor (see paragraph 2.121).

Further recommendation

2.125 All detainees should receive written reasons for detention and reviews of detention following a change of circumstances, and at least monthly, in a language they can understand.

2.126 The foreign national prisoner awareness training should be further developed and delivered on a regular basis. (3.105)
Not achieved. Foreign national awareness training was not delivered.
We repeat the recommendation.

2.127 The facility to make a five-minute monthly telephone call in exchange for visiting orders should be more effectively advertised and actively offered to prisoners. (3.106)
Partially achieved. The local operating procedure for foreign national prisoners referred to a free monthly five-minute international telephone call for those who received no social visit during that month. Prisoners had to know about it and make an application, attaching unused visiting orders. This information was not readily available in languages other than English at induction. The telephone clerk reported 60 such calls authorised in June 2008 across the men's and women's prisons, but we met foreign national women who did not know about the facility or had found out about it only after they had been in the prison for some time.
We repeat the recommendation.

2.128 The international dialling cards should be reinstated. (3.107)
Achieved. Women could buy international dialling cards from the prison shop.

2.129 Foreign national prisoners should have unlimited access to their private cash to make international calls. (3.108)
Achieved. Foreign national women could add an extra £50 to their account for international calls and this was renewable.

Mothers and babies

2.130 Emergency contact numbers should be readily available for all babies in case of separation. (3.119)
Achieved. Emergency contact numbers were readily available for all babies on the unit.

2.131 Care plans should be developed for all pregnant women in the prison and regularly reviewed. (3.120)
Achieved. All women were seen by mother and baby unit staff on arrival and pregnant women were identified and given information about the unit. Mother and baby unit staff prepared individual care plans for each pregnant woman, who was seen initially every four weeks and then once a week as her pregnancy advanced. Plans included risk assessments for workplaces and identified any special requirements.

2.132 Women who give birth during their sentence and are separated from their children should have care plans that reflect their special circumstances and which residential staff understand and take into account. (3.121)
Achieved. No woman had been separated from her new-born baby since the last inspection, but one was about to be in this position. A formal plan had not yet been prepared as social services reports were awaited, but mother and baby staff and staff on the wing we spoke to were aware of and understood her situation. The woman was held on a wing where some of the staff were mother and baby unit trained, which helped provide a more supportive

environment. However, irrespective of social services input, a formal care plan was required before she gave birth and returned to the prison so that all residential staff could take her circumstances into account. We were assured this would be done.

2.133 Pregnant women and mothers should be able to use the lift to the first floor at all times. (3.122)
Achieved. Women could now use the lift at all times.

Applications and complaints

2.134 A consistent approach to recording the receipt and return of applications to prisoners should be developed across all wings. (3.173)
Achieved. All wings recorded and returned applications using a general application log. On house block one, each wing had an application log and staff we spoke to were clear that, wherever possible, applications should be dealt with directly by them and referred to others only when necessary. On house block two, wings recorded applications in a single general application log kept in the hub. A senior prison custody manager checked all applications to ensure that only those that could not be dealt with on the wing were forwarded to the appropriate department.

2.135 Applications should be sorted out promptly. In the absence of wing administrators, custody officers should be trained and resourced to deal with simple applications directly. (3.174)
Not achieved. A considerable number of recorded applications did not appear to have received a reply. Some replies went directly to prisoners, so were not logged as returned. General applications were not taken at weekends. There had been an increased emphasis on wing staff resolving simple applications directly and managers had raised this at staff briefings. However, many women continued to express frustration with the application system, describing applications going missing and staff reluctant to pursue and follow up submitted applications. Staff did not routinely follow up outstanding replies. We saw a number of complaints about issues that could have been addressed by wing staff and the use of the confidential access complaint system was high. Forty-one percent of all complaints received in April 2008 were submitted under confidential access, which indicated a lack of confidence in the general applications procedure. Residential managers were introducing changes to help deal with these problems.
We repeat the recommendation.

2.136 Wing officers should not be responsible for emptying complaints boxes. (3.175)
Partially achieved. A local operating procedure (July 2007) identified a night manager or a nominated representative as responsible for emptying all complaint boxes. Collected complaints were placed in a sealed envelope marked for the attention of the complaints administrator. The key to the complaints boxes was located in the main gate and the key log showed that responsibility for emptying the boxes was usually delegated to an officer.

Further recommendation

2.137 Officers should not be responsible for emptying complaints boxes.

2.138 Posters in a range of languages should advise prisoners that information about the complaints system is available in languages other than English. (3.176)
Partially achieved. A poster giving a brief description of the complaints system in four

languages was displayed on some, but not all, wings. The complaints clerk was responsible for replenishing complaint forms and all wings had a plentiful supply, including confidential access envelopes.

Further recommendation

2.139 Information about the complaints system in a range of languages should be displayed beside complaints boxes on all wings.

2.140 Managers should monitor trends in complaints and routinely sample the quality of replies to ensure that they answer the points raised and do not unnecessarily refer prisoners elsewhere. (3.177)
Partially achieved. The head of female prisoner services reviewed a random selection of 10 complaint replies each month and recorded her findings. In January 2008, the quality of responses had been described as 'poor and unacceptable'. This had been discussed at a residential team meeting and it was agreed that a residential manager would provide training and guidance for staff and managers. The replies we examined were generally polite and respectful, although some were not written in the first person. Some indicated that the respondent had spoken directly to the complainant, but the outcome of the discussion was not fully recorded. The complaints administrator carried out a monthly analysis of complaints. Residential managers were aware of this, but it was not discussed regularly at team meetings or any action taken as a result of identified trends.

Further recommendation

2.141 The monthly analysis of complaints from female prisoners and any trends identified should regularly be discussed at team meetings and appropriate action taken as a result.

Legal rights

2.142 Information about legal services should be available in languages other than English. (3.186)
Not achieved. The legal services officer (LSO) had provided the diversity manager with written information about legal services and bail information to be translated into other languages, but this was not yet available to prisoners.
We repeat the recommendation.

2.143 The 'access to justice' computers should be publicised through the legal services officers. (3.187)
Not achieved. The prison had two 'access to justice' computers. An application procedure to use these had been agreed and a compact drawn up to ensure that women using them understood their responsibilities. The LSO had drafted a notice to prisoners about the application procedure and the compact, but this had not yet been published.
We repeat the recommendation.

Substance use

2.144 Substance misuse nursing provision should be extended to reflect the demand and requirements of those subject to clinical support. (3.201)
Achieved. One nurse with special interest in substance misuse delivered detoxification

services. This nurse was supported by a healthcare assistant trained to Royal College of General Practitioners (RCGP) level 2. A further substance misuse nurse was being recruited to bring staff numbers to an adequate level.

2.145 All women withdrawing from drugs or alcohol should be seen by a doctor the morning after arrival. (3.202)
Achieved. Records confirmed that all patients who had been screened positive for withdrawal were seen by the GP the morning after arrival.

2.146 Provision of clinics from a substance misuse GP with special interest should be extended to reflect demand at the prison. (3.203)
Achieved. A GP trained to RCGP substance use treatment level 1 was on duty during working hours, including weekends. Out-of-hours cover was provided by a GP with special interest in substance use who was also trained to RCGP level 1.

2.147 Clinical procedures and protocols should be developed to cover all aspects of clinical provision and support. (3.204)
Achieved. Clinical protocols were in place for detoxification and maintenance prescribing. Separate protocols covered the counselling, assessment, referral, advice and throughcare (CARAT) service provision, referral and information exchange between CARAT and mandatory drug testing (MDT) teams, CARATs and the short duration programme, and CARATs and the offender management unit.

2.148 Comprehensive assessments should be undertaken on all prisoners accessing clinical support before the commencement of a specific regime to ensure safe prescribing. (3.205)
Achieved. First night symptomatic relief was given where necessary. The following day, the GP seeing patients with drug detoxification or maintenance needs conducted a full assessment (including contact with previous prescribers) before the start of any prescribing regime.

2.149 Clinical provision should be extended to offer the option of buprenorphine (Subutex) as an alternative to methadone for all prisoners. (3.206)
Achieved. Subutex or suboxone were available to women who had either previously been prescribed this drug or for whom the prescribing doctors deemed it suitable as an alternative to methadone.

2.150 Psychosocial support, including peer support and group work, should be developed specifically for those women subject to clinical management. (3.207)
Achieved. CARATs workers provided one-to-one support for all who asked for it. Prisoners could work through in-cell drug awareness work packs at their own pace while accessing clinical management and these were then used as a basis for follow-up one-to-one sessions. Adfam, an external agency working with family issues, offered group support to prisoners on detoxification. Peer support was provided through Alcoholics Anonymous and ad hoc groups organised by the women themselves.

2.151 Prison custody officers working on the detoxification wing should be given additional training to enable them to work more effectively with prisoners. (3.208)
Achieved. A series of accredited training events had been commissioned from HIT, a national drugs training organisation, to train officers and other staff involved with the detoxification wing. Officers said the training had helped to increase their understanding of the issues.

2.152 Alcohol provision should be extended to offer appropriate group work and individual interventions. (3.209)

Achieved. 'Drinksense', a local external agency, had been engaged to deliver one-to-one alcohol key-working and a two-day group work alcohol awareness programme. One 12-place group was held each month. Prisoners we spoke to reported high levels of satisfaction with this service.

2.153 A protocol for joint working and dual-diagnosis should be developed between CARATs and the mental health in-reach team. (3.210)
Achieved. A suitable protocol had been established and published. Staff reported a working knowledge of the protocol and records demonstrated adherence and successful joint working. A dedicated dual-diagnosis worker was part of the mental health in-reach team.

2.154 Information on the availability of substance misuse services should be available within the mandatory drug testing suite. (3.211)
Achieved. A good range of information was available, including leaflets and booklets on drugs awareness, harm reduction issues and services available in the prison and in the community. The mandatory drug testing rate was low, averaging 6% over the last six months.

Health services

2.155 The current provision of midwifery services should be continued. (4.72)
Partially achieved. Midwifery services were provided by the same midwife who provided midwifery services to vulnerable women in the local community. The hours provided had been significantly reduced. We were told that steps had been taken to increase the hours.

Further recommendation

2.156 Sufficient midwifery input should be provided to meet the complex needs of pregnant women.

2.157 An urgent review of staffing and skill mix should be undertaken. (4.73)
Partially achieved. Staffing levels and skill mix had been reviewed informally, but there was no documentary evidence to support this. A skills mix audit was also underway. Additional qualified nurses and healthcare assistants had been recruited to improve overall numbers and the skill mix of health professionals. An improved grading structure provided better management of specialist areas and improved career progression for health professionals. Administrative support was adequate.

Further recommendation

2.158 Once completed, the information from the skills mix audit should be used to inform future recruitment.

2.159 All staff should have access to clinical supervision. (4.74)
Partially achieved. Clinical supervision was being introduced for nursing staff, but dedicated supervisors had not yet been identified for the majority of healthcare staff. The clinical governance lead was a trained supervisor and nurses were encouraged to establish links with external supervisors. Protected time to undertake supervision was in place. The mental health in-reach team (MHIRT) had established clinical supervision within their specialty.
We repeat the recommendation.

2.160 All staff should have at least annual resuscitation and defibrillation training. (4.75)
Partially achieved. The majority of, but not all, staff had received training in the previous 12 months.
We repeat the recommendation.

2.161 An emergency childbirth kit should be available. (4.76)
Not achieved. Staff said it had not been possible to obtain an emergency childbirth kit as the local trust was concerned that only midwives should use such items. While we agree that nurses should only work within their professional competence, an emergency childbirth kit should be available for the immediate needs of an emergency delivery and include items such as sterile swabs, pressure pads and towels.
We repeat the recommendation.

2.162 Health services staff who administer medications should adhere to Nursing and Midwifery Council guidelines for the safe administration of medications at all times. (4.77)
Not achieved. Healthcare staff did not always adhere to Nursing and Midwifery Council guidelines for the administration of medications. There continued to be some secondary dispensing, particularly at lunchtimes.
We repeat the recommendation.

2.163 Clinical records should be kept securely in accordance with data protection and the Caldicott principles. (4.78)
Achieved. Clinical records were held securely in healthcare. A dedicated filing system appeared to be well managed and only health staff could access clinical records. Electronic records were maintained on SystmOne, which was password protected.

2.164 Record keeping should be in line with best practice guidelines for health services professionals. (4.79)
Partially achieved. Records were well maintained. All electronic entries were automatically attributable to the person making the entry, dated and timed. The hard copies were well maintained and easy to find. However, the hard copies were not routinely available in the consultation room during clinics, meaning that clinical decisions were made without the benefit of all clinical information held on a patient being readily available. Good use was made of the electronic patient information system.

Further recommendation

2.165 All clinical information, including records and medicine charts, should be present whenever a prisoner is being assessed by a health professional.

2.166 The beds in health services should not form part of the prison's certified normal accommodation and admission should be based only on an assessment of clinical need. (4.80)
Not achieved. The healthcare beds remained on the prison's certified normal accommodation. The healthcare centre also acted as the first night centre for most women apart from young adults. The first night women and healthcare patients were fully integrated, including sharing cells and dormitory accommodation. The use of the healthcare centre as a first night centre was inappropriate. (See also section on first days in custody.)
We repeat the recommendation.

2.167 Inpatients should have multidisciplinary care plans. (4.81)
Partially achieved. Multidisciplinary care plans were completed for each in-patient, but the quality needed to be improved. Initial plans outlined patient needs and plans for care, but daily entries did not refer back to the planned care. Review dates on many of the plans had not been adhered to and there was a need for nursing staff to review care plans more frequently to ensure care staff had the necessary guidance for prisoners in their care. Prison custody officers had been trained in handling clinical information and confidentiality by the local primary care trust and had full access to care plans, which were kept in their office. Nursing staff and custody officers made regular entries.

Further recommendation

2.168 Multidisciplinary care plans should be regularly reviewed and quality checked by a senior member of the nursing staff.

2.169 The induction session and health services leaflet for new prisoners should be improved and updated to provide relevant, accurate and informative information. (4.82)
Partially achieved. The induction presentation was good, but not all the information was up to date. A new healthcare information booklet was being developed and in the meantime a well presented healthcare newsletter was distributed to prisoners.
We repeat the recommendation.

2.170 Prisoners not attending health services appointments should be routinely followed up. (4.83)
Not achieved. Patients who did not attend appointments were not followed up and were responsible for rebooking missed appointments.
We repeat the recommendation.

2.171 Triage algorithms should be developed to ensure consistency of advice and treatment for all prisoners. (4.84)
Partially achieved. Triage algorithms had been piloted in the men's prison and the results were being evaluated before the algorithms were put into regular use in both the men's and women's prisons. A policy for the use of algorithms had been developed.
We repeat the recommendation.

2.172 A doctor should be contactable at all times. (4.85)
Achieved. Out-of-hours medical cover was provided by the same locum agency as the routine GP provision. The doctors' rota was available and healthcare staff we asked knew who was on call and how to contact them.

2.173 Women who would automatically be called for health screening in the community should routinely be offered the same opportunity while in prison. (4.86)
Partially achieved. All women over the age of 50 were invited for breast screening and women could attend screening in the local community. There was information on cervical screening, which took place at the well woman clinic at the prison, but women had to apply for this rather than being routinely called.
We repeat the recommendation.

2.174 Applications to health services should be dealt with promptly and effectively and women should be able to make appointments to see a doctor within 24 hours. (4.87)
Not achieved. Women applied to healthcare by using the application forms available on the wings and placing them in the healthcare box. These boxes were meant to be emptied daily by

healthcare staff, but we were told this was not always the case. We saw applications dated more than two days previously being entered onto the appointments system, which meant these patients would wait for at least three days for their appointments. Appointments were allocated by healthcare assistants and were not prioritised by trained staff.
We repeat the recommendation.

2.175 Barrier protection should be available to prisoners while in prison and on release. There should be a policy in place reflecting this. (4.88)
Partially achieved. Women had access to dental dams on request, but there was no provision for women to be given condoms or other barrier protection on release.

Further recommendation

2.176 Women should be provided with condoms on release.

2.177 All prescriptions should be legally written and should include the quantity prescribed, date prescribed and be signed by the prescriber. (4.89)
Partially achieved. Prescriptions were signed and dated by a prescriber and included the number of days supply. Controlled drugs prescriptions were not legally written as they did not include the quantity of unit doses required in words and figures. There were few diagnoses on the charts and no review dates. The name of the patient was not written at the top of each page of the prescriptions. These omissions could lead to patient safety issues.

Further recommendation

2.178 All prescriptions should be entered correctly and in accordance with legal requirements. A pharmacist or responsible health worker should oversee the management of medicine charts to ensure that they are completed correctly and reviewed regularly. Medication reviews should be conducted regularly.

2.179 Medication labelled for individual patients should not be placed in stock. (4.90)
Achieved. No medication labelled for individual patients was found with stock medication.

2.180 Medicines should be stored at an appropriate temperature. (4.91)
Achieved. Refrigerator temperatures were monitored daily and actions taken when necessary. An air conditioning unit ensured that room temperatures were suitable for medication storage.

2.181 Secondary dispensing into Henley bags should stop. (4.92)
Not achieved. Medication was issued in Henley bags for the evening for patients on the alcohol detoxification programme who required a night time dose. Single doses of indigestion medication were also issued in Henley bags to use later if needed.
We repeat the recommendation.

2.182 Medication should be prescribed and administered according to appropriate clinical need rather than meeting the aim of administering medicines twice a day. (4.93)
Not achieved. Night sedation, where used, was issued at 6pm on weekdays and 4pm at weekends on a see to take basis, which was inappropriate. Items needing 12-hourly dosages were not given according to clinical requirements. Medicines such as paracetamol were prescribed three times a day rather than the usual four to six hourly as required and other medicines prescribed as twice a day were not given 12 hours apart. Prisoners were not risk

assessed to enable them to have medicines such as paracetamol and ibuprofen in possession, which is normal practice.

Further recommendations

2.183 Pain relief such as paracetamol and ibuprofen should be allowed in possession following risk assessment.

2.184 Medicines prescribed as 12-hourly should be given as such and night sedation should be given immediately before lock up for the night.

2.185 Methadone mixture should be measured using appropriate glass measures or other approved measuring devices. (4.94)
Achieved. A pump had been provided and was in use. Auditable records for the cleaning and calibration of the pump were not available.

Further recommendation

2.186 Auditable records for the cleaning and calibration of the pump should be introduced.

2.187 Patients should have only one prescription chart. (4.95)
Achieved. We did not see any duplicate prescription charts.

2.188 The medication trolleys should be taken to the wings for each treatment time and alternative locations to the kitchen found to avoid the risk of contamination. (4.96)
Not achieved. Wing staff kitchens were still used to administer medications and medication trolleys were not taken to the wings at the lunch treatment time. There was little opportunity for prisoners to discuss health issues in private.

Further recommendation

2.189 A dedicated health room should be provided on the wings to facilitate the safe custody of medicines and provide a confidential area for prisoners to discuss any health issues with visiting health staff.

2.190 The pharmacist should make regular visits to the prison and audit faxed prescriptions against the originals. (4.97)
Achieved. The pharmacist visited weekly to undertake an audit of faxed prescriptions against original prescriptions.

2.191 The medicines trolleys should be secured to the fabric of the building and kept locked when not in use. (4.98)
Achieved. Medicine trolleys were locked when not in use and were secured to the wall both in the kitchens and the room where they were stored.

2.192 The use of patient-named medication should be encouraged. (4.99)
Partially achieved. Only 30% of prisoners received their medication in possession and much of this was administered from stock rather than named-patient medication. This was not good practice and resulted in excessive stock being held.
We repeat the recommendation.

2.193 The in possession risk assessments of each drug and patient should be documented and any reasons for the determination recorded. (4.100)
Partially achieved. There was an in possession policy, but it was unclear when prisoners underwent an assessment and whether all prisoners had been risk assessed. Very few prisoners were allowed in possession medication for up to 28 days.

Further recommendations

2.194 An in possession risk assessment should be undertaken on all prisoners during the reception health assessment and on all medicines as they are prescribed. The assessment should be co-located with the medication chart.

2.195 The default position for prisoners holding in possession medication should be for 28 days unless otherwise indicated following a risk assessment.

2.196 Trained pharmaceutical staff should attend the prison regularly to allow prisoners the opportunity to obtain advice about the benefits and risks of medications. (4.101)
Partially achieved. A pharmacist visited weekly, but there were no pharmacy clinics or patient medication reviews.
We repeat the recommendation.

2.197 Health services should provide day care for women less able to cope with life on the wings because of mental health problems. (4.102)
Not achieved. There was no day care for women less able to cope with life on the wings due to mental health problems. Primary mental health services delivered by prison staff were minimal, with only one registered mental nurse working with women, who also covered generic duties. However, the mental health in-reach team provided a service for the primary mental health needs of women.
We repeat the recommendation.

2.198 A formal arrangement for the provision of mental health out-of-hours support should be established. (4.103)
Achieved. Any prisoner in crisis was referred to and seen by a member of the mental health in-reach team and/or the GP. If the crisis could not be resolved, the community crisis intervention team was contacted for support. It had not yet been necessary to use this facility, which was testament to the mental health team's excellent management of prisoners.

Learning and skills and work activities

2.199 Arrangements for induction, initial assessment and allocation to activities should be improved and capture all new arrivals. (5.17)
Achieved. Induction to education was good. The recent introduction of a computer-based system for initial assessment of literacy and numeracy provided accurate and thorough screening opportunities for learning needs. This was used well to develop individual learning plans, which were used effectively in most lessons to monitor progress. Students contributed well to targets that appropriately supported and guided their learning. There was significantly improved advice and guidance on activities and courses. This was covered thoroughly at induction and reinforced by information on the residential wings, in workshops and through well-produced information leaflets. A well resourced and managed facility brought together a range of external agencies, including JobCentre Plus and NACRO, which encouraged and advised on education, training and employment and provided signposting to relevant agencies

within the prison. Allocation to work was now satisfactory and took into account women's identified needs.

2.200 All allocations to education should be on the basis of assessed educational need. (5.18)
Achieved. Since the introduction of a computer-based initial assessment (see above), prisoners' individual needs were more clearly identified and understood by education and training staff and allocations to education were based on identified educational need. Prisoners were now on courses and programmes that clearly met their educational and personal needs.

2.201 Arrangements for movements should ensure that prisoners arrive at education classes on time. (5.19)
Achieved. A free flow system had been introduced, which had helped movements. Punctuality was mainly satisfactory and the late arrival of a few women did not interrupt the flow of the lesson. Attendance was good and monitored well.

2.202 Women should have open access to the library during their allocated wing times without the need for an escort. (5.20)
Achieved. Women had access to the library during allocated wing times through the free flow system. This allowed them the opportunity to move around the prison without escort every 15 minutes.

2.203 The number of books in languages other than English and books suitable for prisoners with low reading skills should be increased. (5.21)
Partially achieved. The number of books in languages other than English and for prisoners with low reading skills had increased, although their percentage of the total stock had remained static in the previous 18 months. Library records indicated that few of these types of book were issued, although the way the figures were compiled and presented could have masked the accurate borrowing rates. There was an appropriate range of books, including easy readers and a small number of audio books.

Further recommendation

2.204 Accurate records of borrowing rates of books in other languages and books suitable for prisoners with low reading skills should be kept and any issues of usage addressed.

2.205 A complete set of Prison Service Orders and Instructions should be available. (5.22)
Achieved. Hard copies of the major Prison Service Orders were made available on request. The complete range of Prison Service Orders was stored on computer and available on screen or in printed form.

Physical education and health promotion

2.206 Timetabled physical education sessions should be introduced for older women. (5.29)
Achieved. Following a reorganisation of the services provided by the gym, staff had introduced a range of regularly planned activities for women over the age of 40.

2.207 Learning support for key skills should be introduced into physical education. (5.30)
Achieved. Education staff had introduced and embedded key skills in the vocational courses in the gym. Many women were transferred or discharged before completion of the key skills, but those who remained on the programme usually achieved the qualification.

2.208 Formal links should be developed between physical education and health services to encourage women to adopt a healthy lifestyle. (5.31)
Achieved. Formal links had been developed and good communications provided information on women to enable gym staff to support them in adopting a healthy lifestyle. Gym staff kept detailed records of women's needs and had established monthly monitoring activities to update the records. Short duration drug programmes, detoxification programmes and an accredited healthy lifestyle management course were available.

Faith and religious activity

2.209 All prisoners should be able to speak to a chaplain on their first night or the following morning and this should be documented. (5.43)
Achieved. The number of women seen daily as part of the chaplaincy's statutory duties was recorded on a 'world faith log'. When compared to the reception lists, any discrepancies were due to new arrivals who were discharged the following day for court or transferred before they were seen by a chaplain.

2.210 A female chaplain should be available for Muslim women. (5.44)
Achieved. A female Muslim chaplain had been appointed and worked for four hours each Friday leading prayers and Qur'anic studies.

2.211 Prisoners should not have to apply to attend services in advance. (5.45)
Not achieved. Prisoners still had to make an application to attend services. This had to be by the Wednesday before the service and approved by the security department, although residential staff had sometimes telephoned the chaplaincy if this had not been done and this had been sufficient. This called into question the need for security clearance. The chaplain was not aware of any prisoners refused permission to attend services.
We repeat the recommendation.

2.212 Services should not clash with other activities. (5.46)
Not achieved. Services clashed with the gym and other activities and were frequently disturbed by noise from the gym.
We repeat the recommendation.

2.213 Chaplains should be able to minister to prisoners individually and in groups without the supervision of a prison custody officer. (5.47)
Achieved. Chaplains could now supervise services and run group activities without a prison custody officer supervising. However, officers now returned to the wings after escorting prisoners to the world faith centre so there was no officer with responsibility for patrolling the area.

Further recommendation

2.214 An officer should patrol the area when chaplaincy activities are taking place.

Additional information

2.215 A local operating procedure (revised January 2008) outlined the work of the world faith centre. Fourteen percent of women said they were Roman Catholic, but the Roman Catholic minister worked only five hours a week, which was too little time for pastoral work after saying mass in

the men's and women's prisons on Saturday mornings. A previous full-time Roman Catholic chaplain had not been replaced.

2.216 Poor escort arrangements meant prisoners often arrived late or not at all for services and chaplaincy activities. This was a source of considerable frustration for chaplaincy staff and made planning activities with outside groups and volunteers difficult.

Further recommendations

2.217 The hours allocated to chaplains and faith leaders should better reflect the religious denominations of prisoners.

2.218 Escorts should be provided to allow prisoners to arrive at chaplaincy services and activities in good time to start at the advertised times.

Time out of cell

2.219 Time out of cell should be increased for those unable to take part in activities. (5.53)
Not achieved. Although there was better use of part-time work to allow more women out of cell, time out of cell for prisoners not involved in any activities had not improved. A snapshot taken at 2.30pm on 2 July indicated that 34% of women were locked in cell.
We repeat the recommendation.

2.220 The timetable of the regime should be reviewed to ensure that prisoners do not have to choose between gym and medication. (5.54)
Achieved. Although gym sessions overlapped with the issue of medication on some of the units, prisoners could collect their medication when they returned to their unit.

2.221 All women should have the opportunity to spend one hour each day in the open air. (5.55)
Partially achieved. Prisoners rarely had more than 45 minutes of outside exercise a day due to slippage in the core day. According to the core day, exercise was supposed to begin at 12.15pm on weekdays, but delays confirming the roll meant it rarely started before 12.30pm. The situation had improved recently as evening exercise had started for the summer months, but this was temporary. The exercise yards contained seating and had been improved by the addition of flowerbeds.
We repeat the recommendation.

2.222 Association facilities should be improved. (5.56)
Not achieved. Association facilities remained very limited. There were pool tables on some units, but little else to occupy women during association.
We repeat the recommendation.

Security and rules

2.223 A free-flow system for movements to activities should be introduced. (6.12)
Achieved. A free flow system to activities had recently been introduced and appeared to be working well.

2.224 Targeted mandatory drug tests should take place within three days of the test being requested. (6.13)

Achieved. Records indicated that target tests were conducted within 72 hours of the need being identified (see section on substance use).

2.225 Reviews of closed visits should be documented. (6.14)
Achieved. Reviews were held every month and documented and prisoners were informed of the outcome.

2.226 All female prisoners should be issued with a copy of the rules applying to them at Peterborough and these should also be displayed on wings. (6.15)
Not achieved. As part of first night procedures, prisoners were issued with a copy of local guidance on standards of behaviour. However, this was not sufficiently detailed and some women were unsure what behaviour might result in a disciplinary charge. This local guidance was posted on some residential notice boards, but no other information on the rules was displayed.
We repeat the recommendation.

2.227 Categorisation paperwork should be completed fully by all contributing departments. (6.16)
Achieved. Contributions to categorisation reviews were mostly completed fully by all contributing departments.

2.228 The prison should receive an appropriate quota of places in other women's prisons for re-allocation. (6.17)
Achieved. The number of moves out of the prison had improved significantly, with 29 progressive moves in one sample month, mostly to Send, New Hall and East Sutton Park. Once re-categorised to the open estate, women were moved quickly. The re-role of women's prisons in the south east had led to many more women being held long distances from their home areas. This continued to be a problem for long-term women requiring closed conditions, but progressive moves were not usually delayed.

Discipline

2.229 Guidance on the level of punishment for failure to attend activity should be reduced from the suggested five days cellular confinement. (6.36)
Achieved. The adjudications guidelines had been reviewed in December 2007 and the tariff for failure to attend activity reduced. The minimum recommended punishment was seven days stoppage of earnings at 50% and seven days loss of canteen, access to private cash, television, gym and association. The maximum was seven days cellular confinement. This was severe and to be used for persistent offenders, but we found no examples of this punishment being given.

2.230 Prisoners should be told of their right to appeal at the end of an adjudication rather than only receiving written information. (6.37)
Achieved. Adjudicators routinely explained the right to appeal after informing prisoners of their punishment and every prisoner was given a copy of the form explaining the procedure.

2.231 Adjudicators should satisfy themselves that all women are mentally fit for adjudication. Those with mental health issues who are placed on report and are otherwise deemed fit to answer charges should have an advocate to speak on their behalf. (6.38)
Achieved. Adjudicators consulted the mental health in-reach team when they had concerns about the mental health of women placed on report. There were no examples of women having an advocate to speak on their behalf due to mental health issues, but adjudications had been adjourned or not proceeded with due to concerns about prisoners' mental health.

2.232 Authorisation and certification of the use of force should not be done by the same person. (6.39)
Achieved. The format of the use of force forms dictated that in certain circumstances, such as spontaneous incidents, authorisation and certification were necessarily done by the same person. However, all use of force records for the previous six months were complete and had been checked and signed by the orderly officer.

2.233 A central register should be maintained of prisoners located in the special cell and original copies of special cell documentation should be retained. (6.40)
Achieved. The special cell had been used only once in 2008 and not at all in 2007. The original documentation was retained and appropriately filed.

2.234 The exercise yards in the separation and care unit should have some seating. (6.41)
Achieved. The segregation unit had two exercise yards and both had been supplied with bench seating. One yard was out of use as the seating had been damaged by a prisoner and was unsafe. This had not curtailed the regime for women on the unit, all of whom received time in the open air.

2.235 Staff in the separation and care unit should receive training in mental health issues and there should be more health services input into the unit. It should not be used to accommodate women who are acutely mentally ill. (6.42)
Achieved. Mental health awareness training had been introduced. The separation monitoring and review group (SMARG) report for the previous two quarters indicated that all staff working on the unit had been trained. All the staff we spoke to had found it useful. There was a good working relationship between discipline staff and the mental health in-reach team, who regularly spent time on the unit and gave advice and support to staff on caring for women located there.

2.236 Safety algorithms for women held in the separation and care unit should be completed on time. (6.43)
Achieved. All safety algorithms for the previous six months had been completed within two hours of the woman being placed in segregation and usually immediately afterwards. They were correctly completed by healthcare staff and signed by an appropriate manager. In a few cases, the manager completing the algorithm had not circled the box indicating they had read the comments made by healthcare staff.

Additional information

2.237 The number of adjudications had reduced from an average of 180 a month to an average of 120 a month. However, this remained comparatively high. Three women in the segregation unit were repeatedly placed on report, including one often for several offences on the same day. Although their behaviour was challenging and some charges involved alleged assaults on staff, the use of the disciplinary system to manage their behaviour appeared wholly ineffective. In one case, a care plan from a previous establishment had specifically noted that the use of the disciplinary system was unproductive. Prisoners in the segregation unit had care plans, but some lacked detail and provided little information for staff about what strategies worked in caring for and managing these very challenging women.

2.238 The number of use of force incidents had significantly reduced to an average of 18 incidents a month. This was a similar level to that found in other closed women's prisons.

Further recommendations

2.239 Women should not be placed on report repeatedly if the disciplinary system has proved ineffective in managing their behaviour.

2.240 Care plans for women in the segregation unit should contain information to assist staff in caring for and managing challenging prisoners.

Incentives and earned privileges

2.241 There should be a separate incentives and earned privileges scheme for the women's prison with appropriate incentives for women. (6.52)
Not achieved. Although the prison had published a separate incentives and earned privileges (IEP) policy for women, it was almost identical to that for male prisoners. The only discernible difference in incentives was that women at all levels of the scheme had access to a slightly larger amount of private cash than men. There were plans to change the facilities list for women and a number of consultation groups had been held to inform this.
We repeat the recommendation.

2.242 Staff should be encouraged and guided to deal with minor issues without resorting to formal warnings. (6.53)
Not achieved. The published policy outlined the criteria for earning and retaining privileges, including full engagement in the prison regime, participation in sentence planning, relationships with staff and prisoners and adherence to rules and regulations. Wing files contained little information about a woman's progress towards sentence plan targets, which would have informed discussion about the appropriate IEP level. Women we spoke to said IEP warnings were often issued unfairly, inconsistently and for petty reasons. A number of women had formally complained about the administration of the scheme. The form staff used to issue a formal warning contained a section to record the prisoner's response, but this was frequently blank. Residential managers conducted random monthly quality assurance checks of completed IEP reviews and used the findings to inform discussion at staff briefings, but wing history files demonstrated that staff frequently issued formal warnings for minor matters. One woman had received a formal warning for having a small safety pin attached to her clothes. In March 2008, one residential manager had described the reviews he had seen as 'inconsistent and divisive'.
We repeat the recommendation.

2.243 The incentives and earned privileges scheme should be simplified and the number of forms reduced. (6.54)
Achieved. The number of forms used had been reduced. Women we spoke to were clear about how the scheme worked and the privileges available at each level.

2.244 Incentives and earned privileges status should be reviewed automatically every 12 weeks. (6.55)
Not achieved. The IEP policy stated that all women should have their IEP status reviewed annually. Annual reviews were not appropriate or relevant, given that only 11% of women had been in the prison for over 12 months. A number of wing files showed that during a management check, senior prison custody officers had prompted personal officers to consider a review of a woman's IEP status as the file contained evidence that this was appropriate.
We repeat the recommendation.

2.245 All appeals should be heard by the senior prison custody officer within a week. (6.56)
Achieved. An appeal form was issued to women following an IEP regime review board and this was recorded in the wing history sheet. Appeals were dealt with by residential managers, rather than senior prison custody officers, within seven days of the review board.

2.246 Prisoners on basic should be given specific targets aimed at improving behaviour. (6.57)
Partially achieved. Some, but not all, women on the basic level of the scheme had been set behaviour improvement targets following an IEP review. Women on the basic level were reviewed weekly and this was supposed to be informed by a form completed by their personal officer or wing staff, summarising their behaviour against published criteria in the previous week. In some files, however, this form had not been used to inform review decisions. Most women were returned to the standard level at the first review.

Further recommendation

2.247 All women on the basic level should be given specific targets aimed at improving behaviour, with weekly reviews of progress.

Additional information

2.248 A separate IEP scheme for young adult women had been introduced in October 2007. The published scheme described three behaviour levels of gold, silver and bronze. Movement between the levels was based on a points system, with points awarded for attendance at work, assisting staff and helping others. Young women were encouraged to take a comments sheet with them when they left the wing for staff to endorse. Points were deducted for a range of infringement of wing and prison rules.

2.249 Staff on B1, where young women were located, were positive about the scheme, but it was still not fully embedded. Wing history sheets included examples of staff who did not regularly work with the young women using paperwork from the adult scheme. Young women who reached 400 points or below were subject to loss of association, which was a concern. Young women were not immediately set improvement targets at the bronze level, but they could be issued with a behaviour compact, particularly if they had been at the bronze level for some time. It was unclear from the policy exactly what this compact would consist of and how it would be used.

Further recommendations

2.250 Residential managers should ensure that all staff working with young adults are familiar with and adhere to the incentives and earned privileges scheme for young women.

2.251 The incentives and earned privileges policy for young women should clarify the purpose and use of a behaviour compact.

2.252 Young women at the bronze level should not routinely lose association.

Catering

2.253 Kettles should be provided to all prisoners to make a hot drink after evening lock up. (7.8)
Not achieved. Only women on the lifer wing had been supplied with kettles. Everyone else was given a flask, but many complained that these were too small and did not keep water hot for long enough.
We repeat the recommendation.

2.254 Lunch should not be served before noon and the evening meal should be served after 5pm. (7.9)
Not achieved. The core day indicated that lunch was served at 11.45am and women were locked in their cells by noon. Activities stopped at 11.45am, so there was little time for women to be served and eat their food. The evening meal was scheduled to begin to be served at 4.45pm on weekdays and 5.15pm at weekends. We saw meals being served at 4.30pm.
We repeat the recommendation.

2.255 All prisoners preparing or serving food should be suitably trained in this work. (7.10)
Achieved. Women preparing food in the kitchen had a programme of one-to-one modular training and had to complete the relevant module for each piece of equipment or activity before being allowed to work unsupervised. Every kitchen worker had an individual training record. Wing servery workers had to complete training in food hygiene before being employed.

2.256 Prisoners working with food should have the opportunity to gain appropriate national vocational qualifications. (7.11)
Not achieved. Women working in the kitchen did not have the opportunity to gain national vocational qualifications. The prison was bidding for funding to introduce an accredited course.
We repeat the recommendation.

2.257 A caterer should attend all the prisoner consultation meetings and read and respond to food comments books. (7.12)
Achieved. Catering staff attended the monthly prisoner consultation groups. The catering manager also had plans to introduce a bi-weekly meeting with prisoner representatives, which had been introduced in the men's prison and had been successful. Food comment books were reviewed and annotated by catering staff weekly, but some responses were perfunctory.

Additional information

2.258 Prisoners complained to us that food started to be served before they returned from work and was often cold by the time they collected their meal. Prisoners also said that they did not always get their choice of meal and that staff took food from the hotplates. We saw staff eating food from the prisoners' hotplate on a number of occasions.

Further recommendations

2.259 Prisoners should receive their selected meal served at an appropriate temperature.

2.260 Staff should not eat food from the prisoners' hotplate.

Prison shop

2.261 Black and minority ethnic women should be specifically consulted about the range of goods in the shop so that their requirements can be better met. (7.19)
Partially achieved. Some additional specific requirements had been identified under the race equality scheme, but there was no formal structure to identify systematically the requirements of black and minority ethnic women.
We repeat the recommendation.

2.262 Tinned goods should be allowed. (7.20)
Partially achieved. There had been concern that tins could be used to self-harm, but tinned tuna had been introduced on a trial basis in January 2008 and there had been no appreciable increase in levels of self-harm.

Further recommendation

2.263 The range of tinned goods available from the shop should be extended.

Strategic management of resettlement

2.264 The resettlement policy committee should use performance and other data to develop the resettlement strategy. (8.8)
Partially achieved. There was no designated resettlement policy committee, but a monthly business planning meeting drew on data such as key performance target information and numbers of women accessing particular services. There were regular reports on the various resettlement pathways, which used information from education and providers in the Link. The reducing re-offending plan was still in draft (see section on progress on main recommendations) and was not sufficiently time bound or strategic (see additional information).

Additional information

2.265 The prison had developed a reducing re-offending action plan in place of the resettlement policy committee meetings. The key priorities for 2008/09 were to ensure that recommendations from outside agencies were met, reduce the level of self-harming and deliver an integrated regime with targeted interventions. The plan was based on a needs analysis using the offender assessment system (OASys), thus excluding women on remand or serving less than 12 months. These data indicated that relationship, emotional and thinking skills were the areas of greatest need, identified in over 70% of women serving over 12 months. In addition to the mandatory pathways, the plan included the recommended additional pathways specific to women.

2.266 The plan was detailed and provided objectives and action points. All pathways were assigned to managers or the women's management team, but there were no time bound objectives and no forum for action points to be discussed. The lack of custody planning for short-term prisoners was also a deficit. There were 157 women on remand or serving sentences of less than 12 months. Some good provision was available through the Link, but there was a need to provide structured needs analysis of this group.

Further recommendations

2.267 The needs analysis contained in the draft reducing re-offending action plan should include a detailed section on the specific needs of young adults, those serving short sentences and women on remand, and how they will be met.

2.268 Objectives and actions identified in the reducing re-offending action plan should be tasked to named individuals and revisited regularly through documented meetings with resettlement pathway leads. A named manager should provide a strategic lead to ensure that the plan is delivered.

Offender management and planning

2.269 Women should be able to take part in the enhanced thinking skills programme soon after they have been assessed as suitable. (8.27)
Achieved. Enhanced thinking skills had been introduced and the waiting list was short. Most women completed the course within three months of being assessed as suitable. The prison had exceeded the target for course completions. Eight women were waiting for an assessment and six who had been deemed suitable were waiting for a course. The average wait was three to four months.

2.270 Greater use should be made of release on temporary licence with full account taken of the provisions of PSO6300. (8.29)
Achieved. A local operating policy (updated in January 2008) incorporated the guidance in Prison Service Order 6300. Thirty-one women had been released on temporary licence (ROTL) in 2008. Most ROTL was linked to childcare leave, overnight resettlement leave or special purpose (medical appointments).

2.271 A pre-release course should be provided to help prisoners prepare for reintegration into the community. (8.30)
Partially achieved. A pre-release course provided through the education contract took place over six weeks, which was not suitable for many short-term women. The course allowed women to spend time on areas such as disclosure of criminal records, employment search and CV writing. The education department was establishing some links with outside agencies willing to employ former prisoners.

Further recommendation

2.272 A shorter pre-release course that meets the needs of the population should be provided.

2.273 Potential and sentenced lifers and other indeterminate prisoners should receive up-to-date written information and regular continuing support and information about their position. (8.31)
Partially achieved. Potential mandatory sentenced lifers were identified through the offender management system and met offender supervisors during their remand period. Although potential indeterminate sentence (IPP) prisoners were identified on reception, no specific support was provided. Two offender supervisors were responsible for IPP men and women and had large caseloads. There were 13 potential IPP prisoners and 11 potential mandatory lifers. A further 37 women were serving indeterminate sentences (life or IPP). The prison had recently started to issue a NOMS information leaflet about indeterminate sentences.

Further recommendation

2.274 Support should be offered to prisoners identified as potentially facing indeterminate sentences.

2.275 A MALRAP should be arranged as soon as practicable after a relevant life sentence is imposed. (8.32)
Achieved. There had been some delays in convening multi-agency lifer risk assessment panels (MALRAPs), but these had largely been addressed. Two MALRAPs were outstanding, one of which concerned a woman who had arrived from another prison with the reports outstanding.

2.276 Peterborough should not undertake a specialist first stage lifer role for women until there are resources for specialist assessments and a clearly worked out strategy explaining how their different needs will be met. (8.33)
Not achieved. The prison had taken over the role of a specialist first stage lifer prison at the end of 2006, but was not sufficiently resourced to meet this need. There was no strategy setting out how to meet the needs of this group (see additional information).

Additional information

2.277 A small lifer team managed mandatory life sentenced men and women. This consisted of a lifer manager, a clerk and two full-time offender supervisors. A further two offender supervisors managed indeterminate sentenced prisoners. The team was stretched. There was no cover for the lifer clerk and few staff outside the team were aware of the prison's responsibilities. Around 30 staff had received lifer training shortly after the prison had taken over the role of first stage lifer centre, but they were dispersed throughout the prison. There was little written information. Until very recently, the prison had been issuing the out-of-date (2001) booklet produced by the Prison Reform Trust, although a new NOMS leaflet was now in circulation. There was no local information for indeterminate sentenced prisoners. There were 17 mandatory life-sentenced women, most of whom were fairly recently sentenced. There were 20 IPPs with tariffs ranging from six months to four years. Six women were post-tariff.

2.278 There was no psychology team to carry out risk assessments or complete any one-to-one work. Many women had been identified as having complex and acute needs. A counselling psychologist, who was part of the mental health in-reach team, carried out some work with the more acute cases, but this was only a small part of her work. There was no forensic psychologist and a sessional worker employed to carry out risk assessments had not been available for most of 2008. Only two of the mandatory lifers and IPP prisoners had had a psychological assessment, although 10 had received a psychiatric assessment.

2.279 Interventions were limited to enhanced thinking skills, the short duration drug programme and a number of lifestyle courses. There was no accredited anger management programme, although the chaplaincy was shortly due to start a locally devised course. Nine women were serving indeterminate sentences for arson, for which there were no interventions available. A further eight women were remanded for arson charges. Some women had transferred to the therapeutic community at HMP Send.

2.280 Most mandatory life sentenced prisoners were located on A2, but other indeterminate sentenced women were spread throughout the houseblocks. The wing was not set up to meet the needs of a long-term population, with few association facilities and no opportunities to prepare food. Staff on A2 were largely conversant with life sentence issues, although staffing

shortages meant that relief officers were not always lifer-trained. Women on A2 expressed frustration at the lack of regular lifer meetings and support. A meeting with the lifer manager had taken place in January 2008, but this was undocumented and there was no regular structured support. Lifer days were held and were well received. Nine women, two of whom had been sentenced in 2006, were overdue a sentence plan, which added to the frustration and left prisoners feeling that they lacked direction. The prison had started to tackle the delays in sentence planning and some women had sentence planning boards during the inspection.

2.281 Offender management for determinate sentenced prisoners largely worked well. There was a backlog in some areas, including 10 missing or overdue offender assessment system (OASys) assessments for women in scope for phase 2 (high-risk cases) principally because of delays with external offender managers. Phase 3 (indeterminate sentenced prisoners) had been planned for January, but a team and resources had been in place only since April. A team of 10 offender supervisors covered those in scope across the men's and women's prisons. OASys assessments were largely good quality and most staff were either trained or about to go on the four-day assessor course. Higher risk prisoners were generally allocated to probation officers with more experience of managing risk and an experienced senior probation officer provided documented quality checks of assessments. Offender management staff mostly worked weekdays and their work was ring-fenced. They were rarely, if ever, taken off to do other prison custody officer duties.

2.282 Links with offender managers in the community were variable. Although some offender managers were able to attend the prison, the size of the catchment area, particularly for women, and financial constraints on home probation services meant this was not always possible.

2.283 Offender supervisors based in the prison had good contact with prisoners and clearly knew a great deal about the domestic situation, family and offences of those they were responsible for.

Further recommendations

2.284 The prison should no longer take first stage life-sentenced women until it has sufficient resources, including psychology support, commensurate with other first stage lifer prisons to identify and assess risk factors and how to deal with them.

2.285 The lifer manager or a designated and suitably trained member of staff should meet regularly with groups of indeterminate-sentenced prisoners (lifers and IPPs) to provide advice and guidance. This should be minuted.

2.286 Long-term prisoners on A2 should be given the opportunity to cook for themselves and maintain independent living skills.

Resettlement pathways

Accommodation

2.287 All prisoners' housing needs should be identified during induction and services made available to assist in meeting those needs. (8.43)
Partially achieved. Some good housing advice was available through the Link. Connections workers asked prisoners about housing needs on reception and any problems such as rent

arrears or homelessness were passed to a full-time adviser. At the time of the inspection, the adviser was absent on long-term sick leave and there was no formal cover.

Additional information

2.288 Usually, housing advice was provided by a worker employed directly by the prison and had proved to be reasonably successful. However, many women faced difficulties in finding accommodation on release. The vast catchment area of the prison meant that housing advisers had to work with a huge number of housing providers. Discharge interviews were carried out six weeks before release, but there was frequently insufficient time to find accommodation for someone who had not previously been identified. The absence of a housing advice worker for some time was a problem. There was no trained cover and no other staff had access to the housing adviser's computer systems or databases. Emergencies were picked up by other staff and by the housing advice worker in the men's prison, who already had a large caseload. Prisoner peer workers were keen and motivated to help, but could not use the telephone or access any information from the internet or prison computer system.

Further recommendations

2.289 There should be a trained adviser to cover annual leave or sick leave and provide housing advice.

2.290 Prisoner peer advisers should be trained to provide housing advice and, subject to security clearance, given access to telephones, computers and internet services.

Education, training and employment

2.291 All prisoners' education, training and employment needs should be identified during induction and services made available to assist in meeting those needs. (8.49)
Partially achieved. Women's education and employment needs were accurately and thoroughly identified at induction and they were placed on appropriate courses and programmes. There was relevant employment across the prison and women undertook a diverse range of jobs, but there were insufficient courses and programmes to meet assessed need. There was little accreditation for language courses and vocationally-related skills developed at work. This prevented prisoners from presenting an accurate assessment of their skills when applying for employment on release.

Further recommendation

2.292 A full range of accredited programmes should be introduced to meet the needs of all women and to recognise their achievement of work-related and language skills.

Finance, benefit and debt

2.293 All prisoners' finance, benefit and debt needs should be identified during induction and services made available to assist in meeting those needs. (8.54)
Partially achieved. Connections workers asked prisoners about financial issues at induction. Advice and services had previously been provided through Citizens Advice (CAB) debt

sessions, but had been discontinued. Jobcentre Plus visited three times a week and advised on community care grants, benefit claims and general enquiries.

2.294 Prisoners should be able to obtain training in personal budgeting and finance. (8.55)
Achieved. Since April 2008, 11 women had completed a money management course run by the education department. This took place over 30 hours and included sessions by agencies such as the CAB and Jobcentre Plus.

Additional information

2.295 OASys information indicated that 40 women subject to offender management had identified financial problems linked to their offending. This did not take into account those on remand or serving sentences of less than 12 months. There was no information on whether provision was sufficient to meet the finance pathway. The prison's own assessment indicated some concerns about the quality of debt advice and the only agency providing this service had been withdrawn in April 2008.

Further recommendation

2.296 The pathway lead for finance and debt should draw together all information collected on women who have stated a need for financial/debt advice and formulate an action plan to meet this need.

Mental and physical health

2.297 Prisoners should be given information and assistance to access health and social care services on release. (8.60)
Partially achieved. All women leaving the prison were given a leaflet about NHS Direct to help them locate a GP if they were not already registered with one. The leaflet also gave some information about health services for the homeless. The prison's address and telephone number were included so that health professionals in the community could contact Peterborough for more information about any treatment delivered by the prison healthcare team. Those on medication were given supplies to last at least a week, but there were no formal discharge clinics. Women who had been under the care of the mental health team were more likely to be helped to reintegrate into local health services in their community.

Further recommendation

2.298 All prisoners should be invited to attend a pre-release clinic where dedicated time is allotted to ensure that their health needs are assessed and addressed before discharge.

2.299 A palliative and end of life care policy should be developed in partnership with local care services. (8.61)
Achieved. An appropriate palliative and end of life care policy was in place.

Drugs and alcohol

2.300 The drug strategy document should incorporate alcohol and include a needs analysis, developmental targets and objectives. (8.70)

Partially achieved. Alcohol was incorporated in the strategy with the inclusion of services from Drinksense into the alcohol treatment approach. However, the strategy did not include any reference to needs analysis or related developmental targets and objectives.

Further recommendation

2.301 An in-depth analysis should be undertaken of the specific clinical and psychosocial needs of women with drug- and alcohol-related problems. This should then inform the drug and alcohol strategy to enable specific developmental targets and objectives to be established.

2.302 The drug strategy document should reflect the specific needs of the women's population. (8.71)
Not achieved. The strategy did not reflect the specific needs of female prisoners. A questionnaire sent to men and women asked prisoners about drug use and treatment expectations. This was referred to as a needs analysis, but even this had not informed the strategy document. It did not consider the views of workers, drug using trends among the national and local populations and specific differences between male and female drug users' clinical and psychosocial treatment needs.
We repeat the recommendation.

2.303 Harm reduction provision and checklists should be introduced consistently for all prisoners with a substance misuse history and monitored to ensure consistent application. (8.72)
Achieved. Case files included checklists and records of harm reduction information given to prisoners. Supervision records further demonstrated regular monitoring of case files by the CARATs manager.

2.304 Casework supervision and file reviews should be undertaken on a regular basis to ensure consistent service delivery and staff personal development. (8.73)
Achieved. Each CARATs worker had signed a supervision contract with the manager. Supervision sessions were held monthly and detailed logs of these sessions were kept on file. Quality assurance checks on case files were conducted monthly by the CARATs manager. The target of checking 10% of all live files each month was being exceeded.

2.305 Caseload management systems should be introduced to prioritise service delivery. (8.74)
Achieved. Each CARATs worker operated a time management system that enabled accountability of time spent on each prisoner's case. The CARATs manager had introduced a database system that allowed monitoring of each worker's caseload using information from the time management systems. From this database, decisions were made as to which worker could take on new prisoners' cases.

2.306 Group work, covering key aspects of provision, should be introduced. (8.75)
Achieved. A four-week short duration programme had been introduced in October 2007 to work with prisoners with drug-related problems. A two-day alcohol awareness group was run monthly by Drinksense, with 12 places per course. Alcoholics Anonymous groups ran weekly. Monthly parenting groups were run by Adfam, also with up to 12 places per group.

2.307 Prison custody officers working on the voluntary testing unit should be given additional training to enable them to work more effectively with prisoners with substance misuse histories. (8.76)
Achieved. Training for officers was arranged on a rolling programme, with courses on drugs

awareness, drug treatment and other related issues provided by the HIT national training organisation and Bridgegate, a local provider.

Children and families of offenders

2.308 Prisoners should receive their post within 24 hours of its arrival at the prison. (3.143)
Not achieved. Staffing levels continued to delay post being delivered to prisoners. This was unacceptable.
We repeat the recommendation.

2.309 Telephones should be placed in booths for privacy, with additional telephones provided on overcrowded wings. (3.144)
Not achieved. The number of telephones on wings had not increased. They were clustered together in busy areas with ineffective hoods and could not be used in private.
We repeat the recommendation.

2.310 The visitors' centre should be developed to provide information, advice, support and refreshments to visitors. (3.145)
Partially achieved. The visitors' centre was little changed, although a range of information on local and national agencies and visiting procedures was now displayed. Adfam workers ran monthly information and awareness days at the centre on topics such as alcohol, drugs and debt, and had a display of most frequently asked questions. The centre was still staffed by just one auxiliary officer who sat behind a screen, which discouraged any engagement and ensured that conversations could not be held in private. There was no one to befriend and help first time visitors. There were no refreshments or toilet facilities. The toilets were closed due to continuing vandalism, which suggested a lack of supervision. The centre continued to be a booking in facility rather than one to help and support visitors.

Further recommendation

2.311 The reception centre should be further developed to provide supportive information and advice to visitors. Some refreshments and toilets should be provided.

2.312 Visitors should not be required to produce photographic identification. (3.146)
Not achieved. Visitors had to bring photographic identification as well of proof of address on every visit. Those without photographic identification still had to bring a letter and photograph confirming their identity, signed by someone like a solicitor, which was expensive for visitors. The prison continued to take photographs and finger scans of all visitors, but still insisted on photographic identification. Utility bills or rent books, usually accepted at other prisons, were not accepted. The local operating procedure said identification was not required after the first visit, but visitors who arrived without it could be refused entry if the computer system was inaccessible.
We repeat the recommendation.

2.313 Closed visits should be authorised only when justified by security intelligence. (3.147)
Not achieved. Any visitor indicated by the drug dog was still offered a closed visit or asked to leave, without an individual risk assessment or additional security information.
We repeat the recommendation.

2.314 Babies should not routinely have to have their nappies changed on entering visits without appropriate specific security intelligence and authorisation by a manager. (3.148)
Achieved. Babies no longer had to have their nappies changed on entering visits.

2.315 All visits should start at the booked time. (3.149)
Not achieved. Visitors queued in the gate house to have their photographs and finger scans compared to existing records and their identification checked. Photographs and finger scans of new visitors were also taken. This delayed other visitors booking in. All visitors were then searched and had to wait to be escorted to the visits room. During the inspection, the first visitors did not arrive in the visits room until 15 minutes after the start of visits.
We repeat the recommendation.

2.316 Basic visits should last a minimum of one hour. (3.150)
Not achieved. The basic visits entitlement for remand prisoners was still 30 minutes.
We repeat the recommendation.

2.317 Improved arrangements should be made to book visits by telephone. (3.151)
Achieved. Most visitors said it was usually easy to contact the booking clerk depending on when they rang. We got through to the clerk on our first attempt one morning and after holding for three minutes one afternoon.

2.318 The visits hall should be made a more welcoming environment with seating that allows better contact between prisoners and their visitors. (3.152)
Not achieved. The visits room was unchanged and seating remained fixed. Most seating was for four people and there were no free-standing chairs to accommodate larger groups. Smaller children could sit on an adult's lap, but teenage children had to use one of the fixed chairs, so the size of the group was restricted. A family room adjacent to the visits room was used only for supervised visits of children by social services. This was soon to change to allow women to apply to have their visit in more relaxed surroundings.
We repeat the recommendation.

Further recommendations

2.319 The number of visitors should not be dictated by the number of fixed chairs available and free-standing chairs should be provided when necessary.

2.320 All women should have the opportunity to use the family room for visits with their children.

2.321 The play area in the visits room should be supervised by an appropriately qualified worker and a range of suitable toys should be provided. Mothers should be able to play together with their children in the play area. (3.153)
Not achieved. The play area remained unsupervised and mothers could not play with their children there. There were no books and the choice of toys was limited, although funding had recently been agreed to purchase some new toys.
We repeat the recommendation.

2.322 Regular children's days should be introduced. (3.154)
Achieved. Around six children's days each year were open to all mothers and grandmothers and their children or grandchildren up to the age of 16. These ran from 10am to 1.45pm. A

range of organised activities was provided in the mother and baby unit, supervised by staff from the unit, nursery nurses and gym staff.

2.323 Prisoners should not have to wear bibs in the visits room. (3.155)
Achieved. Prisoners no longer had to wear bibs in the visits room.

2.324 Visitors should be able to buy a range of suitable refreshments. (3.156)
Not achieved. The refreshment choice was limited to crisps, sweets, some dried fruit and nuts and hot and cold drinks. Visits were available during the evening and many visitors travelled some distance, but there was no opportunity for them to buy or bring in a sandwich for their evening meal.
We repeat the recommendation.

2.325 Visitors should be able to provide feedback on their experience. (3.144)
Not achieved. The action plan stated that a comments book was provided in the visitors' centre, but this was not the case.
We repeat the recommendation.

2.326 Information about the resettlement services provided should be advertised to prisoners and visitors. (8.84)
Partially achieved. Information about resettlement services was widely advertised to prisoners on wing notice boards and there was a good level of awareness about the Link providers. Little information about what was available in the prison was advertised to visitors.

Further recommendation

2.327 Information about resettlement services should be advertised in the visitors' centre.

2.328 Relationship counselling should be available to prisoners and their families and appropriate parenting/relationship programmes provided for prisoners. (8.85)
Not achieved. Relationship counselling was available to prisoners and information about support agencies such as Relate and Adfam was advertised to visitors, but prisoners could not take up relationship counselling or mediation meetings with their partners or family members. No accredited parenting or relationship courses were run.
We repeat the recommendation.

2.329 Prisoners should be able to send letters to family members in other parts of the prison without having to use the external post. (8.86)
Not achieved. Letters to partners or family members in other parts of the prison still had to be sent out in the normal way, which was unreasonable.
We repeat the recommendation.

2.330 Inter-prison visits should be allowed more frequently for family members in the prison, and with partners in the adjoining men's prison. (8.87)
Partially achieved. The local operating procedure for inter-prison visits (January 2008) said prisoners could apply for an inter-prison visit with a family member in the prison or in the adjoining prison every six weeks. Prisoners in the men's prison whose partner was in the mother and baby unit could apply for one visit each month, but this was not known to staff or prisoners who thought these visits took place every three months. No mention of the visits was included in the prisoners' information booklet.

Further recommendation

2.331 Staff and prisoners should be made aware of the timings of all inter-prison visits.

2.332 A confidential helpline for visitors should be introduced and advertised. (8.88)
Not achieved. A notice in the visitors' centre advised visitors pressured to bring drugs into the prison to ring the national Crimestoppers agency. The number of the anti-bullying line was also advertised, as were the services of Adfam. Visitors were supposed to be able to post an application in a box to see or speak to an Adfam worker, but no application forms were provided. There was no information about what visitors should do if they had any concerns about a prisoner or wanted simply to ask a question. There was no one in the visitors' reception centre to whom a visitor could talk in confidence. (See also paragraph 2.310.)
We repeat the recommendation.

2.333 Women who are carers should be provided with free outgoing telephone calls to enable them to maintain contact with their children. (8.89)
Not achieved. There was no provision to allow such calls.
We repeat the recommendation.

2.334 Women should be able to receive incoming calls from children or to deal with arrangements for them. (8.90)
Not achieved. There were no incoming calls.
We repeat the recommendation.

2.335 A qualified family support worker should be provided. (8.91)
Not achieved. All new arrivals were seen by a member of the mother and baby team to check whether they were pregnant, had a child under the age of 18 months or had other childcare issues. The team was primarily employed to work with women on the mother and baby unit and there was still no qualified family support worker known to and helping all mothers, irrespective of the age of their children, to maintain and carry out their parental responsibilities and to advise and support those with child protection issues. Child care matters were inadequately identified and insufficiently managed.
We repeat the recommendation.

Attitudes, thinking and behaviour

2.336 The work needed to motivate, prepare and support those prisoners suitable for interventions should be identified and arrangements made to meet them. (8.92)
Achieved. The enhanced thinking skills programme offered some scope for tutors to provide motivational work for those attending the course, but there was no strategy for dealing with women who did not want to engage.

Further recommendation

2.337 The reducing re-offending plan should address how the prison should motivate prisoners who lack self-motivation to attend interventions.

2.338 Prisoners should be prepared for progressive moves and/or release. (8.95)
Partially achieved. Some preparation was possible through the pre-release course, but this did not meet the needs of all women (see paragraph 2.271). There was no preparation for

progressive moves, a particular gap since the prison had begun to take first stage life-sentenced women.

We repeat the recommendation.

Section 3: Summary of recommendations, housekeeping points and good practice

The following is a listing of recommendations, housekeeping points and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

Main recommendations — To the Director

3.1 Services for women with substance use problems, from clinical care on arrival to resettlement support on release, should be based on a needs assessment and appropriately resourced. (2.4)

3.2 An effective clearly defined personal officer scheme should be developed with officers given training, guidance and resources to carry out their role. (2.5)

3.3 A safer custody strategy specifically for women should be established covering all aspects of safety and involving female prisoners to help ensure a generally safe environment and improve support and care for those at risk of self-harm. (2.7)

3.4 The foreign nationals policy, which should include a targeted action plan, should be updated in consultation with foreign national women and publicised to staff and prisoners so that all who need to know are aware of the services and support available. (2.9)

3.5 A full review of all health services should be undertaken to ensure that women at Peterborough have appropriate and safe health services based on an assessment of their needs and which match the standard of care provided in the community. The primary care trust's clinical governance strategy should be followed to provide a framework to support improved services to prisoners. (2.10)

3.6 All prisoners, including unconvicted prisoners, should have a sentence or custody plan based on their individual risk and specific resettlement needs. Their reintegration needs should be identified during induction and they should be case managed so that progress in meeting these needs can be tracked throughout their time at Peterborough. (2.16)

Recommendation — to NOMS

Offender management and planning

3.7 Checks on addresses for home detention curfew should be carried out more quickly to allow release on the due date. (2.17)

Recommendations — to UKBA

Foreign national prisoners

3.8 All detainees should receive written reasons for detention and reviews of detention following a change of circumstances, and at least monthly, in a language they can understand. (2.125)

Courts, escorts and transfers

3.9 Private cash should accompany unsentenced prisoners to court and sentenced prisoners on transfer. (2.19)

3.10 Escort vans should be clean and comfortable. (2.20)

3.11 Reception staff should ask female prisoners whether they have been offered a comfort break and this should be recorded. (2.22)

3.12 Male and female prisoners should be transported separately. (2.23)

3.13 Prisoners should be moved from court cells to the prison within an agreed and acceptable timeframe. (2.24)

3.14 Female prisoners should arrive in reception before 7pm except in exceptional circumstances. (2.25)

3.15 Court and escort staff should be reminded to provide prisoners with information leaflets. (2.27)

3.16 More use should be made of the video link facility and this should be monitored by a manager. (2.28)

First days in custody

3.17 New arrivals should be given clear and simple verbal information about the reception process. (2.30)

3.18 The local operating procedure should refer to the specific needs of female prisoners on reception. (2.31)

3.19 Reception information given to prisoners should be correct. (2.34)

3.20 Mothers should be asked further questions about their children, including whether their current care arrangements are satisfactory, if there are any court orders or social work involvement and if they are in contact with their children. This should be recorded. (2.36)

3.21 Reception staff should know about the emergency telephone numbers and where to find them. (2.39)

3.22 All prisoners should be able to shower on arrival, irrespective of their time of arrival. (2.41)

3.23 Reception and first night records should be fully completed and action taken on all identified needs, particularly relating to children. (2.47)

3.24 A trained custody officer should be present at all times in the women's prison at night. (2.49)

3.25 Prisoners undergoing detoxification should not be included in the induction programme the day after their arrival. (2.50)

3.26 Women should feel safe on their first night and should be supported in appropriate comfortable accommodation. They should not be required to share with in-patients or prisoners withdrawing from drugs and unconvicted women should not have to share with convicted prisoners. (2.55)

3.27 Female prisoners should be kept fully occupied through a comprehensive, structured and multidisciplinary induction programme. (2.56)

3.28 During the induction programme, women should have the opportunity for recorded individual interviews at which their initial feelings about imprisonment are addressed, including any thoughts about suicide or self-harm. (2.57)

Residential units

3.29 Cells designed for one prisoner should not be shared. (2.58)

3.30 Clothing for outside wear in cold weather should be issued to women on request. (2.60)

3.31 All single cells accommodating two women should have fans and a lockable cupboard for each prisoner. (2.62)

Staff-prisoner relationships

3.32 All action points from consultative meetings should have target dates attached and should be followed up with a report to the next meeting as matters arising from the previous meeting. (2.65)

Personal officers

3.33 Personal officers should introduce themselves to prisoners, get to know their personal circumstances and record contact in wing files to build up an accurate chronological account of a woman's time at Peterborough and any significant events affecting her. (2.66)

3.34 The guidance to personal officers should be further developed to encourage them to make active efforts to engage with prisoners, get to know their circumstances, report on their resettlement needs and help them to maintain contact with their families. (2.69)

Bullying and violence reduction

3.35 A senior manager should monitor the quality of investigations. (2.74)

3.36 The anti-bullying policy and strategy should recognise the particular needs and circumstances of women. (2.75)

3.37 All staff working directly with prisoners should receive training in the violence reduction strategy. (2.77)

Self-harm and suicide

3.38 Women who self-harm should routinely be asked what they think will help. This information should be collated, presented in a qualitative report to the self-harm and suicide prevention meeting and used to improve the levels of care. (2.80)

3.39 The help provided to women identified as needing support in the early days should be clearly recorded. (2.82)

3.40 Serious and near-fatal incidents should be formally investigated in order to learn from them. (2.84)

3.41 There should be improved multidisciplinary working and this should include initial assessors from a range of disciplines, and a wider range of attendance of staff from other disciplines at suicide prevention meetings and ACCT reviews. (2.85)

3.42 There should be improved management checks of the quality of ACCT procedures and these should include talking to women at risk about their experience of their care. (2.87)

3.43 ACCT reviews for individual prisoners should be chaired by consistent case managers and ACCT documents should be closed only when a multidisciplinary team is satisfied that this is justified by the level of risk. (2.89)

3.44 Staff from the Bridge and the Link should be better integrated in ACCT procedures to improve the use of the resources for women at risk of self-harm. (2.91)

3.45 Listener recruitment and training should anticipate the release and transfer of trained Listeners to ensure a viable scheme. (2.92)

3.46 All staff responsible for chairing ACCT reviews should have completed case manager training. (2.97)

3.47 A Listeners suite should be available. (2.98)

Diversity

3.48 The women's prison should have an overarching diversity policy encompassing all main minority groups. (2.100)

3.49 The race equality and diversity scheme should outline how the needs of minority groups will be met and monitored to ensure that prisoners from minority groups are not victimised or excluded from any activity. (2.101)

3.50 An action plan arising from a race equality and diversity scheme should include a local needs analysis and have target dates for implementation of action points. (2.103)

3.51 There should be a race equality and diversity manager specifically for female prisoners. (2.104)

3.52 The wing race equality and diversity officers should receive enough facility time to carry out their responsibilities. (2.105)

3.53 The prison should have a designated trained disability liaison officer to undertake integrated care planning in consultation with prisoners, taking account of various provisions across the prison. (2.108)

Race equality

3.54 A comprehensive race equality policy and strategy should be developed and included in the race equality and diversity scheme. This should be based on a needs analysis of the female prisoners. (2.110)

3.55 Planned interventions should be available to challenge those who demonstrate racist attitudes and behaviour. (2.113)

3.56 An external organisation should be involved in quality checking completed racist incident complaint forms. (2.114)

3.57 The race relations group should be proactive in promoting and celebrating racial and cultural diversity within the prison. (2.115)

Foreign national prisoners

3.58 A race equality and diversity manager specifically for women should be given enough time and support to develop work with foreign national prisoners. (2.116)

3.59 Guidance on the appropriate use of face-to-face and telephone interpreters should be re-issued to ensure that services are used when necessary. (2.117)

3.60 Foreign national prisoners' meetings should be held at least monthly. (2.118)

3.61 Foreign national peer supporters should be appointed. (2.120)

3.62 Foreign national prisoners should be made aware of and offered independent immigration advice. (2.121)

3.63 The prison library should have legal reference material explaining immigration law and procedures. (2.122)

3.64 The foreign national prisoner awareness training should be further developed and delivered on a regular basis. (2.126)

3.65 The facility to make a five-minute monthly telephone call in exchange for visiting orders should be more effectively advertised and actively offered to prisoners. (2.127)

Applications and complaints

3.66 Applications should be sorted out promptly. In the absence of wing administrators, custody officers should be trained and resourced to deal with simple applications directly. (2.135)

3.67 Officers should not be responsible for emptying complaints boxes. (2.137)

3.68 Information about the complaints system in a range of languages should be displayed beside complaints boxes on all wings. (2.139)

3.69 The monthly analysis of complaints from female prisoners and any trends identified should regularly be discussed at team meetings and appropriate action taken as a result. (2.141)

Legal rights

3.70 Information about legal services should be available in languages other than English. (2.142)

3.71 The 'access to justice' computers should be publicised through the legal services officers. (2.143)

Health services

3.72 Sufficient midwifery input should be provided to meet the complex needs of pregnant women. (2.156)

3.73 Once completed, the information from the skills mix audit should be used to inform future recruitment. (2.158)

3.74 All staff should have access to clinical supervision. (2.159)

3.75 All staff should have at least annual resuscitation and defibrillation training. (2.160)

3.76 An emergency childbirth kit should be available. (2.161)

3.77 Health services staff who administer medications should adhere to Nursing and Midwifery Council guidelines for the safe administration of medications at all times. (2.162)

3.78 All clinical information, including records and medicine charts, should be present whenever a prisoner is being assessed by a health professional. (2.165)

3.79 The beds in health services should not form part of the prison's certified normal accommodation and admission should be based only on an assessment of clinical need. (2.166)

3.80 Multidisciplinary care plans should be regularly reviewed and quality checked by a senior member of the nursing staff. (2.168)

3.81 The induction session and health services leaflet for new prisoners should be improved and updated to provide relevant, accurate and informative information. (2.169)

3.82 Prisoners not attending health services appointments should be routinely followed up. (2.170)

3.83 Triage algorithms should be developed to ensure consistency of advice and treatment for all prisoners. (2.171)

3.84 Women who would automatically be called for health screening in the community should routinely be offered the same opportunity while in prison. (2.173)

3.85 Applications to health services should be dealt with promptly and effectively and women should be able to make appointments to see a doctor within 24 hours. (2.174)

3.86 Women should be provided with condoms on release. (2.176)

3.87 All prescriptions should be entered correctly and in accordance with legal requirements. A pharmacist or responsible health worker should oversee the management of medicine charts to ensure that they are completed correctly and reviewed regularly. Medication reviews should be conducted regularly. (2.178)

3.88 Secondary dispensing into Henley bags should stop. (2.181)

3.89 Pain relief such as paracetamol and ibuprofen should be allowed in possession following risk assessment. (2.183)

3.90 Medicines prescribed as 12-hourly should be given as such and night sedation should be given immediately before lock up for the night. (2.184)

3.91 Auditable records for the cleaning and calibration of the pump should be introduced. (2.186)

3.92 A dedicated health room should be provided on the wings to facilitate the safe custody of medicines and provide a confidential area for prisoners to discuss any health issues with visiting health staff. (2.189)

3.93 The use of patient-named medication should be encouraged. (2.192)

3.94 An in possession risk assessment should be undertaken on all prisoners during the reception health assessment and on all medicines as they are prescribed. The assessment should be co-located with the medication chart. (2.194)

3.95 The default position for prisoners holding in possession medication should be for 28 days unless otherwise indicated following risk assessment. (2.195)

3.96 Trained pharmaceutical staff should attend the prison regularly to allow prisoners the opportunity to obtain advice about the benefits and risks of medications. (2.196)

3.97 Health services should provide day care for women less able to cope with life on the wings because of mental health problems. (2.197)

Learning and skills and work activities

3.98 Accurate records of borrowing rates of books in other languages and books suitable for prisoners with low reading skills should be kept and any issues of usage addressed. (2.204)

Faith and religious activity

3.99 Prisoners should not have to apply to attend services in advance. (2.211)

3.100 Services should not clash with other activities. (2.212)

3.101 An officer should patrol the area when chaplaincy activities are taking place. (2.214)

3.102 The hours allocated to chaplains and faith leaders should better reflect the religious denominations of prisoners. (2.217)

3.103 Escorts should be provided to allow prisoners to arrive at chaplaincy services and activities in good time to start at the advertised times. (2.218)

Time out of cell

3.104 Time out of cell should be increased for those unable to take part in activities. (2.219)

3.105 All women should have the opportunity to spend one hour each day in the open air. (2.221)

3.106 Association facilities should be improved. (2.222)

Security and rules

3.107 All female prisoners should be issued with a copy of the rules applying to them at Peterborough and these should also be displayed on wings. (2.226)

Discipline

3.108 Women should not be placed on report repeatedly if the disciplinary system has proved ineffective in managing their behaviour. (2.239)

3.109 Care plans for women in the segregation unit should contain information to assist staff in caring for and managing challenging prisoners. (2.240)

Incentives and earned privileges

3.110 There should be a separate incentives and earned privileges scheme for the women's prison with appropriate incentives for women. (2.241)

3.111 Staff should be encouraged and guided to deal with minor issues without resorting to formal warnings. (2.242)

3.112 Incentives and earned privileges status should be reviewed automatically every 12 weeks. (2.244)

3.113 All women on the basic level should be given specific targets aimed at improving behaviour, with weekly reviews of progress. (2.247)

3.114 Residential managers should ensure that all staff working with young adults are familiar with and adhere to the incentives and earned privileges scheme for young women. (2.250)

3.115 The incentives and earned privileges policy for young women should clarify the purpose and use of a behaviour compact. (2.251)

3.116 Young women at the bronze level should not routinely lose association. (2.252)

Catering

3.117 Kettles should be provided to all prisoners to make a hot drink after evening lock up. (2.253)

3.118 Lunch should not be served before noon and the evening meal should be served after 5pm. (2.254)

3.119 Prisoners working with food should have the opportunity to gain appropriate national vocational qualifications. (2.256)

3.120 Prisoners should receive their selected meal served at an appropriate temperature. (2.259)

3.121 Staff should not eat food from the prisoners' hotplate. (2.260)

Prison shop

3.122 Black and minority ethnic women should be specifically consulted about the range of goods in the shop so that their requirements can be better met. (2.261)

3.123 The range of tinned goods available from the shop should be extended. (2.263)

Strategic management of resettlement

3.124 The needs analysis contained in the draft reducing re-offending action plan should include a detailed section on the specific needs of young adults, those serving short sentences and women on remand, and how they will be met. (2.267)

3.125 Objectives and actions identified in the reducing re-offending action plan should be tasked to named individuals and revisited regularly through documented meetings with resettlement pathway leads. A named manager should provide a strategic lead to ensure that the plan is delivered. (2.268)

Offender management and planning

3.126 A shorter pre-release course that meets the needs of the population should be provided. (2.272)

3.127 Support should be offered to prisoners identified as potentially facing indeterminate sentences. (2.274)

3.128 The prison should no longer take first stage life-sentenced women until it has sufficient resources, including psychology support, commensurate with other first stage lifer prisons to identify and assess risk factors and how to deal with them. (2.284)

3.129 The lifer manager or a designated and suitably trained member of staff should meet regularly with groups of indeterminate-sentenced prisoners (lifers and IPPs) to provide advice and guidance. This should be minuted. (2.285)

3.130 Long-term prisoners on A2 should be given the opportunity to cook for themselves and maintain independent living skills. (2.286)

Resettlement pathways

3.131 There should be a trained adviser to cover annual leave or sick leave and provide housing advice. (2.289)

3.132 Prisoner peer advisers should be trained to provide housing advice and, subject to security clearance, given access to telephones, computers and internet services. (2.290)

3.133 A full range of accredited programmes should be introduced to meet the needs of all women and to recognise their achievement of work-related and language skills. (2.292)

3.134 The pathway lead for finance and debt should draw together all information collected on women who have stated a need for financial/debt advice and formulate an action plan to meet this need. (2.296)

3.135 All prisoners should be invited to attend a pre-release clinic where dedicated time is allotted to ensure that their health needs are assessed and addressed before discharge. (2.298)

3.136 An in-depth needs analysis should be undertaken of the specific clinical and psychosocial needs of women with drug- and alcohol-related problems. This should then inform the drug and alcohol strategy to enable specific developmental targets and objectives to be established. (2.301)

3.137 The drug strategy document should reflect the specific needs of the women's population. (2.302)

3.138 Prisoners should receive their post within 24 hours of its arrival at the prison. (2.308)

3.139 Telephones should be placed in booths for privacy, with additional telephones provided on overcrowded wings. (2.309)

3.140 The reception centre should be further developed to provide supportive information and advice to visitors. Some refreshments and toilets should be provided. (2.311)

3.141 Visitors should not be required to produce photographic identification. (2.312)

3.142 Closed visits should be authorised only when justified by security intelligence. (2.313)

3.143 All visits should start at the booked time. (2.315)

3.144 Basic visits should last a minimum of one hour. (2.316)

3.145 The visits hall should be made a more welcoming environment with seating that allows better contact between prisoners and their visitors. (2.318)

3.146 The number of visitors should not be dictated by the number of fixed chairs available and free-standing chairs should be provided when necessary. (2.319)

3.147 All women should have the opportunity to use the family room for visits with their children. (2.320)

3.148 The play area in the visits room should be supervised by an appropriately qualified worker and a range of suitable toys should be provided. Mothers should be able to play together with their children in the play area. (2.321)

3.149 Visitors should be able to buy a range of suitable refreshments. (2.324)

3.150 Visitors should be able to provide feedback on their experience. (2.325)

3.151 Information about resettlement services should be advertised in the visitors' centre. (2.327)

3.152 Relationship counselling should be available to prisoners and their families and appropriate parenting/relationship programmes provided for prisoners. (2.328)

3.153 Prisoners should be able to send letters to family members in other parts of the prison without having to use the external post. (2.329)

3.154 Staff and prisoners should be made aware of the timings of all inter-prison visits. (2.331)

3.155 A confidential helpline for visitors should be introduced and advertised. (2.332)

3.156 Women who are carers should be provided with free outgoing telephone calls to enable them to maintain contact with their children. (2.333)

3.157 Women should be able to receive incoming calls from children or to deal with arrangements for them. (2.334)

3.158 A qualified family support worker should be provided. (2.335)

3.159 The reducing re-offending plan should address how the prison should motivate prisoners who lack self-motivation to attend interventions. (2.337)

3.160 Prisoners should be prepared for progressive moves and/or release. (2.338)

Housekeeping point

First days in custody

3.161 Reception officers should ensure that prisoners are given the correct information and understand the terminology used when completing the cell-sharing risk assessment. (2.37)

Appendix I: Inspection team

Michael Loughlin	Team leader
Joss Crosbie	Inspector
Hayley Folland	Inspector
Paul Fenning	Inspector
Andrea Walker	Inspector
Eileen Bye	Inspector
Lucy Young	Inspector
Mandy Whittingham	Healthcare inspector
Bridget McEvilly	Healthcare inspector
Paul Roberts	Substance use inspector
Alan Hatcher	Ofsted inspector

Appendix II: Prison population profile

Population breakdown by:

(i) Status	Number of adult women	Number of young women	%
Sentenced	213	30	67.5
Remand, convicted but unsentenced	83	10	25.8
Civil prisoners	0	0	0
Detainees (single power status)	3	0	0.8
Detainees (dual power status)	19	2	5.8
Total	318	42	100

(ii) Sentence	Number of sentenced women	Number of sentenced young women	%
Less than 6 months	40	4	16.7
6months to less than 12 months	31	6	14.0
12 months to less than 2 years	44	7	19.3
2 years to less than 4 years	44	7	19.3
4 years to less than 6 years	26	2	10.6
6 years to less than 8 years	6	4	3.8
8 years to less than 10 years	3	0	1.1
10 years and over (less than life)	3	0	1.1
Life	35	2	14.0
Total	232	32	100

(iii) Length of stay	Number of adult women	Number of young women	%
Less than 1 month	99	12	30.8
1 month to 3 months	93	12	29.2
3 months to 6 months	58	7	18.0
6 months to 1 year	35	5	11.1
1 year to 2 years	30	6	10.0
2 years to 4 years	3	0	0.3
4 years or more	0	0	0
Total	318	42	100

(iv) Main offence	Number of adult and young women	%
Violence against the person	82	22.8
Sexual offences	4	1.1
Burglary	25	6.9
Robbery	23	6.4
Theft and handling	58	16.1
Fraud and forgery	19	5.3
Drugs offences	62	17.2
Other offences	82	22.8
Civil offences	0	0
Offence not recorded/holding warrant	5	1.4
Total	360	100

(v) Age	Number of adult women	Number of young women	%
18 years to 20 years	0	42	11.7
21 years to 29 years	142	0	39.4
30 years to 39 years	91	0	25.3
40 years to 49 years	67	0	18.6
50 years to 59 years	16	0	4.4
60 years to 69 years	2	0	0.5
70 plus years	0	0	0
Please state maximum age	65	N/A	N/A
Total	318	42	100

(vi) Home address	Number of adult and young women	%
Within 50 miles of the prison	93	25.8
Between 50 and 100 miles of the prison	151	41.9
Over 100 miles from the prison	33	9.2
Overseas	0	0
NFA	83	23.0
Total	360	100

(vii) Nationality	Number of adult and young women	%
British	298	83
Foreign national	62	17
Total	360	100

(viii) Ethnic group	Number of adult and young women	%
White		
British	267	74.2
Irish	4	1.1
Other White	7	1.9
Mixed		
White and Black Caribbean	4	1.1
White and Black African	1	0.3
White and Asian	1	0.3
Other mixed	7	1.9
Asian or Asian British		
Indian	3	0.8
Pakistani	4	1.1
Bangladeshi	0	0
Other Asian	2	0.5
Black or Black British		
Caribbean	16	4.4
African	11	3.0
Other Black	9	2.5
Chinese or other ethnic group		
Chinese	7	1.9
Other ethnic group	12	3.3
Not Known	5	1.4
Total	360	100

(ix) Religion	Number of adult and young women	%
Church of England	135	37.5
Roman Catholic	51	14.2
Other Christian denominations	20	5.5
Muslim	18	5.0
Sikh	2	0.5
Hindu	2	0.5
Buddhist	6	1.7
Jewish	0	0
Other	2	0.5
No religion	124	34.4
Total	366	100