Report on an unannounced short follow-up inspection of

HMP Preston

23–25 January 2008

by HM Chief Inspector of Prisons

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

HMP Preston is a severely overcrowded local prison occupying a largely Victorian inner-city site. Staff have to manage an ever increasing, transient population of often needy and sometimes challenging prisoners within a dilapidated and antiquated environment. Yet this unannounced short follow up inspection found that the prison, though under pressure and unable to provide sufficient purposeful activity, was still performing reasonably well in many areas.

Maintaining the safety of an ever-changing population that includes many prisoners with drug and mental health problems remained a huge challenge at Preston. This was compounded by an inadequate reception building and detoxification arrangements out of line with those in the community. Nevertheless, first days in custody were generally well managed and work to prevent bullying and reduce violence had improved since our last visit. However, there had been eight deaths in custody since 2004. Action plans were in place to respond to the lessons learned and suicide prevention procedures were reasonable, but there can be no more stark and tragic a reminder of the vulnerability of many prisoners.

The prison was generally clean, access to laundry facilities had improved and there was now some rudimentary screening of toilets. However, many prisoners were held doubled in single cells which were unfit for purpose. Staff-prisoner relationships were generally good, but were not supported by an effective personal officer scheme and the incentives and earned privileges (IEP) scheme was also ineffective. Food was reasonable and faith services were good. Health services required further improvement.

We were surprised to find a significant number of black and minority ethnic and foreign national prisoners housed on one wing. The appropriateness of this arrangement needed to be reviewed.

There had been some improvement in the range and quality of learning and skills opportunities in the prison. Over half the population now had access to some form of education and the range of accredited programmes and physical education courses had improved. The organisation of allocation to work had also improved. Nevertheless, there was insufficient purposeful activity and, on one day during the inspection, we found nearly half of all prisoners locked in their cells.

Preston had continued to develop its resettlement facilities. There was an appropriate, if unimaginative, approach to the strategic management of resettlement. Assessment and custody planning arrangements were sound and the offender management model was being implemented. Reintegration services were basic and needed to be expanded. Substance misuse services required further development and the visits accommodation was poor.

Like most overcrowded Victorian inner-city local prisons, Preston struggled to deliver adequate services for its very needy, growing and transient population. Physical constraints made progress difficult, particularly the provision of sufficient purposeful activity. Overall, however, staff are to be commended on delivering as much as they do, and to a generally reasonable standard.

Anne Owers — June 2008
HM Chief Inspector of Prisons

Fact page

Task of the establishment
Category B local male prison.

Area organisation
North west

Number held
717

Certified normal accommodation
449

Operational capacity
750

Last inspection
Announced inspection: 26–30 July 2004

Brief history
HMP Preston is substantially a Victorian prison. The prison closed in 1931, re-opened for military use in 1939 and became a prison again in 1948. It became a local prison in 1990. Beginning in 1999, the most recent phase of accommodation upgrades has provided the establishment with four main residential wings.

Description of residential units

A wing:	Short-term convicted prisoners
B wing:	Mixed convicted and remand prisoners
C wing:	Convicted prisoners and drug detoxification unit
D wing:	First night centre and induction
F wing:	Convicted prisoners in employment
G wing:	Out of use
A2:	Reintegration unit
C2:	Vulnerable prisoner unit

Section 1: Healthy prison assessment

Introduction

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

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

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

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

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

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

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

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required

amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

Safety

HP4 At the previous inspection in 2004, we considered that the prison was not performing sufficiently well against this healthy prison test and made 38 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented 32 of our recommendations in full or in part, and six had not been implemented. Of the four main recommendations, three had been achieved and one not achieved. We have made 18 further recommendations.

HP5 The reception building was poor and not suitable to deal with the increased number of prisoner movements since the last inspection, let alone the projected further rise. Although procedures were reasonable, the large volume of movements, with prisoners sometimes arriving at the same time, compounded by the poor facilities, meant there were some delays for prisoners, although fewer than at the last inspection.

HP6 Most new arrivals spent their first days on the designated induction unit. They were generally given an appropriate level of care and information during their induction, with the support of prisoner peer supporters. New arrivals were generally positive about their experience, although arrangements were less satisfactory for prisoners who required protection.

HP7 Arrangements for managing bullying and violence reduction – known as 'tackling anti-social behaviour' (TAB) – worked reasonably well. There was now a full-time coordinator, better consultation with prisoners and investigation of all potential indicators of anti-social behaviour.

HP8 Regrettably, there had been eight deaths in custody since the previous inspection, and coroners' inquests had not yet taken place for most of these. The Prisons and Probation Ombudsman had, however, investigated each death and the establishment had an action plan. An appropriate level of resources had been assigned to this critical area of work, and procedures and practices appeared sound. Assessment, care in custody and teamwork (ACCT) self-harm monitoring forms were of reasonable quality, and were subject to regular quality assurance by managers. There had been no deaths in the previous nine months.

HP9 The use of force by staff against prisoners had increased significantly, even taking the rise in population into account, and there was no clear explanation for this. Trend analysis was inadequate. Use of special accommodation was also high and recording of decisions was not always satisfactory, although prisoners rarely spent more than one hour in this accommodation. A reintegration unit on A2 landing had been opened since the last inspection to manage prisoners who were not settling in a normal location. This unit was still relatively new and the formal strategy was not yet fully implemented, but the early signs were encouraging. It had the potential to reduce the need for longer-term residents in the segregation unit, although this had not yet been evaluated formally.

HP10 The prescribing protocol on the drug detoxification unit still did not follow national prescribing guidelines and this needed to be addressed urgently. Methadone

maintenance arrangements were insufficient to meet demand, and prisoners were not always able to get the same dosage levels that they received in the community.

HP11 We still had some significant concerns in this area but, given that most of our previous recommendations had been achieved and that there had been recent significant advances in safer custody, we concluded that sufficient progress had been made to raise the previous assessment. On the basis of this short follow-up inspection, we considered that the prison was performing reasonably well against this healthy prison test.

Respect

HP12 At the previous inspection, we considered that the prison was performing reasonably well against this healthy prison test and made 15 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented 12 of our recommendations in full or in part, and three had not been implemented. The one main recommendation had been partially achieved. We have made seven further recommendations.

HP13 The establishment was generally clean and standards of maintenance were good. All wings now had access to laundry facilities. In-cell toilets now had rudimentary screening, although single cells were still unsuitable for doubling.

HP14 The incentives and earned privileges (IEP) scheme had been revised early in 2007 and a new facilities list had been issued. The IEP scheme, however, did not operate effectively and there was little evidence from wing files that staff used it to address poor behaviour effectively.

HP15 Staff–prisoner relationships were generally good, with lots of use of first names. However, prisoners on the vulnerable prisoner unit told us that they had less positive relationships with the staff redeployed there in place of the regular staff.

HP16 The personal officer scheme was ineffectual. Although implemented more than two years previously, many staff had little detailed knowledge of its aims or objectives. A planned review after 12 months had not materialised. In practice, the scheme led to little more than observational comments about prisoners in their wing files, with apparent superficial engagement of personal officers with prisoners. There was no managerial oversight and, overall, the scheme made little or no meaningful impact on the lives of most prisoners.

HP17 The midday meal was still served too early, but we received few overall complaints about the catering. Prisoners got a proper breakfast on weekdays, which was unusual. Prisoners who worked in the kitchen could attain qualifications.

HP18 The number of black and minority ethnic prisoners had increased to 14% of the population, many of whom were located on one wing (B wing). We were told that this related to the locating of large numbers of foreign national prisoners on the wing, apparently to ease language difficulties. However, we were told about some operational problems that had resulted, and we noted that the arrangement had not been impact assessed.

HP19 The number of foreign national prisoners had also increased and now accounted for 5% of the population. Most were also located on B wing. The foreign national policy was weak and out of date. There was a full-time foreign nationals' coordinator, who was still new to the role. The foreign nationals policy and the induction booklet and not yet been translated into other languages.

HP20 Chaplaincy services were good. Facilities had improved since the last inspection, and the chaplaincy was well involved with other key regime activities, such as ACCT reviews. The chaplaincy team also ran some non-faith based activities, such as race awareness and a victim awareness programme.

HP21 There continued to be shortfalls in health services staffing. There were innovative arrangements in the mental health crisis intervention team and the deployment of the dental nurse. However, there were long delays to see the general practitioner, and prescriptions for patients on long-standing medications were reduced without consultation. There was no nurse triage.

HP22 The establishment had made good progress in implementing our recommendations, but our new concerns about diversity, plus some continuing concerns with health services, meant that progress was insufficient to raise the previous assessment. On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Purposeful activity

HP23 At our previous inspection, we considered that the prison was not performing sufficiently well against this healthy prison test and made seven recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented six of our recommendations in full or in part, and one had not been implemented. The one main recommendation had been partially achieved. We have made four further recommendations.

HP24 Prisoners now had access to a wider range of learning and skills programmes. Information and communications technology provision had expanded, and the range of accredited programmes and physical education (PE) courses had improved. Classes for English for speakers of other languages had been introduced. Just over half the population had some contact with education each week. However, there were waiting lists of between one and three weeks for all the education courses.

HP25 The education provider had changed to Morecambe and Lancaster College. There was evidence of commitment to quality assurance, and there had been an increase in the teaching hours. Classroom efficiency was around 85%. Vulnerable prisoners now had access to the main education department one day a week, and unsuitable teaching accommodation on F wing was no longer in use.

HP26 Work allocation arrangements were better organised than at the previous inspection, and the information, advice and guidance worker offered advice about work allocation to improve prisoners' employability. Prisoners could now undertake qualifications for working in the kitchen, and a few were taking catering national vocational qualifications. On one day during the inspection, 368 prisoners were occupied, but 325 were locked up without work.

HP27 Since the previous inspection, resistance machines and cardiovascular equipment had been improved and additional PE equipment introduced. However, some equipment in the cardiovascular and free weights areas was in a poor state of repair.

HP28 There were daily outdoor exercise periods, but prisoners in work could not access these in the winter. Association arrangements were good and rarely cancelled.

HP29 On the basis of this short follow-up inspection, we concluded that there had been some improvements, although not enough to raise the previous assessment. The establishment was still not performing sufficiently well against this healthy prison test.

Resettlement

HP30 At our previous inspection, we considered that the prison was performing well against this healthy prison test and made 23 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented 20 of our recommendations in full or in part, and three had not been implemented. We have made two further recommendations.

HP31 There was a reducing reoffending delivery plan, describing provision across the resettlement pathways, although this was principally based on existing delivery and key performance targets. There was no use of release on temporary licence as a means of reintegrating prisoners into the community before release.

HP32 A reasonably effective assessment and custody planning system ensured that the reintegration needs all prisoners were evaluated shortly after their arrival, with referrals to specialist support. An offender management unit had been created to oversee delivery of the NOMS case-management model. Phases two and three of the offender management project appeared to have been implemented effectively. However, most prisoners remained out of scope of these developments. A basic range of reintegration services was available but more were needed.

HP33 The life-sentenced prisoner population had fallen to only six at the time of this inspection. There were sound arrangements to manage life-sentenced prisoners and those serving indeterminate sentences for public protection.

HP34 A team of specialist substance use nurses had been established, although it was not up to full strength and cover for this specialist role had to be found from elsewhere in the primary care team. More work was needed to bring substance misuse clinical services up to the required standard and level of delivery.

HP35 The visits accommodation remained a poor environment, and visitors had to make a long walk around the prison to reach the area.

HP36 On the basis of this short follow-up inspection, we considered that the prison was now performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from the previous report) To the Governor

2.1 There should be an effective anti-bullying scheme. Its contents should be clearly communicated to all staff and prisoners, and its use closely monitored by management. (HP41)

Achieved. The tackling anti-social behaviour (TAB) scheme was well established, and staff and prisoners knew how it operated. All new staff underwent TAB training as part of their induction, and the subject was covered as part of prisoner induction, although the old anti-bullying paperwork was still in use. The scheme was monitored routinely at meetings of the violence reduction committee and the senior management team.

2.2 Arrangements for the detoxification of prisoners should be safe, comprehensive and consistent. (HP42)

Not achieved. At the time of the inspection, prisoners were not receiving a clinical detoxification in line with national guidelines, although the establishment was working towards providing this level of service. While some prisoners could receive methadone maintenance on confirmation that they had received a maintenance prescription in the community, they were not always given their previous dose as clinical staff only gave a maximum of 40 mg/ml per day. Prisoners were not able to receive maintenance buprenorphine, and the only detoxification regimen for opiate users consisted of dihydrocodeine administration. We also found cases of prisoners who had abused alcohol and opiates in the community, and were currently detoxified from both at the same time.
We repeat the recommendation.

2.3 Prisoners at risk of self-harm or suicide should be placed in the special cells only in exceptional circumstances where risk assessments dictate this, and should not be deprived of clothing. (HP43)

Achieved. Staff told us that the special cells were rarely used for prisoners at risk of self-harm, and the documentation (use of special cell forms and self-harm monitoring records) confirmed this.

Additional information

2.4 There were no safer cells with reduced potential ligature points. At-risk prisoners were placed in one of the three care suites, in a camera cell in the healthcare department or in the gated cell in the drug dependency unit, in preference to the segregation unit.

Further recommendation

2.5 A safer cell should be installed.

2.6 All prisoners held in special accommodation should be formally reviewed after the first hour with a view to removing them as soon as it is safe to do so. (HP44)

Achieved. There was no evidence that special cells were used excessively, and reviews were conducted promptly to ensure that prisoners were removed at an early opportunity.

2.7 The quality of healthcare offered to prisoners should be improved by the recruitment of sufficient staff to provide an appropriate level of service. (HP45)

Partially achieved. Some aspects of health services had improved; for example, the new healthcare department facilities, the introduction of a primary care mental health crisis team, and the provision of inpatient facilities for prisoners from other prisons. Some staff had been recruited, and further nursing posts were due to be advertised. However, in some cases it had taken over six months from advertisement for a new recruit to take up their post, mainly due to security clearance.
We repeat the recommendation.

2.8 All prisoners should engage in meaningful and accredited work or education on a daily basis. (HP46)

Partially achieved. Lancaster and Morecambe College had taken over the education contract in August 2005. The original contract had covered delivery of 12,000 teaching hours; this had increased to 16,000 hours of education and training over a 50-week year. The new provider had a good strategy to cover staff absenteeism to ensure that all the contracted hours were delivered. Prisoners now had access to a wider range of learning programmes, and approximately 55% went to education at some point during the week. However, there were waiting lists of between one and three weeks for all the courses. The number of places in work remained small, and accredited qualifications were only available in painting and decorating, and catering. In education, there were approximately 200 sessional places each day, and there were 52 places available in workshops. There were too few work and education places to meet prisoners' education and training needs.

Further recommendation

2.9 The establishment should continue to increase the range and number of places available in education and work.

Recommendations to the Director General

2.10 A national policy on referrals to independent adjudicators should be devised. (6.30)

Achieved. Instructions on the referral policy had been issued to prisons when the use of independent adjudicators had been introduced. In our 2004 inspection we found that the establishment had referred too many charges to the independent adjudicator. We reviewed the adjudication policy during this short follow-up inspection, and examined records of adjudications conducted during three months of 2007. The only adjudications referred to the independent adjudicator during this period had been in line with national and local policy.

Other recommendations to the Governor

Arrival in custody

First days in custody

2.11 Individual interviews of prisoners by reception staff should be conducted in private. (1.26)

Not achieved. Partitions had been erected at the main counter in reception where prisoners had initial interviews. Staff told us that they normally interviewed only one prisoner at a time, and we observed this to be the case when we visited reception. However, the arrangements remained inadequate, as interviews were still conducted at the main desk and the new partitions did not offer adequate privacy. Overall, the environment was not conducive to prisoners sharing personal and confidential information.
We repeat the recommendation.

2.12 Prisoners should move from reception to residential wings as soon as initial essential interviews have been conducted. (1.27)

Partially achieved. Officers had been deployed to take prisoners from reception to the first night centre on D wing or to other locations, and this had reduced the average length of time that prisoners were held in reception. Although escort vans usually arrived at the prison throughout the afternoon, there were still occasions when large numbers of prisoners arrived together, and, given the poor facilities in reception, this inevitably resulted in longer delays. However, we found no evidence of the excessive delays observed at the previous inspection.

2.13 More time should be allocated to the information-giving module of the induction programme (currently known as 'citizenship') to ensure that policies and procedures can be covered in sufficient detail and prisoners are helped to understand the information through repetition and reinforcement. (1.28)

Partially achieved. The time allocated to the citizenship module remained one hour, although staff told us that they extended this if necessary – for example, to respond to the needs of a larger prisoner group or to give more attention to those in custody for the first time. However, other mechanisms had been introduced to ensure that prisoners received information and were able to raise queries and have them answered. The induction booklet had been expanded significantly, and prisoner Insiders were available to advise and support prisoners during their first few days. New arrivals were kept on the first night centre for at least 48 hours after their reception, so that they had access to experienced induction staff. Prisoners on induction were invited to complete a feedback questionnaire, and these generally indicated satisfaction with the speed and quality of the programme.

2.14 Induction sessions should be delivered in an area that is quiet and free from interruptions and distractions. (1.29)

Achieved. A sizeable area at the end of the first night centre had been partitioned off to provide a suitable classroom for induction sessions.

2.15 The general preparation for work programme should be reviewed to ensure it produces the desired outcomes for all prisoners. (1.30)

Achieved. The preparation for work programme was no longer an obligatory part of the induction programme. Only prisoners who were required, or wanted, to work while at the establishment had to complete it, and this was separate from the main induction programme.

2.16 All prisoners should have access to the same induction programme irrespective of their location. (1.31)

Partially achieved. After new arrivals had spent some time on the first night centre for first night interviews, those on detoxification programmes were moved to the drug detoxification unit (DDU), and those requiring protection from other prisoners went on to a dedicated unit on C2 landing. Few new arrivals were moved from reception to the healthcare department, the segregation unit or straight to the DDU or C2 landing. We met with a group of 10 vulnerable prisoners, and over half told us that they had initially been on other locations before they moved to C2. The induction received by prisoners on the DDU was comparable with that on the first night centre, but it was not clear that this was the case for C2 prisoners. Prisoners on C2 who were undergoing detoxification did not have the same level of support as those on the DDU.

Further recommendation

2.17 The induction and detoxification arrangements for prisoners on the vulnerable prisoner unit should be the same as for other prisoners.

Additional information

2.18 The maximum number of prisoners that could be held at the establishment had risen from 620 at the last inspection to 750, and there were plans to increase that number to around 800. The reception area had been built to deal with a population of 480 and was a very poorly designed and unsuitable environment. During 2007, there had been over 17,000 movements of prisoners through reception, and it appeared unlikely that the present building would be able to meet the demands of a further increase in population.

2.19 The facilities for vulnerable prisoners were particularly limited, and these prisoners described their reception, escort and court experience as 'shocking'. At various stages, they were in full view of other prisoners (and at one local court were required to share a holding cell with them). They felt that this reduced their chances of moving back on to normal location, as they could be identified by other prisoners, and some said that they had been subjected to verbal abuse while on the escort van or at court.

Further recommendation

2.20 The reception area should be refurbished or replaced to ensure that it provides an environment that is fit for purpose and enables all prisoners to be treated decently.

Environment and relationships

Residential units

2.21 All toilets should be effectively screened. (2.14)

Achieved. Toilets were appropriately screened with basic curtains, although it was still inappropriate for two prisoners to share cells designed for one person, as they had to eat their meals next to a toilet.

2.22 A dedicated staff team should be appointed specifically for F wing. (2.15)

No longer relevant. At the previous inspection, F wing had accommodated vulnerable prisoners, but it now accommodated only prisoners who were in full-time employment, and a dedicated team was no longer necessary. At the time of the inspection, there were 17 prisoners on F wing, which could hold up to 20 prisoners.

2.23 F wing should have a designated and appropriately equipped area for the serving of prisoners' meals. (2.16)

Not achieved. F wing did not have a dedicated serving area, and meals continued to be served from a hot plate on the landing. However, the prison had purchased a new servery, which was awaiting installation on the landing.
We repeat the recommendation.

2.24 Prisoners on all wings should have at least weekly access to facilities to wash their personal clothing. (2.17)

Achieved. All wings now had access to laundries. C wing, which previously had no laundry facilities, had a laundry on the vulnerable prisoner landing (C2), managed by the residents there. There was a clear schedule for laundry collections and returns for the other three landings on C wing.

Staff–prisoner relationships

2.25 All staff should address prisoners by their first name or by their title and family name. (2.23)

Achieved. We observed staff interacting with prisoners in a respectful manner during association and throughout the day. Prisoners were rarely referred to by their surname only. In the healthcare department, in particular, prisoners' surnames were prefixed with 'Mr'. Staff–prisoner relationships continued to be generally positive, although there was little evidence, for example in wing history files, that staff had detailed knowledge of prisoners' circumstances.

Personal officers

2.26 The effectiveness of the personal officer scheme should be regularly reviewed. (2.30)

Not achieved. The personal officer strategy document issued in August 2005 had been due to be reviewed in September 2006. However, this had not taken place, and the review had only

commenced shortly before the re-inspection. Staff on two of the wings were not clear about the minimum expectations for frequency of entries in wing files, or the main objectives of the role of personal officer.
We repeat the recommendation.

2.27 Entries in wing history files should be sufficiently detailed to provide the reader with up-to-date information on the prisoner and his individual circumstances. (2.31)

Not achieved. A random selection of wing files on B, C and D wings indicated that entries were made with varying regularity, and it was not clear if they had been made by the personal officer. The majority of notes were observational, with a rudimentary rubber stamp to address prisoners' incentives and earned privileges (IEP) status and conduct. There were no management quality checks, and no evidence that personal officers addressed issues that might be relevant to prisoners' resettlement needs or individual circumstances.
We repeat the recommendation.

Further recommendation

2.28 Managers should regularly check wing files to ensure that personal officers are interacting with prisoners, understand their personal circumstances and custody planning objectives, and record this information on the files.

Additional information

2.29 The personal officer scheme was not widely advertised on all wings, and as currently operated made little meaningful impact on prisoners. Staff told us that there were plans to allocate them to prisoners, rather than particular cells, although we saw no firm evidence of these plans. The outdated strategy for the scheme currently in operation was likely to hinder the effectiveness of such a system.

Further recommendation

2.30 The personal officer policy should be updated and circulated to all staff, and be available to prisoners. Staff training should be prioritised, and there should be clear systems for ongoing monitoring and evaluation of the scheme.

Duty of care

Bullying and violence reduction

2.31 All potential indicators of bullying behaviour should be copied to the security department and the anti-bullying coordinator and should be fully investigated. (3.9)

Achieved. The anti-bullying coordinator had easy access to security information reports, received any prisoner complaints with a bullying element, and routinely followed up any unexplained injuries to prisoners. Between March and December 2007, the coordinator had completed 44 investigations, and 249 TAB documents had been opened (on suspected bullies or known victims). At the time of the inspection, 15 prisoners were monitored under the TAB scheme.

2.32 A procedure to investigate unexplained injuries should be introduced. (3.10)

Achieved. See above.

2.33 A bullying survey should be conducted and the results publicised. The information generated from it should directly influence policy and practices. (3.11)

Achieved. The manager responsible for safety and decency had issued a survey to all prisoners in November 2006; one-third had responded, which was a reasonable response rate. The results were published in April 2007 and were followed up in September 2007 with two violence reduction workshops, involving 15 main location and 18 vulnerable prisoners.

2.34 A full-time dedicated anti-bullying coordinator should be appointed. (3.12)

Achieved. The safety and decency team consisted of one manager grade, a principal officer, a senior officer (suicide prevention officer), and an officer (suicide prevention), and an officer (anti-bullying coordinator). The present anti-bullying coordinator had been in post since April 2007.

Self-harm and suicide

2.35 Newly trained Listeners should be held at Preston for a given period providing this is consistent with individual custody/sentence plans. (3.24)

Achieved. Trained Listeners were held at Preston for six months, unless the opportunity arose for a progressive move to another prison. There were sufficient Listeners to deal with the demands of the prisoner population.

2.36 All prisoners who request it should be given access to a Listener at night. (3.25)

Achieved. In addition to the observation books held on each unit, a separate observation book in the centre office recorded all significant incidents and issues. This included details of when prisoners had requested use of the Samaritans telephone or a Listener. Such information was included in a daily report to the senior management team's morning meeting. Records for the previous month showed that access to Listeners had been facilitated on a number of occasions, at different times of the night.

2.37 The prison should develop a safer custody/establishment approach to prisoner safety incorporating in particular suicide prevention, anti-bullying and substance use strategies. (3.26)

Achieved. A safety and decency team had been established (see paragraph 2.34) and a violence reduction strategy and plan developed. Following three prisoner suicides in 2004 (before our previous inspection), more resources had been put into this area. The establishment had switched to the assessment, care in custody and teamwork (ACCT) system of managing prisoners at risk of self-harm in January 2005. While the suicide prevention and anti-bullying aspects of safer custody had improved and been well developed, the detoxification regime was poor (see section on resettlement).

2.38 Monitoring of telephone calls and mail for prisoners subject to F2052SH procedures should be targeted appropriately as part of the agreed support plan. (3.27)

Not achieved. All telephone calls and mail of prisoners subject to monitoring under suicide

and self-harm prevention procedures were still routinely monitored. The prisoners were not aware of this, and it did not feature as an action point in any of the care plans we read. This practice had resulted from a recommendation following a death in custody investigation, and some managers we spoke to defended it, even though prison managers had accepted our recommendation. We still considered this practice to be inappropriate.
We repeat the recommendation.

2.39 Listeners should not be asked or expected to take on work additional to their agreed role. (3.28)

Achieved. A protocol had been developed and we found no evidence that the role of Listeners was extended to cover other areas of work. The safety and decency team monitored the use of Listeners, and Listeners had the right to refuse work that they considered inappropriate or potentially unsafe.

Additional information

2.40 Since the previous inspection, eight prisoners had died while at Preston: two in 2005, four in 2006 and two in 2007. The most recent death had been in April 2007. At least one of these deaths was due to natural causes, but coroners' inquests had not been held on the others due to a significant backlog of work. An action plan had been developed based on recommendations from the investigations by the Prisons and Probation Ombudsman, although some action points were beyond their review date.

2.41 Between January and November 2007, there had been 229 incidents of self-harm and 270 ACCT documents had been opened; 18 were open at the time of the inspection. In the small sample of ACCT documents that we read, the care plans and written entries were generally of a good quality. The suicide prevention officer made regular checks, and any poor or inappropriate entries were taken up with the wing manager. There was good monitoring of self-harm incidents. In the week before the inspection, there had been the first meeting of a safety forum to talk about individual foreign national and indeterminate sentence for public protection (IPP) prisoners, as these groups had been identified as particularly high risk. The analysis of data had shown that most self-harm incidents occurred at night, so there had been specific training for the operational support grade staff who worked on night duty.

Diversity

No recommendations were made in this area at the last inspection.

Additional information

2.42 A diversity manager had been recruited in May 2007 and was a member of the senior management team. She had responsibility for the race equality officer (REO) and the foreign nationals coordinator. A diversity and race communication strategy had been developed to address and communicate all areas of diversity and race.

2.43 Staff training was a distinct part of the diversity and race strategy, and 53% of uniformed staff and 37% of non-uniformed had attended diversity training. The diversity manager had implemented morning meetings with the REO and foreign nationals coordinator to improve communication. A number of cultural events had taken place and were planned, and were well publicised to increase awareness of the different cultures and faiths in the establishment

2.44 An equal opportunities committee met quarterly, chaired by the governor, with members including departmental unit managers and staff working in key diversity roles. The group provided strategic direction for all areas of diversity.

2.45 Although a residential member of staff was supposed to be allocated facility time for the role of disability liaison officer, this role was not profiled, so he could only address the needs of prisoners in a reactive and unplanned manner. New arrivals identified as registered disabled or possessing a disability were referred to the DLO. The DLO aimed to carry out an interview and/or assessment within 24 hours. However, he told us that he had approximately 16 interviews and assessments to complete, but that he had not been allocated the time to do so. Prisoners were also frustrated that they could not see the DLO promptly.

2.46 There was only one cell with wheelchair access, which was on C2 landing. This cell had recently been allocated to a prisoner using a wheelchair who had been waiting for some time for suitable accommodation. The education department and the chapel were not accessible to prisoners using a wheelchair or to anyone with mobility difficulties.

Further recommendations

2.47 The disability liaison officer should be allocated sufficient time to be active in his role and carry out a full range of required duties, including assessing new arrivals with specific needs within their first 24 hours.

2.48 There should be better physical access to the chapel and education department.

Race equality

2.49 The number of prisoner representatives on the prisoners' consultative committee should be increased to at least one per wing. (3.39)

Achieved. Joint consultation meetings with black and minority ethnic and foreign national prisoners took place bi-monthly. There was at least one wing representative per wing. We saw the minutes from the October 2007 prisoner consultative committee meeting, which showed that representatives from three of the six wings had attended. The consultative committee had not met since then, however, owing to the sickness absence of the REO. Prisoner representatives also attended the race equality action team (REAT) meeting and had an agenda item to raise any issues on behalf of black and minority ethnic prisoners.

Further recommendation

2.50 There should be cover arrangements for absence of the race equality officer.

2.51 Formal consultation meetings with prisoners from minority ethnic groups should take place regularly. (3.40)

Achieved. See above.

2.52 Prisoners from minority ethnic groups should have the opportunity to meet with each other formally to discuss any issues of concern. (3.41)

Achieved. The REO held regular consultative meetings with black and minority ethnic and foreign national prisoners. It was mainly the nominated prisoner representatives who attended this meeting and there was scope for involving other black and minority ethnic prisoners from the wider prison population.

Further recommendation

2.53 Consultation meetings should be opened up to include more prisoners from the wider population.

2.54 A needs analysis for minority ethnic prisoners should be conducted to inform changes to policy. (3.42)

Partially achieved. Since the previous inspection, the number of black and minority ethnic prisoners had increased to 14% of the population. A questionnaire had been distributed to black and minority ethnic prisoners in April 2006, which did not highlight any major concerns at that time. Discussions about black and minority ethnic prisoners at the REAT meetings did not extend to analysing the various ethnic groups held, how their needs as individuals or as groups might be met, or the impact of current policies and procedures on their time at Preston.
We repeat the recommendation.

2.55 The full-time race relations liaison officer should take up post. His identity and role, and that of the race relations representatives, should be publicised and promoted. (3.43)

Achieved. A full-time race equality officer was in post, although on sick leave during our inspection. Minutes of meetings indicated that he played a key role in holding meetings for black and minority ethnic prisoners and attended REAT meetings, and his role was well publicised on the wings.

Additional information

2.56 At the time of the inspection over half of all the black and minority ethnic prisoners were located on B wing. Managers told us that this was a consequence of housing foreign national prisoners together to ease language difficulties. However, the consequences of this action did not appear to have been fully thought through. Some staff indicated that the policy had created difficulties, and that some white prisoners had refused to be located on B wing. At one REAT meeting, a black and minority ethnic representative had commented that prisoners located on B wing could not work in the kitchen and had to move to another wing to do so, but some black and minority ethnic prisoners were reluctant to move from B wing. This matter was resolved by allowing prisoners on B wing to remain there and still have the opportunity to work in the kitchen. The arrangement had not been impact assessed. We also noted that, despite the number of black and minority ethnic and foreign national prisoners located on B wing, some of whom did not speak English, no translated information or extra resources were provided.

Further recommendation

2.57 The prison should formally impact assess the effects of the decision to co-locate large numbers of black and minority ethnic and foreign national prisoners on one wing.

Foreign national prisoners

2.58 A distinct foreign nationals policy should be developed and a dedicated foreign nationals coordinator should be appointed. (3.49)

Partially achieved. The number of foreign national prisoners had increased from 2% to 5% of the population. A foreign nationals policy was available but was out of date and incorrect. The foreign nationals coordinator told us that the document had not been translated or distributed to foreign national prisoners, despite its information relevant to this group. The coordinator had worked in the role part-time since May 2007 and full-time since October 2007, and was still establishing an understanding of the role and remit.

Further recommendation

2.59 The foreign nationals policy should be updated, in consultation with foreign national prisoners.

2.60 Reception and first night information and the induction pack should be translated into languages other than English. (3.50)

Not achieved. Reception and first night information, including induction packs, was not translated into other languages. The foreign nationals coordinator said that many of the policies and procedures were available in other languages on the intranet, but confirmed that prisoners who did not speak English did not benefit from the information currently available. We repeat the recommendation.

2.61 The induction programme for foreign national prisoners should be reviewed to include needs analysis and impact assessments. (3.51)

Not achieved. The induction programme for foreign national prisoners was the same as for other prisoners, and their language barriers and cultural differences had not been considered. The foreign nationals coordinator confirmed that he completed a questionnaire with all foreign national prisoners and used translation services to do this. He had purchased handheld computers that could translate verbal information into a variety of languages. The establishment was testing this out on a small group of Vietnamese prisoners.
We repeat the recommendation.

2.62 Foreign national prisoners should be able to meet together and with representatives of the prison. (3.52)

Partially achieved. Foreign national prisoners could participate in joint consultation meetings with black and minority ethnic prisoners (see paragraph 2.49), but there were no formal arrangements for them to meet together or as a group with staff.

Further recommendation

2.63 Foreign national prisoners should be able to meet as a specific group with staff.

Contact with the outside world

2.64 The system of issuing legal correspondence should be reviewed to ensure that legally privileged correspondence is not opened by staff. (3.64)

Achieved. The system had changed to ensure that prisoners' legal mail was not opened by staff. Staff sorted the mail for each wing, and we observed that all legal correspondence was intact.

2.65 Prisoners should have fair and equal access to telephones. (3.65)

Achieved. There had been an increase in the number of telephones on each wing, and most had privacy hoods. When we visited during association, there were no queues and prisoners did not express any concerns about accessing the telephones.

2.66 The visitors' centre should be refurbished to provide a decent and welcoming environment. (3.66)

Achieved. The visitors' centre was a clean and light environment, with useful information for visitors. It had a refreshments vending machine and lockers for visitors' belongings. There was a small area with children's books, but this was not staffed and parents were expected to take responsibility for their children. There was a television, which was not working at the time of the inspection. Staff were polite and the manager ensured that all visitors were treated with respect.

2.67 The closed visits area should be refurbished to provide a secure, clean and less oppressive environment. (3.67)

Achieved. The closed visits area had been partitioned to create more privacy, and had a capacity for two closed visits. Although the carpet had been changed and the walls had been redecorated, it was still not very comfortable. However, with the building of a new visits hall (see below), any further work on this area would have been a poor use of resources.

Additional information

2.68 Visitors were escorted around the prison wall to the visits hall, which was at the rear of the establishment. An area for leaving pushchairs was in a poor condition, and the visits hall waiting area was dull and in a poor state of decoration. The visits hall was large, but not a welcoming environment. A new visits hall was being built, and due to be ready in June 2008.

Further recommendation

2.69 The new visits hall should be opened as soon as possible and without any delay.

Legal services

2.70 Cover should be provided for bail information and legal services work to ensure that all prisoners have equal and timely access. (3.76)

Partially achieved. Two staff shared the role of legal services officer. However, they did not perform these duties every day, and we were told that it was not always possible to detail one of these officers in the role when the other was not available. Therefore, prisoners did not always have equal or timely access to a legal services officer. However, there was an experienced bail information officer who responded to all applications within 24 hours. He drew necessary matters to the attention of the legal services officers, or sometimes dealt with these himself.
We repeat the recommendation.

Health services

2.71 The health services manager should be a member of the senior management team to ensure that the appropriate professional input is provided at meetings. (4.63)

Achieved. The head of health services, who was new to the role, was a member of the senior management team. The integrated service manager from Central Lancashire Primary Care Trust (PCT), who had overall responsibility for HMPs Preston, Garth and Wymott, had also been invited to attend the meetings to support the new health services manager.

2.72 Primary care should be developed to include the introduction of nurse triage. (4.64)

Not achieved. There was no nurse triage, although the prison's action plan of April 2006 stated that there was such a system. Prisoners could ask to see a nurse as 'special sick', and she assessed their needs and referred them appropriately. One of the staff was training to be an advanced nurse practitioner and planned to develop a nurse triage service. The one full-time general practitioner (GP) saw all applications and, on the basis of the information provided by the prisoner, assessed whether the case was urgent or routine. We found one application in which a prisoner had stated that he had 'bad chest pains when I cough', who would have had to wait 25 days for an appointment with the GP. Other prisoners told us of waits of up to three weeks to see the doctor.
We repeat the recommendation.

2.73 Inpatients should be risk assessed with a view to them attending education classes in the education department. (4.65)

Achieved. Inpatients risk assessed as suitable could attend classes in the education department. Although at the time of our inspection no inpatients were deemed suitable to attend education, we were told of one prisoner who had attended daily information technology classes while awaiting transfer to a secure NHS mental health bed.

2.74 The pharmacy contract should be reviewed and a new service level agreement drawn up to include input by pharmacy staff, and the introduction of medicines management, patient group directions and pharmacist-led minor ailment clinics. (4.66)

Partially achieved. A service level agreement with the local acute hospital pharmacy department stated that there should be a system to identify prisoners who would benefit from counselling by the pharmacist on their medication. However, staff and prisoners told us that prisoners could not see a pharmacist. There was a wide range of patient group directions, but some had not been signed by any staff and others only had two or three signatures. This meant that not all registered nursing staff were able to administer medications without a personalised prescription. We looked at a selection of prescription charts and found evidence of missed doses of medication (in some cases for several days), with no adequate explanation

logged. Patient information leaflets were supplied with medication given in possession, although at the time of the inspection the majority of prisoners did not have in-possession medications.
We repeat the recommendation.

2.75 The dental surgery should be redecorated, an automatic closer fitted to the surgery door and a suitable waiting area provided. (4.67)

Partially achieved. The dental surgery had been redecorated, dental instrumentation storage had been improved and dental sundries were stored in a secure area away from the surgery. There was an automatic closer fitted to the door, to maintain privacy during treatment. However, prisoners waiting to see the dentist had to sit on metal chairs in a thoroughfare, as there was no specific waiting area for them. There were plans to refurbish the dental surgery.

Further recommendation

2.76 The dental surgery refurbishment should be carried out as soon as possible.

Additional information

2.77 Central Lancashire PCT had commissioned and provided health services since April 2005. It had reviewed the contracts with allied health professionals and had recently appointed an independent company to provide GP services to the three prisons for which it commissioned health services.

2.78 Prisoners and the GP told us that the GP regularly reduced prisoners' long-term medications without consultation with them.

2.79 The PCT commissioned mental health in-reach services from Lancashire Care Trust, whose remit only covered those prisoners presenting with severe and enduring mental health problems. The need for a primary mental health service had been identified, and the PCT was introducing a crisis intervention team.

2.80 The PCT had employed a full-time dental nurse, who provided dental health promotion and dental triage sessions, as well as continuity between the three visiting dentists.

Further recommendation

2.81 Health service professionals should involve and consult patients when making decisions about treatment.

Activities

Learning and skills and work activities

2.82 The quantity and range of education and training should be improved to meet prisoners' employability needs. (5.10)

Partially achieved. Since the previous inspection, the range of courses had been increased,

particularly in education. Provision was now available for both short- and longer-term prisoners, with opportunities for progression to higher-level qualifications. The information and communications technology provision now ranged from entry level to level three. The range of accredited foundation and physical education courses had improved, and national vocational qualifications (NVQs) in catering had been introduced. The skills for life provision had increased, and prisoners working in the workshop could now access support for literacy and numeracy. Classes in English for speakers of other languages (ESOL) had also been introduced. Key skills had been effectively linked to courses in the gymnasium and in visual arts to encourage prisoners to develop skills to enhance their employability, which were also addressed in courses to help with resettlement, such as budgeting and money management. Information, advice and guidance (IAG) was now available to direct prisoners to appropriate courses. However, there were still too few accredited vocational courses to help support employment.

Further recommendation

2.83 There should be a wider range of accredited vocational courses to help support employment.

2.84 Education and training should be better coordinated across the prison. (5.11)

Achieved. The management information system had been improved overall and was used well for course planning and curriculum development. Quality assurance of education had also improved, and there were comprehensive arrangements to ensure that the quality of provision continued to develop. Other activities had been better timed to ensure that courses were not interrupted. Classroom efficiency had improved to 85%. Prisoners who did not attend classes were followed up to establish the reason for non-attendance. Recognition of prisoner work in education had been improved, and the provider accredited units towards a qualification to recognise the work that prisoners had completed.

2.85 Teaching facilities in the education department and on F wing should be improved. (5.12)

Achieved. At the previous inspection, vulnerable prisoners had been accommodated on F wing, and literacy and numeracy classes had been delivered on-site by two selected prisoners, with little supervision. The classroom had been ill equipped and unwelcoming. Education for vulnerable prisoners was now provided in the education block and on C wing, where they were now housed. Accommodation was satisfactory, and vulnerable prisoners could participate in most of the courses available to prisoners attending education. In addition, two mentors worked on C wing to support prisoners, aided by education staff. A small workshop had been sited on C wing, giving up to 10 vulnerable prisoners opportunities for work. However, none of this work was accredited.

Further recommendation

2.86 There should be more meaningful work for vulnerable prisoners, with opportunities for them to gain accredited qualifications.

2.87 The system for allocating prisoners to work should be reviewed to ensure that prisoners are not given unrealistic expectations of what is available to them and staff are able to promote the options on offer effectively. (5.19)

Achieved. Prisoner allocation to activities had improved. An IAG worker from the education department now attended induction and gave advice on the courses available and how these might meet the needs of prisoners. A basic skills assessment and, if appropriate, a diagnostic test were carried out to establish the prisoner's support needs. The IAG worker was given information from the offender management unit on the most appropriate courses for prisoners to meet their sentence plan. The role of learning and skills in the establishment was better understood by prison staff than at the previous inspection, and prison officers were mostly effective in ensuring that prisoners attended classes.

Physical education and health promotion

2.88 The quality of physical education facilities and equipment should be improved. (5.25)

Partially achieved. Resistance machines and cardiovascular equipment had been improved and additional equipment introduced. The flooring in the sports hall had been renewed, and lighting and heating improved. The hall was now well used for a variety of activities, such as volleyball, football, basketball and circuit training. However, the changing facilities and showers, particularly in the cardiovascular and free weights areas, remained inadequate and in a poor state of repair.
We repeat the recommendation.

Faith and religious activity

2.89 Plans to redevelop the chapel area should be actioned and should include rooms and facilities to enable the planned expansion of activities for prisoners. (5.33)

Achieved. The chapel had been refurbished and re-opened in January 2007. The world faith room was well equipped to meet the needs of all the faiths in the establishment. Activities such as victim awareness and drugs courses were delivered in the chapel area, as well as the family day project, run in conjunction with Blackburn Diocese. The chapel was large enough to be screened off to give prisoners quiet time or to allow specific groups to meet.

2.90 A dedicated permanent multi-faith facility with washing facilities for Muslim prisoners should be provided. (5.34)

Achieved. A world faith room was available (see above), with washing facilities for Muslim prisoners in an adjacent room.

Additional information

2.91 The chaplaincy team delivered a victim awareness programme on one afternoon a week for four weeks, run in conjunction with Victim Support. The programme was being accredited and had a waiting list of prisoners who wished to participate. The team had also increased the number of activities, which now included meditation classes, yoga and race awareness, as well as weekly prayers in the world faith room.

2.92 A member of the chaplaincy team attended all assessment, care in custody and teamwork (ACCT) reviews and the team was also represented on the senior management team and in REAT meetings.

Time out of cell

2.93 Prisoners should be issued with enough warm, waterproof clothing and shoes to go on outdoor exercise in all weather conditions. (5.42)

Partially achieved. Wet weather clothing was available near the door to the exercise yard. This arrangement had only come into effect a few weeks before the inspection, and it was clear that prisoners were not aware of this change. We saw prisoners on the yard wearing short-sleeved T-shirts, even on a damp and chilly day.

Further recommendation

2.94 The availability of waterproof clothing for outdoor exercise should be advertised to all prisoners.

2.95 Evening activities should be introduced into the regime. (5.43)

Not achieved. There were no evening activities during association times, other than recreational PE.
We repeat the recommendation.

Additional information

2.96 Exercise in the fresh air was scheduled on a rostered basis daily for prisoners with no work or other activity, but those in full-time activity had no opportunity for fresh air exercise during the winter. In the lighter summer evenings, prisoners could take evening open-air exercise.

Further recommendation

2.97 Open-air exercise should be available daily for all prisoners.

Good order

Security and rules

2.98 Prisoners should only be required to 'squat' during a strip search for specific security reasons following reasonable suspicion. (6.10)

Partially achieved. The security strategy set out the circumstances in which staff could require a prisoner to squat during a search, and staff told us that the authority to require prisoners to squat was only implemented when there was suspicion that an item had been concealed. The searches that we observed did not include any requirement to squat routinely. However, some prisoners told us that the order to squat was routinely given, and that this was standard procedure during reception searches.

Further recommendation

2.99 Managers should satisfy themselves that published procedures for squat searches are being implemented.

2.100 A programme of staff searches should be organised with minimum annual targets being set. (6.11)

Partially achieved. A programme of staff searches had operated in accordance with the security strategy target of two-monthly searches until about five months before the inspection, since when there had been no searches. Staff bags were X-rayed daily on entry into the establishment.

Further recommendation

2.101 The security strategy target of staff searches once every two months should be resumed.

2.102 The prison rules and routines should be available in languages other than English. (6.12)

Not achieved. Although the establishment's action plan in response to the previous inspection report said this recommendation had been completed, there was no translated material available on induction, and although national rules were translated, guidance on life in Preston and how to access or understand local arrangements was not routinely available. There were very few notices around the establishment in languages other than English.
We repeat the recommendation.

2.103 Senior managers should check the validity of reasons for placing a prisoner on the hold list and should regularly review the situation to ensure that prisoners are moved on as soon as possible. (6.13)

Partially achieved. At the previous inspection, there had been 64 prisoners (18% of the sentenced population) on the hold list and not actively listed for transfer. This number had increased to 120 prisoners (34% of the sentenced population) at the time of this re-inspection. There were arrangements for the senior officer in charge of observation, classification and allocation to discuss individual cases with his manager as required, although these were informal. We examined the grounds on which prisoners were held in detail, and they all seemed reasonable. There had been no cases in which the establishment had been unable to fulfil its transfer obligations to category C training establishments.

Further recommendation

2.104 A senior manager should formally review prisoners on the hold list quarterly.

Discipline

2.105 Standardisation meetings for adjudications should be held regularly. (6.28)

Achieved. There was a quarterly programme of adjudication standardisation meetings. The outcomes of these were applied consistently in the adjudications we examined.

2.106 Adjudication awards should not be excessive or administrative; mitigating circumstances should be taken into account and this should be demonstrated in the adjudication paperwork. (6.29)

Achieved. There had been 1,216 adjudications in 2007. The adjudication records we examined demonstrated that mitigating circumstances had been taken into account when punishments were given.

2.107 The use of the special cells should be monitored and prisoners should spend the minimum amount of time in them with a formal review after one hour. Use of the special cells should be authorised only by a governor grade. (6.31)

Achieved. The special cell had been used on 26 occasions in 2007. We examined the records of the use of the special cells for the previous year. There were very few occasions when a prisoner had remained in the special cell for more than one hour, and use of this cell was always authorised by an operational manager.

Additional information

2.108 Record keeping on the use of the special cell was not consistent. The recorded grounds for use of this cell were sometimes poor, and a governor had not always authorised removal. On one occasion, a health services worker had been used to visually examine a prisoner's anal area to check if contraband had been concealed.

2.109 There had been a sharp increase in the frequency of use of force since the previous inspection, from 80 to over 200 in the previous 12 months.

Further recommendations

2.110 Record keeping on all aspects of use of the special cell should be clearly completed.

2.111 Health services staff should not be used to take part in any disciplinary search.

2.112 A use of force committee should be set up to review all incidents where force is used against prisoners for appropriateness, and should monitor trends and emerging patterns. The sharp increase in the use of force should be specifically investigated.

Segregation unit

2.113 Prisoners should be afforded daily opportunity to peruse the notice boards on display in the care and separation unit. (6.32)

Partially achieved. Information of interest to prisoners in the care and separation unit (now called the segregation unit) was still displayed on the unit walls and there were few opportunities for them to peruse this. When requests were made, staff enabled prisoners to read the notice boards. It was recognised that this was unsatisfactory, and an information booklet was in preparation for prisoners to read at their leisure.

Further recommendation

2.114 The information booklet for prisoners in segregation should be issued without delay.

2.115 Prisoners in the care and separation unit should be offered daily showers. (6.33)

Achieved. Prisoners were allowed daily showers, telephone calls and exercise. Applications were recorded daily at breakfast time.

2.116 Prisoners should spend the minimum amount of time in the care and separation unit and action plans should be devised to manage the reintegration process. (6.34)

Achieved. A separate unit, known as the reintegration unit, had recently been established on the A2 landing. Referrals to this unit could be made by staff from across the establishment, as well as segregation unit staff. A multidisciplinary panel reviewed all referrals. The unit had space for up to 20 prisoners; there were 15 residents, of whom nine were participating in the reintegration programme and a further six were orderlies who worked around the establishment and were also peer mentors.

Additional information

2.117 The draft strategy for the reintegration unit set out a requirement for each prisoner. This had not yet been implemented, but there were frequent entries in wing history sheets. Prisoners appeared to appreciate the smallness of the unit and the consistency of staffing, and prisoners who had difficulty in settling into a standard regime appeared to be more readily managed in this setting. However, prisoners who spent time on this unit needed clear plans for progression.

Further recommendations

2.118 The strategy for the reintegration unit should be agreed and published.

2.119 All prisoners located on the reintegration unit should have clear targets and individual plans for progression and reintegration to mainstream accommodation. Personal plans should be reviewed regularly.

Incentives and earned privileges

2.120 There should be an immediate review of the introduction of the new incentives and earned privileges scheme and action should be taken to ensure that its implementation is effective. (6.42)

Partially achieved. The incentives and earned privileges (IEP) scheme had been reviewed and a new policy issued in March 2007, alongside a new facilities list. Most wing history sheets contained a signed compact. However, the IEP scheme did not operate efficiently. Personal officer comments were largely superficial (see paragraph 2.29) and did not demonstrate any detailed knowledge of individuals. Prisoners often expressed a lack of motivation to achieve enhanced status. There were better records of the progress made by prisoners on the basic level than for those on the other two levels of the scheme.

Further recommendation

2.121 There should be sufficient differentials between standard and enhanced levels of the incentives and earned privileges (IEP) scheme to motivate and engage prisoners, and the scheme should be evaluated regularly.

Services

Catering

2.122 Prisoners working in the kitchen should be able to gain relevant qualifications. (7.8)

Achieved. NVQs were now available in the kitchen. Over 20 prisoners had achieved relevant qualifications, and four were undergoing their NVQs during our inspection. There was an NVQ coordinator on the catering staff, and the catering manager was an internal verifier. Prisoners taking NVQs were placed on hold for 30 weeks to ensure that they could complete their qualification.

2.123 Lunch should be served between noon and 1.30pm and tea between 5pm and 6.30pm. (7.9)

Partially achieved. The evening meal was served after 5pm but the midday meal was served at 11.45am and hot plates were shut at midday.

Further recommendation

2.124 Lunch should be served between noon and 1.30pm.

Additional information

2.125 There was always a cooked breakfast on weekdays, which is more generous than we often find, and a cold breakfast at weekends. On weekdays, there was mainly cold food at midday and a choice of cooked meals in the evening. At weekends, the midday meal was the hot meal.

Prison shop

2.126 The range of items for sale from the prison shop should increase and should include more goods for black and minority ethnic prisoners. (7.19)

Achieved. The canteen order list contained over 300 items, and these included cosmetic and hair products suitable for black and minority ethnic prisoners.

Resettlement

Offender management and planning

2.127 All eligible prisoners should have a custody and care plan devised within the first two weeks of custody. (8.9)

Achieved. Responsibility for completing the custody and care plan had passed from induction staff to dedicated officers in the offender management unit (OMU). This meant that prisoners could be assessed wherever they were located. A computerised database recorded when the prisoner had been seen, by whom, any action required and referrals made. The database for January 2007 showed that, of the 115 prisoners interviewed, only one had declined an assessment and 18 had no recognised needs. For the remainder, referrals had been made to relevant interventions or departments. Most prisoners were seen within 48 hours of reception.

2.128 The personal officer scheme (or suitable alternative) should be used to ensure that custody or sentence plan targets are prioritised, monitored and achieved. (8.10)

Partially achieved. Only prisoners serving sentences of four years or more were subject to formal sentence planning reviews. All the 110 high-risk or prolific offenders identified under stage two of the national offender management implementation had a nominated offender supervisor who was responsible for tracking progress against the sentence plan targets. The 52 indeterminate-sentenced prisoners also had nominated officers and were subject to regular reviews. For other prisoners (approximately 60% of the population), there was no mechanism for prioritising or monitoring targets during the sentence, although they were all seen a few weeks before release to check on progress.
We repeat the recommendation.

2.129 Any resettlement needs assessment should include information on average length of stay by prisoners. (8.11)

Partially achieved. A full-time data analyst appointed in October 2007 had started to produce information about the status of the prisoner population, including length of stay. This information was analysed and used by senior managers. Those responsible for reducing reoffending and interventions planned to use such information in their review of current service provision.

2.130 The Governor should liaise with the heads of other local agencies to ensure that multi-agency lifer risk assessment panels are held as soon as possible after sentencing. (8.19)

Achieved. Since the previous inspection, the life-sentenced prisoner population had fallen from 13 to six. There had been no delays in completing risk assessment panels after sentencing, and the establishment had a good record of transferring life-sentenced prisoners to other prisons within a reasonable timescale.

2.131 The use of release on temporary licence should be expanded to assist appropriate prisoners to prepare for release. (8.31)

Not achieved. No prisoners had been released on temporary licence in the previous 12 months. Release on temporary licence was not part of the structured planning for a prisoner's

release and was only considered following a prisoner's application.
We repeat the recommendation.

2.132 A detailed action plan should be developed to increase staff awareness and maximise their contribution to the management of prisoners subject to public protection procedures. (8.38)

Achieved. There was a detailed action plan for managing prisoners subject to public protection procedures. There was awareness training on safeguarding children, and staff surgeries to explain the offender assessment system (OASys), which was used to assess prisoners' risks and needs. Work had begun with HMP Wymott as part of the north west area sex offender strategy to run awareness training for the sex offender treatment programme. Minutes of the local risk management meeting – where individual prisoners were discussed – were published on the prison intranet.

Additional information

2.133 Since the previous inspection, various resettlement staff (including discipline, seconded probation and administrative staff) had been brought together to form the OMU, which was responsible for the assessment of all prisoners (including remands), and was involved in the case management of all those serving over four years. A short-term sentence plan was now completed on sentenced prisoners serving less than 12 months. Those serving between 12 and 48 months (who were not in scope for phase two of the offender management model) had an OASys assessment and were given a copy of their sentence plan targets. Those serving four years or more were subject to formal planning and review processes (see paragraph 2.128). All OASys assessments were up to date, and the management of in-scope prisoners was assisted by the fact that 80% of them came from the local Lancashire area, and by the use of dedicated video conferencing facilities.

2.134 The establishment held 46 prisoners serving indeterminate sentences for public protection, although this number had been as high as 65. The length of time that these prisoners had spent at Preston varied from less than a month to two years and three months. OMU staff had a good record of transferring these prisoners to more suitable establishments (in the last three months of 2007, 28 indeterminate-sentenced prisoners had been transferred).

2.135 The reducing reoffending delivery plan (strategy document) described the available provision under each of the seven resettlement pathways (and an eighth pathway for the north west area: victims of crime). There was basic provision of services under each pathway, although the provision was not especially strategic or based on assessed prisoner needs. The delivery plan was mainly fitted around existing provision, and achievement was largely measured by key performance targets. More specific targets and dates were due to be developed following a review of current provision. Managers acknowledged that there were waiting lists for some resettlement services, and that some short-term prisoners would leave the prison before they were assessed.

Resettlement pathways

2.136 Interview space, telephone lines and necessary computer terminals should be provided for agency staff working within the resettlement function. (8.30)

Achieved. All resettlement agency staff had access to the necessary facilities to enable them to undertake their work.

2.137 Regular awareness days should be held to inform all staff of the agencies working within Preston and their respective roles. (8.32)

Partially achieved. Regular awareness days had not been held, but there was now staff awareness training for the enhanced thinking skills programme. In addition, the work of agencies working in the establishment was well promoted, and there was good use of a shared drive on the prison intranet. A portfolio of interventions was kept updated and gave details of the service, eligibility criteria and method of referral. An external agencies forum helped to inform agencies of each other's work.

2.138 The drug strategy should be informed by a local needs analysis and include alcohol services. (8.58)

Partially achieved. There was a drug strategy document dated June 2007. While this was comprehensive, it did not refer to a local needs analysis, although such information could be obtained relatively easily from a database kept by counselling, assessment, referral, advice and throughcare (CARAT) staff.
We repeat the recommendation.

2.139 The drugs policy document should contain detailed action plans, monitoring arrangements and performance measures. (8.59)

Partially achieved. The drug strategy document included key performance targets and standards, as well as a list of monitoring arrangements, but there were no detailed action plans for how the targets would be achieved.
We repeat the recommendation.

2.140 First night symptom relief should be administered consistently and the process closely monitored. (8.60)

Partially achieved. The pro forma detoxification prescription charts did not include symptomatic relief, which was prescribed separately on a prison prescription chart. While the prisoners' charts that we looked at showed that symptomatic relief had been prescribed, some prisoners we spoke to on the drug dependency unit commented that they had not been offered symptomatic relief on their first night. There appeared to be no audit arrangements to ensure that this recommendation was continually met.
We repeat the recommendation.

2.141 A dedicated team of specialist nurses should be appointed to undertake assessments, care planning and follow-ups for all substance-dependent prisoners requiring clinical treatment, irrespective of their location. (8.61)

Partially achieved. While a team had been established, it was not up to full strength at the time of the inspection. Two posts were vacant and a new recruit was still on his orientation programme. During the two days that we were present on the unit, the majority of the medication administration sessions were staffed by nurses from elsewhere in the primary care team. Although they had received some in-house training from nurses in the substance misuse team, they were not able to provide the full range of expertise that prisoners required. We were told that all prisoners who required a clinical detoxification would be seen by one of the nurses, wherever they were located. CARAT staff saw all new arrivals at the establishment.
We repeat the recommendation.

2.142 Joint working protocols between health services and the CARAT service should be developed. (8.62)

Achieved. There was a joint working protocol between health services and the CARAT service. This aimed to establish best practice and promote active multidisciplinary working to identify and meet the needs of substance misusers.

2.143 The new clinical protocol for substance misuse services should be introduced as soon as possible and prescribing brought in line with national clinical guidance. (8.63)

Not achieved. We were told that the PCT had recently appointed specialist doctors to develop substance misuse clinical services, but at the time of the inspection, prisoners were receiving an inadequate detoxification. We met many who complained about the detoxification services; one described the process as 'barbaric'. Another, who had been on a verified maintenance prescription in the community of 70 mg/ml per day, chose to stop it once he arrived at the establishment because he had been told that he would only receive a maximum of 40 mg/ml per day in prison. He said that he was going to 'take my chance' on a DF118 detoxification, even though he expected to feel unwell for at least the next two weeks.
We repeat the recommendation.

2.144 Officers working on the drug dependency unit should all undertake specialist training according to their roles. (8.64)

Partially achieved. Since the previous inspection, two officers on the drug dependency unit had undertaken an Open College Network certificate in substance misuse management, level three. However, they had both since been recruited as dedicated officers with the CARAT team, to meet the needs of another recommendation (see below). A new programme of training specific to the drug dependency unit was due to commence.
We repeat the recommendation.

2.145 Officers assigned to the CARAT team and undertaking casework should be dedicated to the team in order to ensure consistency. (8.65)

Achieved. The CARAT team included two officers with relevant qualifications (see above).

2.146 Specific interventions should be developed for crack/cocaine users. (8.66)

Achieved. The CARAT team had specific interventions for crack/cocaine users. These included work books that were used in one-to-one interviews.

2.147 The purpose of C2, the drug-free landing, should be clarified. (8.67)

Not achieved. The establishment did not have a specific drug-free landing, although it was planned to make C3 and C4 landings drug-free landings.

Further recommendation

2.148 The establishment should develop an action plan to open a drug free landing.

2.149 Voluntary drug testing (VDT) procedures, including the practice of strip searching, should be reviewed and a clear distinction drawn between VDT and compliance testing. A positive VDT should not lead to mandatory drug testing. (8.68)

Partially achieved. Voluntary drug testing was not linked to mandatory drug testing. However, there was no distinction between compliance testing and voluntary testing, and all prisoners were required to undergo a strip search before providing a urine sample. A positive result was reported to the prisoner, his wing and the labour control board.
We repeat the recommendation.

Additional information

2.150 There were two DF118 detoxification programmes, one of nine days' and the other of 12 days' duration. The reasons for assigning prisoners to one rather than the other seemed to be arbitrary, as there was no explanation in the documentation that we observed, including clinical records. Prisoners were also confused by this allocation. Remand prisoners were told that they could not receive methadone.

2.151 We spoke to the resident GP, who, in the absence of specialist prescribers, held clinical responsibility for those prisoners undertaking a detoxification; he was unaware that the protocols in use at the establishment were unsuitable.

Section 3: Summary of recommendations

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

Main recommendations (from the previous report)

3.1 Arrangements for the detoxification of prisoners should be safe, comprehensive and consistent. (2.2)

3.2 The quality of healthcare offered to prisoners should be improved by the recruitment of sufficient staff to provide an appropriate level of service. (2.7)

3.3 The establishment should continue to increase the range and number of places available in education and work. (2.9)

Recommendations

To the Governor

First days in custody

3.5 Individual interviews of prisoners by reception staff should be conducted in private. (2.11)

3.6 The induction and detoxification arrangements for prisoners on the vulnerable prisoner unit should be the same as for other prisoners. (2.17)

3.7 The reception area should be refurbished or replaced to ensure that it provides an environment that is fit for purpose and enables all prisoners to be treated decently. (2.20)

Residential units

3.8 F wing should have a designated and appropriately equipped area for the serving of prisoners' meals. (2.23)

Personal officers

3.9 The effectiveness of the personal officer scheme should be regularly reviewed. (2.26)

3.4 Entries in wing history files should be sufficiently detailed to provide the reader with up-to-date information on the prisoner and his individual circumstances. (2.27)

3.5 Managers should regularly check wing files to ensure that personal officers are interacting with prisoners, understand their personal circumstances and custody planning objectives, and record this information on the files. (2.28)

3.6 The personal officer policy should be updated and circulated to all staff, and be available to prisoners. Staff training should be prioritised, and there should be clear systems for ongoing monitoring and evaluation of the scheme. (2.30)

Self-harm and suicide

3.7 A safer cell should be installed. (2.5)

3.8 Monitoring of telephone calls and mail for prisoners subject to monitoring under suicide and self-harm prevention procedures should be targeted appropriately as part of the agreed support plan. (2.37)

Diversity

3.9 The disability liaison officer should be allocated sufficient time to be active in his role and carry out a full range of required duties, including assessing new arrivals with specific needs within their first 24 hours. (2.47)

3.10 There should be better physical access to the chapel and education department. (2.48)

Race equality

3.11 There should be cover arrangements for absence of the race equality officer. (2.50)

3.12 Consultation meetings should be opened up to include more prisoners from the wider population. (2.53)

3.13 A needs analysis for minority ethnic prisoners should be conducted to inform changes to policy. (2.54)

3.14 The prison should formally impact assess the effects of the decision to co-locate large numbers of black and minority ethnic and foreign national prisoners on one wing. (2.57)

Foreign national prisoners

3.15 The foreign nationals policy should be updated, in consultation with foreign national prisoners. (2.59)

3.16 Reception and first night information and the induction pack should be translated into languages other than English. (2.60)

3.17 The induction programme for foreign national prisoners should be reviewed to include needs analysis and impact assessments. (2.61)

3.18 Foreign national prisoners should be able to meet as a specific group with staff. (2.63)

Contact with the outside world

3.19 The new visits hall should be opened as soon as possible and without any delay. (2.68)

Legal services

3.20 Cover should be provided for bail information and legal services work to ensure that all prisoners have equal and timely access. (2.70)

Health services

3.20 Primary care should be developed to include the introduction of nurse triage. (2.72)

3.21 The pharmacy contract should be reviewed and a new service level agreement drawn up to include input by pharmacy staff, and the introduction of medicines management, patient group directions and pharmacist-led minor ailment clinics. (2.74)

3.22 The dental surgery refurbishment should be carried out as soon as possible. (2.76)

3.23 Health service professionals should involve and consult patients when making decisions about treatment. (2.81)

Learning and skills and work activities

3.24 There should be a wider range of accredited vocational courses to help support employment. (2.83)

3.25 There should be more meaningful work for vulnerable prisoners, with opportunities for them to gain accredited qualifications. (2.86)

Physical education and health promotion

3.26 The quality of physical education facilities and equipment should be improved. (2.88)

Time out of cell

3.27 The availability of waterproof clothing for outdoor exercise should be advertised to all prisoners. (2.94)

3.28 Evening activities should be introduced into the regime. (2.95)

3.29 Open-air exercise should be available daily for all prisoners. (2.97)

Security and rules

3.30 Managers should satisfy themselves that published procedures for squat searches are being implemented. (2.99)

3.31 The security strategy target of staff searches once every two months should be resumed. (2.101)

3.32 The prison rules and routines should be available in languages other than English. (2.102)

3.33 A senior manager should formally review prisoners on the hold list quarterly. (2.103)

Discipline

3.34 Record keeping on all aspects of use of the special cell should be clearly completed. (2.110)

3.35 Health services staff should not be used to take part in any disciplinary search. (2.111)

3.36 A use of force committee should be set up to review all incidents where force is used against prisoners for appropriateness, and should monitor trends and emerging patterns. The sharp increase in the use of force should be specifically investigated. (2.112)

3.37 The information booklet for prisoners in segregation should be issued without delay. (2.114)

3.38 The strategy for the reintegration unit should be agreed and published. (2.118)

3.39 All prisoners located on the reintegration unit should have clear targets and individual plans for progression and reintegration to mainstream accommodation. Personal plans should be reviewed regularly. (2.119)

Incentives and earned privileges

3.40 There should be sufficient differentials between standard and enhanced levels of the incentives and earned privileges (IEP) scheme to motivate and engage prisoners, and the scheme should be evaluated regularly. (2.121)

Catering

3.41 Lunch should be served between noon and 1.30pm. (2.124)

Offender management and planning

3.42 The personal officer scheme (or suitable alternative) should be used to ensure that custody or sentence plan targets are prioritised, monitored and achieved. (2.128)

3.43 The use of release on temporary licence should be expanded to assist appropriate prisoners to prepare for release. (2.129)

Resettlement pathways

3.44 The drug strategy should be informed by a local needs analysis and include alcohol services. (2.138)

3.45 The drugs policy document should contain detailed action plans, monitoring arrangements and performance measures. (2.139)

3.46 First night symptom relief should be administered consistently and the process closely monitored. (2.140)

3.47 A dedicated team of specialist nurses should be appointed to undertake assessments, care planning and follow-ups for all substance-dependent prisoners requiring clinical treatment, irrespective of their location. (2.141)

3.48 The new clinical protocol for substance misuse services should be introduced as soon as possible and prescribing brought in line with national clinical guidance. (2.143)

3.49 Officers working on the drug dependency unit should all undertake specialist training according to their roles. (2.144)

3.50 The establishment should develop an action plan to open a drug free landing. (2.148)

3.51 Voluntary drug testing (VDT) procedures, including the practice of strip searching, should be reviewed and a clear distinction drawn between VDT and compliance testing. A positive VDT should not lead to mandatory drug testing. (2.149)

Appendix I: Inspection team

Francis Masserick	Team leader
Gail Hunt	Inspector
Vinnett Pearcy	Inspector
Elizabeth Tysoe	Healthcare inspector
Stephen Miller	Ofsted inspector

Appendix II: Prison population profile

(i) Status	Number of prisoners	%
Sentenced	419	58.4
Convicted but unsentenced	118	16.4
Remand	168	23.4
Civil prisoners	3	0.4
Detainees (single power status)	6	1
Detainees (dual power status)	3	0.4
Total	717	100

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	68	16
6 months to less than 12 months	25	6
12 months to less than 2 years	61	15
2 years to less than 4 years	117	28
4 years to less than 10 years	92	22
10 years and over (not life)	50	12
Life	6	1
Total	419	100

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month	103	24.6	94	31.5
1 month to 3 months	124	29.6	95	31.5
3 months to 6 months	66	15.8	72	24
6 months to 1 year	74	17.7	32	11
1 year to 2 years	42	10	5	2
2 years to 4 years	9	2.1	0	0
4 years or more	1	0.2	0	0
Total	419	100	298	100

(iv) Main offence	Number of prisoners	%
Violence against the person	180	25.1
Sexual offences	51	7.1
Burglary	103	14.4
Robbery	81	11.3
Theft and handling	42	5.9
Fraud and forgery	9	1.3
Drugs offences	116	16.2
Other offences	124	17.3
Civil offences	2	0.3
Offence not recorded/ Holding warrant	9	1.3
Total	717	100

(v) Age	Number of prisoners	%
21 years to 29 years	338	47.14
30 years to 39 years	240	33.47
40 years to 49 years	109	15.20
50 years to 59 years	21	2.93
60 years to 69 years	8	1.12
70 plus years: *maximum age: 72*	1	0.14
Total	717	100

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	568	79
Between 50 and 100 miles of the prison	59	8
Over 100 miles from the prison	34	5
Overseas	3	1
NFA	53	7
Total	717	100

(vii) Nationality	Number of prisoners	%
British	680	95
Foreign nationals	37	5
Total	717	100

(viii) Ethnicity	Number of prisoners	%
White		
British	615	86
Irish	0	0
Other White	16	2
Mixed		
White and Black Caribbean	3	0.4
White and Black African	1	0.1
White and Asian	2	0.2
Other mixed	2	0.2
Asian or Asian British:		
Indian	4	0.5
Pakistani	40	6
Bangladeshi	3	0.4
Other Asian	4	0.5
Black or Black British		
Caribbean	4	0.5
African	6	0.8
Other Black	5	0.7
Chinese or other ethnic group		
Chinese	5	0.7
Other ethnic group	7	0.9
Total	717	100

(ix) Religion	Number of prisoners	%
Church of England	214	30
Roman Catholic	178	25
Other Christian denominations	16	2
Muslim	60	8
Buddhist	6	1
Other	4	1
No religion	239	33
Total	717	100