Report on an unannounced short follow-up inspection of

HMYOI Rochester

16–18 February 2009

by HM Chief Inspector of Prisons

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Printed and published by:
Her Majesty's Inspectorate of Prisons
1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

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Introduction

Rochester became a dedicated prison for sentenced young adult men in 2002. Since then it has virtually doubled in size. However, education, work or training was available for only about half the expanded population.

The young adult population is a challenging one to manage safely. Though overall Rochester continued to perform reasonably well in this area, we were concerned that both violence reduction and suicide prevention procedures were underdeveloped. Despite a significant number of assaults, and considerable evidence of bullying, there was under-reporting of incidents and, as at the last inspection, little active anti-bullying work. Use of force had increased, but was properly documented; however, usage of the special cell was poorly monitored.

Living conditions varied considerably: they were good in the new units, but poor in some of the older accommodation. Staff-prisoner relationships were good, and staff clearly knew their young prisoners – though personal officer work was unfocused. Aspects of diversity – particularly disability and work with foreign nationals – were underdeveloped. However, considerable efforts had gone into identifying and addressing the perceptions of black and minority ethnic prisoners, who reported favourably on their time at Rochester. Health services were in general satisfactory, though there were staff vacancies and dental waiting lists were too long.

Offender management had recently expanded, but was not yet effectively linked with other resettlement activities or with residential staff. A system (STORNA) had been developed alongside this to assess and deal with the needs of prisoners. It allowed for immediate intervention on arrival, but was not yet an effective custody planning tool. Some of the resettlement pathways – such as work with families, and accommodation support – were well developed, but others were not and, in particular, there were no specialist services for young men with alcohol problems.

The main, and very troubling, area of underperformance was the provision of activity. We found nearly half the population locked in their cells during the working day. Achievements in education were poor in many areas, the curriculum was narrow, and classroom efficiency was as low as 55%. There were only 90 vocational training places, mostly part time, though they provided some useful skills and some young prisoners were able to work outside in the community. Alongside this, however, 85 young men were engaged in repetitive and mundane contract work. The prison was over-reporting prisoners' time out of cell, which was at most eight hours a day, and more usually half that, or even less for the 60 or so prisoners without any employment at all.

It is commendable that this inspection found that Rochester was performing reasonably well against three of our key tests: safety, respect and resettlement. As the population continues to increase, it will be important to strengthen the procedures that underpin safety, given the volatility of the population. It is, however, unacceptable that the provision and quality of purposeful activity had not kept pace with the expansion, and the needs, of the population. This will make it more difficult to run a safe establishment, but crucially it will also do little to improve the life chances, and reduce the risk of reoffending, for many of the young men held there.

Anne Owers
HM Chief Inspector of Prisons

April 2009

Fact page

Task of the establishment
Sentenced male young offender institution

Area organisation
Kent

Certified normal accommodation
642

Operational capacity
642

Number held
17 February 2009: 602

Last inspection
Full announced inspection: 9–13 January 2006

Brief history
Originally built as a prison in 1874, Rochester was extensively rebuilt in the early 20th century as the Borstal Institution (taking its name from an adjacent village). Its pioneering methods in dealing with young men and boys were used as a model for the creation of other borstal institutions, which were given statutory authority in 1908 and lasted until their abolition in 1983, when Rochester converted to a youth custody centre. In 1988, the prison changed its role to operate as a remand centre for the Kent courts and sentenced category C and D adult males. Further changes resulted in a mixed site holding immigration detainees, a resettlement unit for adult male prisoners at the end of their sentences, and a remand and allocation centre for under-21-year-old males.

In January 2002, Rochester re-roled to a dedicated site for sentenced young men up to the age of 21. An expansion programme increased operational capacity by 300 spaces in July 2008. A second phase, expected to be completed by May 2009, will provide another 64 spaces to make an operational capacity of 756, making Rochester the largest sentenced young offender institution in Europe.

Description of residential units
A wing – first night centre, 32 (single cell/shared accommodation)
B wing – 102 (single cell/shared accommodation)
C wing – 102 (single cell/shared accommodation)
D wing – 100 (single cell/shared accommodation)
E wing – induction unit, 120 (single cell/shared accommodation)
F wing – 60 double cells
G wing – 60 double cells
H wing – 120 single cells
R wing – resettlement unit, 60 double cells

Section 1: Healthy prison assessment

Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2006 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

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

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

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

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

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

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

Safety

HP4 In 2006 we judged Rochester to be performing reasonably well against this healthy prison test. Of the 37 recommendations in this area at our last inspection, we found that 13 had been achieved, five partially achieved, 17 not achieved and two were no longer relevant.

HP5 About 10 new prisoners arrived each day and their management was good, but their supervision in reception needed improvement and there was no television or reading material in the reception holding rooms. Staff were respectful to new arrivals, although the reception process could take up to three hours.

HP6 All new arrivals spent their first 48 hours on the first night centre. The accommodation was poor, but prisoners had satisfactory access to showers and telephones. New arrivals were seen by staff, two Insiders (peer supporters) were available on the first night, and there were reasonable processes for monitoring and staff handover of those on their first night.

HP7 The induction process was initiated on the first night centre and included elements of the STORNA (short-term offender resettlement needs analysis) initial needs assessment process. Prisoners completed their induction with a move to E wing for an eight-day rolling induction programme. Although the programme was comprehensive, prisoners on induction spent a lot of time locked in cell between sessions. General wing staff appeared disconnected from induction staff and the purpose of the wing.

HP8 The violence reduction strategy document was over-complicated, many components had not been implemented, and the violence reduction coordinator was not given time to carry out duties. There was under-reporting of incidents, a significant number of assaults, and a lack of resources to investigate properly or respond to information in security information reports (SIRs). Links with security were poor and information from SIRs was not used to inform action or to help identify trends. The number of prisoners on anti-bullying measures was low, despite indications that bullying was a problem.

HP9 The safer custody meeting was well attended and self-harm prevention given an appropriately high priority. The suicide prevention coordinator was full-time and supportive of prisoners. There were seven trained Listeners and access to them was reasonable, although none worked in reception and there was no Listener suite and not enough safer cells. The quality of assessment, care in custody and teamwork (ACCT) self-harm monitoring documents was mixed, and many were perfunctory. Reviews were on time and inclusive, and care mapping was good.

HP10 Almost 2,500 SIRs were submitted in 2008. Key areas covered were disorder, possession of unauthorised goods, and drugs and alcohol. They were processed

within 72 hours, but security office action was often delayed. The prison reported good relationships with the police. Attendance at security committee meetings was variable. Analysis of use of force incidents needed to be improved, and links to violence reduction work and resettlement were underdeveloped.

HP11 The segregation unit had increased to 28 cells. Environmental standards and cleanliness were poor, although the newer spur provided better accommodation. Prisoners were on two regime levels, but all those we saw there during the inspection were on the lower level, including two prisoners on open ACCT documents. The unit had up to 10 occupants during the inspection, with most subject to cellular confinement and two there at their own request. Most prisoners did not stay long enough to warrant a review, but the reviews that took place tended to have mundane targets.

HP12 There was a high number of adjudications, 1,389 in 2008. Prisoners were properly included and assisted during hearings, standardisation meetings were held quarterly, and adjudication records indicated that hearings were conducted fairly. The independent adjudicator attended twice monthly and usually heard up to 10 cases, mostly related to possession of mobile telephones or drugs.

HP13 Force was used 165 times in 2008. In the last six months of the year, ratchet cuffs had been used on 74 occasions, or 63% of all use of force incidents, which was a significant proportion. Quarterly reports on the use of force were submitted to the security committee, and use of force documentation provided appropriate assurance concerning application and de-escalation. Planned removals were not routinely videoed. Special accommodation had been used 38 times in 2008 and 13 times since January 2009, which was high. Lengths of stay in special accommodation were not excessive, but the accommodation was extremely dirty and documentation and oversight were poor.

HP14 The mandatory drug testing rate was low at 2% in the year to date, against a target of 5.5%. Positive results were mainly for cannabis, but there had recently been some positive findings for Subutex. The prison operated the integrated drug treatment system (IDTS) and, although there was no detoxification work, a few prisoners were on maintenance programmes. Clinical support and interventions were provided by a small, trained team who worked in cooperation with the counselling, assessment, referral, advice and throughcare (CARAT) service and healthcare.

HP15 At the conclusion of this short follow-up inspection, we judged that Rochester continued to perform reasonably well against this healthy prison test.

Respect

HP16 In 2006, we assessed Rochester as performing reasonably well against the healthy prison test. Of the 33 recommendations we made then, we found that 13 had been achieved, eight partially achieved and 12 not achieved.

HP17 Living conditions in the new units, opened in late 2008, were very good. Communal areas were clean, bright and well maintained, and cells were clean and properly furnished. B wing was also acceptable, given its age and usage. D and E wings were in a poor condition. Toilets on the older wings were not adequately screened and there was graffiti. As at the last inspection, prisoners were still not permitted to wear

their own clothes, and there were no facilities for them to dine in association. Access to amenities such as telephones and showers was generally satisfactory. The grounds and outside communal areas were clean and well maintained.

HP18 The incentives and earned privileges (IEP) scheme was embedded, and wing history files showed a strong adherence to the key elements of the scheme, and regular reviews. Most prisoners were on the standard regime, and fewer than 10 were on the basic level.

HP19 Staff-prisoner relationships were good, and we observed much positive and respectful engagement between them. Preferred names and titles were used routinely and there was evidence that staff had knowledge of their prisoners. There was a published personal officer scheme, although this needed to be updated. There was some evidence of personal officer work, but the quality was mixed and it lacked structure and purpose.

HP20 The kitchen provided meals for Cookham Wood as well as Rochester. A four-week menu cycle offered a range of imaginative meals, and prisoners had a high degree of satisfaction with the food. The food we saw was good and plentiful, but breakfast packs were still issued the night before consumption.

HP21 The contract for provision of shop services was due to move to DHL during our inspection. The range and number of products, including healthy items, had increased from 189 to 349 since 2006, but tinned products were still not allowed. There had been no shop surveys, but there was regular consultation at the prisoner consultation group.

HP22 There was no overarching diversity policy, and all aspects of diversity, including disability and foreign national prisoners, were subsumed within the race equality action team (REAT). The diversity staff team had no identified lead on disability, and the work undertaken on disability was not coordinated with healthcare or education assessments. There had been no work on sexual orientation.

HP23 Over half the population, 54%, were from black or minority ethnic backgrounds. Race equality was managed through a properly constituted REAT that included prisoner representation. The REAT considered the results of ethnic monitoring, impact assessments and statistical evaluations, and action planning was effectively monitored. The REAT was supported by a prisoner diversity group that met fortnightly. The prison had received just 65 racist incident forms 2008, but these appeared to be properly investigated. Black and minority ethnic prisoners spoke positively about their experiences and treatment in Rochester.

HP24 Although there were over 120 foreign national prisoners (21% of the population), work with these prisoners was underdeveloped. There were no foreign prisoner representatives, peer support structure or specific foreign nationals' action plan managed through the REAT. There was little take-up of the international telephone call facility and relatively low use of interpretation services. The UK Border Agency held regular surgeries.

HP25 There were effective systems to record and track simple applications, and there was evidence that applications were managed quickly. Access to the formal complaints system was good, and replies were timely and generally respectful. A trained legal services officer was available, but access was not well promoted.

HP26 The well-resourced chaplaincy team provided a range of faith services, which were well attended, as well as faith-based teaching groups and activities. The team supported other aspects of the prison's work and its facilities included a large chapel and new multi-faith room.

HP27 Health services were commissioned by the primary care trust but provided by the prison, and were generally of a reasonable standard. There were two healthcare facilities: the newer one was an appropriate environment for the delivery of clinical care and groups, but the older facility was crowded and less suitable. Staffing had not kept pace with the recent expansion in population, and there were nurse vacancies. Healthcare induction for all new arrivals included health promotion and the offer of a well man clinic. Primary and secondary mental health provision was accessible and satisfactory. Although dental sessions had been increased to four a week, the waiting list had grown with the population, and there was a wait of up to four months for appointments.

HP28 At the conclusion of this short follow-up inspection, we judged that Rochester continued to perform reasonably well against this healthy prison test.

Purposeful activity

HP29 In 2006 we concluded that Rochester was not performing sufficiently well against this healthy prison test, and made eight recommendations. We found that only two of these had been achieved, three partially achieved and three were not achieved.

HP30 There had been a lack of coherence and delay in developing the education provision to meet the needs of the population. There was little educational achievement on offer above level one, and the skills for life provision was underdeveloped. Most participation in education was part time, which ensured that prisoners had access to both work and education or training. Since August 2008, achievements in education had been low in many areas, and there had been no qualifications at all in some elements of provision. Classroom attendance over the last three months had averaged 87-90%, but classroom efficiency was as low as 55%. In many respects, educational provision had regressed since our last inspection.

HP31 Vocational training had expanded to reflect the needs of employers and prisoners, and approximately 90 places were available, mostly part time. There was a range of construction courses, such as brickwork and plumbing, and national vocational qualifications were offered in the kitchen and in PE. Release on temporary licence (ROTL) was used reasonably well to support employment placements, and 14 prisoners were currently working out or about to take up a community placement.

HP32 There were approximately 300 full-time-equivalent work places, including education, which was insufficient for the population. This provided activity for about 50% of prisoners. At the time of inspection, 61 prisoners, 10% of the population, were classified as unemployed, and some classes and workshops were cancelled due to staff shortages. Contract work accommodating some 85 prisoners remained repetitive and mundane, with no recognition of skills developed there. There was some outreach work in the workshops, but this was hampered by low education staffing levels.

HP33 The library was restricted by resources, staffing and funding, and was not open in the evening or at weekends. There were no library facilities on the newly opened site and access was limited. However, education classes made use of the library, which was also used to support education, training and employment (ETE) resettlement work.

HP34 PE was strong and had benefited from increased resources on the new site. It offered a range of appropriate accredited courses, and was open in the evenings and weekends, as well as during the day. About 85% of the population participated in some form of PE activity.

HP35 Access to time unlocked had hardly improved. A fully employed prisoner could access between 7.5 and eight hours a day, but the experience of time unlocked for unemployed and part-time prisoners was much worse. Association was rarely cancelled, but restricted to about 50 minutes each evening.

HP36 At this short follow-up inspection, we concluded that Rochester continued to be not performing sufficiently well against this healthy prison test.

Resettlement

HP37 In 2006 we assessed the establishment as performing reasonably well against this healthy prison test. Of the 17 recommendations we made, we found that three were achieved, two were partially achieved, and 12 were not achieved.

HP38 There was a limited offender management and resettlement strategy document, which had not been updated to reflect recent changes in population and was not based on a needs analysis. There were complicated separate structures for offender management and management of resettlement pathways interventions. There was a dedicated resettlement wing that could accommodate up to 60 prisoners, but allocation was not sufficiently embedded in sentence planning and most prisoners went there through application and self-referral. The assessment of all new arrivals through STORNA resulted in some appropriate and immediate referrals to interventions service providers.

HP39 The offender management unit was still developing after its recent expansion to a multidisciplinary team of 11 offender supervisors and OASys (offender assessment system) assessors. There were 116 in-scope prisoners who were appropriately allocated. Contact by offender supervisors was limited, and links with residential staff and offender managers were underdeveloped. Sentence planning for prisoners not in scope was limited. There was a significant OASys backlog. The use of STORNA required development but could become an effective custody planning tool for shorter-term prisoners. Public protection arrangements appeared well managed, with interdepartmental risk management meetings and appropriate referrals to probation and police on release.

HP40 An accommodation service was provided by the De Paul Trust, and in the year to date all but 8% of discharged prisoners had gone out to settled accommodation. The Trust also facilitated access to a community resettlement worker.

HP41 A prison officer was the ETE lead and the work was embedded in the resettlement unit. ETE staff delivered a well-planned transit to work course with training in CV writing, interviewing techniques and job applications, although not all prisoners on the

resettlement unit had completed this. There were links to some employers and voluntary sector organisations, and opportunities for a few prisoners on ROTL to undertake community placements before release. Prisoners could gain employer-led qualifications in some placements, but arrangements to record non-accredited skills development in other placements were underdeveloped.

HP42 Though a quarter of prisoners said they had financial problems, the prison was not in partnership with a specialist service to provide advice on the finance, benefit and debt pathway. However, two prison officers provided an advocacy service and facilitated access to specialist services for prisoners with identified needs, as well as assistance with opening bank accounts.

HP43 Resettlement primary care discharge clinics helped to identify a GP in the community, if required, before release. Prescribed medication was arranged for discharged prisoners if needed.

HP44 The drug and alcohol strategy was generic to the area and there was also a local document. A needs assessment had been undertaken. A CARATs worker saw all new arrivals for an individual interview and encouraged them to engage with CARAT services as appropriate. The P-ASRO (prison addressing substance related offending) accredited drugs programme was delivered by an independent provider. There were no specialist alcohol services.

HP45 A full-time visitors' centre manager had been appointed to focus on family visits and engage with families in the visitors' centre. The booking of visits could be problematic. The old visits facility was used for extended family visits, and there were some good partnership arrangements with outside agencies to provide parenting support and courses. The visits environment was good, but prisoners were required to wear bibs during visits and all babies' nappies had to be changed beforehand.

HP46 There were no accredited offending behaviour programmes, except for P-ASRO and a victim awareness course, but the establishment had secured funding to deliver enhanced thinking skills (ETS) and controlling anger and learning to manage it (CALM).

HP47 At the conclusion of this short follow-up inspection, we judged that Rochester was 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)

2.1 Anti-bullying arrangements should be improved as a priority. (HP44)

Not achieved. Although there was a three-stage system to identify incidents of bullying, challenge this behaviour and address persistent bullies, the protocols in the violence reduction strategy document were not followed consistently, and there was no effective supervision of processes. The quality of investigations into suspected bullying incidents was poor and often did not fully address the important issues. Some incidents we found reported in security information reports (SIRs) had not been investigated at all. Outcomes of investigations were seldom reported, and staff said that they were unsure how to implement published procedures fully. Only eight prisoners had been on formal measures from September 2008 to January 2009. This was despite a high number of assaults (about eight a month) and bullying incidents reported through SIRs (about 19 a month).There were no prisoners on formal measures at the time of our inspection.
We repeat the recommendation.

2.2 Arrangements for foreign national prisoners should be improved in line with our expectations. (HP45)

Not achieved. There had been little work in developing arrangements for foreign national prisoners since our 2006 inspection, although the foreign national population had risen from 69 prisoners (19% of the population) to 126 (21%).
We repeat the recommendation.

2.3 There should be sufficient work to occupy all the young men for the whole working day, five days a week. The work introduced should lead to the acquisition of useful skills with recognised qualifications. (HP46)

Not achieved. There were only approximately 300 full-time equivalent work places, which was insufficient for the population. Only about half of the prisoner population were employed at any time, including those on induction and P-ASRO (prison addressing substance related offending) courses. This included 84 wing workers. At the time of inspection, 61 prisoners (10%) were unemployed. Vocational training provided accredited qualifications that were mostly at level one, but kitchen work and PE were accredited at national vocational qualification (NVQ) level two. The contract work for about 85 prisoners remained low level, mundane and repetitive, and did not recognise skills developed by prisoners, such as work ethos and team working. Fourteen prisoners were working out in placements under release on temporary licence (ROTL).
We repeat the recommendation

2.4 Prisoners should be unlocked for a minimum of 10 hours each weekday. (HP47)

Not achieved. Although the prison had reported a time unlock figure rising from 7.4 hours to over 9.5 hours in the latter part of 2008, this was not the reality for many prisoners. Under the

core day, the maximum achievable time unlocked for a fully employed prisoner was between 7.5 and eight hours a day, well short of our expectation of 10 hours. A random roll check revealed 271 prisoners, 46% of the population, locked in their cells during the working part of the day, which suggested an actual experience of nearer four or five hours a day unlock for those with restricted or part-time access to the regime. Some of the 60 unemployed prisoners would have had even more limited time out of cell, although this was mitigated by access to recreational gym during the day and hour-long exercise periods.
We repeat the recommendation.

2.5 There should be a needs analysis of sentence planning and resettlement requirements. The results should be implemented. (HP48)

Partially achieved. The recent significant expansion of the prison population had led managers to consider the resources allocated to sentence planning and resettlement work. Although there had been a prisoner survey to assess resettlement needs, the results were not available to the prison to inform these decisions (see paragraph 2.217). As a result of securing additional funding, the offender management unit had recently increased in size, and a well-resourced interventions department to deliver work across the resettlement pathways had been established. These developments were recent, and it was too early to assess whether the offender management and interventions resources would be sufficient to meet the needs of the prisoners (see further recommendation 2.225).

Recommendations To NOMS

Resettlement strategy

2.6 The lack of opportunities for prisoners in the 18 to 21 age-group to move to open conditions in the South of England should be addressed. (8.7)

Not achieved. The only opportunity for prisoners aged 18 to 21 to progress to open conditions was to transfer to HMP Hollesley Bay. We were told that no prisoners had transferred there during 2008. Prisoners eligible for open conditions when they reached 21 could transfer to open conditions in the adult estate, but opportunities to do so were also limited.
We repeat the recommendation.

Offending behaviour programmes

2.7 An offending behaviour needs analysis for young adults should be undertaken to identify which programmes should be delivered by whom and at what stage in an offender's sentence. (8.52)

Not achieved. The prison was not aware of any offending behaviour needs analysis. There were plans to introduce two accredited offending behaviour courses in 2009 – enhanced thinking skills (ETS) and controlling anger and learning to manage it (CALM). The prison had identified the need for these offending behaviour courses at Rochester through offender assessment system (OASys) assessments, and had discussed appropriate programmes with the national interventions team and the Kent area psychologist.
We repeat the recommendation.

Reintegration planning

2.8 Prisoners should not be transferred unnecessarily while their risk assessments for home detention curfew are being carried out. (8.36)

Not achieved. Offender management case administrators were responsible for processing and collating home detention curfew (HDC) risk assessments for eligible prisoners in their allocated caseload. Case administrators said that prisoners continued to be transferred to Rochester with HDC risk assessments under way. The related paperwork often did not accompany the prisoner, and it was therefore unclear if the assessment process had begun or what stage it had reached. This led to a duplication in work and could delay the processing of assessments. There had even been cases of prisoners transferred to Rochester who had been assessed as suitable for HDC.
We repeat the recommendation.

Recommendations — To the governor

Courts, escorts and transfers

2.9 Reception staff should be scheduled for duty at times when prisoners are arriving and should have enough time to process them properly. (1.8)

Achieved. Staff were usually scheduled to work during the day, and prisoners usually arrived between 11.30am and 1.30pm when staff were on duty. Prisoners being released or taken to court were processed before new receptions arrived. We were told that it was relatively rare for new receptions to arrive late. Although scheduled to close during lunchtime, the unit usually stayed open to manage those arriving.

Additional information

2.10 Escort services were provided by Serco. Staff said that the relationship with the contractor was generally good, and we observed helpful engagement and appropriate information-sharing between the staff. Appropriate documentation was completed. Journeys to the establishment were rarely longer than an hour and a half. New arrivals had been told in advance that they were coming to Rochester; and given written information about the establishment and what they could expect.

First days in custody

2.11 Prisoners locked in reception holding rooms should be properly supervised. (1.26)

Not achieved. Although the new reception area had two holding rooms, and a third that was rarely used, supervision was limited. The initial holding room was visible from the main desk, but the room used after prisoners had been searched was not. Both rooms were covered by CCTV, but the monitor was upstairs in the healthcare area and no staff were allocated to view it when the holding rooms were in use.
We repeat the recommendation.

2.12 All communal areas in reception should be clean, well decorated and in a good state of repair. (1.27)

Achieved. The reception area was new and had only been in operation since October 2008. The communal areas, including the three holding rooms, were clean and light.

2.13 Residential staff on the induction unit should be involved in the delivery of the induction programme. (1.28)

Partially achieved. Induction was delivered across A and E wings. A wing was primarily the first night centre, where new arrivals usually stayed for 48 hours before moving to E wing. The staff group of 26 worked across both units, but not all were involved in the delivery of the induction programme. Usually the more experienced staff delivered the programme, while the newer staff undertook day-to-day tasks. This continued to result in some dislocation of provision, and many staff were unaware of prisoners' individual progress during induction, even those for whom they were personal officers.
We repeat the recommendation.

2.14 Residential officers should regularly access and record information in wing files of prisoners on induction. (1.29)

Not achieved. All prisoners on A and E wing had wing files, but these did not refer to their progress through induction. There was a further record of the induction modules completed, but this also gave no details. Some wing files had no entries for several weeks, and entries were usually about wing incidents (see also further recommendation 2.37).
We repeat the recommendation.

2.15 Needs assessments should be regularly reviewed and linked to sentence planning. (1.30)

Achieved. The prison had introduced STORNA (short-term offender resettlement needs analysis) approximately two years previously, which identified initial resettlement needs against the seven pathways. The electronic document was completed on A wing during induction, generally within the first 48 hours. Where particular issues were identified, email referrals were automatically made. The system generally worked well, but the previous post-induction case conferences had been replaced by a basic checklist of what had been covered and it was not clear how identified resettlement or sentence planning objectives were subsequently taken forward (see also further recommendation 2.236).

Additional information

2.16 The new reception area was well managed by dedicated staff. An average of about 10 prisoners were received each weekday, except Wednesday. There was an appropriate area for strip searching, and we were told that prisoners were only required to squat during searches on the basis of security intelligence. There were showers but these were rarely used, as new arrivals could shower on the first night centre. Holding rooms were generally appropriate, although they had no televisions or reading material. First night officers from A wing and healthcare staff saw new arrivals, and the reception process usually took about three hours.

2.17 At the time of the inspection, 14 prisoners on the resettlement unit were working outside the prison, and they were processed in a separate reception area in a Portakabin attached to the unit. This area was too small for the number of prisoners, and was cold and grubby.

2.18 First night procedures were reasonable. All new arrivals had an opportunity to shower and make a telephone call. Two prisoner Insiders saw all new arrivals on their first night, went through basic information and answered any questions. The range of information was reasonable, but was not written down. A *Rough guide to Rochester* booklet had been withdrawn for updating, but had not yet been reintroduced. A wing was oriented to new arrivals and staff were sensitive to issues that might arise. Staff were reasonably knowledgeable of newly arrived prisoners.

2.19 The eight-day rolling induction programme started the day after arrival and was spread over a two-week period. Induction officers delivered key aspects of the programme which, on the first morning, consisted of a multi-media presentation outlining the induction programme and all key aspects of the regime at Rochester. The induction programme was relatively new and had been revised from the original five-day programme when the induction unit had moved to A and E wings in October 2008. An initial expansion to 10 days had been reduced to the current eight days, but some modules were still being developed.

2.20 Induction continued once prisoners moved to E wing, and some aspects continued to be provided from induction classrooms on A wing. Relevant departments had induction slots, including the chaplaincy, counselling, assessment, referral, advice and throughcare service (CARATs), education and the gym, and the healthcare department offered a well man clinic. A diversity officer presented a diversity session, which included a disability assessment (see paragraph 2.66).

2.21 Although the induction programme was comprehensive, many prisoners on it still spent a considerable time locked up. Although each module took an hour or more, individual assessments took only a few minutes, and staff believed the whole programme could be delivered in five days, as previously.

Further recommendations

2.22 There should be reading material and televisions in the reception holding rooms.

2.23 The resettlement unit's reception area should be enlarged to accommodate the number of prisoners processed, and should be kept clean and warm.

2.24 New arrivals should be given written information about the regime at Rochester.

2.25 The induction programme should occupy participants throughout, and they should not be locked in cells for long periods.

Residential units

2.26 Prisoners should be allowed to wear their own clothes. (2.09)

Not achieved. Although prisoners were supplied with enough clean prison clothes every week, they were not permitted to wear their own clothes, even though most residential units had

laundries.
We repeat the recommendation.

Additional information

2.27 Eight residential wings held up to 642 prisoners in a mix of single and double cells. The population had increased since the last inspection, with four new residential units (Frinstead, Greatstone, Headcord and the resettlement unit) adding 210 spaces. At the time of inspection C wing, a large Victorian residential wing, was being refurbished and not in use.

2.28 Living conditions on the new units were of a good standard. Cells were clean, well decorated and bright. In-cell toilets were properly screened and all cells had working showers. Communal areas were well maintained, cleaning schedules were adhered to, sightlines for supervision were good, and association equipment was adequate and well maintained. Notice boards on all landings had up-to-date information about how prisoners could access resettlement and activity services and contact staff if they needed help. Although outside areas were clean and well kept, exercise yards were bare and had no benches or activity equipment.

2.29 The environment on the old Victorian units was mixed. Given its age and use, the general conditions on B wing were good. Cells were clean and adequately furnished, communal areas were clean and bright, and galleried landings provided sightlines. Conditions on E and D wings were poor. Many cells were dirty and poorly decorated, in-cell toilets were not adequately screened, and there was offensive graffiti on many walls and ceilings. Cells on E wing (induction) were particularly poor and not suitable to accommodate new arrivals. Floors and stairs on E and D wings were ingrained with dirt, landings were dark and the overall atmosphere was unwelcoming. The first night centre (A wing) was clean and adequately decorated. Although cells were small, they were clean and free from graffiti.

2.30 All prisoners had access to an emergency call bell in their cells. We found that they worked and were responded to quickly, usually within five minutes. All prisoners could have a shower and use the telephones every day during association or on request.

Further recommendations

2.31 Cells and communal areas on D and E wings should be kept clean, well decorated and in a good state of repair.

2.32 Conditions in the exercise yards should be improved.

Staff-prisoner relationships

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

Additional information

2.33 The relationships between staff and prisoners appeared to be a strength of the establishment. We observed engagement that was both friendly and respectful, and the atmosphere on the wings was relaxed. Staff spoke positively of their work with prisoners, the use of prisoners' preferred names and titles was well embedded, and there was considerable evidence that staff had knowledge of their prisoners.

Personal officers

2.34 The role of the personal officer should be expanded to include involvement in sentence planning and resettlement/reintegration planning. (2.21)

Not achieved. There was no evidence that personal officers had any meaningful involvement or engagement with sentence planning or resettlement.
We repeat the recommendation.

Additional information

2.35 There was a detailed and comprehensive personal officer policy document, but it dated from 2006 and required revision. There was little evidence that staff routinely referred to or accessed the policy. Personal officers were allocated by location, although the allocation was not acknowledged on the prisoner's cell card as required. The approach to personal officer work appeared low key, although some work was being done. The wing files we reviewed were mixed. Some showed reasonable levels of engagement with prisoners and considered their needs and issues, while others were more superficial. Quality assurance checks were similarly mixed and inconsistent.

Further recommendations

2.36 The personal officer policy should be updated.

2.37 There should be routine and consistent management checks of wing files to monitor the quality of personal officer entries.

Bullying and violence reduction

2.38 The violence reduction coordinator should receive enough facility time each week to cover the workload and develop the role. (3.9)

Not achieved. Although a principal officer had been appointed as the violence reduction coordinator, he had not been allocated time for the role so he was unable to carry out most of the duties. As a result, important elements of the violence reduction strategy document were not implemented. Alleged incidents were not investigated, wing observation books were not scrutinised for bullying incidents, protocols for managing bullies were not implemented consistently on residential units, and information on bullying from the security department was not acted upon.

Further recommendation

2.39 A full-time violence reduction coordinator should be appointed.

2.40 The safer custody committee should routinely review bullying incidents and relevant monitoring information to identify bullying 'hot spots', inform local policy and ensure appropriate remedial action. (3.10)

Not achieved. Although some information on recent incidents was discussed during safer custody meetings, there was no systematic analysis of all related information to inform changes in strategy or to identify problem areas.
We repeat the recommendation.

2.41 Interventions should be available for identified bullies and support plans drawn up for victims of bullying. (3.11)

Not achieved. There was no evidence of meaningful interventions for bullies, apart from segregation or removal to other residential units, and there were no support plans for victims.
We repeat the recommendation.

2.42 Valuable items of property should be security-marked before being issued to prisoners. (3.12)

Achieved. Although prisoners' valuable property was not security marked, there were effective systems to record and identify any valuable property prisoners were allowed to have in possession.

Additional information

2.43 An overarching violence reduction policy document had been published in 2006, but had not been revised. Although it set out the prison's strategic direction for reducing violence, including dealing with bullying behaviour, many of its components had not been implemented, staff did not understand its content, and monitoring arrangements had not been adequately developed.

2.44 Overall responsibility for monitoring the policy and reviewing strategy lay with the safer custody group, which also managed the suicide prevention policy. A multidisciplinary violence reduction team described in the policy document had not been appointed to monitor, review and supervise the implementation of the violence reduction strategy.

2.45 The safer custody group met monthly. Meetings were chaired by the deputy head of residence, often without support from managers in relevant areas, such as security and healthcare. Attendance was generally erratic, and representation from senior managers was inconsistent. Minutes showed that meetings focused predominantly on prisoner self-harm and suicide prevention, and other forms of violence were underemphasised. The residential governor provided some information on the number of reported violent incidents, but details were limited and there was no analysis of wider trends or information on violent incidents from other areas of the prison.

2.46 Links with the security department were not adequately developed, and we were not given assurances that all relevant information was shared with the safer custody group and that initiatives to reduce violence were coordinated.

Further recommendations

2.47 The violence reduction policy should be revised.

2.48 Staff should be aware of their role as described in the policy document in dealing with bullying behaviour and the reduction of violence.

2.49 Violence reduction training should be given to staff, particularly residential officers and managers.

2.50 There should be better attendance at safer custody meetings to deal with violence reduction and reflect the protocols in the violence reduction document.

2.51 There should be stronger links between violence reduction and security.

Self-harm and suicide

2.52 The suicide prevention coordinator should receive enough facility time each week to cover the work load and develop the role. (3.23)

Achieved. A senior officer had been appointed as the full-time suicide prevention coordinator. She was responsible for ensuring that protocols to manage prisoners at risk of self-harm were properly implemented, and was also a centre point for advice and guidance to staff and prisoners. Her role was well known by staff and prisoners throughout the prison.

2.53 Prisoners should have access to Listeners at any time during the day or at night. (3.24)

Achieved. There were seven trained Listeners, based in the resettlement unit. Although this number seemed sufficient to deal with demand, they did not work in reception or on the first night unit. Prisoners had access to Listeners, and to the Samaritans direct line telephone, at all times during the day and night. Officers were quick to respond to requests, and prisoners said that they could contact a Listener when they needed to.

Further recommendation

2.54 Listeners should be employed in reception and the first night centre.

2.55 An appropriate number of safer cells should be provided across the establishment. (3.25)

Achieved. Four safer cells had been introduced: one in the segregation unit and three in residential units.

2.56 Checks by night staff on prisoners subject to open F2052SH documents should be frequent and unpredictable. (3.26)

Achieved. Although the quality of written entries in assessment, care in custody and teamwork (ACCT) self-harm monitoring documents (which had replaced F2052SH) were mixed (see below), they showed that night staff made frequent but irregular checks.

Additional information

2.57 There was a prison-specific self-harm and suicide policy document that was well known to staff, and we found copies in all the wings, communal areas and reception. Although the suicide prevention coordinator oversaw protocols, there was day-to-day case management from residential staff.

2.58 The monthly safer custody group meeting monitored the suicide and self-harm prevention policy and procedures. Although its membership represented a range of disciplines, attendance by senior staff was inconsistent (see also paragraph 2.45). Minutes of meetings showed that relevant issues were discussed appropriately, and all individual open cases were reviewed. There was, however, little use of historical information to help identify trends or patterns of behaviour. The suicide prevention coordinator was aware of this and was setting up a database to enable better analysis of information on self-harming behaviour.

2.59 At the time of our inspection, there were 11 open ACCT documents. The quality of entries in documentation was mixed. While some, particularly those from healthcare staff, showed an in-depth understanding of the prisoner's individual circumstances and feelings, others were poor with cursory comments that generally did not demonstrate knowledge of the prisoner. Only 42% of staff had been trained in ACCT procedures.

2.60 Case reviews were well organised, usually by the suicide prevention coordinator, and attended by staff who knew the prisoner. The records showed that prisoners were fully involved in the process, encouraged to express their thoughts, and given the opportunity to take part in activities as part of formal care plans. The care plans we saw were generally of a very good quality, with consistent input from health are staff. The suicide prevention coordinator monitored progression through the plan.

Further recommendations

2.61 The quality of written entries in assessment, care in custody and teamwork (ACCT) documents should be improved.

2.62 All staff should be trained in ACCT procedures.

Diversity

2.63 Confidence-building training should be provided to diversity group representatives. (3.34)

Partially achieved. There were eight wing diversity prisoner representatives at the time of the inspection, but they were mainly oriented to race. There had been some training for diversity representatives, but their turnover made this task problematic. Scheduled training covered ethnic monitoring, racist incident report forms (RIRFs) and impact assessments. The prisoner representatives met fortnightly, and minutes of their meetings indicated that there were reasonable attempts to help prisoners understand issues and develop confidence in their understanding. The training of wing representatives needed to be extended beyond race to incorporate their wider diversity role.

Further recommendation

2.64 Training for diversity group representatives should be extended to cover a wider range of diversity issues.

Additional information

2.65 There was no overarching diversity policy. There was a full-time diversity team of three, led by a senior officer. Its primary function was race, and it covered little else under wider diversity. The prison had just started to run a half-day diversity training programme for all staff. There was no work on sexual orientation.

2.66 Diversity officers presented a dedicated module on the induction programme covering race and diversity, and undertook individual disability assessments. The assessment tool was comprehensive and included learning difficulties and poor reading and writing skills. However, education and healthcare staff also undertook their own assessments of disability, and these were different. The assessments by diversity officers were not used to trigger specific interventions, and the information collected was not used to assess levels of need or patterns over time.

2.67 There were two cells on H wing adapted for prisoners with disabilities, although neither had been used for such prisoners since the wing had opened in September 2008. The doorways into the two dormitories on A wing, formally the healthcare centre, were wide enough to admit a wheelchair, but there had been no further adaptations to these cells.

Further recommendations

2.68 There should be an overarching diversity policy with specific development objectives under key constituent headings, including disability and sexual orientation, and identified leads working directly with the diversity team.

2.69 Assessments of disability should be applied across all departments, and result in appropriate interventions.

2.70 Individual action plans should be developed to address and/or manage specific issues of diversity.

Race equality

2.71 Written replies to racist incident report forms should routinely be provided. (3.35)

Achieved. There had been 65 racist incident report forms (RIRFs) submitted in 2008 and eight in January 2009. This number appeared low for the population. One of the two diversity officers investigated all RIRFs. All responses were typewritten, and were appropriately detailed and respectful. All recipients were also asked to indicate their satisfaction with the investigation/response.

2.72 Negative perceptions among black and minority ethnic prisoners should be addressed with the black and minority ethnic prisoner group and an action plan put in place to address the issue. (3.36)

Achieved. The prisoner diversity representatives discussed a wide range of issues in their meetings, including ethnic monitoring and issues raised via RIRFs (although not the RIRFs themselves). Diversity and race were also standing agenda items at the general prisoner consultation meetings and wing meetings – although they rarely covered issues wider than

race. The diversity manager had developed an action plan, which was updated monthly to take identified issues forward, and there was an agreed timetable to undertake and review impact assessments. All such assessments included focus groups and, in some cases, surveys. Because the diversity team felt that the number of RIRFs was low for the population, it was conducting a prisoner survey to gauge confidence in the system and what could be done to improve it. Black and minority ethnic prisoners consistently told us that the problems they experienced were the same as for white prisoners, and they gave no examples where they felt more negatively about their circumstances or treatment.

Additional information

2.73 Black and minority ethnic prisoners made up just over half of the population at Rochester, 54%, rising to 58% during 2008. The monthly race equality action team (REAT) was chaired by the governing governor and was appropriately constituted and attended by representatives from all key departments. The race relations communications strategy and offender communications strategy, dated October 2008, covered all the main issues relating to effective race relations, and were supported by the race equality action plan (REAP) that was reviewed quarterly through the Prison Service race equality action group.

2.74 Investigations following the submission of RIRFs were generally appropriate, although there were some inconsistencies. There were attempts to apply relatively low-level sanctions where incidents were relatively minor, and these were discussed with the victim, where appropriate. These incidents were subsequently sometimes marked as 'non-racist'. There was no ongoing log of incidents to track any repeated behaviour or to ensure that outcomes and sanctions were consistent. The very detailed annual race equality report, published in March 2008, did not include any analysis of RIRFs.

2.75 Any prisoner convicted of a racially motivated offence was monitored, and this was reflected appropriately in cell sharing risk assessments, but there was no programme to address such behaviour, or that of prisoners who behaved in a racist manner while at Rochester.

Further recommendations

2.76 There should be a database to monitor racist incident reports and to analyse patterns and trends.

2.77 The prison should clarify what constitutes a racist incident and apply this consistently.

2.78 There should be a programme addressing issues of racism and cultural awareness for those prisoners convicted of a racially motivated offence and/or racist incident within the prison.

Foreign national prisoners

2.79 The contents of the foreign nationals' policy and guidance for staff should be more widely disseminated and appropriate training given. (3.44)

Not achieved. The foreign national policy was updated in 2007. It was comprehensive, advised staff on how to support and engage with foreign national prisoners, and included information about external support groups and bodies. However, the policy remained little used or known by most wing staff. Staff said that they tended to pass on any issues to, or seek

advice from, the diversity officers. There was no foreign national prisoner training.
We repeat the recommendation.

2.80 A foreign national prisoners' consultation group should be established and should advise on how to improve negative perceptions among foreign national prisoners. (3.45)

Not achieved. There were still no foreign national prisoner representatives. Foreign national prisoner issues were subsumed under race and included in the race equality action team meetings. Prisoner diversity representatives also covered foreign nationals in principle, but these prisoners were not effectively represented in practice. The role of prisoner representative was not feasible for prisoners with limited English, and there was no other forum for foreign nationals. The prison did not know the general views of foreign national prisoners as it had no means to ascertain them.
We repeat the recommendation.

2.81 Foreign national prisoners should have access to advice from the immigration and nationality service and interested community groups. (3.46)

Partially achieved. The UK Border Agency held a bi-monthly surgery. Prisoners could apply for an interview space and information about the surgery was advertised on all wings, but in English only.

Additional information

2.82 There was no identified foreign national coordinator and foreign national prisoner issues were picked up by one of the diversity officers. There were attempts to be sensitive to the needs of new arrivals with little or no English and, where appropriate, they were allocated close to those able to communicate with them. No staff undertook initial interviews and/or assessments with newly arrived foreign nationals and, while some basic information was available in foreign languages, information about the regime at Rochester was only provided in English. Interpretation services had only been used on 26 occasions in the previous six months.

2.83 Although all foreign national prisoners were entitled to a monthly five-minute telephone call abroad in lieu of visits, on average only four prisoners took this up. Most foreign nationals did not know of this entitlement, for which they had to make a written application each time, which was an added barrier for those unable to write in English.

Further recommendations

2.84 The prison should actively seek to introduce independent immigration advice from legal and community groups.

2.85 The prison should identify a foreign national prisoner coordinator.

2.86 All foreign national prisoners should be seen on induction to ascertain their current circumstances and identify specific issues.

2.87 There should be greater use of interpretation services.

2.88 Induction information and other information about the establishments' regime should be provided in a prisoner's first language.

Applications and complaints

2.89 Complaints boxes should be emptied by a person unconnected with the wing on which the complaint has been made. (3.65)

Not achieved. As at the last inspection, complaints boxes were emptied at night by a senior prison officer and delivered to the complaints clerk the following morning.
We repeat the recommendation.

2.90 The prison should take action including consulting with prisoners to improve the perception that complaint replies are slow and unfair. (3.66)

Achieved. There were notices on all residential units describing how prisoners could access the formal requests and complaints system. Information included published timelines for completion, and an explanation of the appeals process. Minutes of monthly consultation meetings between staff and prisoners showed that staff responded to issues raised by prisoners about prison routines and conditions. Minor complaints were discussed, and staff gave justifiable reasons for their decisions.

2.91 There should be regular management checks on the quality and pertinence of replies. (3.67)

Achieved. The head of residence made regular management checks on the quality of staff replies to formal requests and complaints. There was evidence that checks were meaningful, and we saw many examples where cursory replies that did not address the issue and those that had taken too long to complete were challenged appropriately.

Additional information

2.92 There were effective systems to process and track day-to-day applications. Prisoners had access to forms, and there was information about how to use the system on all residential units. Staff logged applications in a book kept on the wings, with a record of the time the application was made, the nature of the request, and the area or department it was sent to for action. This meant that its progress could be monitored. Staff ensured that applications were dealt with quickly, and followed up those not responded to within 24 hours.

2.93 Formal request forms were readily available on residential units. Prisoners could post completed forms in secure boxes away from staff offices on their residential units.

2.94 There had been 375 formal complaints between August 2008 and January 2009. The quality of responses was generally good. They were prompt, legible and respectful, and addressed the appropriate issues. There were tracking systems to ensure that complaints were answered on time, and the complaints clerk made regular checks to ensure consistency. The subject of complaints was categorised and submitted to the monthly senior management team for analysis.

Legal rights

2.95 All prisoners should have access to trained legal services officers. (3.72)

Partially achieved. Although a trained legal services officer had been appointed and worked

as part of the offender management team, his role was poorly advertised and he did not routinely see all prisoners as part of their induction programme.

Further recommendation

2.96 The role of the legal services officer should be properly advertised and explained to all prisoners during their induction programme.

2.97 Sufficient suitable facilities should be provided to accommodate private legal visits (3.73)

Achieved. There were now suitable facilities for confidential legal visits. Legal visits took place on Monday to Thursday in discrete booths in the main visits room. They were clean and comfortable, with appropriate privacy.

Additional information

2.98 A register of appellants was maintained, and officers in the offender management unit ensured that prisoners could access legal advice and understood the legal correspondence about their appeals. Recalled prisoners were identified and given a written explanation about the reason for recall and their rights to make representation and appeals. Lists of solicitors and professional legal advisers were available to prisoners on request, although prisoners said that access to them was poor. The library was well stocked with a range of legal textbooks and Prison Service Orders, although access was restricted (see paragraph 2.144).

Further recommendation

2.99 Prisoners should have access to lists of solicitors and professional legal advisers.

Substance use

2.100 Target testing should be undertaken within the required timeframe. (8.65)

Partially achieved. Target testing was due to be carried out within 72 hours. If this did not take place, the situation was monitored. There had been measures to reduce the number of tests not undertaken by enabling principal officers to authorise testing. We were not able to identify the number of target tests not undertaken because they were out of time.

Further recommendation

2.101 The number of target tests not undertaken because they exceed the timeframe should be recorded.

Additional information

2.102 The mandatory drug testing rate was low at 2% in the year to date at the time of our inspection, against a target of 5.5%. Positive results were mainly for cannabis, but there had been some recent positive results for Subutex.

2.103 The integrated drug treatment system (IDTS) had been introduced. There were currently four prisoners on the programme, which was planned to expand to take 10 participants. The team of three staff offered individual support and group interventions, as well as clinical support.

Vulnerable prisoners

2.104 Vulnerable prisoners held on C wing should be reviewed regularly and able to access key areas of the regime. (6.62)

No longer relevant. C wing had closed for refurbishment, and its residents had been transferred to other prisons or reintegrated into normal residential units. There was no vulnerable prisoner unit at Rochester, and all prisoners had access to the same regime.

Health services

2.105 Algorithm-based nurse triage should be introduced. (4.62)

Partially achieved. Although triage algorithms had been introduced, the forms used had only a checklist of symptoms. They did not indicate action to take and so did not ensure consistency of treatment.

Further recommendation

2.106 Triage algorithm forms should include action to be taken to ensure consistency of treatment.

2.107 The well man/induction sessions should be extended to ensure that all prisoners, except those on very short sentences, can attend. (4.63)

Achieved. The third day of the induction course included a healthcare presentation, which gave prisoners information on health services at Rochester and how to access them, and health promotion information, including hand washing, care of the teeth and testicular self-examination. Following the presentation, prisoners were offered individual consultation with a nurse for a well man check up, where they received a general health check and could ask confidential health questions.

2.108 Health promotion material should be available in a range of appropriate languages. (4.64)

Not achieved. Although the healthcare induction information was being translated into a variety of languages, and there were attempts to provide health promotion information in a range of languages, the current health promotion information was in English only.
We repeat the recommendation.

2.109 The flooring in the counselling room should be replaced and the painting programme completed. (4.65)

Achieved. The floor covering in the counselling room had been replaced with a carpet, which was clean and in a good state of repair. The room had also been painted.

2.110 All clinical areas should be kept clean and uncluttered. (4.66)

Partially achieved. The rooms in the new healthcare centre were clean, bright and uncluttered, and had appropriate provision for storage. The rooms in the old healthcare centre was not in as good a condition, and some of the small rooms were overcrowded and cluttered. The dental suite had items stored on the floor, as well as a freestanding medicine trolley used solely for prisoners' personal items while they had treatment, which added to the clutter in the room. The old healthcare centre was also noisy and dusty during our inspection, because of work to extend the pharmacy.

Further recommendations

2.111 Items should not be stored on the floor in the dental room.

2.112 The medicine trolley in the dental room should be removed, and there should be more appropriate arrangements to hold prisoners' personal items during treatment.

2.113 The revision of pharmacy-standard operating procedures should be completed. (4.67)

Achieved. There was a wide range of pharmacy standard operating procedures, including new procedures for the introduction of the integrated drug treatment system (IDTS).

2.114 Licensed prescription-only medicines should not be supplied in place of licensed pharmacy-only products. (4.68)

Achieved. Licensed prescription-only medicines were no longer supplied in place of licensed pharmacy-only products.

2.115 Patient group directions should be introduced to enable supply of more potent medication by the pharmacist and nurses and avoid unnecessary consultations with the doctor. (4.69)

Partially achieved. Patient group directions (PGDs) had been written, but had not yet been introduced. There had been some nurse training to prepare for their introduction.
We repeat the recommendation.

2.116 Only complete packs of medication that are licensed as general sales list medicines should be supplied to patients as special sick remedies. Medicines should not be packed down or repackaged. (4.70)

Achieved. Prisoners were only supplied with special sick remedies that were licensed as general sales list medicines, and these were complete packs of medication that had not been repackaged. Notices to this effect were prominently displayed on the cupboards where medication was stored.

2.117 The provision of sexual health clinics should be formalised and increased to meet the needs of the population. (4.71)

Achieved. There were two sexual health clinics a week, one in each healthcare centre, which were run by nurses who had been appropriately trained.

2.118 There should be increased medical input to healthcare to include medicines management and clinical audit. (4.72)

Not achieved. GPs rarely attended the quarterly medicines and therapeutics committee, and no GP from Rochester had attended the meetings in over a year. The GP services appeared to have little activity outside the provision of GP clinics. One of the GPs had been involved in planning for the introduction of IDTS.
We repeat the recommendation.

2.119 Clinical supervision should be formalised and available for all staff. (4.73)

Not achieved. Although senior staff recognised the value of clinical supervision, nursing staff did not access it. There were plans to develop joint clinical supervision with a nearby establishment.
We repeat the recommendation.

2.120 The service level agreement for dental services should be agreed with the primary care trust. (4.74)

Not achieved. There was still no service level agreement for dental services.
We repeat the recommendation.

2.121 Procedures/protocols should be drawn up to ensure weekly dental compressor maintenance and to provide appropriate certification, documentation and written policies on the provision of dental care in accordance with regulations. (4.75)

Partially achieved. Although there were no policies or protocols for weekly maintenance of the dental equipment, and the dentist was unaware of any maintenance or who was responsible for it, we found records of planned preventative maintenance arranged through the works department. We were told that the compressor was regularly drained, but we were unable to find any written record of this.

Additional information

2.122 Health services were commissioned by Medway primary care trust (PCT) and provided by prison-employed nurses. The increase in population had been reflected in an increase in nursing posts. There were vacancies for five nurses and two other healthcare workers at the time of our inspection, and agency staff were used to fill the gap.

2.123 Most mental health need was primary care, and the primary mental health team was expanding to meet the increase in population. However, there was no additional office space and the full team of up to seven nurses would have to work out of a two-person office, with only one computer terminal to access patient clinical records. There were weekly mental health liaison groups, and communication between mental health and primary care staff.

2.124 IDTS had been introduced and one nurse and two healthcare support workers had been employed for this programme (see paragraph 2.103).

2.125 There were 141 prisoners on the dental waiting list, with the longest wait of four months. The number of dental sessions had been increased from two to four, but the wait for appointments was long.

Further recommendations

2.126 Nursing vacancies should be filled as soon as possible.

2.127 Appropriate accommodation should be identified for the mental health nurses.

2.128 Dental services should meet the needs of the population.

Learning and skills and work activities

2.129 Better use should be made of individual learning plans and these should be linked to sentence plans (5.17)

Achieved. All new arrivals had an initial assessment for literacy, numeracy and language support needs, using a nationally recognised target skills assessment. The results were discussed with the prisoner during their induction, and a learning plan agreed. This was stored electronically in a short-term offender resettlement needs analysis (STORNA) programme, and audited and reviewed every four weeks. All learning and skills and offender management staff had access to the individual learner information.

2.130 The range of vocational provision should be extended. (5.18)

Partially achieved. The range of vocational training had been extended to include more construction courses, and 90 places were available, mostly part time. However, there needed to be courses above level one and appropriate progression routes. The multi-skills provision was beneficial, but did not provide specific higher level training for employment in a particular area, such as plumbing (see also recommendation 2.3).

Further recommendation

2.131 There should be more vocational courses above level one and more progression routes.

2.132 Outreach support should be made more available. (5.19)

Partially achieved. Outreach support was available in workshops and on residential units, and focused primarily on literacy, numeracy and language support needs. However, this work was not put into context sufficiently and there were not enough staff to provide adequate support.

Further recommendation

2.133 Outreach support should be appropriate to the context in which it is delivered, and there should be more staff to provide support.

2.134 A systematic approach to continuous staff development should be developed. (5.20)

Partially achieved. Prison staff appraisal and performance monitoring processes were well embedded, and support for staff development was strong. However, staff appraisal and development for A4E staff were inadequate. There had been no appraisals and sessions observations for some time, in some cases over four years. Some staff were new and

inexperienced, and some were unqualified as teaching or training staff, although working towards an appropriate qualification. There were no systems to support staff or replace staff who had been promoted.
We repeat the recommendation.

2.135 Quality assurance procedures should be fully established. (5.21)

Not achieved. Self-assessment and target setting for improvement lacked a consistent and rigorous process. Data collection was poor and unsystematic, and the use of data to inform targets for improvement was weak. The quality improvement group had met recently to discuss and redefine its terms of reference and provide a basis for improving the provision. The education manager had recently reintroduced self-assessment for A4E staff, and it was yet to be embedded. The staff observation process had yet to be fully implemented, although external consultants had been recruited to assist.
We repeat the recommendation.

Additional information

2.136 Since the previous inspection, the education contractor had changed from Amersham and Wycombe College to A4E. The recently appointed education manager had been in post for five weeks at the time of the inspection.

2.137 Induction and initial assessment were thorough and provided detailed individual support needs. Learning plans were used as an integral part of the sentence planning process. All education could be accessed on a part-time basis, and the pay structure offered the highest pay for attending education.

2.138 Following the prison expansion, an additional education facility had been built. Most basic skills classes were delivered on this new site, with information technology (IT) courses on the old site. Attendance at the new site was low, with only two or three learners in classes. Attendance and punctuality depended on regime movement patterns. Classroom attendance had averaged 87–90% in the previous quarter, but classroom efficiency was as low as 55%.

2.139 The education curriculum was narrow. It comprised skills for life courses, art, media, IT, English for speakers of other languages (ESOL) and some distance learning. Many of the courses were accredited by the Open College Network (OCN) and OCR (Oxford, Cambridge and RSA examinations board) at entry level and level one, and there was little provision at level two or above. Key skills in application of number, communications and IT were delivered through outreach in workshops and on the residential wings, but support was limited due to funding and staff shortages. ESOL was sufficient to meet the needs of the population, but not formally accredited. The skills for life provision lacked structure and coordination. A curriculum leader had recently been appointed, but had not yet developed the provision.

2.140 Staff were frequently absent, and many of the current staff were new and not fully experienced or qualified. Classrooms were small and in some cases cramped, and the education department on the old site needed redecorating. Resources for vocational training were satisfactory.

2.141 Since August 2008, achievements in education had been poor in many areas, and in some cases no qualifications were obtained, for example, barbering, painting and decorating, and social and life skills. This had been primarily due to portfolio processing and staff problems. Data collection for achievement had been hampered because the A4E department was not connected electronically to its head office to facilitate the collation and analysis of data.

2.142 The prison and A4E provided vocational training in barbering, industrial cleaning, painting and decorating, information and communications technology, kitchen national vocational qualifications (NVQs), and gardening. West Kent College provided construction multi-skills courses in brickwork, plumbing and carpentry. Approximately 90 places were available, mostly part time, except for the construction multi skills programme.

2.143 There were approximately 300 full-time-equivalent activity places. Most work was part-time, which allowed prisoners to attend education, PE or other appointments. Approximately 270 prisoners were occupied in each session, which left around half the population locked in their cells (see paragraph 2.4). At the time of inspection, 61 prisoners were classified as unemployed. When courses or workshops were cancelled due to staff shortages, prisoners were returned to their cells. Contract work, for example headphone refurbishment and strawberry punnet assembly, remained repetitive and mundane with no recognition of skills developed by learners. At the time of inspection there were 84 wing cleaners.

2.144 The library was in the old education site and was pleasant, though cramped. The library service was subcontracted to Medway library service. It was managed by a part-time librarian, employed for 16 hours a week and supported by two part-time library assistants, together employed for 37 hours a week. The library was well used by the education department and part of class time was often library-based. The response to specific requests for books and other information was reasonably prompt. Book deliveries arrived every week. There was no library on the new site, and prisoners had to be escorted to the old site if they put in an application. The library was not open in the evenings and weekends. The library had access to an electronic job point with job vacancies. Library staff provided opportunities for prisoners to take driving theory tests.

Further recommendations

2.145 There should be a broader curriculum of accredited educational courses, with opportunities for progression beyond level one.

2.146 There should be a skills for life strategy that provides rigorous assessment of individual needs, supports high quality literacy and numeracy teaching and learning, and offers suitable English for speakers of other languages qualifications.

2.147 Attendance at education and training should be improved and action taken to reduce drop-out rates.

2.148 The prison should introduce work linked to resettlement needs, which provides formal recognition and recording of prisoners' skills development.

Physical education and health promotion

2.149 Access time to the gym should be reviewed to minimise disruption to other activities (5.30)

Achieved. Gym access had been improved to allow prisoners attending work to use the PE department during the core day. The majority of work, education and training was part-time, and sessions were allocated on a unit basis. Those who were working out or working in the prison full time could use PE provision before or after work. Weekend provision was also available.

Additional information

2.150 Physical education continued to be well delivered by highly qualified staff with good resources. Prisoners had access to an appropriate range of indoor and outdoor activities on both sites, although the new site was better equipped. About 85% of the population participated in some form of PE activity.

2.151 Achievements of accredited PE qualifications had been good in the last year. Orderlies were encouraged to take additional courses, such as NVQs in exercise and fitness. There were links with local sports facilities for work placements.

2.152 The sports facility on the new site had good quality resources, although the sports hall had no running water or toilets and showers. These facilities were in the adjacent building, although most prisoners preferred to shower in their cells. There were showers in the sports facilities on the old site.

Faith and religious activity

No recommendations were made under this heading at the last inspection

Additional information

2.153 There was a large chaplaincy team coordinated by a full-time Muslim chaplain, which included a full-time Church of England chaplain as well as a full-time lay member. There were also sessional and visiting chaplains representing the main Christian denominations and world faiths. Attendance at formal services was very high, with about 120 of the approximately 140 Muslim prisoners attending prayers, and more than 100 prisoners attending the two principal Christian services.

2.154 There was a broad range of faith-based groups, including Bible studies, Islamic teaching and an inter-faith discussion group, as well as plans to develop mentoring within the faith team. Facilities were good and included a spacious traditional chapel, and a large new multi-faith room.

Time out of cell

See also paragraph 2.4.

Additional information

2.155 The prison operated to a published core day that facilitated a general unlock and domestic period each morning, and activity periods of approximately three hours both morning and afternoon. There was a reasonable level of assurance that the prison adhered to published routines. There were two hours of association each evening, but only half the prisoners on a wing were allowed out at a time, which meant about 50 to 55 minutes of association for each prisoner each evening. Association was rarely cancelled and there were generally good recreational facilities. Each wing provided an hour's exercise, although this tended to be ad hoc and subject to staff discretion. There was evidence that a few wings did not provide exercise periods every day, and that prisoners in full-time employment could not access exercise. The exercise yards were small and stark (see paragraph 2.28 and recommendation 2.32).

Further recommendation

2.156 An hour's exercise should be provided on every wing daily.

Security and rules

2.157 Authorised reasonable suspicion mandatory drug tests should be routinely completed. (6.11)

Achieved. Reasonable suspicion MDT took place monthly, and their completion and outcomes were reported to the security committee. There were no backlogs of tests at the time of the inspection, and staff said that this was usually the case. A principal officer ensured that security information reports (SIRs) relating to drug use were processed speedily, and any resulting tests were carried out in a timely manner. This process appeared to work well.

2.158 Prisoners' categories should be reviewed annually. (6.12)

Not achieved. There was no regular process to review prisoner categorisation. Managers in the offender management unit (OMU) had recently written to all prisoners eligible for a review to advise them of the possibility of transfer to the nearest open prison with accommodation for young adults, which was usually HMP/YOI Hollesley Bay. Some prisoners had expressed an interest in this establishment, but recategorisation boards had yet to meet.
We repeat the recommendation

Additional information

2.159 A large security team was responsible for a broad range of functions, including segregation. There were links with police intelligence and police liaison staff who worked across the prison area. The violent and sexual offenders register (VISOR) was about to be installed. The security team said it had good links with residential staff, but that links to violence reduction and resettlement required further improvement, especially with the increasing number of prisoners who worked outside the prison (see also further recommendation 2.51).

2.160 The security committee met monthly, but attendance varied between departments. Meetings received a monthly management information report and a quarterly use of force analysis. The use of force analysis did not highlight trends or hotspots for staff.

2.161 There had been 2,494 SIRs in 2008 from a range of departments, and the main areas of reporting were possession of unauthorised goods, disorder and drugs and alcohol. Most SIRs were processed efficiently in the early stages of receipt, but we noted some delays in the signing off of security office actions. There was no regular trend analysis of SIRs reported to the security committee.

2.162 Rules were well publicised around the prison.

Further recommendations

2.163 Attendance at security committee meetings should be improved.

2.164 Quarterly use of force data should provide trend analysis of the location of incidents.

2.165 The security committee should consider regular trend analysis of security information reports.

Discipline

2.166 The level of alleged assaults should be kept under constant review to identify trends and potential 'hotspots'. This information should be used to inform the violence reduction strategy. (6.36)

Not achieved. Although the number, location and nature of assaults were recorded, we saw little evidence that this information was used systematically to inform much action or to identify trends and hotspots (see paragraph 2.45).
We repeat the recommendation.

2.167 Prisoners should not be banned from physical education without the safeguards of a formal system. (6.37)

Achieved. Staff in the PE department said that they no longer banned prisoners from gym in an ad hoc manner, and they were aware of the formal procedures to institute bans. Staff were clear about prisoners' formal entitlements to regular physical education. `

2.168 Prisoners remaining in special accommodation should not be routinely strip searched without risk assessment or deprived of their normal clothing. (6.38)

Not achieved. The use of special cell paperwork since January 2009 showed that virtually all prisoners located in special accommodation were strip searched and placed in strip clothing. In most cases, these decisions did not appear to be informed by a risk assessment. The special cell had been used 13 times since January 2009, and strip clothing had been issued on the nine occasions for which paperwork was fully completed. Special accommodation had been used on 38 occasions in the previous year. The paperwork for the last six months of 2008 also indicated high use of strip searching and strip clothing. Staff confirmed it was usual to strip search all new arrivals to the segregation unit, regardless of whether they were allocated to special accommodation or a cell in the segregation unit, and risk assessments were not used before a full search.
We repeat the recommendation.

2.169 Documentation for authorising the use of special accommodation should be completed properly, with clear reasons recorded and all sections completed. (6.39)

Not achieved. We reviewed most of the use of special accommodation documentation for 2008 and the year to date. We found many examples where governors had failed to complete the authorisation for use of special cell, or had provided insufficient information to sanction its use appropriately. In some instances where permission to use special accommodation had been sanctioned via a telephone call to a duty governor, the paperwork was not completed retrospectively the following day. This lack of oversight had included cases where special accommodation had been used overnight.
We repeat the recommendation.

2.170 Planned control and restraint interventions should be recorded on video. (6.40)

Not achieved. Although recording equipment had been purchased, it was located in the security department and was not routinely used to record planned control and restraint

incidents. Only one incident had been recorded since January 2009, even though there were usually several instances a month.
We repeat the recommendation.

2.171 Necessary arrangements should be put in place to raise and maintain the standards of cleanliness in the segregation unit. (6.41)

Not achieved. The segregation unit had been extended since the last inspection. The new spur had been in use for approximately six months, and standards of cleanliness and hygiene were better there. The older accommodation remained dirty. The special accommodation cell and the cell next to it were exceptionally dirty. Showers were filthy, were not thoroughly cleaned each day, and tiles were cracked and missing. Prisoners' wet clothes were strewn about the showers, and communal toilets were unsanitary. Outside the shower areas there were piles of clean and dirty prisoner clothing, which should have been stored in a separate area. Cells had abusive graffiti and did not appear to be subject to a regular repainting programme. In-cell toilets required deep cleaning. The staff group appeared to lack oversight in ensuring that there were high standards of cleanliness. Communal internal areas were grubby and required attention, but external exercise yards were clean. One prison cleaning orderly attended the unit each afternoon, but this was insufficient to ensure the full cleaning needed.
We repeat the recommendation.

Further recommendations

2.172 The showers in the segregation unit should be refurbished.

2.173 Prisoners' laundry should not be stored in communal areas of the segregation unit.

2.174 Prisoners should have daily access to exercise, showers, the library and telephones. The level of access each individual receives should be demonstrated in clear written records. (6.42)

Partially achieved. Prisoners in segregation confirmed that they were offered daily access to showers, exercise and telephones, and the staff recorded the daily take-up of these facilities. However, there was no current formal published regime, and exercise and showers were offered at different times each day. Prisoner take-up of exercise and showers was not recorded in their wing history sheets. The segregation unit had a few books, but their quality and range were limited.

Further recommendations

2.175 There should be a published segregation unit regime that is adhered to.

2.176 There should be daily entries in prisoners' wing history files while they are in the segregation unit detailing their participation in the regime and their interaction with staff.

2.177 Library staff should regularly update the reading material in the segregation unit.

2.178 Education work should be provided to prisoners held in the segregation unit. (6.43)

Not achieved. Education staff did not routinely attend the segregation unit to assess whether

work could be provided to prisoners. Prisoners in the segregation unit at their own request could spend long periods there and would have benefited from constructive work. Staff said that education staff only visited if requested by prisoners.
We repeat the recommendation.

2.179 Written records of good order or discipline reviews should be comprehensive and demonstrate any active plans considered to assist the individual's return to normal location. (6.44)

Partially achieved There was evidence that good order and discipline reviews took place at the required intervals for prisoners in the segregation unit. Action plans were not always challenging and focused on the achievement of mundane targets, such as compliance with the segregation unit regime. On the positive side, not many prisoners remained in the segregation unit for long periods, although we noted that one individual had been in the unit for three months and there was little likelihood of his return to normal location. He had become resigned to long periods alone, and did not receive appropriate support or psychological input.
We repeat the recommendation.

Further recommendation

2.180 Prisoners remaining in the segregation unit for longer than 30 days should have a care plan to avoid psychological deterioration.

2.181 Use of force documentation should be completed properly and certified by an appropriate manager who was not involved in the original incident. (6.45)

Not achieved. In our review of the use of force paperwork for the previous six months, there were many instances where the paperwork was not certified by a manager at all or was certified by a manager who was involved in the incident. In 2008, force had been used on 165 occasions and 63% of these incidents had involved the use of ratchet cuffs. There were some efforts to improve the completion of paperwork, as managers indicated paperwork that required completion on separate forms. However, this did not seem to be followed up; the request for paperwork was left with the original form, and requests for statements from staff were still outstanding in some cases.
We repeat the recommendation.

Further recommendation

2.182 There should be a regular quality check of use of force paperwork.

2.183 Monitoring checks by staff on prisoners in special accommodation should be frequent and unpredictable. The exact time of each check should be recorded. (6.46)

Achieved. Special cell paperwork showed that staff made frequent and unpredictable checks on prisoners in special accommodation, and this was recorded.

Additional information

2.184 A large bright adjudication room had been opened since the last inspection. Prisoners were held in one of two holding rooms before they were given a rub-down search and taken into the adjudication room. The holding rooms had benches, but no natural light. They were clean and free from graffiti. Prisoners had access to writing material in the adjudication room. Proceedings were managed swiftly, but adjudicators ensured prisoners understood the process. There had been 1,389 adjudications in 2008.

2.185 Standardisation meetings took place quarterly and were chaired by the governor. The independent adjudicator attended regularly for cases involving more serious breaches of prison discipline, such as possession of mobile telephones or accessories. Days were usually added to sentences for such offences.

2.186 The segregation unit had increased from 21 to 28 cells with the newly built spur, which had also added a disabled-access toilet, a new adjudication room, two new holding cells and a safer cell that had not yet been fully commissioned. Three cells were designated as special accommodation, but only one special cell was in use. There were three exercise yards, which were clean and had recently been fitted with seating.

2.187 During our inspection, the segregation roll varied between six and nine, and two prisoners were on open ACCT documents, including one complex case. We had concerns about whether the special needs of these prisoners could be met effectively within a segregation unit regime.

2.188 Two regime levels were offered in the segregation unit. The level A regime was offered only to prisoners there at their own request. This permitted use of hand-held games and a TV, but after 5pm only, with the rationale that the segregation unit should not be seen as offering an attractive regime. Prisoners complained of boredom and lack of constructive activity to pass the time. Most prisoners in the segregation unit were on the level B regime, which just offered basic facilities.

2.189 Entries in wing history files varied in quality and frequency. Some staff entries were qualitative, but others were more distant and based on observation rather than direct contact with the prisoner. Prisoners commented that staff did not have frequent contact with them each day. Staff working in the segregation unit had undergone a basic selection process, which was being refined for some new recruits.

Further recommendations

2.190 Prisoners on open ACCT documents should not be accommodated in the segregation unit.

2.191 Segregated prisoners on the level A regime should have access to television at all times.

Incentives and earned privileges

2.192 Prisoners on standard regime should be allowed duvets and personal pillowcases. (6.57)

Not achieved. Only prisoners on the enhanced level of the incentives and earned privileges

(IEP) scheme could have their own duvets and pillowcases, and the prison had no plans to change this arrangement. However, the IEP scheme was being revised and the prison was looking at improvements to the scheme.
We repeat the recommendation.

Additional information

2.193 The published IEP policy had been updated in April 2008. At the time of our inspection, 79% of prisoners were on the standard regime and 19% were enhanced. Fewer than 10 prisoners were on the basic regime. The scheme offered the usual differentiations in access to private cash, visits and time out of cell. Enhanced prisoners could only wear their own clothes on outside activities (see recommendation 2.26). They could also have a play station and were eligible to apply for assessment to move on to the resettlement wing.

2.194 Wing history files showed that the scheme was implemented consistently across wings, and prisoners were given stage one and two warning notices when appropriate. There was evidence in files that staff used the IEP scheme as a motivational tool, and encouraged standard level prisoners to apply for enhanced status when required thresholds had been met. IEP boards were held, and there were agreed action plans for prisoners to demonstrate changes in behaviour to achieve enhanced status or return to the standard level from basic regime. Prisoners were given notices on how to appeal if they disagreed with decisions. There were few examples in wing history files of positive behaviour entry sheets, as the policy stated.

Catering

2.195 Breakfast packs should be issued on the morning they are meant to be eaten. (7.8)

Not achieved. Breakfast packs of cereal and longlife milk were still issued when evening meals were served, and prisoners said that they frequently ate these in the evening if they were hungry.
We repeat the recommendation.

Additional information

2.196 There was a four-week rolling menu. Choices included a broad range of options, including some imaginative dishes. The prison also provided food for HMP Cookham Wood. The kitchen used a scanning method to collate weekly menu sheets and could immediately identify the most popular dishes. There were 13 prisoners working in the kitchen, of whom 10 were working towards NVQs. Catering managers attended consultative meetings with prisoners and responded to suggestions for change. Food surveys were held twice a year. The June 2008 survey had indicated a general satisfaction with the food: 58% of respondents said the food was average, but 33% said it was good, and 76% believed their cultural dietary needs were met. The food we tasted was satisfactory.

2.197 Prisoners received a lunch bag on weekdays, which consisted of a filled baguette, yoghurt, crisps, fruit and a cake. A hot lunch was served at weekends.

2.198 Wing serveries were clean and well maintained, although some areas needed an upgrade. Prisoners serving food had received food hygiene training, but not all wore kitchen whites and beard nets were not used. In some areas, there was no suitable storage space for kitchen whites, and clean and dirty whites were piled together in a disused cupboard. The Muslim chaplain had assisted kitchen staff in developing a serving guide to avoid cross-contamination

of meat and vegetables, and halal with non- halal items. This was displayed in some serveries and was helpful. Meals were served efficiently and were well managed by staff.

2.199 Food comments books were not available on all serveries, and catering managers did not make written responses to comments in them.

Further recommendations

2.200 Kitchen workers should wear appropriate protective clothing, including beard nets.

2.201 There should be suitable storage facilities for servery workers' protective clothing.

2.202 Food comments books should be available on all wings.

2.203 Kitchen managers should respond to comments in food comments books.

2.204 The older wing serveries should be upgraded.

Prison shop

2.205 The range of goods available through the prison shop should be expanded to reflect the needs of all prisoners. (7.14)

Achieved. The prison shop was now based at HMP Blantyre House, and the number of goods available had increased to 349 from 189 in 2006.

2.206 Canteen orders should be delivered to prisoners at their cell door to minimise opportunities for bullying. (7.15)

Achieved. An attempt to deliver canteen orders to cell doors had proved problematic, as it had taken too long. The prison had reverted to the system where prisoners collected canteen bags on the wings, but the number let out at a time was reduced to limit the opportunities for bullying, which had been identified at the last inspection.

2.207 Tinned and healthy snack items should be made available from the prison shop. (7.16)

Partially achieved. Some healthy products were currently available, including fruit packs and supplements, but there were still no tinned products.

Further recommendation

2.208 Tinned products or their equivalent in sealed non-tin containers should be available from the prison shop.

Additional information

2.209 The contract for the prison shop was about to move to DHL. As the service operated from another establishment, there were few opportunities to offer flexibility. Prisoners arriving at Rochester on a Monday could not place orders until the following weekend for a delivery the next Friday. New arrivals could, therefore, wait for almost two weeks to receive their first shop

order. There had been no shop surveys in the previous 12 months, although the shop was a standing item at the prisoner consultation meetings.

Further recommendations

2.210 New arrivals should be able to access the prison shop within their first 24 hours.

2.211 There should be an annual survey of prisoners' views of the prison shop to ensure their needs are met.

Strategic management of resettlement

2.212 Progression to A wing should be based on identified resettlement need and risk reduction through completion of sentence planning objectives. (8.8)

Not achieved. The resettlement unit had moved from A wing to a 60-cell unit on the new site. The criteria for the unit included actively working towards completing OASys targets, and a booklet about the unit, produced in January 2009, emphasised one of its key aims as enabling prisoners to meet identified resettlement needs. However, progress to the unit was still largely based on self-referrals rather than identification of prisoners through the sentence planning process. The unit was not full at the time of the inspection, and prisoners who did not meet its criteria were sometimes located there because of population pressures elsewhere in the prison.

Further recommendation

2.213 Progression to the resettlement unit should be based on identified resettlement need and risk reduction through completion of sentence planning objectives.

2.214 Subject to risk assessment, prisoners on A wing should be allowed to seek paid employment opportunities before release. (8.9)

Not achieved. The resettlement unit operated a four-tier progression route system. Prisoners entered the unit on level one, which was used primarily as a period of assessment. Upon successful progression to level two, prisoners could undertake semi-supervised work in the gardens or staff mess party. Prisoners who progressed to levels three and four could take up unpaid community work and a range of other training and employment, although there were no paid employment opportunities at the time of the inspection. Four prisoners who were completing training programmes with Southern Water and SEESA Electricity Alliance continued to be paid by the prison, although the company paid for their training, and the prisoners hoped to secure employment following their training when released. On some occasions, prisoners who had successfully completed the training programme had received a payment equivalent to an accrued salary when they were released from custody.

Further recommendation

2.215 Subject to risk assessment, prisoners on the resettlement unit should be allowed to seek paid employment opportunities before release.

2.216 The exit surveys should be extended to all wings and the results used to inform the local resettlement strategy (8.10)

Not achieved. Although the exit survey continued to be issued to all prisoners released from the resettlement unit, there had been no analysis of completed surveys to inform the development of the unit or the resettlement strategy. Surveys were only given to prisoners located on the resettlement unit at the time of their release from custody.
We repeat the recommendation.

Additional information

2.217 The published offender management and resettlement strategy gave a brief description of services offered across each resettlement pathway. The document had not been updated to reflect the significant increase in the prison population or the consequent changes in the provision of services. The policy was not a strategic document, was not underpinned by a current needs analysis, and was not cross-referenced to a regional resettlement strategy. There had been a prisoner survey about 12 months previously to gauge the level of resettlement need for the seven resettlement pathways. The completed surveys had been forwarded to the area office, but the prison had not yet received any feedback.

2.218 Governance arrangements for offender management, resettlement and interventions were complicated. The head of interventions chaired a monthly interventions strategy meeting, and a separate bi-monthly offender management strategy board meeting, chaired by the head of offender management, was the resettlement policy committee. To avoid duplication and ensure a consistent approach, the two functional heads met with the deputy governor, who was also the head of reducing reoffending. However, this arrangement had recently lapsed following the absence of the deputy governor on maternity leave.

2.219 Some resettlement data was discussed at the resettlement meeting, but there was little evidence of analysis and monitoring of trends to inform strategic development.

2.220 Resettlement unit managers had recently introduced a monthly progression board to monitor individual prisoner progress through the four regime levels on the unit, and to ensure they were clear about what was expected of them to progress to the next level.

2.221 The full-time voluntary and community sector manager who had been appointed in September 2008 was working with the resettlement unit and employment, training and education manager to broaden the scope and range of community and employment opportunities for prisoners on the unit. As a result, there were several new projects, such as the TimeBank volunteering project facilitated by West Kent Extra. Two full-time project officers had recently been appointed to ensure appropriate support and supervision for prisoners working out of the prison on community projects.

2.222 The interventions department had primary responsibility for delivering and coordinating work across each of the seven resettlement pathways. Following a recent planning day, the head of interventions was producing a development plan to record and monitor delivery. There were leads for six of the seven pathways, and a lead for attitudes, thinking and behaviour work had recently been recruited. Managers had recognised that more promotional work was required to make staff and prisoners aware of available interventions and how to access resettlement services, and funding had been secured to produce a DVD to promote resettlement services and opportunities.

2.223 Pathway leads and resettlement service providers took referrals from the completed short-term offender resettlement needs analysis (STORNA) and sentence planning targets. STORNA had been introduced in May 2007. A STORNA assessment was completed on all new arrivals during their induction (see paragraph 2.15), and the information was stored electronically on a shared drive for all staff to access. STORNA also provided some management information to pathway leads about level of need among the population and to inform the strategic development of service provision.

Further recommendations

2.224 The prison should develop a resettlement strategy that accurately reflects current provision, and is underpinned by an action plan to identify and track progress against key priorities and development milestones.

2.225 There should be an annual comprehensive needs analysis to inform the resettlement strategy.

2.226 The resettlement policy committee should routinely collate and analyse relevant data to ensure a more strategic focus on the effective implementation and development of resettlement work.

Offender management and planning

2.227 All prisoners serving over 12 months should have a full OASys assessment within eight weeks of arrival at Rochester. (8.17)

Not achieved. Assessments were prioritised by sentence length and prisoner risk, with priority given to prisoners serving over 12 months, those with identified public protection issues, and prolific and other priority offenders. There was a significant backlog of assessments and prisoners continued to arrive at Rochester without a full OASys assessment. At the time of the inspection, there were 72 prisoners serving over 12 months and in scope of offender management without a current OASys, as well as 157 prisoners serving over 12 months not in scope of offender management. Of these, 28 assessments were still at the previous establishment and a further 55 had a pre-sentence report OASys only. Between October 2008 and January 2009, when the OMU team had two full-time and one part-time assessor, 56 initial assessments and 62 reviews were carried out. Once assessments were allocated to assessors, they were completed within reasonable timescales.
We repeat the recommendation.

2.228 Assessors should have all relevant information available to them when carrying out assessments. Targets and objectives should reflect all identified needs and risk areas. (8.18)

Achieved. In addition to relevant paperwork, such as pre-sentence reports and OASys, assessors had access to electronic individual learning plans for each prisoner, which included their education assessment. Assessors also had access electronically to STORNA assessments completed during induction. In the sentence plans we sampled, appropriate targets were set to reflect identified needs and risks.

2.229 Following initial OASys assessments, multidisciplinary sentence planning boards should be held where targets and objectives can be agreed. (8.19)

Not achieved. Those prisoners not in scope of offender management received written

confirmation of their sentence plan targets, which they were asked to sign. Prisoners in scope of offender management had a meeting with their offender manager and offender supervisor, but these were not multidisciplinary.
We repeat the recommendation.

2.230 The current custody planning arrangements for those serving less than 12 months should be developed into a more formal structured process where all prisoners have a custody plan in which short-term objectives can be set and subsequently monitored. (8.20)

Not achieved. Only 18 prisoners serving sentences of less than 12 months had a current OASys, with a further three assessments in progress. Although the STORNA assessment during induction gave resettlement service providers and interventions staff an early indication of prisoner resettlement needs without the need to complete an OASys, short-term prisoners were not set objectives or targets, and case conferences at the end of induction no longer took place. There was no follow-up coordinated case management of STORNA referrals or communication with prisoners, and prisoners were unclear about whether referrals had been progressed. Reception staff completed STORNA exit surveys on prisoners' day of discharge. Managers had recognised that this was an unsatisfactory arrangement, which did not provide an opportunity for proper follow-up of outstanding referrals or to monitor progress.

Further recommendation

2.231 The current immediate needs analysis tool (STORNA) should be developed into a custody plan in which short-term objectives are set and subsequently monitored.

2.232 Greater use should be made of release on temporary licence and prisoners should be provided with more published information about it. (8.37)

Not achieved. There had been 66 releases on temporary licence (ROTL) between September 2008 and January 2009, but use was generally for prisoners on the resettlement unit. Although a little information was provided during induction, we did not see any published information about ROTL anywhere in the prison, and staff were not aware of any published material.
We repeat the recommendation.

Additional information

2.233 The offender management unit (OMU) had recently increased, and newly appointed staff had only just completed the required OASys training. New systems had been introduced to allocate cases and track progress.

2.234 The NOMS offender management model had been introduced since the previous inspection, and 116 prisoners currently came under the scope of phase two or three. Cases were allocated appropriately across the multidisciplinary team, which consisted of eight prison officers (although only six were in post at the time of the inspection, two of whom were not currently fully operational), two probation officers and one probation service officer. The two probation officers were offender supervisors for the prisoners who were high risk and the four prisoners on indeterminate sentence for public protection (IPPs), as well as the seven prisoners who were serving detention and training order sentences. The remaining in-scope prisoners were allocated across the rest of the team. Prisoners not in scope were allocated across the team alphabetically.

2.235 Communication with community-based offender managers for prisoners in scope of offender management was described as variable. The prison had recently installed a video link facility, although this was not yet operational, and there were no teleconferencing facilities. Offender supervisors kept electronic records of contacts with offender managers, other departments in the prison and prisoners. Our examination of a sample of logs showed that recorded contact between offender supervisors and prisoners to date had been limited, and there did not appear to be a clear consensus in the team about expected levels of contact. There appeared to be little contact between OMU staff and residential staff, particularly personal officers, who did not make written contributions to OASys reviews or attend sentence planning boards (see recommendation 2.34).

2.236 Public protection arrangements were appropriate. The head of public protection was based in the prison three days a week, and there was a part-time public protection coordinator and support from a full-time public protection clerk. A published public protection policy had been reviewed in August 2008. There were systems to review all new arrivals and identify those who were subject to public protection arrangements. Comprehensive databases were maintained and external agencies, such as the police and probation, were given notice of prisoner release dates. There were monthly interdepartmental risk management meetings, which were not consistently attended by the police liaison officer and security department (although the meeting in January 2009 had been).

2.237 The prison had only recently begun to accept prisoners serving indeterminate public protection sentences. There were currently four IPPs in the prison, all of whom had arrived in November 2008. We spoke to two of the IPP prisoners. They had been seen by OMU staff since their arrival, and understood the IPP sentence structure. All four IPPs had completed a recent victim awareness course and had, therefore, had an opportunity to meet, which they had found beneficial.

2.238 The IPP prisoners we spoke to said they had had little, if any, contact with their community-based offender manager. The prison had also had difficulties in engaging with their offender managers and had had to involve Kent area office to assist in this. Only one IPP prisoner had arrived at the prison with a completed initial OASys assessment. There had been no multi-agency risk action plan (MARAP) for any of the four prisoners before their arrival at Rochester.

Further recommendations

2.239 All offender supervisors should regularly engage with prisoners to implement sentence plans actively and monitor progress against targets, and this should be reflected in records of contact.

2.240 Community-based offender managers should play a full and active part in sentence planning.

2.241 Sending prisons should ensure that all prisoners on indeterminate sentence for public protection have a completed initial OASys assessment, and that multi-agency risk action plan (MARAP) meetings have been convened before the prisoner transfers to Rochester.

Resettlement pathways

Reintegration planning

Accommodation

2.242 More resources should be targeted towards finding prisoners housing on release. (8.34)

Achieved. The prison had a contract with the De Paul Trust to assist prisoners in securing suitable accommodation on release. A full-time manager and a prison resettlement worker worked on site under this contract, and in November 2008 a full-time prison officer had been appointed to work with the team. Each team member dealt with a caseload of approximately 30 prisoners, and the team had worked with 89 clients since the start of January 2009.

Additional information

2.243 The housing team took referrals from prisoners who were homeless or had no accommodation on release, as well as those with tenancy-related problems, such as rent arrears. Most referrals came from STORNA. In January 2009, approximately a third of all referrals were from prisoners serving short-term sentences of under three months.

2.244 The team prioritised cases according to release date. As prisoners were discharged to several geographical areas, the team had built extensive relationships with a range of housing providers in many regions. Of the 648 prisoners released between April 2008 and the end of January 2009, 92% had been discharged into settled accommodation.

2.245 Prisoners discharged to the London area had access to a De Paul community resettlement worker who continued to work with them following release. The prison was also working to introduce a modular-based housing course delivered by the Amber Trust.

Education, training and employment

2.246 All prisoners seeking progression to the resettlement unit should complete the access to employment course. (8.35)

Partially achieved. The education, training and employment (ETE) staff who delivered the access to employment course (Transit) prioritised prisoners on the resettlement unit. At the time of the inspection, 17 prisoners on the unit had completed the course and a further 13 were on the waiting list.
We repeat the recommendation.

Additional information

2.247 A prison officer had the role of ETE 'champion'. ETE work was well embedded in the resettlement unit. The prison had developed links with public utility employers, and prisoners within four months of release could work out on release on temporary licence (ROTL), for example, in charity shops, and fitness centres. Unpaid community work was available before they could take up employer-based work.

2.248 There were comprehensive processes and procedures for vetting placements, and prison staff visited all placements before prisoners were placed there. Prisoners could gain employer-led qualifications in some community work placements, but arrangements to recognise and record non-accredited skills development in other work placements were underdeveloped. A construction company provided sponsorship for two years for prisoners to acquire the construction skills certificate scheme (CSCS) card.

2.249 ETE staff delivered a well-planned transit to work course for those nearing release. This provided training in CV writing, interviewing techniques and job applications. Prisoners were targeted according to their release date, and there were waiting lists. Employers came into the prison and provided mock interviews and interviews for jobs. The library offered a career club and internet-connected job point.

Finance, benefit and debt

No recommendations were made under this heading at the last inspection

Additional information

2.250 Information obtained from STORNA indicated that approximately 25% of prisoners felt they had resettlement needs associated with finance, benefit and debt. These were mainly related to outstanding court fines and credit card and mobile telephone debt. The prison had recently appointed two full-time prison officers who offered an advocacy service for prisoner referrals. This included facilitating contact with specialist debt management and advice services, and helping prisoners to open bank accounts. The staff could also refer prisoners to a money management course delivered by the education department, which ran four times a year.

2.251 The prison did not currently work in partnership with a specialist advice service, although referrals were still made to the Citizens Advice Bureau, which had previously been based in the prison, and an on-site debt management service was due to be offered.

Further recommendation

2.252 Specialist finance, benefit and debt advice and support should be available for all prisoners.

Mental and physical health

No recommendations were made under this heading at the last inspection

Additional information

2.253 Prisoners were invited to discharge clinics before their release, and if they did not have a GP in the community, they were helped to identify local practices and told how to register. Prisoners under the care of the mental health team were referred to community mental health teams if required. Discharge medication was arranged for prisoners on prescribed medication who needed it on release.

Drugs and alcohol

2.254 The drug strategy document should be reviewed and developed to reflect work undertaken and include local developmental targets and objectives. (8.60)

Partially achieved. The drug and alcohol strategy document had been developed at area level, and was supported by a local document, which was covered in the drug strategy meeting. The local document was based around eight priorities, but did not include clear objectives.

Further recommendation

2.255 The local drug strategy should include clear measurable objectives.

2.256 The prison should undertake a needs analysis of the prisoner population at least annually to guide service provision. (8.61)

Achieved. A needs assessment had been undertaken and published in December 2008. The assessment had been in preparation for the introduction of IDTS, but had included all types of substance use, including alcohol.

2.257 The prison should ensure that a suitably qualified and experienced person is able to offer clinical supervision and guidance to the CARAT team and advise the case management board. (8.62)

Not achieved. The counselling, assessment, referral, advice and throughcare (CARAT) team was managed by a principal officer who was undertaking the managing substance misuse course. He provided management and support to the team. However, there was no provision for clinical supervision and guidance beyond this.
We repeat the recommendation.

2.258 A mechanism for evaluating CARAT-based treatment outcomes, including service-user feedback, should be developed. (8.63)

Achieved. All participants were invited to provide feedback on CARAT courses, and care was reviewed at the case management boards.

2.259 The difference between voluntary and compliance testing should be reflected in separate compacts. (8.64)

No longer relevant. Compliance testing had not been used in the prison since August 2007.

2.260 An appropriate naltrexone protocol should be developed and this provision extended for prisoners being released where appropriate. (8.66)

Not achieved: There was no protocol for the use of naltrexone. Although its use was rare (once in the past year), a policy was still required.
We repeat the recommendation.

2.261 The alcohol strategy should be further developed with an implementation strategy to include the alcohol management programme and other necessary treatment and support. (8.67)

Not achieved. There was an alcohol section in the area-wide drug and alcohol strategy, but no implementation strategy to include the alcohol management programme and other necessary treatment and support. There was no reference to alcohol in the local document. The IDTS

team was starting to provide sessions relating to alcohol use, and the primary care trust was exploring the possibility of more alcohol-related work in the prison.
We repeat the recommendation.

Children and families of offenders

2.262 The delivery and despatch of prisoner mail should be improved. Mail should be delivered on the day it is received at the establishment. (3.55)

Achieved. Incoming mail was normally delivered to residential units within 24 hours of its arrival, after it was opened, checked and sorted in a central post room. There were no restrictions on the number of letters prisoners could send or receive, they could send one free letter a week, and stationery and stamps were available in the prison shop.

2.263 Refreshments should be available in the visitors' centre. (3.56)

Not achieved. There were still no refreshments available in the visitors' centre, although we were told vending machines had been ordered. We spoke to several visitors who had had lengthy journeys to the prison and who felt that refreshments would be beneficial.
We repeat the recommendation.

2.264 Strip searching of young prisoners should be on the basis of individual risk assessment. (3.57)

Not achieved. Following each visits session, a minimum of 10% of prisoners were randomly subject to a full search without a risk assessment.
We repeat the recommendation.

Additional information

2.265 A new visitors' centre and social visits area had been built under the prison expansion, and the old visits building was now used for monthly family visits. The new centre was clean, had lockers, a small children's play area, and a range of relevant information, including leaflets on assisted visits. A visitors' centre manager had been appointed in October 2008 to take the lead on developing family visits, and to have a regular presence in the centre to assist visitors. The manager was also producing a visitors' survey.

2.266 Visits were for two hours and took place on every afternoon except Friday, and on Tuesday, Wednesday, Thursday and Saturday mornings. There were also plans to introduce evening visits. Visitors were generally positive about their treatment by staff, but many said it was difficult to book visits, which they could only do through the telephone booking line. Managers were aware of the problems, and had extended the opening times of the line, ordered new equipment for a second line, and planned to introduce a facility for visitors to book a visit in person.

2.267 A recently revised process of collecting visitors from the centre and escorting them to the gate was chaotic. Some visitors waited in the centre to be collected, while others went directly to the prison gate and, as a consequence, were admitted into the prison first.

2.268 All babies were required to have their nappies changed in the presence of two staff before they could be admitted to visits. This policy appeared to be disproportionate. A positive drug dog

indication resulted in the offer of a closed visit on that occasion, and the security department wrote to the visitor informing them of the prison's policy.

2.269 The new visits room could accommodate 31 open visits and there were eight closed visits booths. Furniture was fixed and tables were very close together. The small play area was not staffed. There was a tea bar staffed by volunteers. All prisoners had to wear bibs, which seemed unnecessary as all visitors were screened with ultraviolet light on admission and exit.

2.270 A visits policy action group had recently been established and an action plan was in place. This provided a useful forum to discuss developments under the children and families pathway. Management data obtained from completed STORNA assessments indicated that approximately 20% of prisoners were fathers and had identified family resettlement needs.

2.271 All prisoners could apply to participate in family visits, referred to as messy play days. These were delivered in conjunction with Sure Start and were often themed. There was no limit on the number of children who could attend or the number of visits that fathers could apply for. The prison was working in partnership with Parentis, who were also delivering parenting course in the community for Medway Council, to deliver a joint 10-session toddler and tantrum toolkit in the prison. A community midwife was due to start delivering some ante-natal advice sessions for prisoners about to become fathers. There had also been some work with social services in the family visits area, such as a social worker parenting ability assessment of a father in custody. The De Paul Trust (see paragraph 2.242) also ran a family mediation service.

Further recommendations

2.272 The practice of requiring all babies to have their nappies changed before admission to visits should cease.

2.273 Closed visits should only be authorised where there is significant risk justified by security intelligence.

2.274 Prisoners should not be required to wear bibs during visits.

2.275 The play area in the visits room should be staffed by trained staff.

Attitudes, thinking and behaviour

Additional information

2.276 The only accredited offending behaviour courses currently delivered in the prison were P-ASRO (prison addressing substance related offending), and a victim awareness course. Delivery of the latter had lapsed during 2008 and had just re-commenced. The course was 10 sessions and delivered over two weeks, and currently had a waiting list of 37 prisoners. Referrals were taken from sentence planning targets, with priority to indeterminate-sentenced prisoners, prolific offenders and those subject to multi-agency public protection arrangements (MAPPA). A pathway lead had recently been identified, but had yet to take up post. Recruitment of additional staff to tutor the enhanced thinking skills (ETS) and controlling anger and learning to manage it (CALM) courses planned for 2009 was under way.

Section 3: Summary of recommendations

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

Recommendations — To NOMS

3.1 The lack of opportunities for prisoners in the 18 to 21 age-group to move to open conditions in the South of England should be addressed. (2.6)

3.2 An offending behaviour needs analysis for young adults should be undertaken to identify which programmes should be delivered by whom and at what stage in an offender's sentence. (2.7)

3.3 Prisoners should not be transferred unnecessarily while their risk assessments for home detention curfew are being carried out. (2.8)

3.4 Community-based offender managers should play a full and active part in sentence planning. (2.240)

Recommendations — To the governor

First days in custody

3.5 Prisoners locked in reception holding rooms should be properly supervised. (2.11)

3.6 Residential staff on the induction unit should be involved in the delivery of the induction programme. (2.13)

3.7 Residential officers should regularly access and record information in wing files of prisoners on induction. (2.14)

3.8 There should be reading material and televisions in the reception holding rooms. (2.22)

3.9 The resettlement unit's reception area should be enlarged to accommodate the number of prisoners processed, and should be kept clean and warm. (2.23)

3.10 New arrivals should be given written information about the regime at Rochester. (2.24)

3.11 The induction programme should occupy participants throughout and they should not be locked in cells for long periods. (2.25)

Residential units

3.12 Prisoners should be allowed to wear their own clothes. (2.26)

3.13 Cells and communal areas on D and E wings should be kept clean, well decorated and in a good state of repair. (2.31)

3.14 Conditions in the exercise yards should be improved. (2.32)

Personal officers

3.15 The role of the personal officer should be expanded to include involvement in sentence planning and resettlement/reintegration planning. (2.34)

3.16 The personal officer policy should be updated. (2.36)

3.17 There should be routine and consistent management checks of wing files to monitor the quality of personal officer entries. (2.37)

Bullying and violence reduction

3.18 Anti-bullying arrangements should be improved as a priority. (2.1)

3.19 A full-time violence reduction coordinator should be appointed. (2.39)

3.20 The safer custody committee should routinely review bullying incidents and relevant monitoring information to identify bullying 'hot spots', inform local policy and ensure appropriate remedial action. (2.40)

3.21 Interventions should be available for identified bullies and support plans drawn up for victims of bullying. (2.41)

3.22 The violence reduction policy should be revised. (2.47)

3.23 Staff should be aware of their role as described in the policy document in dealing with bullying behaviour and the reduction of violence. (2.48)

3.24 Violence reduction training should be given to staff, particularly residential officers and managers. (2.49)

3.25 There should be better attendance at safer custody meetings to deal with violence reduction and reflect the protocols in the violence reduction document. (2.50)

3.26 There should be stronger links between violence reduction and security. (2.51)

Self-harm and suicide

3.27 Listeners should be employed in reception and the first night centre. (2.54)

3.28 The quality of written entries in assessment, care in custody and teamwork (ACCT) documents should be improved. (2.61)

3.29 All staff should be trained in ACCT procedures. (2.62)

Diversity

3.30 Training for diversity group representatives should be extended to cover a wider range of diversity issues. (2.64)

3.31 There should be an overarching diversity policy with specific development objectives under key constituent headings, including disability and sexual orientation, and identified leads working directly with the diversity team. (2.68)

3.32 Assessments of disability should be applied across all departments, and result in appropriate interventions. (2.69)

3.33 Individual action plans should be developed to address and/or manage specific issues of diversity. (2.70)

Race equality

3.34 There should be a database to monitor racist incident reports and to analyse patterns and trends. (2.76)

3.35 The prison should clarify what constitutes a racist incident and apply this consistently. (2.77)

3.36 There should be a programme addressing issues of racism and cultural awareness for those prisoners convicted of a racially motivated offence and/or racist incident within the prison. (2.78)

Foreign national prisoners

3.37 Arrangements for foreign national prisoners should be improved in line with our expectations. (2.2)

3.38 The contents of the foreign nationals' policy and guidance for staff should be more widely disseminated and appropriate training given. (2.79)

3.39 A foreign national prisoners' consultation group should be established and should advise on how to improve negative perceptions among foreign national prisoners. (2.80)

3.40 The prison should actively seek to introduce independent immigration advice from legal and community groups. (2.84)

3.41 The prison should identify a foreign national prisoner coordinator. (2.85)

3.42 All foreign national prisoners should be seen on induction to ascertain their current circumstances and identify specific issues. (2.86)

3.43 There should be greater use of interpretation services. (2.87)

3.44 Induction information and other information about the establishment's regime should be provided in a prisoner's first language. (2.88)

Applications and complaints

3.45 Complaints boxes should be emptied by a person unconnected with the wing on which the complaint has been made. (2.89)

Legal services

3.46 The role of the legal services officer should be properly advertised and explained to all prisoners during their induction programme. (2.96)

3.47 Prisoners should have access to lists of solicitors and professional legal advisers. (2.99)

Substance use

3.48 The number of target tests not undertaken because they exceed the timeframe should be recorded. (2.101)

Health services

3.49 Triage algorithm forms should include action to be taken to ensure consistency of treatment. (2.106)

3.50 Health promotion material should be available in a range of appropriate languages. (2.108)

3.51 Items should not be stored on the floor in the dental room. (2.111)

3.52 The medicine trolley in the dental room should be removed, and there should be more appropriate arrangements to hold prisoners' personal items during treatment. (2.112)

3.53 Patient group directions should be introduced to enable supply of more potent medication by the pharmacist and nurses and avoid unnecessary consultations with the doctor. (2.115)

3.54 There should be increased medical input to healthcare to include medicines management and clinical audit. (2.118)

3.55 Clinical supervision should be formalised and available for all staff. (2.119)

3.56 The service level agreement for dental services should be agreed with the primary care trust. (2.120)

3.57 Nursing vacancies should be filled as soon as possible. (2.126)

3.58 Appropriate accommodation should be identified for the mental health nurses. (2.127)

3.59 Dental services should meet the needs of the population. (2.128)

Learning and skills and work activities

3.60 There should be sufficient work to occupy all the young men for the whole working day, five days a week. The work introduced should lead to the acquisition of useful skills with recognised qualifications. (2.3)

3.61 There should be more vocational courses above level one and more progression routes. (2.131)

3.62 Outreach support should be appropriate to the context in which it is delivered, and there should be more staff to provide support. (2.133)

3.63 A systematic approach to continuous staff development should be developed. (2.134)

3.64 Quality assurance procedures should be fully established. (2.135)

3.65 There should be a broader curriculum of accredited educational courses, with opportunities for progression beyond level one. (2.145)

3.66 There should be a skills for life strategy that provides rigorous assessment of individual needs, supports high quality literacy and numeracy teaching and learning, and offers suitable English for speakers of other languages qualifications. (2.146)

3.67 Attendance at education and training should be improved and action taken to reduce drop-out rates. (2.147)

3.68 The prison should introduce work linked to resettlement needs, which provides formal recognition and recording of prisoners' skills development. (2.148)

Time out of cell

3.69 Prisoners should be unlocked for a minimum of 10 hours each weekday. (2.4)

3.70 An hour's exercise should be provided on every wing daily. (2.156)

Security and rules

3.71 Prisoners' categories should be reviewed annually. (2.158)

3.72 Attendance at security committee meetings should be improved. (2.163)

3.73 Quarterly use of force data should provide trend analysis of the location of incidents. (2.164)

3.74 The security committee should consider regular trend analysis of security information reports. (2.165)

Discipline

3.75 The level of alleged assaults should be kept under constant review to identify trends and potential 'hotspots'. This information should be used to inform the violence reduction strategy. (2.166)

3.76 Prisoners remaining in special accommodation should not be routinely strip searched without risk assessment or deprived of their normal clothing. (2.168)

3.77 Documentation for authorising the use of special accommodation should be completed properly, with clear reasons recorded and all sections completed. (2.169)

3.78 Planned control and restraint interventions should be recorded on video. (2.170)

3.79 Necessary arrangements should be put in place to raise and maintain the standards of cleanliness in the segregation unit. (2.171)

3.80 The showers in the segregation unit should be refurbished. (2.172)

3.81 Prisoners' laundry should not be stored in communal areas of the segregation unit. (2.173)

3.82 There should be a published segregation unit regime that is adhered to. (2.175)

3.83 There should be daily entries in prisoners' wing history files while they are in the segregation unit detailing their participation in the regime and their interaction with staff. (2.176)

3.84 Library staff should regularly update the reading material in the segregation unit. (2.177)

3.85 Education work should be provided to prisoners held in the segregation unit. (2.178)

3.86 Written records of good order or discipline reviews should be comprehensive and demonstrate any active plans considered to assist the individual's return to normal location. (2.179)

3.87 Prisoners remaining in the segregation unit for longer than 30 days should have a care plan to avoid psychological deterioration. (2.180)

3.88 Use of force documentation should be completed properly and certified by an appropriate manager who was not involved in the original incident. (2.181)

3.89 There should be a regular quality check of use of force paperwork. (2.182)

3.90 Prisoners on open ACCT documents should not be accommodated in the segregation unit. (2.190)

3.91 Segregated prisoners on the level A regime should have access to television at all times. (2.191)

Incentives and earned privileges

3.92 Prisoners on standard regime should be allowed duvets and personal pillowcases. (2.192)

Catering

3.93 Breakfast packs should be issued on the morning they are meant to be eaten. (2.195)

3.94 Kitchen workers should wear appropriate protective clothing, including beard nets. (2.200)

3.95 There should be suitable storage facilities for servery workers' protective clothing. (2.201)

3.96 Food comments books should be available on all wings. (2.202)

3.97 Kitchen managers should respond to comments in food comments books. (2. 2030)

3.98 The older wing serveries should be upgraded. (2.204)

Prison shop

3.99 Tinned products or their equivalent in sealed non-tin containers should be available from the prison shop. (2.208)

3.100 New arrivals should be able to access the prison shop within their first 24 hours. (2.210)

3.101 There should be an annual survey of prisoners' views of the prison shop to ensure their needs are met. (2.211)

Strategic management of resettlement

3.102 Progression to the resettlement unit should be based on identified resettlement need and risk reduction through completion of sentence planning objectives. (2.213)

3.103 Subject to risk assessment, prisoners on the resettlement unit should be allowed to seek paid employment opportunities before release. (2.215)

3.104 The exit surveys should be extended to all wings and the results used to inform the local resettlement strategy (2.216)

3.105 The prison should develop a resettlement strategy that accurately reflects current provision, and is underpinned by an action plan to identify and track progress against key priorities and development milestones. (2.224)

3.106 There should be an annual comprehensive needs analysis to inform the resettlement strategy. (2.225)

3.107 The resettlement policy committee should routinely collate and analyse relevant data to ensure a more strategic focus on the effective implementation and development of resettlement work. (2.226)

Offender management and planning

3.108 All prisoners serving over 12 months should have a full OASys assessment within eight weeks of arrival at Rochester (2.227)

3.109 Following initial OASys assessments, multidisciplinary sentence planning boards should be held where targets and objectives can be agreed. (2.229)

3.110 The current immediate needs analysis tool (STORNA) should be developed into a custody plan in which short-term objectives are set and subsequently monitored. (2.231)

3.111 Greater use should be made of release on temporary licence and prisoners should be provided with more published information about it. (2.232)

3.112 All offender supervisors should regularly engage with prisoners to implement sentence plans actively and monitor progress against targets, and this should be reflected in records of contact. (2.239)

3.113 Sending prisons should ensure that all prisoners on indeterminate sentence for public protection have a completed initial OASys assessment, and that multi-agency risk action plan (MARAP) meetings have been convened before the prisoner transfers to Rochester. (2.241)

Resettlement pathways

3.114 All prisoners seeking progression to the resettlement unit should complete the access to employment course. (2.246)

3.115 Specialist finance, benefit and debt advice and support should be available for all prisoners. (2.252)

3.116 The local drug strategy should include clear measurable objectives. (2.255)

3.117 The prison should ensure that a suitably qualified and experienced person is able to offer clinical supervision and guidance to the CARAT team and advise the case management board. (2.257)

3.118 An appropriate naltrexone protocol should be developed and this provision extended for prisoners being released where appropriate. (2.260)

3.119 The alcohol strategy should be further developed with an implementation strategy to include the alcohol management programme and other necessary treatment and support. (2.261)

3.120 Refreshments should be available in the visitors' centre. (2.263)

3.121 Strip searching of young prisoners should be on the basis of individual risk assessment. (2.264)

3.122 The practice of requiring all babies to have their nappies changed before admission to visits should cease. (2.272)

3.123 Closed visits should only be authorised where there is significant risk justified by security intelligence. (2.273)

3.124 Prisoners should not be required to wear bibs during visits. (2.274)

3.125 The play area in the visits room should be staffed by trained staff. (2.275)

Appendix I: Inspection team

Martin Lomas	Team leader
Keith McInnis	Inspector
Marie Orrell	Inspector
Gordon Riach	Inspector
Andrea Walker	Inspector
Mandy Whittingham	Healthcare inspector
Bob Cowdrey	Ofsted inspector

Appendix II: Prison population profile

(i) Status	Number of prisoners	%
Sentenced	597	*99*
Detainees (single power status)	5	*1*
Total	602	100

(ii) Sentence	Number of prisoners	%
Less than 6 months	53	*9*
6 months-less than 12 months	49	*8*
12 months-less than 2 years	139	*23*
2 years-less than 4 years	283	*47*
4 years-less than 10 years	74	*12*
Life	4	*1*
Total	602	

(iii) Length of stay	Number of prisoners	%
Less than 1 month	123	*20*
1 month to 3 months	182	*30*
3 months to 6 months	192	*32*
6 months to 1 year	64	*11*
1 year to 2 years	26	*4*
2 years to 4 years	15	*3*
Total	602	

(iv) Main offence	Number of prisoners	%
Violence against the person	94	*17*
Burglary	70	*12*
Robbery	159	*26*
Theft and handling	27	*4*
Fraud and forgery	5	*1*
Drugs offences	105	*17*
Other offences	121	*20*
Offence not recorded/ Holding warrant	21	*3*
Total	602	

(v) Age	Number of prisoners	%
18 years	112	*19*
19 years	217	*36*
20 years	234	*39*
21 years	39	*6*
Total	602	100

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	422	*70*
Between 50 and 100 miles of the prison	79	*13*
Over 100 miles from the prison	23	*4*
No fixed address	78	*13*
Total	602	100

(vii) Nationality	Number of prisoners	%
British	476	*79*
Foreign nationals	126	*21*
Total	602	100

(viii) Ethnicity	Number of prisoners	%
White:		
British	260	*43*
Irish	4	*1*
Other White	27	*4*
Mixed:		
White and Black Caribbean	29	*5*
White and Black African	7	*1*
White and Asian	3	*1*
Other Mixed	8	*1*
Asian or Asian British:		
Indian	11	*2*
Pakistani	12	*2*
Bangladeshi	14	*2*
Other Asian	13	*2*
Black or Black British:		
Caribbean	95	*16*
African	70	*12*
Other Black	30	*5*
Chinese or other ethnic group:		
Chinese	6	*1*
Other ethnic group	13	*2*
Total	602	

(ix) Religion	Number of prisoners	%
Church of England	129	*22*
Roman Catholic	109	*18*
Other Christian denominations	32	*5*
Muslim	138	*23*
Sikh	7	*1*
Buddhist	14	*2*
Jewish	9	*2*
Other	24	*4*
No religion	140	*23*
Total	602	