

Report on an unannounced short follow-up inspection of

HMP Send

18 – 22 August 2008

by HM Chief Inspector of Prisons

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Introduction

HMP Send, in Surrey, is a closed adult female training prison. When we last inspected in early 2006, we assessed the prison as being very safe and respectful, with reasonable purposeful activity and resettlement provision. On our return, for this unannounced short follow up inspection, we were concerned to find the prison struggling with the impact of a less settled prisoner population and serious difficulties recruiting and retaining staff. As a result, there had been a significant deterioration in key areas, including safety, and a weakening of some other areas of previous strength.

Women spent too long in reception and faced an unnecessary routine strip search. The subsequent induction programme was haphazard. There was no violence reduction strategy and anti-bullying arrangements were weak. Incidents of self-harm had increased since our previous visit and, tragically, there had been two deaths in custody and a number of near deaths. Self-harm prevention documentation was variable in quality and access to Listeners was not as easy as it should have been. Problems were compounded by the large number of new or detached duty staff who were often unfamiliar with the particular risks and needs of women in prison.

Staff-prisoner relationships were generally positive, but were undermined by the churn of staff and the difficulty of ensuring an appropriate proportion of female officers. Both the personal officer and incentives and earned privilege (IEP) schemes required improvement. Accommodation was generally good quality, and there was caring support available from a stretched chaplaincy. Race issues were well managed, but support for foreign nationals was still in its infancy. Prisoners were dissatisfied with healthcare, which also suffered from staff shortages.

Women continued to spend plenty of time out of cell and could access a range of activities. However, Send had expanded since our previous inspection and there had been insufficient development of the regime to ensure an equivalent increase in activity places. In addition, the pay scheme acted as a disincentive to education and there was too little accreditation available in the workshops. The library was a good resource and physical education was popular but, yet again, limited by staff vacancies.

The resettlement strategy had not been updated to focus on the latest analysis of needs, particularly those of the increased proportion of short-term prisoners. There was a backlog in offender assessments and no custody planning for short sentenced prisoners. The range of interventions to address need was limited but drug services, notably the RAPt course, were good. Provision for family and friends was sound. Send benefited from the only female therapeutic community (TC) in the country. There was now a healthy waiting list for this impressive facility, although the number of participants was restricted because the TC could not retain sufficient staff.

Send has gone through a very unsettled period, with an expansion of its population and an increase in short-term prisoners, but without sufficient investment in the regime. The pervasive impact of the inability to recruit and retain staff had resulted in shortages, an influx of inexperienced staff and difficulty in maintaining an appropriate gender balance. On top of this, there had been an excessive turnover of governors – three in less than two years – and further uncertainty created by a new clustering arrangement with a women's prison in Sutton. The outcome had been slippage in some important areas since our previous inspection, including a worrying deterioration in aspects of safety. Send requires regional and national support to

achieve a period of badly needed stability, so that it can focus on addressing the increased challenges that it faces.

Anne Owers
HM Chief Inspector of Prisons

October 2008

Fact page

Task of the establishment

Closed adult female training prison

Brief history

In June 1998, in response to the large increase in the numbers of female prisoners, Send was re-roled as a closed female prison and underwent a large-scale refurbishment. In 2007, further expansion started to accommodate a further 64 prisoners. In March 2008, the first of the additional prisoners arrived. The prison accommodates the only female prison therapeutic community (TC).

Operational area

South central

Number held

276 on 18 August 2008

Certified normal accommodation

282

Operational capacity

282

Last full inspection

13 - 17 February 2006

Description of residential units

All cells are single occupancy apart from D wing, which has 10 double rooms.

- A wing is made up of 40 cells over two floors. All spaces are allocated to the TC. However, the TC accounts for approximately 24 spaces at any one time.
- B wing is made up of 38 cells over two floors.
- C wing is made up of 40 cells over two floors and is identified as the induction wing.
- D wing (RAPt Unit) accommodates 20 prisoners.
- E and F wings (resettlement unit) accommodate 40 prisoners on each wing.
- India wing is made up of three spurs accommodating 64 prisoners.

Section 1: Healthy prison assessment

Introduction

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

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

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

...performing well against this healthy prison test.

There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

...performing reasonably well against this healthy prison test.

There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

...not performing sufficiently well against this healthy prison test.

There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

...performing poorly against this healthy prison test.

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

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

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

Safety

- HP4 In February 2006, we concluded that the prison was performing well against this healthy prison test. We made 31 recommendations in this area, 18 of which had been achieved either in whole or in part and 13 not achieved. We have made 29 further recommendations.
- HP5 Few new receptions arrived each week, but there were around 100 movements a week due to the high number of hospital escorts and women on temporary release. Interviews were not conducted in private and all those processed through reception were strip-searched, which was unnecessary. Women regularly spent up to five hours in reception and were frequently located late onto the first night centre. They were regularly monitored during their first 24 hours, but reported feeling unsafe, partly due to the design of the wing and partly due to lack of access to staff on the first night.
- HP6 Induction was haphazard and did not run to timetable. Some departments regularly missed their induction slots. Management attention to this area was insufficient. Following induction, many women waited up to three weeks before starting work, which resulted in long periods locked up during the day when induction was not taking place.
- HP7 There was little evidence of assaults, but women reported concerns about verbal intimidation and threats. Most reported issues related to name-calling and relationship problems. There was no violence reduction strategy and the prison was unclear about who was responsible for coordinating investigations. Most investigations took two to three weeks, with one taking three months. Women reported little confidence in the system. Record-keeping was poor and there was insufficient analysis of incidents. Some incidents, such as unexplained injuries, were not routinely reported to the anti-bullying coordinator.
- HP8 The number of self-harm incidents had increased from about eight a month at the previous inspection to an average of 20 in 2008. This could not completely be explained by the increase in population. Two deaths in custody had taken place in 2007 and were being investigated. A further 12 incidents resulting in outside hospital treatment had not been investigated, although they were discussed at safer custody meetings.
- HP9 Women continued to arrive at the prison on open assessment, care in custody and teamwork (ACCT) documents and in half of all cases this information had not been communicated by the sending establishment. ACCT procedures were variable, although there were some good examples of individual care. Listener numbers had increased, but all Listeners lived on the resettlement unit, which limited the opportunities for informal contact.
- HP10 There continued to be little use of adjudications, although some offences were still minor and could have been dealt with under the incentives and earned privileges (IEP) scheme.

- HP11 Force was little used, with just four incidents in the previous six months. The holding cell had not been used for 18 months. The constant observation cell had been used 12 times, but documentation was inconsistent and not subject to sufficient management attention.
- HP12 The good work carried out by staff in dealing with some vulnerable and difficult women was undermined by the high number of detached duty staff. Although these staff appeared to be willing, most had little or no experience of working with women and some had come straight from prison officer training. On some days during the inspection, most wing staff were on detached duty. Although the prison was trying hard to arrange longer periods of attendance, some staff were at the prison for less than a week. This eroded continuity, meant that women did not have a regular member of staff to talk to about their problems and affected feelings of safety.
- HP13 On the basis of this short follow-up inspection, we considered that the prison was not performing sufficiently well against this healthy prison test.

Respect

- HP14 In 2006, we concluded that the prison was performing well against this healthy prison test. We made 40 recommendations in this area, 24 of which had been achieved either in whole or in part and 16 not achieved. We have made 25 further recommendations.
- HP15 Staff-prisoner relationships were mostly positive and we observed some good interactions. Staff and prisoners usually referred to each other by first names. Relationships were jeopardised by the high numbers of detached duty staff drafted into the prison to deal with the additional staffing requirements of the new accommodation. Too many detached staff were male. The prison had requested a better gender balance, but had little control over the supply of staff. Most prisoners knew who their personal officer was and some reported positively, but many complained they were never available. Wing history sheets reflected little knowledge of prisoners. Personal officers did not contribute to sentence planning boards. Regular Send staff were frequently in a minority on the wing and were consequently stretched.
- HP16 Most areas of the prison were generally clean and J wing (the new build) was particularly well maintained. Most women commented positively about their accommodation, although many reported problems in getting cleaning materials.
- HP17 The IEP policy had few differentials in the incentives available for foreign national women and others without external support. Most history sheets were limited to entries about behaviour and demonstrated little involvement of personal officers in the IEP scheme, although there were some exceptions.
- HP18 Prisoners had good access to religious services and there was a good range of sessional chaplains. The lack of any permanent part-time assistant meant the chaplain was restricted in time spent with women because of commitments to administrative tasks.
- HP19 Most women were satisfied with the food. The product range in the shop was wide, but some women had to wait up to 10 days to receive their canteen orders.

- HP20 There was little confidence in the applications system and some formal complaints were submitted because of a lack of responsiveness to general applications. The number of complaints had risen significantly. Consultation meetings had just started.
- HP21 Twenty nine per cent of women were from black and minority ethnic backgrounds. Race equality meetings were well attended and multidisciplinary, although many action plan objectives were repeated every month. Racist incident report forms were well investigated and thorough. Prisoner representatives attended all meetings and there were diversity displays throughout the prison.
- HP22 Almost 20% of the population were foreign national women and work with this group was in its infancy. There were regular foreign national meetings with representatives, but very little use of interpreters including for medical issues. There was no access to independent immigration advice and only one immigration surgery had been run by the UK Border Agency.
- HP23 Some prisoners were very dissatisfied with healthcare and this was the single biggest source of complaints. There was no permanent manager, a predominance of agency staff and problems with accessing the doctor and dentist. A range of nurse-led clinics was offered, but there were some gaps in provision. There was a lack of continuity of care and some errors in the issuing of medication. Mental health provision was good, but staff were very stretched.
- HP24 On the basis of this short follow-up inspection, we considered that the prison was performing reasonably well against this healthy prison test.

Purposeful activity

- HP25 In 2006, we concluded that the prison was performing reasonably well against this healthy prison test. We made 14 recommendations in this area, nine of which had been achieved either in whole or in part, four not achieved and one was no longer relevant. We have made nine further recommendations.
- HP26 Time out of cell continued to be resettlement over nine hours each weekday for all women on the main block. Women on the unit were not locked up. Nearly all women were engaged in activities, although some of these were part time. Those not working were locked up during the day. This was more problematic on C wing (induction) where prisoners could wait up to three weeks for employment.
- HP27 On paper, there were sufficient activity places for prisoners, although no extra resources had been provided as part of the new build. In practice, many women worked part-time, combining activities such as education and employment. There were some gaps in activity and on one afternoon of the inspection, 38 out of 68 women from the resettlement units were on the wing without purposeful activity.
- HP28 The pay scheme in some areas acted as a disincentive for education as potential earnings in the contract workshops were significantly higher. No qualifications were available in the workshops, although in most cases outcomes were good, as were relationships between the provider and participants.

- HP29 The library continued to be a good resource. There was no full time qualified librarian, but usage was high and there was a good stock of suitable material, including for speakers of other languages and those studying particular areas.
- HP30 The physical education department had been short of staff for around 18 months and this had impacted on delivery of recreational classes. There had been further restrictions as a result of the building programme, but women spoke positively about classes and access was good, with particular sessions for those on the RAPt programme and for medical reasons.
- HP31 On the basis of this short follow-up inspection, we considered that the prison continued to perform reasonably well against this healthy prison test.

Resettlement

- HP32 In 2006, we concluded that the prison was performing reasonably well against this healthy prison test. We made 25 recommendations in this area, 16 of which had been achieved either in whole or in part and nine not achieved. We have made 20 further recommendations.
- HP33 The resettlement strategy was pathway based, but had not been informed by the results of a comprehensive needs analysis completed in February 2008. The population profile of the prison had changed significantly. The new build had increased the population from 193 at the last inspection to 276. The proportion of women staying less than three months had also increased from just under 20% to 34% and the number of monthly discharges was rising. The reintegration needs of this increased and changing population had yet to be built into the prison's resettlement strategy.
- HP34 Most prisoners were serving over 12 months, with 266 women eligible for assessment under the offender assessment system (OASys), 152 of whom had an up to date assessment. The quality of those completed was generally good. Women serving less than 12 months did not have a custody plan, although the work carried out by probation staff on arrival was geared to addressing immediate and resettlement needs.
- HP35 The number of life-sentenced women had increased from 14 in 2006 to 44 and there were 15 women serving indeterminate sentences for public protection (IPP). The increase had been agreed to provide suitable women for the therapeutic community (TC), where a minimum period of 12 months was required.
- HP36 There were some gaps in interventions, particularly in areas such as healthy relationships and domestic violence. There were significant issues about alcohol misuse, but no treatment programmes available other than for those who also had a drug problem.
- HP37 The TC continued to offer the only opportunity for women in England and Wales to participate in this form of intensive therapy. Women who had graduated from the course spoke highly about what they had gained from it. In theory, the community offered 40 places. The current roll was 20 (although it had been 24 several months earlier) and there was an active waiting list of 18. In practice, staff problems meant the number was capped at 20. There were just four prison officers against a

requirement of 12 working on the TC. Two senior staff were due to leave and the only senior officer was also leaving. Although the TC had been given the security of a long-term future, its location in an area of the country where recruitment problems were entrenched was hindering its development.

- HP38 There were enough telephones for women to contact their family and friends and access to them was good. Family visits took place monthly and were well received, although the split between pre-school and school-age children presented an unnecessary restriction. Wing files did not evidence much knowledge of prisoners' family circumstances, but we saw a number of instances where staff had been instrumental in helping prisoners with problems outside.
- HP39 The drug strategy was comprehensive and the RAPt course continued to be well run with motivated and involved staff. The use of shared accommodation on D wing for those participating acted as a barrier for some, notably in the case of women who could not share accommodation. Participants were positive about the unit.
- HP40 On the basis of this short follow-up inspection, we considered that the prison continued to perform reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations

To the Governor

- 2.1 **There should be an effective first night strategy and induction programme, involving peer supporters, to ensure that women have a consistent introduction to Send which meets their needs. (HP40)**
Partially achieved. There was a first night strategy that covered appropriate topics, but it was overdue for review (Dec 2007). It did not include induction and the induction programme itself was inconsistently presented.
We repeat the recommendation.
- 2.2 **All incidents of suspected bullying should be recorded, investigated and monitored as part of the violence reduction strategy. (HP41)**
Not achieved. The violence reduction strategy was not used effectively to deal with bullying. On average, only eight bullying referrals were submitted each month and only three women had been formally monitored since the beginning of 2008. No one was being monitored during the inspection. Prisoners were unsure where they should post a bullying referral. Staff said referrals should be put in one of four dedicated boxes, but we could not find any of them. We were told that until very recently a senior officer and two officers had been responsible for conducting investigations, but no one could tell us the current arrangements. It usually took three weeks before a bullying referral was investigated, but it could be as long as two months, which was unacceptable and eroded confidence in the system. Investigations were logged, but there was no evidence that any woman had been on levels two or three of the strategy. Only seven of the 20 recent bullying-related security information reports submitted and only one of the six unexplained injury forms had been investigated under the violence reduction strategy.
We repeat the recommendation.
- 2.3 **An analysis of the needs of foreign national women prisoners at Send should be undertaken to ensure that services appropriately reflect those needs and inform the strategy so that foreign national women are aware of and able to access appropriate services. (HP42)**
Not achieved. There was no evidence of any needs analysis.
We repeat the recommendation.
- 2.4 **The range of employment opportunities should be expanded and accreditation of skills extended to all suitable work areas. (HP43)**
Partially achieved. Strategies to develop education and training continued to be well implemented and some success had been achieved in expanding the range of employment opportunities and extending skills accreditation. The education curriculum and been widened and skills and qualifications appropriate to prisoners' needs provided. There was improved provision for ICT, skills for life including English for speakers of other languages, and social and life skills provision including creative arts and craft courses. Accredited programmes were being expanded in horticulture and the kitchen. However, difficulties in recruiting some appropriate staff had slowed the rate of development and accredited learning was still not provided in hairdressing and the contract workshop. Pay structures encouraged prisoners to

engage in some low skilled activities providing poor skills development (see section on learning and skills and work activities).

Further recommendation

- 2.5 The prison should continue to develop its range of activities to enable prisoners to gain qualifications and employability skills.
- 2.6 **Women with sentences of 12 months or more should have sentence plans completed within 12 weeks of their arrival at Send. (HP44)**
Not achieved. There were 266 women with sentences of 12 months or more. Of these, 152, including 44 lifers and 15 women sentenced to indeterminate sentences for public protection, had an up-to-date offender assessment system (OASys) assessment and sentence plan. These were rarely completed within the first 12 weeks and women who had one within this timeframe had usually arrived with it. Only one member of staff was allocated part time to completing assessments and aimed to complete eight a month, which was not enough to reduce or even maintain the growing backlog. Assessments were prioritised on the basis of parole, approaching discharge and multi-agency public protection arrangement level.
We repeat the recommendation.
- 2.7 **Identifying, referring and encouraging suitable women prisoners to attend the therapeutic community should be a national responsibility of the women's policy team at Prison Service Headquarters.**
Partially achieved. The therapeutic community (TC) had received some national support and had raised national awareness through road shows. The allocation criteria were publicised regularly at the women and young people's group meetings. As a result, the population had increased from 13 in 2006 to a high of 24 in May 2008. There was a waiting list of prisoners at Send and other establishments wanting to join the TC (see also section on the therapeutic community).
- 2.8 **The resettlement strategy should be based on a comprehensive needs analysis, including the specific needs of women. (HP46)**
Not achieved. An up-to-date resettlement strategy was pathway based and made brief references to the two additional pathways for women relating to domestic abuse and prostitution. A comprehensive needs survey and useful analysis had been completed in February 2008, but had not been used to tailor the strategy specifically to the needs of women at Send.
We repeat the recommendation.

Recommendation

to the Chief Executive, NOMS

- 2.9 **Swab testing should be piloted at Send as an alternative to urine testing for women who have signed voluntary and compliance drug testing compacts. (8.75)**
Not achieved. This had been recommended in light of the very poor urine testing facilities and the fact that it would be less intrusive and embarrassing. New mandatory and voluntary drug testing facilities were being built. We were told that HMP Downview was due to introduce swab testing and that this practice was likely to transfer to Send as part of the twinning process in the near future.
We repeat the recommendation.

Recommendations

to the Director General

- 2.10 **The cost of telephone calls for prisoners should be reduced. (3.91)**
Partially achieved. The cost of some calls for foreign national women had been reduced, but this benefited only a limited number of women.
We repeat the recommendation.
- 2.11 **The therapeutic community at Send should be given the security of at least a two-year future to allow it to develop the necessary stability. (8.53)**
Achieved. The TC was established as a national resource and the community was embedded in Send and well publicised around the women's estate. However, other factors were restricting its potential (see section on the therapeutic community).

Recommendation

to the Director General and the Governor

- 2.12 **The prison should note all 'at risk' women arriving at Send about whom they have not been previously notified, and forward this to the women's team at Prison Service headquarters to raise with governors and area managers of the sending establishments. (3.40)**
Partially achieved. Sending establishments were contacted when at risk women were received at Send, but there was no formal protocol for informing the women's team at Prison Service headquarters.
We repeat the recommendation.

Recommendation

to the escort contractor

- 2.13 **Vans escorting prisoners should make a toilet stop every two hours. (1.6)**
Partially achieved. Few women had long journeys to Send and those transferred from distant prisons were normally lodged at another establishment overnight. However, prisoner escort records did not indicate that regular comfort breaks were provided.
We repeat the recommendation.

Recommendations

To the Governor

First days in custody

- 2.14 **Reception interviews should be carried out in private. (1.28)**
Not achieved. Reception interviews were carried out in the reception staff office, which was in view of the holding room and did not guarantee privacy.
We repeat the recommendation.
- 2.15 **Staff should have direct observation of both holding rooms. (1.29)**
Not achieved. The second holding room could not be directly observed from the staff office and was used to store one prisoner's property. Staff said women were held in this room only for short periods while waiting for a strip search and would be supervised by a member of staff. We were not able to observe this.
We repeat the recommendation.

- 2.16 Reception packs for smokers and non-smokers should be available on reception. (1.30)
Achieved. Both packs were available to new arrivals.
- 2.17 A stock of clean, good quality donated clothing that meets the needs of prisoners should be available (1.31)
Achieved. Appropriate clothing was now available from reception, stores or the chaplaincy.

Additional information

- 2.18 Reception staff were caring and dedicated. Procedures were thorough, with healthcare screening, cell-sharing risk assessments and property dealt with. However, women waited up to five or six hours in reception and some were not fully processed before going to the wing. Listeners did not regularly attend reception to meet new arrivals, but were called to see women on request. All women coming through reception, including those working out every day, were routinely strip searched.
- 2.19 Procedures were adequate to ensure that most women were cared for on their first night. New prisoners on the induction unit were usually locked on a spur with no direct access to staff, which was potentially unsafe. Several women said they had felt unsafe and that new arrivals were bullied for their reception packs. Some women were located on a separate wing alongside prisoners on the rehabilitation of addicted prisoners trust (RAPt) programme. This did not appear to cause any problems and they were able to attend the induction programme. Insiders met new arrivals in reception and on the first night centre and passed on some induction and first night information.
- 2.20 Several departments regularly failed to attend their slot on the induction programme so some women did not receive all the information they needed. Listeners did not have an allocated slot. Women were locked in their cells when not attending induction and often stayed on the unit for up to four weeks before being allocated to work.

Further recommendations

- 2.21 The amount of time women spend in reception should be reduced.
- 2.22 Listeners should meet all new arrivals in reception and be allocated a regular slot in the induction programme.
- 2.23 Strip searching in reception should be carried out only on the basis of individual risk assessment.
- 2.24 Prisoners on the induction unit should have direct access to staff during periods of unlock.
- 2.25 Induction should be delivered according to the published programme.
- 2.26 The amount of time prisoners spend on the induction unit should be kept to a minimum.
- 2.27 Procedures should be reviewed to ensure that women are allocated to work more quickly.

Residential units

- 2.28 **Detergent should be provided to prisoners for handwashing underwear together with drying facilities. (2.13)**
Achieved. Women on the main block and E and F wings were given detergent monthly to hand wash items of clothing. Women on J wing had more frequent access to supplies. All women had a drying rail in their cell.
- 2.29 **Prisoners should have easy access to cleaning materials. (2.14)**
Not achieved. Women continued to describe access to cleaning materials as difficult. Apart from on J wing, women were issued a monthly supply of all-purpose disinfectant, but many said this was inadequate. Women had to apply for all items other than toilet rolls outside the monthly supply.
We repeat the recommendation.
- 2.30 **Appropriate emergency call bells should be installed for disabled prisoners. (2.15)**
Partially achieved. J wing, the new build wing, contained two cells for women with disabilities and two for women with reduced mobility, all of which were properly equipped. The two adapted cells on B1 had alarm bells in the main living area, but not in the bathroom. These needed to be refurbished as the floors were uneven and the table obstructed wheelchair access.

Further recommendation

- 2.31 The adapted cells on B1 should be refurbished to appropriate standards for wheelchair users.
-

Staff-prisoner relationships

- 2.32 **Efforts should be made to achieve a female to male officer ratio of 70:30. (2.22)**
Not achieved. The staffing ratio was 60:40, but the prison also received around 20 detached duty, mostly male, staff a day (see additional information below). The prison had requested more female staff from area.
We repeat the recommendation.

Additional information

- 2.33 Send had experienced significant staff shortages. J wing had opened in March 2008 with insufficient staff and there were enduring staffing deficits. As with other prisons in the area opening new accommodation, Send was reliant on detached duty staff. The prison was making considerable efforts to improve the continuity of the staff group, but many staff were deployed to Send for a matter of days and some were deployed direct from training school. Most had little or no experience of working with women.
- 2.34 Despite this, there were some good and respectful interactions between staff and prisoners, with even short-term staff making efforts to deal with the women constructively. The high number of detached staff with little knowledge of the prison who could not access the computer system to answer enquiries about prisoners' monies or other issues placed an additional strain on regular Send staff. On several occasions during the inspection, staff on the main block

were, with the exception of the senior officer, all detached duty. Detached staff were moved around the prison every day, which significantly undermined staff-prisoner relationships.

Further recommendations

- 2.35 Efforts should be made to ensure improved continuity of detached duty staff and the recruitment of more permanent staff.
- 2.36 Detached duty staff should be able to use the Send intranet to enable them to carry out key tasks.

Personal officers

- 2.37 **Personal officers should be trained for their role and provided with model examples of good wing history sheet entries. (2.31)**
Not achieved. The personal officer guidance document was out of date and did not include examples of what was required. Many wing history sheets contained little or no information about the prisoner.
We repeat the recommendation.
- 2.38 **Entries in wing history sheets should comment on prisoners' progress in their sentence and show knowledge of their family backgrounds and their reintegration needs. (2.32)**
Not achieved. Although there were some exceptions, notably for women on the RAPt programme, most history sheets contained no references to sentence planning, family circumstances or resettlement issues.
We repeat the recommendation.
- 2.39 **Personal officers should contribute to sentence plans and other reviews and, where possible, attend boards to support the prisoners for whom they are responsible. (2.33)**
Not achieved. Personal officers were sometimes invited to sentence planning boards, but there was no evidence that any did so. This was primarily due to the acute staffing situation. Some personal officers contributed through the OASys request for information system.
We repeat the recommendation.

Additional information

- 2.40 Wing history sheets indicated minimal personal officer involvement and that this had slipped significantly in recent months. Most files contained little information and some contained gaps of over a month between entries. Most information related to behaviour and there was little evidence of awareness of offending behaviour needs or family circumstances. Separate files maintained for those on the therapeutic community (TC) showed detailed knowledge of the circumstances of the women. There was evidence of some management checks of history sheets, but rarely any comment or advice to staff.
- 2.41 Wing observation books were generally much better and contained some useful information on particular problems or circumstances. Most women we spoke to knew who their personal officer was. Some spoke positively about the relationship and support they had received, but others had not seen their personal officer for some time.

- 2.42 The effect of large numbers of detached duty staff was undermining. Women said they did not know who to go to for advice and support as many staff were there only temporarily. They also reported problems in getting answers to simple requests and long delays in applications.

Further recommendations

- 2.43 The personal officer scheme should be updated.
- 2.44 Staff should be given training, advice and guidance about the particular issues of women prisoners.
- 2.45 Managers should ensure that information entered in wing observation books is also logged in history sheets to ensure that important observations remain on individual records.

Bullying

- 2.46 **The membership of the violence reduction meeting should be clarified, and members or a representative from their department or functional area should attend regularly. (3.15)**
Achieved. The violence reduction meeting had moved under the umbrella of safer custody. Safer custody meetings took place monthly, chaired by the head of safer custody, and were generally well attended by the departments named in the strategy terms of reference.
- 2.47 **A dedicated safer custody post should be created to coordinate the prison's work on all aspects of safety. (3.16)**
Not achieved. There had been a number of recent management changes in the violence reduction team and there was confusion about roles. Two staff we spoke to thought they had until recently been the anti-bullying coordinator and staff involved in anti-bullying gave the names of four different people currently thought to be the anti-bullying coordinator. The head of safer custody was on leave, but staff and managers should have been clear about how the violence reduction strategy operated. No one knew how many hours the anti-bullying coordinator was able to dedicate to the role and there was no job description. The person we believed to be the previous coordinator had had to fit the work around his primary role of catering manager.
We repeat the recommendation.
- 2.48 **The anti-bullying coordinator should closely monitor the new arrangements for recording, investigating and reporting the outcomes of incidents of suspected bullying, and make reports to the violence reduction meeting. (3.17)**
Partially achieved. The previous anti-bullying coordinator, who was waiting to hand over to a new coordinator, still maintained a log of incidents of suspected bullying that included the outcomes of investigations. The log was about a month behind and outcomes of investigations were not recorded on the investigation paperwork. The coordinator produced a report for the safer custody meeting each month. Trends were discussed and poor practice, such as the poor quality of investigations, was highlighted, but there was no analysis of the type or location of bullying.

Further recommendations

- 2.49 The violence reduction strategy log should be kept up to date.

2.50 Routine violence reduction data analysis should include the nature and location of bullying incidents.

2.51 Staff should be trained in the prison's anti-bullying strategy. (3.18)

Not achieved. There had been no violence reduction training in the previous six months and no one could provide any figures for training completed before this.

We repeat the recommendation.

2.52 There should be a course to challenge bullies. (3.19)

Not achieved. There were a number of interventions that bullies could attend depending on need, including RAPt, theTC, the enhanced thinking skills programme and the Sycamore Tree victim awareness course. However, there was no evidence of any attempt to understand bullies' behaviour or to refer them to interventions that could help them.

Further recommendation

2.53 Women identified as bullies should be helped to understand their behaviour and its effect on others. Targets should be set as part of violence reduction monitoring to help them to do this.

2.54 Victims should be supported and kept informed of the outcomes of investigations. (3.20)

Not achieved. Violence reduction strategy documents were opened on bullies, but not on victims and there was no clear approach to supporting victims. Communication with victims was inconsistent and most received a generic and inappropriately formal letter giving minimal information about their case. Some letters were addressed to the prisoner only by her number and surname. Investigators sometimes spoke to the victim, but this was not usual. There was no care plan for victims and no evidence of any additional support offered. Victims were often moved wings, which was not appropriate.

We repeat the recommendation.

Additional information

2.55 The management of bullying had deteriorated. Bullying had been a factor in all three cases of women taking their own lives (see section on self-harm and suicide). Staff said there was an up-to-date violence reduction strategy document, but the only version produced was dated January 2006. This referred to 2052SHs and Rule 43s and made no reference to the new arrangements whereby violence reduction was managed under safer custody.

2.56 A centre office for A, B and C wings was located on the main corridor and there was no staff office on the wings. This did not encourage a sense of safety or feeling of staff presence and Insiders said it did not help the occasional bullying of new arrivals. Women were almost constantly knocking on the wing exit doors to attract staff attention. Most women we spoke to said staff would help with bullying if they were told about it, but women tended not to tell them. A violence reduction strategy manager believed that most incidents of bullying went unreported.

2.57 A recent anti-bullying survey had attracted few returns and was to be redone. The lack of a survey and the absence of analysis of bullying figures by incident type meant there was no basis on which to understand the nature of bullying. Our own investigation indicated that there had been 10 assaults in the previous six months, with most reported incidents being

verbal/intimidation. Taking this along with the Ombudsman's findings and reports from the women, it appeared that most bullying was centred around relationships between women, but there was no strategic attempt to understand this better or to train staff in what to look for or how to manage it.

Further recommendations

- 2.58 There should be an up-to-date violence reduction strategy document that is informed by the needs of women at Send as identified in a violence reduction strategy survey.
- 2.59 There should be an office on each wing where a member of staff is based during each shift.
- 2.60 The nature of bullying at Send should be analysed and discussed at the safer custody meeting, based on at least the findings of investigations, security information reports and the violence reduction strategy survey.
- 2.61 Staff should be trained in how to identify and manage bullying within relationships.

Self-harm and suicide

- 2.62 **Analysis of trends of self-harm incidents should be improved and considered regularly at the violence reduction meeting. (3.39)**
Achieved. Suicide and self-harm and the violence reduction strategy came under the remit of safer custody, and trends in self-harm were discussed at the monthly safer custody meeting. Action points from these discussions were put in the safer custody continuous improvement plan and followed up at each meeting.
- 2.63 **Listeners and Samaritans should contribute to staff induction and training. (3.41)**
Not achieved. Listeners and Samaritans did not contribute to staff induction or training.
We repeat the recommendation.
- 2.64 **Listeners should be available informally on the induction landing and should contribute to induction. (3.42)**
Not achieved. There were five experienced Listeners and seven more in training. One was resident on I wing and the rest were based on E or F wing. None worked on the induction wing and Listeners were not routinely involved in induction, although this was planned. Women in reception were asked if they wanted to see a Listener. There were two Insiders, both of whom had a detailed job description and contributed to the induction programme. One was located on the induction unit and routinely saw all new arrivals, while the other, based on B wing, greeted all new arrivals in reception. They were able to attend the safer custody meeting.
We repeat the recommendation.
- 2.65 **Work on the observation room should be completed, and the protocol for its use should ensure that ward officers carry out constant watches and that full records are kept. (3.43)**
Partially achieved. Work on the observation cell was complete, but it was not ready for use. The bedding was dirty and there were dirty cups and unpackaged sanitary towels on the floor. The protocol for the use of the cell was included in the suicide prevention and self-harm management document, but was generic rather than specific to Send. It covered irrelevant details such as how to deal with juveniles when none were held at Send and did not include how use of the main corridor, where the cell was located, would be managed when the cell

was occupied or how the prisoner would access facilities such as showers and telephones. It did not make clear whether the cell should be staffed by healthcare staff or wing officers. Records of the use of the cell were kept and it had been used 12 times to date in 2008. (See also section on discipline.)

Housekeeping point

2.66 The constant observation room should be clean and ready for use.

2.67 **Personal officers, or a key worker with whom the prisoner is familiar, should contribute to the reviews of prisoners at risk and provide ongoing support. (3.44)**

Not achieved. Personal officers and key workers rarely contributed to reviews and were not usually specifically involved in support plans for women at risk of self-harm or suicide. **We repeat the recommendation.**

2.68 **Free, confidential telephone access to the Samaritans should be provided, including from landing telephones. (3.45)**

Achieved. The orderly officer carried a Samaritans mobile telephone, but there was no log of requests or use so it was not possible to identify whether the provision met need (see additional information). Women could call the Samaritans and a range of other helplines free of charge on the landing telephones. A list of relevant telephone numbers was displayed by each telephone.

Good practice

2.69 *The list of free helpline numbers next to each telephone gave women additional support options that they could access confidentially and easily.*

Additional information

2.70 A comprehensive 210-page suicide prevention and self-harm management strategy document had been completed in August 2008 and was in its final stages of ratification. The document was good, albeit generic in parts rather than specific to the needs and risks of women at Send and it did not highlight themes identified by the Ombudsman's reports following suicides or information from surveys.

2.71 The safer custody meeting was held monthly (see section on bullying). On average, five prisoners attended the first part of the meeting, leaving when more confidential issues were discussed. Minutes reflected discussion of key areas, including women being monitored, the outcome of management checks of assessment, care in custody and teamwork (ACCT) documents and learning from serious self-harm incidents across the estate. However, it was not evident that this information was disseminated to staff.

2.72 Send had scored a poor 58% on its most recent suicide and self-harm prevention audit. As a result, a full-time senior officer suicide prevention coordinator had been in post since March 2008 and reported to the residential governor who was head of safer custody. An administrator post allocated to safer custody was vacant.

2.73 Twelve women were on an ACCT and 97 had been monitored on an ACCT to date in 2008. On average, there were 20 self-harm incidents a month compared to eight at the time of the

previous inspection, an increase that could not be explained by the recent rise in population. There had been two self-inflicted deaths since the previous inspection, one in April 2007 and one in September 2007. The Prison and Probation Ombudsman's report on both had not been published so no action plan had been developed. Apart from removing bathroom doors, which had been used as ligature points in all incidents, no changes had taken place as a result of the deaths. There was an action plan relating to the death of a woman who had committed suicide shortly after transferring from Send to HMP Eastwood Park. A number of the Ombudsman's recommendations in this case related to Send.

- 2.74 ACCT documents were of mixed quality and entries did not reflect satisfactory levels of engagement with women. Only 24 staff had completed the ACCT foundation training, but there were 13 trained case managers and six assessors.
- 2.75 Since January 2008, 12 women who had self-harmed had been taken to outside hospital, but none of these incidents had been investigated.
- 2.76 Information on notice boards was out of date, such as old lists of Listeners, and copies of the safer custody meeting minutes were not displayed.
- 2.77 The Listener coordinator was on leave, but we were told they had no facility time for this role. Requests for, and use of, Listeners was not monitored so it was not possible to tell whether the provision met need. Listeners met together weekly and had a meeting with the Samaritans every fortnight. The Samaritans were positive about recent support from the prison. Listeners reported a number of operational problems, most of which were confirmed by the Samaritans and the suicide and self-harm prevention coordinator. Women often had to wait to see a Listener (Listeners said this could be up to two hours), follow-up visits were not always allowed, the rota was often not adhered to, some women requesting a Listener had incorrectly been told that Listeners were busy and Listeners were not involved in induction for staff or prisoners. Listeners also said they had inappropriately been called to see women who did not want to see them and whose issues should have been dealt with by staff.
- 2.78 There were no safer rooms. Two cells had been knocked together to create a Listener suite for use at night, but it was dirty and not ready for use. There was no protocol for, or log of, its use.
- 2.79 All residential staff carried ligature knives.

Further recommendations

- 2.80 The suicide prevention and self-harm management strategy document should be more tailored to the specific needs of women at Send as identified by management information, surveys and investigation reports.
 - 2.81 Key information from the safer custody meeting, including how ACCTs need to improve, should routinely be disseminated to staff.
 - 2.82 Minutes from the safer custody meeting should be available to staff and prisoners.
 - 2.83 All incidents of self-harm should routinely be investigated to establish causes and look for lessons to prevent further occurrences and, in the event of serious self-harm, investigations should be more detailed.
 - 2.84 ACCT documentation should routinely demonstrate that staff are engaging with the woman being monitored.
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- 2.85 All staff should be trained in the ACCT process.
- 2.86 Notice board information on safer custody should be up to date.
- 2.87 The Listener coordinator should be given facility time to manage the Listener scheme.
- 2.88 There should be formal monitoring of requests for, and use of, Listeners, the Samaritans telephone and the care suite, and logs should routinely be analysed to ensure provision matches need.
- 2.89 There should be a protocol on the operation of the Listener suite.
- 2.90 The Listener scheme should be supported by the establishment and not frustrated by operational issues.
- 2.91 At least one safer room should be available.

Housekeeping point

- 2.92 The Listener suite should be clean and ready for use.

Diversity

Additional information

- 2.93 There was no overarching diversity policy and nothing incorporating attention to sexual orientation. There was a disability policy and women with disabilities were systematically identified and recorded. About 60 women identified with disabilities were in Send. Their conditions ranged from mental health problems to dyslexia and mobility problems. The disability liaison officer (DLO), a senior manager, was known to the women. However, it was not always clear what level of individual support was provided, especially to those with less visible disabilities, given the lack of time the DLO could devote to this area of work. Evacuation plans were in place, but there was a lack of systematic care planning. Disability issues were a standard agenda item at race equality and diversity action team meetings, although little discussion had recently taken place. Some new buildings had been erected without lifts.

Further recommendations

- 2.94 Prisoners with disabilities should be subject to care plans.
- 2.95 New buildings should have lift access wherever possible and be constructed in accordance with the Disability Discrimination Act.

Race equality

- 2.96 There should be a clear race relations policy, published to prisoners, explaining what is expected of prisoners and how the prison promotes equality of opportunity and positive race relations, including descriptions of the work of the race relations liaison officer and prisoner representatives. (3.59)

Partially achieved. A clear prison race relations policy statement was posted alongside other relevant information on diversity notice boards around the prison. However, there was no reference to the work of the race equality officer or that of prisoner representatives and the latter did not have job descriptions.

Further recommendation

2.97 The role of prisoner race equality representatives should be clarified and publicised to all prisoners.

2.98 **Interventions should be provided to challenge racism. (3.60)**
Not achieved. There was no specific intervention to deal with racist attitudes.
We repeat the recommendation.

2.99 **Ethnic monitoring should be extended to areas of particular relevance to Send, its prisoners and its resettlement work. (3.61)**
Achieved. Ethnic monitoring had been extended and now covered additional areas of relevance to Send, including the therapeutic community (TC) and community work.

2.100 **Training for staff working directly with prisoners should develop knowledge and awareness of cultural differences. (3.62)**
Not achieved. Staff still received only the standard three-hour Prison Service diversity course, which paid little attention to race and cultural difference.
We repeat the recommendation.

Additional information

2.101 Twenty-nine per cent of women were from black and minority ethnic backgrounds. Race equality and diversity action team meetings had a wide membership including prisoner representatives, were thorough and covered a range of relevant issues. However, the action plan reviewed at the meetings had many incomplete objectives, repeated from month to month. Racist incident report forms were completed to a reasonable standard, but there were a number of outstanding investigations, reflecting long delays in some cases.

Further recommendations

2.102 Action points on the race equality and diversity action plan should be systematically addressed and concluded as quickly as possible.

2.103 Racist incident investigations should be completed expeditiously.

Foreign national prisoners

2.104 **There should be a foreign national prisoner information leaflet to inform prisoners and staff about the special provisions available, and personal officers should ensure that foreign national women for whom they are responsible receive appropriate support. (3.71)**
Partially achieved. The national prisoner information book developed by the Prison Service, Probation Service and Prison Reform Trust was available in the library in 21 languages, but there was no local translated information leaflet for foreign national women. A number of

foreign national women with little English had little knowledge of, or contact with, their personal officers and lacked systematic support.

We repeat the recommendation.

- 2.105 The prison should liaise closely with the Immigration and Nationality Directorate to ensure that women subject to deportation orders who have finished their sentence transfer to an Immigration Removal Centre or are released to their home. (3.72)**
Partially achieved. An immigration surgery had been held in May 2008, with 13 women attending. The intention was to hold these surgeries every two months, but no further surgeries had taken place. Three people were detained at end of sentence and staff said the large number of former prisoners already in the crowded immigration detention estate meant that it was not always possible to transfer women at the end of sentence.

Further recommendations

- 2.106** The establishment should liaise with the UK Border Agency to ensure that advice surgeries take place every two months as planned.
- 2.107** A foreign national liaison officer should assist foreign national women to obtain independent legal advice and assistance, both when they are detained and when they are close to detention.

- 2.108 There should be impact assessments of key policies, such as the incentives and earned privileges scheme, provision of clothing, and catering, to ensure they do not disadvantage foreign national prisoners and meet their needs appropriately. (3.73)**
Not achieved. Completed impact assessments did not include consultation with foreign national women or reflect their views. The governor issued clear prisoner information notices listing the concern areas from impact assessments and what action was being taken, which helped to promote knowledge and confidence.

Further recommendation

- 2.109** Impact assessments should include specific consideration of impact on different nationalities, incorporating consultation with foreign national women.

Good practice

- 2.110** *Prisoner information notices listing the concern areas from impact assessments and action taken helped to promote knowledge and confidence among the women.*

- 2.111 Foreign national prisoners should be helped to make practical arrangements for their release and in re-establishing contact with their family for their return home. (3.74)**
Not achieved. There were no individual or group sessions to assist women with pre-release arrangements and foreign national orderlies had not yet been appointed. Hibiscus, which provides some pre-release assistance, was not contracted to work in the prison.
We repeat the recommendation.

Additional information

- 2.112 Almost 20% of women were foreign nationals, but provision for this group remained in its infancy. The foreign national policy was being revised and the diversity orderly posts had been created, but not filled. Three foreign national meetings had taken place with foreign national wing representatives, the resettlement officer, the diversity manager and the race equality officer in attendance. These had been useful, but there was no forum where all foreign national women could obtain information and support. A telephone interpreting service had been used 14 times in the previous six months, but we met some women with little or no English who said they had not been spoken to through an interpreter.

Further recommendations

- 2.113 There should be foreign national information and support group meetings open to all foreign national prisoners.
- 2.114 Detainees not fluent in English should be interviewed through a professional interpreter, particularly for interviews that require sensitivity and confidentiality such as healthcare consultations.

Contact with the outside world

- 2.115 **Telephones should be placed in booths. (3.90)**
Not achieved. There was no space to install booths around existing telephones so funding was being sought to re-site telephones in booths.
We repeat the recommendation.
- 2.116 **Prisoners should be able to exchange unused visiting orders for extra telephone credit or letters so that those with families a long way away can maintain good family contact. (3.92)**
Partially achieved. Women could exchange visiting orders for telephone credit (£1 per visiting order), but only if they did not receive any visits. They therefore had to choose between visits and telephone calls.

Further recommendation

- 2.117 Prisoners should be able to exchange unused visiting orders for extra telephone credit or letters regardless of whether they have received visits.
- 2.118 **There should be shelter for visitors waiting to be searched. (3.93)**
Achieved. Visitors waited to be searched in a portakabin, which was adequate for the purpose.
- 2.119 **The closed visit booth should be out of sight and hearing of other visitors and prisoners. (3.94)**
Partially achieved. The three closed visits booths were out of hearing, but in sight, of other visitors and prisoners.

2.120 The option of a closed visit or leaving should not be the only response to indication by a drug dog on a visitor without additional supporting intelligence. (3.95)

Not achieved. Visitors indicated by a drugs dog were offered a closed visit or had to leave. The closed visit was a one-off event unless other evidence came to light to warrant full closed visits.

We repeat the recommendation.

2.121 Prisoners should have access to a toilet during visits. (3.96)

Not achieved. Women were not able to use the toilet during visits unless they had a medical reason confirmed by the doctor.

We repeat the recommendation.

Additional information

2.122 Visits sessions had been increased to accommodate the additional population. Take-up was reasonable, although sessions were rarely full. Visitors and prisoners said visits regularly started late and this happened during the inspection. Visitors were treated respectfully and had access to a visitors' centre and support from staff in that area. Family visits were available monthly for pre-school children and bi-monthly for children aged up to 17 years. This disadvantaged women with children in both age groups who had to have separate visits with their children. Only one carer was allowed to attend with the children, which proved difficult for at least one woman whose child had special needs and required two carers. The visits booking line was staffed by one person who had no cover for when they were on leave and visitors were therefore unable to book visits. However, most prisoners said their families had little difficulty otherwise in booking visits.

Further recommendations

2.123 Women should be able to have all their children under 17 years included on the same family visit.

2.124 More than one carer should be allowed to accompany children on family visits where necessary.

2.125 Visits should start at the published time.

2.126 The visits booking line should be staffed consistently.

Applications and complaints

2.127 Prisoners' poor perception of the complaints process should be addressed, involving prisoner wing representatives and by publishing information about timeliness of replies. (3.105)

Not achieved. Prisoners continued to have poor perceptions of the complaints system. Complaints were answered reasonably quickly and politely, but complaints monitoring data were not published to prisoners. Some complaints were the result of unanswered applications. Minutes of an inaugural prisoner consultation committee held a couple of weeks before the inspection showed that the delay in answering applications had been raised as a concern. There was a common perception among prisoners that they had to put in an application for small requests because many staff, often detached duty staff, could not answer simple queries.

Further recommendation

- 2.128 Prisoners' poor perception of the complaints and applications processes should be addressed, involving prisoner wing representatives and by publishing information about timeliness of replies.
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Legal rights

- 2.129 **There should be improved management and monitoring of the legal services available to prisoners. (3.110)**

Not achieved. None of the three legal services officers listed on notices to prisoners was available at the time of inspection. Prisoners did not remember having seen them. Wing managers said there was usually no one to cover the area and that prisoners with legal needs were referred to prisoners recently trained by the Prisoners' Advice Service. We spoke to one of the trained prisoners, who had received one day of training mainly in use of the relevant Prison Service Orders and Instructions. This was a useful initiative, but not a replacement for an effective legal services provision. There was no evidence of effective management oversight of this area and no one could tell us how many legal services applications had been made or dealt with.

We repeat the recommendation.

- 2.130 **A legal services officer should be routinely involved in the induction programme. (3.111)**

Not achieved. Legal services officers did not contribute to the induction programme, although one of the women recently trained by the Prisoners' Advice Service had just started to attend. Theoretically, all new receptions were referred to the legal services team, but none of the prisoners asked had seen a legal services officer on arrival.

We repeat the recommendation.

Health services

- 2.131 **There should be a regular cleaning programme for the healthcare department to ensure that all floors and work surfaces are clinically clean to reduce the risk of cross-infection. (4.49)**

Partially achieved. A regular prisoner cleaner cleaned all offices and clinical areas in healthcare daily and the area was generally clean. However, this arrangement still meant nurses were spending valuable clinical time supervising cleaning activities.

Further recommendation

- 2.132 Civilian cleaners should be employed in healthcare.
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- 2.133 **Medicine trolleys should be locked when unsupervised, and locked and fixed to the wall when not in use. (4.50)**

Not achieved. Medicine trolleys were locked when unsupervised or not in use, but we saw keys left in the trolley locks on several occasions. Baskets containing medications were left on top of the trolleys. The trolleys were not fixed to the fabric of the building.

We repeat the recommendation.

- 2.134 **Staff needs and skills should be analysed to ensure there are sufficient and appropriately qualified staff to deliver care to prisoners. (4.51)**

Partially achieved. A staff needs and skill analysis had been produced by the former primary care trust (PCT) in August 2007, seven months before the commissioning and provision of healthcare services had been taken over by Surrey PCT in March 2008. This had been a period of great change and instability, with the sudden departure of the previous healthcare manager, continued difficulty recruiting permanent healthcare staff, uncertainties over the twinning process with HMP Downview and increased prisoner numbers following the recent expansion of Send.

We repeat the recommendation.

2.135 The need for mental health support should be reviewed to ensure sufficient resources. (4.52)

Partially achieved. The mental health team consisted of a newly appointed highly motivated part-time registered mental health nurse (RMN) to look after women with primary mental health needs. She was just beginning to offer group and individual sessions to women with anxiety, depression, stress and sleep disorders. We were concerned that women with mental health needs were not supported sufficiently because different agency nursing staff were on duty every day, which led to a lack in continuity of care.

2.136 The mental health in-reach service supported women with more serious mental health problems. This was a 9am to 5pm service Monday to Friday. The team consisted of a service manager based at another prison who visited 0.5 days a week, two part-time RMNs, one part-time approved social worker and one part-time psychologist. A consultant psychiatrist and a specialist registrar supported the team on 0.5 days a week. Four counsellors provided a service four days a week. The support time and recovery worker (STR) was a new mental health in-reach initiative of employing a prisoner to be a peer support worker and liaising between prisoners and the in-reach team. The in-reach RMNs had a case load of 12 to 15 women, with a waiting time of approximately two months to help women with issues such as bereavement, loss, separation and adjustment disorders. Additional strains and pressures on the mental health services were due to the high proportion of agency nursing staff and insufficient dedicated interview/consultation rooms. Mental health staff also had insufficient training to provide reports to the offender management programmes with links to healthcare and none of the RMNs was dual qualified (mental health and substance misuse specialists). Mental health awareness training was inconsistent due to the high level of officers on detached duty and the large numbers of agency nursing staff.

2.137 The in-reach team kept its own paper-based mental health clinical records on each client that were inserted into the hard copy of the prisoners' clinical records. The contemporaneous clinical records were all computer-based Egton Medical Information System (EMIS), which meant there were no in-reach entries on this system. It would not be easy for a healthcare professional reviewing a patient to establish the mental health history or the mental health support she had received.

2.138 Self-harm documents for the previous six months indicated that few of the women had any mental health assessment carried out, nor was it apparent on their record on EMIS that they had self-harmed. Staff we spoke to had not received specific training in the presentation and management of self-harming behaviour.

Further recommendations

2.139 A mental health needs analysis should be commissioned to inform the level of services required to meet the full needs of the women at Send.

2.140 Mental health awareness training should be delivered to all new staff, including detached duty and agency staff on induction.

2.141 The mental health in-reach team should make an entry on EMIS each time they see a client to inform the rest of the healthcare team.

Good practice

2.142 *The mental health in-reach initiative employing a prisoner as a peer support worker was very well supported by the women.*

2.143 **There should be prisoner focus groups to inform prisoners of changes in healthcare delivery and to enable them to raise their concerns. (4.53)**

Partially achieved. A prisoner advisory liaison service (PALS) had been established in February 2008 with good links to the PCT. A prisoner representative attended weekly meetings in healthcare, but these meetings were sometimes ineffective because the nurse representing healthcare was different each time and often an agency nurse unable to answer prisoners' questions or concerns. One of the complaints often raised at meetings was that women waited up to two weeks to see the GP.

We repeat the recommendation.

Further recommendation

2.144 The healthcare representative at the prisoner focus groups should be a dedicated senior permanent member of the healthcare team.

2.145 **Chronic disease patients should have routine follow up appointments. (4.54)**

Achieved. The introduction of the EMIS provided a recall system for follow-up appointments.

2.146 **Extra dental sessions should be introduced to reduce treatment waiting lists. (4.55)**

Not achieved. The waiting time to see the dentist for a routine appointment was up to 15 weeks. The dental service was provided by a local dentist and a dental nurse who conducted a session one day a week. Women were confused about the application process. All women were assessed by a nurse on reception and asked if they wanted to see the dentist. However, those who said yes were not, as they assumed, added to the dental waiting list and instead had to submit an application. They were then subject to dental triage carried out by one of the nurses who prioritised the urgency. The triage forms were screened by the dental nurse, who entered them onto the dental computer, which was a stand alone system. The computer system was new and often crashed, resulting in long delays entering the women onto the system. The dental health of prisoners was very poor, with women needing on average six sessions to rectify their problems. This had repercussions on the length of the waiting list and the need for additional dental provision.

We repeat the recommendation.

2.147 **The primary care trust and the prison should review the pharmacy service and establish clear responsibilities for its professional and supply aspects to enable appropriate lines of communication between all parties. (4.56)**

Partially achieved. A local retail pharmacy provided a supply only service, with a pharmacist and pharmacy technician from HMP Highdown visiting one day a week. There was clearly a need for additional pharmacist and pharmacy technician provision to ensure safer systems of

practice.

We repeat the recommendation.

- 2.148 There should be medication reviews, in accordance with national service frameworks, to provide clinical audit and prescribing advice. (4.57)**

Achieved. Medication reviews were part of the medicines and therapeutics committee meetings, which were chaired by the chief pharmacist from HMP Highdown and attended by the acting head of healthcare. The GPs from Send did not attend. Methadone, Subutex and Diazepam reviews were also conducted by the deputy healthcare manager and the GPs at Send. In addition, there was a monthly medication review in association with RAPt, which was well supported by healthcare and the GPs.

- 2.149 Nurses should administer all prescribed medication directly to the patient from the original medicine containers. (4.58)**

Achieved. All prescribed medication was administered from the original medicine containers.

- 2.150 Prescribers must complete the prescription charts in full at the time of administration, recording diagnoses and dates. (4.59)**

Achieved. The prescription and administration charts were completed at the time of administration.

- 2.151 The in possession policy should be reviewed urgently in consultation with the pharmacy provider, and a risk assessment tool developed and implemented. (4.60)**

Achieved. The in-possession policy had been reviewed and a risk assessment for both patient and medication was in place.

- 2.152 Prisoners who have been risked assessed to have medication in possession should be able to keep their medicines safely and securely in their rooms. (4.61)**

Achieved. All cells had been fitted with secure lockable metal cupboards.

- 2.153 Any pre-packed medicines supplied by the pharmacy department should be dual-labelled and one label should be fixed to the prescription at the point of supply to inform the pharmacist that the correct item has been supplied. (4.62)**

Partially achieved. Dual labelling had vastly improved, but there were examples where this was missing.

We repeat the recommendation.

Additional information

- 2.154** A pharmacy audit had been completed in August 2008 due to the PCT's concerns about prescribing practices and safety issues. We observed the wrong dosage of medication being sent from the retail pharmacy for a prisoner. Several prisoners said they had received another prisoner's medication and this was reflected in the minutes of the prisoner forum group. Doctors were using EMIS to order medication and nurses were transcribing the medication onto the prison prescription sheets to use them as administration charts without signatures. It was unclear when changes to dosages had been made and the propensity for mistakes was therefore high.

- 2.155** Administration of medication took place at several venues. We observed a treatment time in the main healthcare centre. The treatment hatch opened directly onto the waiting room allowing the women little opportunity to discuss any matter in confidence.

- 2.156 Healthcare services were under strain due to problems recruiting permanent nursing staff. The healthcare department was staffed by a full-time acting head of healthcare from HMP Highdown, a part-time deputy healthcare manager and substance misuse nurse. They were supported by two full-time registered general nurses (RGNs), a part-time RMN and a full-time healthcare assistant. The healthcare department provided cover between 7.30am and 9pm seven days a week. There were four healthcare staff on the early and late shifts. There were 11 agency nurses regularly on duty, which led to problems such as a lack of continuity of care and unfamiliarity with healthcare procedures. On some occasions, healthcare was staffed exclusively by agency staff.
- 2.157 Lack of regular staff affected every discipline in healthcare. Agency staff who conducted nurse triage clinics were sometimes RMNs without the appropriate skills to conduct a thorough physical health assessment. This led to GPs having to conduct triaging clinics after they had seen all the patients on their clinic list. A number of nurse-led clinics were also affected and GPs were seeing women who should have been seen at nurse-led clinics. Lack of continuity of care affected the safeguards in place to support women with mental health needs in that both the primary mental health and in-reach services were part time.

Further recommendations

- 2.158 Doctors should write their prescriptions directly onto the prison prescription charts and sign them to reduce the risk of medication errors.
- 2.159 The practice of nurses transcribing medications should cease.
- 2.160 The treatment hatch should be re-sited to give women the opportunity to discuss their concerns with healthcare staff in confidence.

Learning and skills and work activities

- 2.161 **Sufficient staff should be recruited to offer the published range of curriculum. (5.14)**
Achieved. A new English for speakers of other languages (ESOL) tutor had been appointed and the prison was adequately meeting the learning needs of women with poor communication skills. An additional ICT tutor had also been appointed to expand provision and there was a new part-time coordinator for social and life skills. The curriculum was broader, including courses in preparation for work and the 'unlock' financial skills programme, which were making a positive contribution to the resettlement agenda.
- 2.162 **Achievement and retention data should be collected to identify trends in learning. (5.15)**
Achieved. The use of management information systems had improved. The head of learning and skills received monthly data reports enabling evaluation of performance against profiled targets for participation, progress and achievement in education and work. Data were used appropriately at quarterly partnership meetings with the education contractor to identify areas for improvement. The collection and use of achievement data were now routine.
- 2.163 **The range of information and communications technology, numeracy and literacy provision should be increased. (5.16)**
Achieved. The prison now offered a good range of modular ICT courses to meet women's different needs and skills levels. Courses ran from entry level to level 3 and, being modular in design, enabled prisoners to achieve in incremental stages. The number of ICT tutors had increased to four. ICT remained popular, with waiting lists for prisoners. The prison had

responded to prisoners' requests by providing courses in text processing and web design. Resources for ICT were good. The prison offered a full range of levels for literacy and numeracy. A team of five specialist tutors met the support needs of women attending education. Outreach support for prisoners in work areas was poor. The Toe by Toe project was making a positive impact in supporting those with skills for life needs, including ESOL.

2.164 Staff should ensure that prisoners arrive at classes at the published times. (5.17)

Partially achieved. Arrangements for ensuring efficient movement around the prison enabling punctual arrival of prisoners were improving. However, during July 2008, 276 women had failed to arrive at classes due to operational failures. Average attendance had improved to 85%. Many women still arrived late at classes and not enough action was taken by staff when they did so. Further improvements using movement slips to eliminate the need for escorts were due to be introduced in September 2008.

Further recommendation

2.165 Arrangements to ensure prisoners arrive at classes at the published times should be further improved.

2.166 Hairdressing training should be accredited. (5.18)

Not achieved. The hairdressing salon continued to offer only facilities for prisoners and no formal training. Five women were assigned to work in the salon supervised by two temporary experienced hairdressers. However, the supervisors were not qualified trainers or assessors and accredited training had not been introduced. Attempts by the education contractor to appoint suitable trainers had been unsuccessful. Hairdressing had relocated to a new salon offering good facilities to support skills training and accreditation. The salon helped develop women's self-confidence and inter-personal skills as well employability skills, such as responsibility and reliability. Women could now also develop and use Afro-Caribbean hairdressing skills.

We repeat the recommendation.

2.167 The library should have more books on information and communications technology and also black fiction. (5.19)

Achieved. The black fiction section had been greatly expanded and now contained over 200 titles. The library had also responded to the needs of foreign national women by including books in languages such as Bulgarian. ICT resources were adequate, with two computers, printers and CD ROMs for prisoners' use. The library had on-line connection to Surrey Library Services for the tracking and ordering of books. The library was popular, with over 500 visits weekly. There was no qualified librarian, but good access, including in the evenings and at weekends, was maintained by six orderlies.

2.168 Accredited qualifications, such as a profile of achievement, should be offered in the contract workshop. (5.27)

Not achieved. The contract workshop offered work servicing audio headphones for up to 29 women. The work was very low-skilled and repetitive, but the relatively high wages made the workshop popular and there was a waiting list. The nature of the work did not increase employability skills, support accredited training or contribute positively to the resettlement agenda by improving the women's chances of finding jobs on release. The prison was still considering plans to introduce meaningful work and accredited training.

Further recommendation

2.169 The type of work offered in the contract workshop should be changed to enhance employability skills and accredited training should be introduced.

2.170 **Accredited horticulture qualifications should be offered. (5.28)**

Partially achieved. The impressive horticulture facilities had been maintained and an area for re-cycling prison waste introduced offering an additional 18 work places. Two new horticulture trainers had been appointed and there was now a full complement of horticulture staff. Work places in gardens had increased from 35 to 50. Seven learners were on the NOCN course in floristry, which provided a good opportunity to achieve accreditation at level 1. One of the new staff members was a qualified teacher and was tasked with extending the horticulture offer to NOCN accredited courses.

Further recommendation

2.171 The prison should expand the number of accredited courses in horticulture.

2.172 **Literacy and numeracy support should be provided in all work activities. (5.29)**

Not achieved. A qualified skills for life tutor appointed to offer literacy and numeracy had left and a replacement had not been found. Skills for life support was still provided informally by unqualified trainers in areas where accredited vocational training was taking place, such as the kitchen and gardens. Support with portfolio building for women on the floristry course was provided by a volunteer tutor, who was a qualified florist. There were no formal arrangements for providing literacy and numeracy in many work areas, including the contract workshop, hairdressing, cleaning parties or in the gym.

Further recommendation

2.173 Opportunities for literacy and numeracy support should be reinstated in all work activities.

Physical education and health promotion

2.174 **Prisoners should have access to recreational PE at the weekend. (5.38)**

Not achieved. Access to physical education (PE) during the week was good and met demand. However, there had not been a full complement of PE staff for many months and insufficient staffing levels had precluded the extension of gym opening hours at weekends. A new PE instructor had been appointed and was due to start work in September 2008.

Further recommendation

2.175 A needs analysis should be completed and access to the gym at weekends extended to meet demand.

Faith

- 2.176 **Prisoners should have access to a minister of their faith outside formal services. (5.45)**
Partially achieved. The faith team included chaplains from a range of different religions, including Christian, Muslim, Pagan, Sikh and Hindu. We received no complaints about restrictions on access to chaplains. The coordinating chaplain was concerned about the limited funds available to pay for sessional work and the impact this might have on future provision. He lacked an assistant chaplain, which inevitably meant that chaplaincy provision was sometimes restricted, particularly when he was on leave.

Further recommendation

- 2.177 The coordinating chaplain should have an assistant to ensure consistent chaplaincy provision.

- 2.178 **An adequate heating system should be provided for the chapel. (5.46)**
No longer relevant. The chapel was being rebuilt and was due to reopen in the autumn.

Additional information

- 2.179 Funding restrictions meant that the Sycamore Tree restorative justice programme was to be reduced from four to three courses a year, despite being consistently oversubscribed.

Further recommendation

- 2.180 The Sycamore Tree programme should be resourced to provide sufficient places to meet demand.

Time out of cell

- 2.181 **The times of morning and afternoon unlock should be coordinated with the start times of education and work. (5.52)**
Achieved. The unlock times had been coordinated, although there was slippage in movement to work times and women were often late to activities.

Further recommendation

- 2.182 The published core day should be adhered to.

Additional information

- 2.183 The number of women unlocked on their units daily with no purposeful activity was a concern. We carried out a roll check and almost half the women on the resettlement wings were unlocked, but either associating or carrying out domestic tasks and were not gainfully employed.

Further recommendation

- 2.184 Prisoners remaining on wings during the core day should be purposefully occupied.
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Security and rules

- 2.185 Prisoners should have regular recategorisation reviews linked to their OASys (offender assessment system) reviews. (6.11)
Achieved. A database had been developed to record when reviews were due and all reviews were up to date. Additional reviews were also facilitated when requested by women. All categorisation reviews were linked to OASys reviews.
- 2.186 A record should be maintained of how many and which prisoners are subject to each security categorisation. (6.12)
Achieved. The database contained this information.
- 2.187 Letters informing prisoners that they are to stay on closed prison status should include the reason for the decision, and how they might progress for the next review. (6.13)
Achieved. All women were sent a letter after their categorisation review giving the result, the reasons and the targets they needed to meet.

Discipline

- 2.188 Formal authorisation and records should be completed whenever a prisoner is locked in the holding or observation cell. (6.24)
Partially achieved. Documentation was completed for all women held in the observation and holding cells. However, it was of varying quality and inconsistently used. Some were recorded on good order or discipline paperwork, some on a local form and some had the initial safety screen algorithm. Others had a combination of these documents opened.

Further recommendation

- 2.189 The quality of documentation completed for women held in the observation and holding cells should be improved and it should be used consistently.
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- 2.190 Women waiting for adjudications should be locked into a cell only if necessary for security reasons. (6.25)
Achieved. Women were not routinely held in cells before adjudication.

Additional information

- 2.191 There were no clear protocols governing the use of the holding and observation cells. The holding cell had not been used for over 18 months, but the observation cell had been used 12 times to date in 2008. The shortest stay was overnight and the longest 10 days. The cells were in an unsuitable location, with little privacy for women held in the observation cell. Use of force levels were low, with just four incidents in the previous six months.

Further recommendations

- 2.192 A clear protocol governing the use of the observation and holding cells should be developed.
- 2.193 The observation and holding cells should be relocated to a more appropriate part of the establishment.
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Incentives and earned privileges

- 2.194 **Personal officers should take an active role in the incentives and earned privileges (IEP) scheme. (6.38)**
Partially achieved. Wing files contained various amounts of information and many had entries several months apart. A few evidenced regular and meaningful personal officer contacts, which allowed discussion of personal issues and behaviour and linked this to IEP reviews. However, many others contained little or no evidence of personal officer work.
We repeat the recommendation.
- 2.195 **There should be more imaginative incentives that are not just relevant to prisoners who have external financial and social support. (6.39)**
Partially achieved. There had been some changes to the scheme, including allowing enhanced women to buy and send more photographs to help maintain family ties. However, most enhancements still had little relevance to foreign national women with little money or no visitors in this country.
We repeat the recommendation.
- 2.196 **The IEP policy should clearly state that the drug testing as a condition for enhanced status is compliance testing and not voluntary. (6.40)**
Partially achieved. While the revised IEP policy referred to compliance testing, the IEP policy statement displayed on units and available to prisoners stated that prisoners 'should engage in voluntary drug testing' to achieve enhanced status.
We repeat the recommendation.

Catering

- 2.197 **Breakfast should be served on the morning it is eaten. (7.7)**
Not achieved. Breakfast packs were still distributed the night before they were to be eaten.
We repeat the recommendation.

Shop

- 2.198 **The product range in the shop should reflect identified need. (7.17)**
Achieved. The shop list contained 660 products, many added following prisoner requests. However, there were some concerns that the list was about to be reduced to 350 products in line with a new shop contract agreed nationally.
- 2.199 **Prisoners should be able to use the shop within 24 hours of arrival. (7.18)**
Not achieved. Shop items were ordered on Tuesdays and women arriving on Wednesday mornings usually had to wait until the following Friday, 10 days later, to receive their orders.
We repeat the recommendation.

- 2.200 **A range of catalogues, including a clothing catalogue, should be introduced. (7.19)**
Achieved. Five catalogues were now available, including two for cosmetics and specialist hair and beauty products, one for health food and vitamins, one for general goods and one for clothes. However, the clothing catalogue offered mainly sports goods rather than more general clothes that women often wanted to purchase.

Further recommendation

- 2.201 A general fashion catalogue should be available.

- 2.202 **Prisoners should be able to buy daily newspapers. (7.20)**
Achieved. Newspapers and magazines were available to buy, but very expensive as a 60 pence delivery charge applied to each one. The catering manager had tried to negotiate a cheaper price, but without success.

Further recommendation

- 2.203 Further attempts should be made to reduce the unreasonable newspaper delivery charges and in the meantime Send should make more newspapers available.

Resettlement strategy

- 2.204 **The resettlement policy committee should use performance and other data to develop resettlement policy. (8.8)**
Achieved. The resettlement policy group met every two months and membership was multidisciplinary. A part of the meetings discussed the nine pathway areas. Performance data relating to each were discussed in detail and used to make decisions and generally drive the strategy forward.
- 2.205 **The work of throughcare should be fully integrated into that of the resettlement department and clearly defined in the resettlement strategy. (8.09)**
Achieved. Responsibility for throughcare now lay within the offender management unit, which came under the umbrella of the head of reducing reoffending. There were separate strategies for the offender management unit and resettlement, but responsibilities were clear and work was well integrated.

Additional information

- 2.206 The throughput of the prison had recently increased, with an average of 22 women a month released in spring 2008 compared to just 13 in winter 2007/08. This was largely due to receiving women with shorter sentences, but the differing needs of this change in population needed to be considered in the strategy.

Further recommendation

- 2.207 Changes in population needs should be reflected in the resettlement strategy.

Sentence and custody planning

- 2.208 **Prisoners sentenced to less than 12 months should have a custody plan. (8.15)**
Partially achieved. Only 10 women had sentences of less than 12 months. They had no custody plan, but probation staff completed a comprehensive induction interview with all women highlighting areas of need and making necessary referrals. However, no targets were set and nothing was given in writing. This could easily be turned into a custody plan for all women and was a missed opportunity.
We repeat the recommendation.
- 2.209 **All eligible prisoners should have a sentence plan compiled within 12 weeks of arrival at Send.(8.16)**
Not achieved. See paragraph 2.6.
- 2.210 **Personal officers should provide reports for OASys (offender assessment system) assessments and reviews and attend boards. (8.17)**
Partially achieved. Personal officers routinely provided 'request for information' reports for OASys assessments, but rarely attended boards. We were told this was due to staff shortages. Personal officers completed release on temporary licence documentation, contributed to multi-agency public protection arrangement meetings and attended 40% of enhanced thinking skills post-programme case reviews.
We repeat the recommendation.

Additional information

- 2.211 The offender management unit was well established. There were four probation officer offender supervisors, although they had other roles as well. All prisoners were allocated to a probation officer even though only 60 were formally in scope for offender management.
- 2.212 The video link facility in the offender management unit board room was good and families were routinely invited to boards.

Life-sentenced prisoners

- 2.213 **There should be sufficient psychology resources to meet the needs of all life-sentenced prisoners. (8.26)**
Not achieved. There were psychology resources for women in the therapeutic community (TC), but not for other life-sentenced prisoners. An area post had been recruited and we were told that 50% of their hours would be allocated to lifers at Send.
We repeat the recommendation.
- 2.214 **Life-sentenced prisoners nearing the third stage of their life sentence should be able to move to the resettlement unit, as preparation for open conditions. (8.27)**
Achieved. Twelve lifers were within 12 months of their parole date and eligible for town visits. Ten places had been reserved on the resettlement unit specifically for these lifers to help them prepare for their third stage.

Additional information

- 2.215 The management of lifers lay within the offender management unit. There were 44 lifers and 15 women serving indeterminate sentences for public protection. This was a significant increase on the 14 lifers at the previous inspection, but there was no discussion in the resettlement strategy of how their needs would be met. Lifers were integrated across the prison, but there were only three lifer-trained staff. This was not enough to complete reports and non-trained staff had to do them. A senior officer acted as lifer manager and was able to give about two-thirds of her time to the role. Life sentence plans were still in operation. Staff said plans and boards would be up to date by the end of the inspection and that lifers also had up-to-date OASys assessments, which seemed excessive given that they were not in scope and other women had no sentence plan at all.

Further recommendation

- 2.216 There should be sufficient numbers of trained lifer staff.

Offending behaviour programmes

- 2.217 **There should be an analysis of the offending behaviour needs of the population, and any programmes identified should be provided. (8.36)**
Partially achieved. A brief analysis of offending behaviour needs was included in the needs analysis completed in February 2008. While it did not conclude with a list of programmes required, there appeared to be a need for additional interventions relating to domestic violence, substance use, money-related issues and emotion management. There also appeared to be a need for a relationships skills intervention (see section on bullying). The prison offered a number of well delivered quality interventions to help change behaviour: RAPt, theTC, the enhanced thinking skills programme and the Sycamore Tree programme. However, there was no strategy for enabling additional needs to be met using services elsewhere across the women's estate.

Further recommendation

- 2.218 All women should have their offending behaviour needs detailed in their sentence or custody plan and, if the need cannot be addressed at Send, women should be supported to move to a location where their needs can be met.

Therapeutic community

- 2.219 **The therapeutic community should be flagged as an intervention to be considered in the OASys (offender assessment system) and the option of joining the TC should be discussed with all women serving a life sentence as part of their sentence plan. (8.54)**
Achieved. The therapeutic community (TC) received regular numbers of women from the main part of Send for whom this was part of their sentence plan. Around 60% of all women resident were life-sentenced prisoners. Due to the changing population, this was the group most likely to have enough time left to serve. Forty-three per cent of women at Send were serving less than four years compared to 27% at the previous inspection.

2.220 There should be a corridor link between the residential accommodation and the therapy rooms so that the therapeutic community can make better use of its accommodation, including some communal cooking and eating facilities. (8.55)

Partially achieved. A roof had been provided to allow all-weather access to the therapy rooms from the main block. Women had no opportunity to cook and the ongoing building programme meant that therapy rooms were used for other activities such as chaplaincy due to accommodation shortages (see also additional information).

2.221 A facility should be provided within the prison to allow women in therapy to spend time together with their children. (8.56)

Achieved. The prison ran four or five family days a year. These were well attended, but families could not visit the TC or see where the women lived.

Further recommendation

2.222 Families should be given the opportunity to visit the therapeutic community to help them understand more about how it operates and to allow women to share their experiences.

Additional information

2.223 The women and young people's group had declined to take responsibility for allocating to the TC, but had assisted in raising national awareness of the facility and encouraging more prisons to put forward suitable applicants. Efforts made by the prison included road shows and establishment visits, which had increased the population and there was a healthy waiting list of applicants. The TC was profiled for 12 prison officers, but staff shortages in the area meant only four were in place. One senior officer was directly responsible for the TC compared with a profile of two. These difficulties were likely to be exacerbated by the departure of the director of therapy and another senior member of staff. The location of the TC in an area of the country characterised by endemic recruitment problems was limiting the potential for development.

2.224 The TC was valued by the women who participated in it and many clearly found it an extremely positive experience. The TC continued to be the only therapeutic community for women in England and Wales. It was supported by the wider prison, although there were problems in attracting staff. The location on A unit was also less than satisfactory as women participating in therapy shared the unit with others who were not involved in the programme. There was a separate living area, but no room to cook or eat communally. Therapy rooms in the adjacent building were not accessible outside the core day without staff supervision and were sometimes used by other departments. Staff supervising the residential unit were frequently not involved in the programme.

Further recommendations

2.225 There should be a strategic plan that sets out the future of the therapeutic community at Send. This should incorporate support and involvement from the women and young people's group that focuses on staffing and management of the unit and ensures that the maximum capacity and participation is reached and that the best value is obtained from this resource.

2.226 The therapy rooms should be made available to those on the programme for additional activities, including living skills.

Substance use

- 2.227 **The alcohol strategy should be finalised and incorporated into the drug strategy. (8.76)**
Not achieved. There was an alcohol testing policy, but no alcohol strategy. Other than twice-weekly Alcoholics Anonymous self-help groups, there was minimal support for women with solely alcohol misuse problems.
We repeat the recommendation.
- 2.228 **A dual diagnosis service should be developed for women who experience both mental health and substance-related problems. (8.77)**
Not achieved. A high proportion of women had both mental health and drug misuse issues, but none of the nurses were RMN and substance misuse trained.
We repeat the recommendation.
- 2.229 **Joint work between healthcare and the CARAT (counselling, assessment, referral, advice and throughcare) service should be formalised to facilitate care coordination. (8.78)**
Achieved. A senior substance misuse lead nurse was in post and responsible for effective joint working between the services. There was a weekly meeting between the counselling, assessment, referral, advice and throughcare (CARAT) and healthcare teams to coordinate care. There was also a larger multidisciplinary monthly meeting with representatives from healthcare, CARATs, RAPT, psychology, the TC and a residential governor.
- 2.230 **The addiction treatment unit (ATU) should be staffed by its full complement of dedicated officers. (8.79)**
Partially achieved. There were four dedicated ATU discipline staff. They had a good rapport with the women on the unit, but we observed one occasion when the unit was staffed by an officer on detached duty who had not previously worked there and was unfamiliar with the treatment approach.
We repeat the recommendation.
- 2.231 **The ATU should have appropriate facilities for one-to-one counselling. (8.80)**
Achieved. The ATU team had two group rooms and three one-to-one rooms. These rooms were dedicated to the ATU and sufficient to meet the needs of the unit.
- 2.232 **Compacts should clearly distinguish between voluntary and compliance drug testing. (8.81)**
Not achieved. We could not determine any differences between voluntary drug testing (VDT) and compliance drug testing compacts as only VDT was in use. The compact signed by women on the ATU, TC and resettlement units was an agreement to VDT. This was actually location-based compliance testing as few women on other locations agreed to VDT.
We repeat the recommendation.

Additional information

- 2.233 A total of 142 mandatory drug tests (MDT) had been carried out between January and July 2008. The positive random MDT rate was 1.4%, with a further 3.5% positive tests consistent with prescribed medication and seven occasions when samples could not be tested for reasons such as refusal and dilution of samples. There had been 42 MDTs based on suspicion, with a positive rate of 4.7%.

Reintegration planning

2.234 Debt and benefits advice should be improved. (8.97)

Partially achieved. While services had improved, they were still not meeting need. Finance, benefits and debt was the only pathway area where a lead manager had not been identified. The prison's own needs analysis highlighted that 21% of women needed help with debts and 57% with benefits and approximately half the women surveyed said their financial situation had contributed to their crime. Citizens Advice referrals were still made, but there was little provision to help with debts. There was a budgeting module to the social and life skills course run by education and a 1.5-hour 'unlock' course available as part of the preparation for work course dealt with use of banks. Outworkers all had bank accounts. Jobcentre Plus offered benefits advice on 2.5 days a week.

We repeat the recommendation.

Additional information

- 2.235 Housing was one of the main areas of concern for women. A number of women who were going out within a few weeks had not had any help finding accommodation. One woman was on an assessment, care in custody and teamwork (ACCT) document as a direct result of concerns about homelessness on release. Two housing peer support workers had been trained by a Shelter employee who came in once a fortnight. The support workers helped women complete applications for housing and gave information about other supported accommodation. They referred more difficult and legal issues to the Citizens Advice representative who also came in once a fortnight. Housing support workers who needed to use a telephone had to find an officer on one of the wings to make a call on their behalf if they had time, but detached duty staff did not have personal identification telephone numbers and could not help them. The workers were based in the resettlement area, which did not allow for good communication with probation staff, with whom they needed to liaise more closely on matters such as hostel referral paperwork. On induction, women were asked if they needed housing advice and those who did were referred. Women were not automatically seen by housing workers before release, but were generally aware of how to speak to them.
- 2.236 There were 15 outworkers and three applications in progress. Of these, five had their own job and 13 were doing community work. This compared to 32 outworkers at the previous inspection, which staff attributed to more lifers and women sentenced to indeterminate sentences for public protection, shorter sentences and more foreign national women. Outworkers frequently could not leave the prison on time and women said it was not unusual to be 40 minutes late for work. Managers agreed that this was a problem. One woman said she had received two warnings for being late for work and another said her work colleagues did not know she lived in a prison and she was concerned that they thought she was being lazy and uncommitted.
- 2.237 Managers said women were more frequently coming in very close to their home detention curfew (HDC) eligibility date with paperwork incomplete, which delayed the HDC process. In the previous six months, 28 of 31 women who applied for HDC had been successful.
- 2.238 Women could have escorted absences, but there were delays of between three and four months between putting in an application and going out.
- 2.239 In the previous six months, 123 of the 138 applications for release on temporary licence had been successful. In the same period, four out of eight paroles had been granted.

- 2.240 Women said that those being discharged were often released at midday. Those with long distances to travel were worried that they would be travelling into the evening when there were reduced transport services and it was dark.

Further recommendations

- 2.241 Housing services provision should match need.
- 2.242 There should be more effective arrangements to enable housing peer support workers to make and receive work-related telephone calls and communicate with relevant departments, particularly probation.
- 2.243 Outworkers should be able to leave for work on time each day.
- 2.244 Send should liaise with sending establishments to check that 'in progress' home detention curfew paperwork is up to date before the women arrive.
- 2.245 Delays in processing escorted absence applications should be reduced.
- 2.246 Women being discharged should be able to leave earlier in the morning to allow for long journeys.
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Section 3: Summary of recommendations

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

Main recommendations **to the Governor**

- 3.1 There should be an effective first night strategy and induction programme, involving peer supporters, to ensure that women have a consistent introduction to Send which meets their needs. (2.1)
- 3.2 All incidents of suspected bullying should be recorded, investigated and monitored as part of the violence reduction strategy. (2.2)
- 3.3 An analysis of the needs of foreign national women prisoners at Send should be undertaken to ensure that services appropriately reflect those needs and inform the strategy so that foreign national women are aware of and able to access appropriate services. (2.3)
- 3.4 The prison should continue to develop its range of activities to enable prisoners to gain qualifications and employability skills. (2.5)
- 3.5 Women with sentences of 12 months or more should have sentence plans completed within 12 weeks of their arrival at Send. (2.6)
- 3.6 The resettlement strategy should be based on a comprehensive needs analysis, including the specific needs of women. (2.8)

Recommendations **to the Chief Executive, NOMS**

Substance use

- 3.7 Swab testing should be piloted at Send as an alternative to urine testing for women who have signed voluntary and compliance drug testing compacts. (2.9)

Race equality

- 3.8 Interventions should be provided to challenge racism. (2.98)
- 3.9 Training for staff working directly with prisoners should develop knowledge and awareness of cultural differences. (2.100)

Recommendation **to the Director General**

Contact with the outside world

- 3.10 The cost of telephone calls for prisoners should be reduced. (2.10)

Recommendation **to the Director General and the Governor**

Self-harm and suicide

- 3.11 The prison should note all 'at risk' women arriving at Send about whom they have not been previously notified, and forward this to the women's team at Prison Service headquarters to raise with governors and area managers of the sending establishments. (2.12)

Recommendation **to the Area Manager**

Staff-prisoner relationships

- 3.12 Efforts should be made to ensure improved continuity of detached duty staff and the recruitment of more permanent staff. (2.35)

Recommendation **to the escort contractor**

Courts, escorts and transfers

- 3.13 Vans escorting prisoners should make a toilet stop every two hours. (2.13)

Recommendations **to the Governor**

First days in custody

- 3.14 Reception interviews should be carried out in private. (2.14)
- 3.15 Staff should have direct observation of both holding rooms. (2.15)
- 3.16 The amount of time women spend in reception should be reduced. (2.21)
- 3.17 Listeners should meet all new arrivals in reception and be allocated a regular slot in the induction programme. (2.22)
- 3.18 Strip searching in reception should be carried out only on the basis of individual risk assessment. (2.23)
- 3.19 Prisoners on the induction unit should have direct access to staff during periods of unlock. (2.24)
- 3.20 Induction should be delivered according to the published programme. (2.25)
- 3.21 The amount of time prisoners spend on the induction unit should be kept to a minimum. (2.26)
- 3.22 Procedures should be reviewed to ensure that women are allocated to work more quickly. (2.27)

Residential units

- 3.23 Prisoners should have easy access to cleaning materials. (2.29)
- 3.24 The adapted cells on B1 should be refurbished to appropriate standards for wheelchair users. (2.31)

Staff-prisoner relationships

- 3.25 Efforts should be made to achieve a female to male officer ratio of 70:30. (2.32)
- 3.26 Detached duty staff should be able to use the Send intranet to enable them to carry out key tasks. (2.36)

Personal officers

- 3.27 Personal officers should be trained for their role and provided with model examples of good wing history sheet entries. (2.37)
- 3.28 Entries in wing history sheets should comment on prisoners' progress in their sentence and show knowledge of their family backgrounds and their reintegration needs. (2.38)
- 3.29 Personal officers should contribute to sentence plans and other reviews and, where possible, attend boards to support the prisoners for whom they are responsible. (2.39)
- 3.30 The personal officer scheme should be updated. (2.43)
- 3.31 Staff should be given training, advice and guidance about the particular issues of women prisoners. (2.44)
- 3.32 Managers should ensure that information entered in wing observation books is also logged in history sheets to ensure that important observations remain on individual records. (2.45)

Bullying

- 3.33 A dedicated safer custody post should be created to coordinate the prison's work on all aspects of safety. (2.47)
- 3.34 The violence reduction strategy log should be kept up to date. (2.49)
- 3.35 Routine violence reduction data analysis should include the nature and location of bullying incidents. (2.50)
- 3.36 Staff should be trained in the prison's anti-bullying strategy. (2.51)
- 3.37 Women identified as bullies should be helped to understand their behaviour and its effect on others. Targets should be set as part of violence reduction monitoring to help them to do this. (2.53)
- 3.38 Victims should be supported and kept informed of the outcomes of investigations. (2.54)

- 3.39 There should be an up-to-date violence reduction strategy document that is informed by the needs of women at Send as identified in a violence reduction strategy survey. (2.58)
- 3.40 There should be an office on each wing where a member of staff is based during each shift. (2.59)
- 3.41 The nature of bullying at Send should be analysed and discussed at the safer custody meeting, based on at least the findings of investigations, security information reports and the violence reduction strategy survey. (2.60)
- 3.42 Staff should be trained in how to identify and manage bullying within relationships. (2.61)

Self-harm and suicide

- 3.43 Listeners and Samaritans should contribute to staff induction and training. (2.63)
- 3.44 Listeners should be available informally on the induction landing and should contribute to induction. (2.64)
- 3.45 Personal officers, or a key worker with whom the prisoner is familiar, should contribute to the reviews of prisoners at risk and provide ongoing support. (2.67)
- 3.46 The suicide prevention and self-harm management strategy document should be more tailored to the specific needs of women at Send as identified by management information, surveys and investigation reports. (2.80)
- 3.47 Key information from the safer custody meeting, including how ACCTs need to improve, should routinely be disseminated to staff. (2.81)
- 3.48 Minutes from the safer custody meeting should be available to staff and prisoners. (2.82)
- 3.49 All incidents of self-harm should routinely be investigated to establish causes and look for lessons to prevent further occurrences and, in the event of serious self-harm, investigations should be more detailed. (2.83)
- 3.50 ACCT documentation should routinely demonstrate that staff are engaging with the woman being monitored. (2.84)
- 3.51 All staff should be trained in the ACCT process. (2.85)
- 3.52 Notice board information on safer custody should be up to date. (2.86)
- 3.53 The Listener coordinator should be given facility time to manage the Listener scheme. (2.87)
- 3.54 There should be formal monitoring of requests for, and use of, Listeners, the Samaritans telephone and the care suite, and logs should routinely be analysed to ensure provision matches need. (2.88)
- 3.55 There should be a protocol on the operation of the Listener suite. (2.89)
- 3.56 The Listener scheme should be supported by the establishment and not frustrated by operational issues. (2.90)

- 3.57 At least one safer room should be available. (2.91)

Diversity

- 3.58 Prisoners with disabilities should be subject to care plans. (2.94)
- 3.59 New buildings should have lift access wherever possible and be constructed in accordance with the Disability Discrimination Act. (2.95)

Race equality

- 3.60 The role of prisoner race equality representatives should be clarified and publicised to all prisoners. (2.97)
- 3.61 Action points on the race equality and diversity action plan should be systematically addressed and concluded as quickly as possible. (2.102)
- 3.62 Racist incident investigations should be completed expeditiously. (2.103)

Foreign national prisoners

- 3.63 There should be a foreign national prisoner information leaflet to inform prisoners and staff about the special provisions available, and personal officers should ensure that foreign national women for whom they are responsible receive appropriate support. (2.104)
- 3.64 The establishment should liaise with the UK Border Agency to ensure that advice surgeries take place every two months as planned. (2.106)
- 3.65 A foreign national liaison officer should assist foreign national women to obtain independent legal advice and assistance, both when they are detained and when they are close to detention. (2.107)
- 3.66 Impact assessments should include specific consideration of impact on different nationalities, incorporating consultation with foreign national women. (2.109)
- 3.67 Foreign national prisoners should be helped to make practical arrangements for their release and in re-establishing contact with their family for their return home. (2.111)
- 3.68 There should be foreign national information and support group meetings open to all foreign national prisoners. (2.113)
- 3.69 Detainees not fluent in English should be interviewed through a professional interpreter, particularly for interviews that require sensitivity and confidentiality such as healthcare consultations. (2.114)

Contact with the outside world

- 3.70 Telephones should be placed in booths. (2.115)
- 3.71 Prisoners should be able to exchange unused visiting orders for extra telephone credit or letters regardless of whether they have received visits. (2.117)

- 3.72 The option of a closed visit or leaving should not be the only response to indication by a drug dog on a visitor without additional supporting intelligence. (2.120)
- 3.73 Prisoners should have access to a toilet during visits. (2.121)
- 3.74 Women should be able to have all their children under 17 years included on the same family visit. (2.123)
- 3.75 More than one carer should be allowed to accompany children on family visits where necessary. (2.124)
- 3.76 Visits should start at the published time. (2.125)
- 3.77 The visits booking line should be staffed consistently. (2.126)

Applications and complaints

- 3.78 Prisoners' poor perception of the complaints and applications processes should be addressed, involving prisoner wing representatives and by publishing information about timeliness of replies. (2.128)

Legal rights

- 3.79 There should be improved management and monitoring of the legal services available to prisoners. (2.129)
- 3.80 A legal services officer should be routinely involved in the induction programme. (2.130)

Health services

- 3.81 Civilian cleaners should be employed in healthcare. (2.132)
- 3.82 Medicine trolleys should be locked when unsupervised, and locked and fixed to the wall when not in use. (2.133)
- 3.83 Staff needs and skills should be analysed to ensure there are sufficient and appropriately qualified staff to deliver care to prisoners. (2.134)
- 3.84 A mental health needs analysis should be commissioned to inform the level of services required to meet the full needs of the women at Send. (2.139)
- 3.85 Mental health awareness training should be delivered to all new staff, including detached duty and agency staff on induction. (2.140)
- 3.86 The mental health in-reach team should make an entry on EMIS each time they see a client to inform the rest of the healthcare team. (2.141)
- 3.87 There should be prisoner focus groups to inform prisoners of changes in healthcare delivery and to enable them to raise their concerns. (2.143)
- 3.88 The healthcare representative at the prisoner focus groups should be a dedicated senior permanent member of the healthcare team. (2.144)

- 3.89 Extra dental sessions should be introduced to reduce treatment waiting lists. (2.146)
- 3.90 The primary care trust and the prison should review the pharmacy service and establish clear responsibilities for its professional and supply aspects to enable appropriate lines of communication between all parties. (2.147)
- 3.91 Any pre-packed medicines supplied by the pharmacy department should be dual-labelled and one label should be fixed to the prescription at the point of supply to inform the pharmacist that the correct item has been supplied. (2.153)
- 3.92 Doctors should write their prescriptions directly onto the prison prescription charts and sign them to reduce the risk of medication errors. (2.158)
- 3.93 The practice of nurses transcribing medications should cease. (2.159)
- 3.94 The treatment hatch should be re-sited to give women the opportunity to discuss their concerns with healthcare staff in confidence. (2.160)

Learning and skills and work activities

- 3.95 Arrangements to ensure prisoners arrive at classes at the published times should be further improved. (2.165)
- 3.96 Hairdressing training should be accredited. (2.166)
- 3.97 The type of work offered in the contract workshop should be changed to enhance employability skills and accredited training should be introduced. (2.169)
- 3.98 The prison should expand the number of accredited courses in horticulture. (2.171)
- 3.99 Opportunities for literacy and numeracy support should be reinstated in all work activities. (2.173)

Physical education and health promotion

- 3.100 A needs analysis should be completed and access to the gym at weekends extended to meet demand. (2.175)

Faith

- 3.101 The coordinating chaplain should have an assistant to ensure consistent chaplaincy provision. (2.177)
- 3.102 The Sycamore Tree programme should be resourced to provide sufficient places to meet demand. (2.180)

Time out of cell

- 3.103 The published core day should be adhered to. (2.182)
- 3.104 Prisoners remaining on wings during the core day should be purposefully occupied. (2.184)

Discipline

- 3.105 The quality of documentation completed for women held in the observation and holding cells should be improved and it should be used consistently. (2.189)
- 3.106 A clear protocol governing the use of the observation and holding cells should be developed. (2.192)
- 3.107 The observation and holding cells should be relocated to a more appropriate part of the establishment. (2.193)

Incentives and earned privileges

- 3.108 Personal officers should take an active role in the incentives and earned privileges (IEP) scheme. (2.194)
- 3.109 There should be more imaginative incentives that are not just relevant to prisoners who have external financial and social support. (2.195)
- 3.110 The IEP policy should clearly state that the drug testing as a condition for enhanced status is compliance testing and not voluntary. (2.196)

Catering

- 3.111 Breakfast should be served on the morning it is eaten. (2.197)

Shop

- 3.112 Prisoners should be able to use the shop within 24 hours of arrival. (2.199)
- 3.113 A general fashion catalogue should be available. (2.201)
- 3.114 Further attempts should be made to reduce the unreasonable newspaper delivery charges and in the meantime Send should make more newspapers available. (2.203)

Resettlement strategy

- 3.115 Changes in population needs should be reflected in the resettlement strategy. (2.207)

Sentence and custody planning

- 3.116 Prisoners sentenced to less than 12 months should have a custody plan. (2.208)
- 3.117 Personal officers should provide reports for OASys (offender assessment system) assessments and reviews and attend boards. (2.210)

Life-sentenced prisoners

- 3.118 There should be sufficient psychology resources to meet the needs of all life-sentenced prisoners. (2.213)
- 3.119 There should be sufficient numbers of trained lifer staff. (2.216)

Offending behaviour programmes

- 3.120 All women should have their offending behaviour needs detailed in their sentence or custody plan and, if the need cannot be addressed at Send, women should be supported to move to a location where their needs can be met. (2.218)

Therapeutic community

- 3.121 Families should be given the opportunity to visit the therapeutic community to help them understand more about how it operates and to allow women to share their experiences. (2.222)
- 3.122 There should be a strategic plan that sets out the future of the therapeutic community at Send. This should incorporate support and involvement from the women and young people's group that focuses on staffing and management of the unit and ensures that the maximum capacity and participation is reached and that the best value is obtained from this resource. (2.225)
- 3.123 The therapy rooms should be made available to those on the programme for additional activities, including living skills. (2.226)

Substance use

- 3.124 The alcohol strategy should be finalised and incorporated into the drug strategy. (2.227)
- 3.125 A dual diagnosis service should be developed for women who experience both mental health and substance-related problems. (2.228)
- 3.126 The addiction treatment unit (ATU) should be staffed by its full complement of dedicated officers. (2.230)
- 3.127 Compacts should clearly distinguish between voluntary and compliance drug testing. (2.232)

Reintegration planning

- 3.128 Debt and benefits advice should be improved. (2.234)
- 3.129 Housing services provision should match need. (2.241)
- 3.130 There should be more effective arrangements to enable housing peer support workers to make and receive work-related telephone calls and communicate with relevant departments, particularly probation. (2.242)

- 3.131 Outworkers should be able to leave for work on time each day. (2.243)
- 3.132 Send should liaise with sending establishments to check that 'in progress' home detention curfew paperwork is up to date before the women arrive. (2.244)
- 3.133 Delays in processing escorted absence applications should be reduced. (2.245)
- 3.134 Women being discharged should be able to leave earlier in the morning to allow for long journeys. (2.246)

Housekeeping points

Self-harm and suicide

- 3.135 The constant observation room should be clean and ready for use. (2.66)
- 3.136 The Listener suite should be clean and ready for use. (2.92)

Good practice

Self-harm and suicide

- 3.137 The list of free helpline numbers next to each telephone gave women additional support options that they could access confidentially and easily. (2.69)

Foreign national prisoners

- 3.138 Prisoner information notices listing the concern areas from impact assessments and action taken helped to promote knowledge and confidence among the women. (2.110)

Health services

- 3.139 The mental health in-reach initiative employing a prisoner as a peer support worker was very well supported by the women. (2.142)

Appendix I - Inspection team

| | |
|--------------------|----------------------|
| Hayley Folland | Team Leader |
| Susan Fenwick | Inspector |
| Sarah Snell | Inspector |
| Hindpal Singh-Bhui | Inspector |
| Karen Dillon | Inspector |
| Margot Nelson-Owen | Healthcare inspector |
| Andrew Boughton | Ofsted |

Appendix II - Prison population profile

Population breakdown by:

| (i) Status | N° of Women | % |
|---------------------------------|-------------|-----|
| Sentenced | 268 | 97 |
| Convicted but unsentenced | 0 | 0 |
| Remand | 0 | 0 |
| Civil prisoners | 0 | 0 |
| Detainees (single power status) | 3 | 1 |
| Detainees (dual power status) | 6 | 2 |
| Total | 277 | 100 |

| (ii) Sentence | N° of Sentenced Women | % |
|------------------------------------|-----------------------|-----|
| Less than 6 months | 4 | 1 |
| 6 months to less than 12 months | 10 | 4 |
| 12 months to less than 2 years | 43 | 16 |
| 2 years to less than 4 years | 61 | 22 |
| 4 years to less than 6 years | 38 | 14 |
| 6 years to less than 8 years | 29 | 10 |
| 8 years to less than 10 years | 12 | 4 |
| 10 years and over (less than life) | 23 | 8 |
| Life | 57 | 21 |
| Total | 277 | 100 |

| (iii) Length of stay | N° of Women | % |
|----------------------|-------------|-----|
| Less than 1 month | 33 | 12 |
| 1 month to 3 months | 63 | 23 |
| 3 months to 6 months | 64 | 23 |
| 6 months to 1 year | 58 | 21 |
| 1 year to 2 years | 28 | 10 |
| 2 years to 4 years | 27 | 10 |
| 4 years or more | 4 | 1 |
| Total | 277 | 100 |

| (iv) Main Offence | N° of Women | % |
|--------------------------------------|-------------|-----|
| Violence against the person | 86 | 30 |
| Sexual offences | 5 | 2 |
| Burglary | 21 | 8 |
| Robbery | 25 | 9 |
| Theft & handling | 22 | 8 |
| Fraud and forgery | 20 | 7 |
| Drugs offences | 69 | 25 |
| Other offences | 21 | 8 |
| Civil offences | 0 | 0 |
| Offence not recorded/holding warrant | 8 | 3 |
| Total | 277 | 100 |

| (v) Age | N° of Women | % |
|----------------------|-------------|-----|
| 18 years to 20 years | 0 | 0 |
| 21 years to 29 years | 81 | 29 |
| 30 years to 39 years | 100 | 36 |
| 40 years to 49 years | 76 | 27 |
| 50 years to 59 years | 13 | 5 |
| 60 years to 69 years | 7 | 3 |
| 70 plus years | 0 | 0 |
| Maximum age | 66 | |
| Total | 277 | 100 |

| (vi) Home address | N° of Women | % |
|--|-------------|-----|
| Within 50 miles of the prison | 120 | 43 |
| Between 50 and 100 miles of the prison | 40 | 14 |
| Over 100 miles from the prison | 91 | 33 |
| Overseas | 1 | 1 |
| NFA | 25 | 9 |
| Total | 277 | 100 |

| (vii) Nationality | N° of Women | % |
|-------------------|-------------|-----|
| British | 224 | 81 |
| Foreign National | 53 | 19 |
| Total | 277 | 100 |

| (viii) Ethnic Group | N° of Women | % |
|-------------------------------|-------------|------|
| White | | |
| British | 180 | 65 |
| Irish | 0 | 0 |
| Other White | 17 | 6 |
| Mixed | | |
| White and Black Caribbean | 6 | 2 |
| White and Black African | 1 | 0.36 |
| White and Asian | 2 | 0.72 |
| Other mixed | 3 | 1 |
| Asian or Asian British | | |
| Indian | 7 | 3 |
| Pakistani | 3 | 1 |
| Bangladeshi | 0 | 0 |
| Other Asian | 5 | 2 |
| Black or Black British | | |
| Caribbean | 18 | 6 |
| African | 15 | 5 |
| Other Black | 16 | 6 |
| Chinese or other ethnic group | | |
| Chinese | 2 | 0.72 |
| Other ethnic group | 2 | 0.72 |
| Total | 277 | 100 |

| (ix) Religion | N° of Women | % |
|-------------------------------|-------------|-----|
| Baptist | 0 | 0 |
| Church of England | 87 | 31 |
| Roman Catholic | 47 | 17 |
| Other Christina denominations | 6 | 2 |
| Muslim | 21 | 8 |
| Sikh | 4 | 1 |
| Hindu | 2 | 1 |
| Buddhist | 5 | 2 |
| Jewish | 2 | 1 |
| Other | 31 | 11 |
| No religion | 72 | 26 |
| Total | 277 | 100 |