Report on an unannounced short follow-up inspection of

HMP Stocken

13 – 15 May 2008

by HM Chief Inspector of Prisons

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Introduction

HMP Stocken is a category C adult male training prison that has been undergoing continuous expansion for a number of years. This expansion has not been without its difficulties and, on our last visit, we shared the concerns of many staff and prisoners that some important aspects of the prison were not performing sufficiently well. On our return for this unannounced short follow up inspection, we noted some improvements, in particular a much-needed expansion in purposeful activity, but more remained to be done.

Reception had been improved and induction was adequate, although first night cells were grubby and there were unnecessary delays in accessing the pin-phone system. Suicide and self-harm prevention arrangements were effective but those to reduce violence were underdeveloped, and both strands could usefully be brought together under a single safer custody banner. A new segregation unit was now in the early stages of operation. Drug use appeared to be relatively low, but the proportionality of measures to combat supply, such as the high use of closed visits, required review.

Extensive building work continued to blight the environment, but accommodation was generally reasonable. A new laundry was about to open and would give prisoners more opportunities to wear their own clothes. Prisoners were less vociferous in their complaints than on our last visit and relations with staff appeared satisfactory. However, personal officer work remained ineffective and the incentives and earned privileges (IEP) scheme required further development. Work on diversity, race relations and foreign nationals all remained inadequate. Health services had also made insufficient progress.

There had been significant improvements in both the quantity and quality of purposeful activity, although the inexorable rise in the population meant that there were still shortfalls in work places, and figures for time spent out of cell were misleading. Fortunately, a number of additional workshops were scheduled to open shortly after the inspection.

The strategic management of resettlement had deteriorated since our last inspection. Progress in introducing the offender management model had been hindered by the frequent cross-deployment of staff and a significant backlog of offender assessments had built up. Similarly, the number of offending behaviour programmes had been affected by staff shortages. A range of basic reintegration services was in place, but required better integration.

Stocken has gone through a lengthy and difficult period of expansion. It is therefore commendable that this inspection found that it remained a reasonably safe prison, and that there had been considerable improvement in the quality and quantity of purposeful activity. However, more remained to be done and it was disappointing that progress on resettlement had not been maintained.

Anne Owers **September 2008**
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Stocken is an adult male category C prison.

Area organisation
East Midlands

Number held
796

Certified normal accommodation
779

Operational capacity
806

Last inspection
16–20 May 2005

Brief history
The establishment was originally designed as a young offender institution, with small, 60-bed living units. It opened in 1985 but changed role to a male category C closed training prison to meet population needs. Since opening, HMP Stocken had expanded, with new wings added in 1990, 1998, 2003, 2007 and 2008. The current expansion had added two new residential wings, a new segregation unit, a new workshop/activities building, a new stores building, a new world-faith room, a visits, education and administration block and extension to the gymnasium. Also refurbishment of reception, the healthcare centre, training room, offender management unit and mandatory drug testing suite.

Description of residential units
Five original wings: A, C, D and E housed 66 on each wing; B (lifer wing) housed 60. All were cellular with four spurs.
Additions: F wing: 99 spaces (traditional design)
H wing: 120 spaces (traditional design)
K wing: 120 spaces (traditional design)
G wing: 40 spaces (modular temporary unit)
J wing: 39 spaces
I wing: 64 spaces

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 2005, we assessed the prison as performing reasonably well against this healthy prison test. Of 31 recommendations in this area, 15 had been achieved, 10 partially achieved and six not achieved.

HP5 Escort traffic had increased recently following the opening of new accommodation and there had been around 80 new arrivals each month, although it was likely that this would slow down now that the establishment was full. Reception had been refurbished and was considerably improved. There were no significant delays in reception, although it was shut between 11.30am and 1.30pm. Prisoners received individual treatment in reception and information sharing was good.

HP6 New arrivals spent their first night and subsequent induction on D wing. The cells on D wing were dirty and unkempt and did not give a good first impression of Stocken for newly arrived prisoners. A first night officer who was based on D wing went to reception to meet all new arrivals. There was good use of Insiders on the induction wing, and they played a meaningful role in the induction process. New arrivals also had a one-to-one interview with a member of staff on their first night. Induction was a rolling two-week programme but in practice only took a week to complete. The programme was delivered mainly by D wing staff, with no dedicated delivery of some of the specialist sections of induction – for example, race equality.

HP7 Telephone numbers that prisoners arrived with on their PIN accounts had to be resubmitted, even though the numbers had all been approved at previous establishments. This caused delays in prisoners being able to use the telephone, and they were only able to make a single telephone call on the day of their arrival. Only 10% of these resubmitted numbers were actually subject to a verification check.

HP8 The two main components of safer custody, suicide prevention and violence reduction, were co-ordinated separately and would have benefited from a combined management approach. Most elements of the suicide and self-harm prevention strategy were delivered reasonably effectively and the quality of care given to prisoners in crisis was good. Violence reduction, however, was under-resourced, with no substantive violence reduction coordinator, which had led to poor delivery across the residential units. Levels of assaults and violent incidents were, however, not high. Managers were aware of the shortcomings and had started to take remedial action, such as updating the monitoring booklets and developing some good work with peer supporters. Referrals to the offender management unit (OMU) had also recently started but, overall, there were serious shortcomings in this area.

HP9 Disciplinary procedures were reasonable and our review of completed paperwork did not highlight any particular concerns. Force appeared to be used appropriately. A new, large segregation unit had recently been opened, the use of the special cell had fallen considerably and overall governance of this facility was good. Cellular accommodation was of a good standard but the exercise yards were small, cage-like and austere. The regime was basic but adequate and was still developing following the change of location.

HP10 The mandatory drug testing (MDT) positive rate was very low, at under 4%, although this figure did not include those who had refused tests. Overall, however, the evidence suggested that supply reduction measures were generally effective. The establishment had introduced the integrated drug treatment system (IDTS) in March 2008. To date uptake had been low and at the time of the inspection only three prisoners were involved on the programme.

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

Respect

HP12 In 2005, we assessed the prison as not performing sufficiently well against this healthy prison test. Of 48 recommendations in this area, 13 had been achieved, 12 partially achieved, 22 not achieved and one was no longer relevant.

HP13 Some of the outside areas were strewn with litter, although there was extensive building work and it was not practicable to have litter parties, as prisoners' access to the grounds was restricted. The quality of accommodation was reasonable, although some wings were scruffy in appearance and some areas suffered from graffiti. Information notice boards were poorly maintained.

HP14 Enhanced level prisoners were able to wear their own clothes while on their wing, although not everyone was aware of this. Clothing had to be purchased from catalogues rather than being sent in. A laundry was due to open shortly and we were told that the restrictions would be relaxed after this point, to allow prisoners greater access to clothing. An X-ray machine had also been delivered, which would facilitate the searching of prisoners' property that had been sent in, although this had not yet been installed.

HP15 The incentives and earned privileges (IEP) scheme functioned adequately but there were few incentives for prisoners on the enhanced regime that motivated them to engage with the process.

HP16 We observed appropriate interactions between staff and prisoners and there was a relatively relaxed atmosphere. The previously high levels of complaints and very vocal dissatisfaction expressed by prisoners about the establishment were no longer evident. However, the personal officer scheme barely functioned. It did not contribute to positive relations, and practice was inconsistent between wings. Two separate wings were piloting different personal officer schemes at the time of the inspection, with neither wing aware of what was happening on the other wing.

HP17 Catering provision was adequate; prisoners had the opportunity to comment on the food and more formal consultation took place through wing meetings. There were very limited opportunities for prisoners to dine out on the lifer wing.

HP18 For prisoners arriving on certain days there was some delay in accessing the first canteen order but, otherwise, we received no complaints about the prison shop.

HP19 Work in the areas of diversity, race equality and foreign nationals was underdeveloped. The race equality officer (REO) had been full time since July 2007 but there was little evidence of proactive work. The REO had no designated office

space and there was no cover for periods of absence. The REO also covered foreign nationals, although the decision to remove this area of work from his remit was taken during the inspection. Racist complaints had decreased in number since the previous year, and were well managed. Nearly 27% of the prisoner population were from a black and minority ethnic background; consultation with these prisoners only took place on an ad hoc basis and there was only one prisoner representative. Little progress had been made with racial impact assessments.

HP20 Although there was a relatively large amount of translated material for foreign national prisoners for whom English was not their first language, services for this growing population were underdeveloped. The foreign nationals policy was poor, out of date and contained little information specific to the establishment. There were no prisoner representatives and no access to independent legal advice. Some immigration surgeries had been held by the UK Border Agency but these were becoming less frequent.

HP21 A system to log prisoners' applications was not used on all wings and there was no monitoring of outcomes. Complaints were, on the whole, reasonably managed. The quality assurance process, however, was too informal.

HP22 The legal visits facility was poor. There were no booths and the area was grubby. Sessions started up to 35 minutes late.

HP23 Faith provision was generally good and the department was well integrated into the rest of the establishment. Members of the chaplaincy team attended key regime meetings and were even involved in sentence planning. The new world-faith room was an excellent facility.

HP24 Health services had made only minimal progress since our previous inspection, and the department was not sufficiently integrated into the overall prison regime. The head of health services was a shared post with nearby HMP Ashwell, although it was planned to create a full-time head of health services for Stocken shortly after the inspection. Clinical supervision arrangements were not yet properly developed. At the time of the inspection, staff shortages, combined with long-term sickness had an adverse impact on patient care. Prisoners' perceptions of the services provided were poor. A small number of prisoners had been trained as health trainers. Mental health services had improved slightly with the commissioning of sessions from a forensic psychiatrist. At the time of the inspection, the department was being expanded to provide more clinic and office accommodation, so staff were working in cramped conditions while the building work was taking place. The department was not sufficiently clean.

HP25 Although there had been some progress overall, this was not sufficient to raise the previous assessment, and in some areas there was still considerable work to be done. On the basis of this short follow-up inspection, we considered that the prison was still not performing sufficiently well against this healthy prison test.

Purposeful activity

HP26 In 2005, we assessed the prison as performing poorly against this healthy prison test. Of 13 recommendations in this area, seven had been achieved, five partially achieved and one not achieved.

HP27 Significant progress had been made, in terms of both the quality and quantity of the provision of purposeful activities and there were increased opportunities for work and learning, both full and part time. This was achieved in the context of a significant increase in the population.

HP28 There were around 280 prisoners engaged in education, and considerable progress had been made. The curriculum offered had clear links with resettlement. This was reflected in an improved assessment at the Ofsted re-inspection in 2006, where a satisfactory rating had been achieved. However, there had been insufficient progress since then, particularly in the areas of planning and quality improvement.

HP29 There were 117 unemployed prisoners. Although this was a concern in a training prison, this was better than at the previous inspection, and there were well advanced plans to address this, with workshops about to come on line in the days and weeks after the inspection. These included a laundry, brick shop, Travis Perkins workshop and an Aramark packing workshop, where prisoners would be able to earn enhanced wages. Managers had hoped to complete the new regime places before filling the new accommodation units but population pressures had prevented this. Once the new workshops were finished, there would be just about sufficient activity places for the whole population.

HP30 Every workshop had embedded learning, to various degrees, delivered by outreach teachers. There was evidence of good sequencing, with prisoners required to get their basic skills up to an appropriate level before being allowed to undertake level 2 courses. There was also a sensible approach to progressing prisoners through the workshops, with everyone starting in the more basic workshops and progressing through to better quality workplaces.

HP31 Library access had improved, and was open for general borrowing at times that did not interfere with core day activities, and was used as a resource centre during the core day. Usage levels were reasonable, with over 300 prisoners visiting the library every week.

HP32 Physical education provision was reasonable. The range of programmes offered had increased and success rates were satisfactory. Access was good.

HP33 Time out of cell was reasonable for those prisoners with scheduled activities, and, as new activity places came on stream, the overall provision would improve for all prisoners. Published key performance target figures, however, were poorly calculated. There was very little cancellation of evening association and exercise was scheduled daily.

HP34 There had been good progress in the key areas where we had expressed significant concerns at the previous inspection, reflected in the improved assessment by Ofsted in their re-inspection. Although there were still some unemployed prisoners, the situation was only temporary and the number would fall considerably within a few weeks of the inspection. On the basis of this short follow-up inspection, we considered that the prison was now performing reasonably well against this healthy prison test.

Resettlement

HP35 In 2005, we assessed the prison as performing reasonably well against this healthy prison test. Of 19 recommendations in this area, four had been achieved, seven partially achieved and eight not achieved.

HP36 The resettlement strategy was weak, out of date and contained no development plan or targets. The most recent resettlement needs analysis had been in November 2006. There were some enthusiastic members of staff in the department but there was too much theory and practice that was informal and not recorded. There was a monthly policy meeting, although in practice this only amounted to an inter-departmental round-up. There had been no meeting of the quarterly strategy team since November 2007.

HP37 There were 265 prisoners in scope for the National Offender Management Service case management model, plus an additional 64 lifers being case managed along the same lines. An OMU had been created to oversee the management of these prisoners. Offender supervisors made regular contact with their prisoners but this was only every two to three months. Attendance at sentence planning boards by external offender managers was rare but there was fairly regular input through telephone conferencing. A team of resettlement officers covered the rest of the establishment's prisoners. These staff were regularly cross-deployed to cover staff shortfalls elsewhere, resulting in a backlog of outstanding offender assessment system (OASys) assessments. Some of the objectives from OASys assessments were too focused around programme completion. There was insufficient integration between the sentence planning process and allocation to activities.

HP38 The programmes department had suffered from a shortage of staff in the previous 12 months and was just beginning to function again. The enhanced thinking skills course had resumed in January 2008. The controlling anger and learning to manage it course, however, was not running at the time of the inspection. There were waiting lists for both programmes but they were better managed than previously. The pre-release programme was no longer delivered, and the lifer course had also ceased.

HP39 The provision of services across the resettlement pathways was basic, although there was a lack of coordination in the delivery of this work. A resettlement unit had been created, which arranged for prisoner passports to be completed for all prisoners, and acted as a signposting service, referring prisoners to appropriate departments and agencies. This unit was located separately from the OMU and there would have been benefits from co-location. There was supposed to be a reassessment three months before a prisoner's release, although there was some slippage with this.

HP40 The drug strategy continued to have a strong emphasis on supply reduction. The size of the counselling, assessment, referral, advice and throughcare (CARAT) team had increased slightly but there were still insufficient staff to keep pace with the increased demand due to the increase in the prison roll. There was an appropriate substance treatment offending programme.

HP41 The overall visits experience was poor, with unnecessary delays in start times. Over 9% of prisoners were subject to closed visits. Although the establishment had been

successful in reducing the supply of drugs into the establishment, this figure was extremely high.

HP42 There had been slippage with the overall strategic focus on resettlement, although, assuming that sufficient effort and appropriate priority were to be given to this, it would be possible to recover this relatively quickly. On the basis of this short follow-up inspection, we considered that the prison was currently not performing sufficiently well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

To the Governor

2.1 **The establishment should implement the violence reduction strategy; train staff in identifying potential bullying situations; support those bullied; and confront and isolate those carrying out the bullying. (HP36)**

Not achieved. A violence reduction strategy was in place but its implementation was haphazard (see paragraph 2.50). There had been no staff training for a considerable period of time and the three-tier scheme did little to address the issue of violence within the establishment. There was no victim support and there were no interventions for perpetrators of violence.
We repeat the recommendation.

2.2 **The policy of segregating all new arrivals who have received a positive indication from the drug dog should be risk assessed, and linked to corroborative security intelligence. (HP37)**

Partially achieved. This still formed part of the establishment's drug strategy but was due to be removed from the revised drug strategy that was being finalised at the time of the inspection. Some reception officers we spoke to still believed that the policy was in operation, although they could not remember the last time it had been applied. Relevant managers were clear that no prisoner would be segregated on the basis of a drug dog indication alone. Segregation unit records showed that no prisoners had been segregated for this reason in the previous six months.

2.3 **The establishment should draw up and implement a clear foreign national prisoners' policy, to ensure all prisoners can participate fully in the regime and that foreign national prisoners' needs are addressed. (HP38)**

Not achieved. A foreign nationals policy had been produced in December 2007, but little of the information it contained was specific to Stocken and there had been no input from foreign national prisoners. We attended the bi-monthly foreign nationals committee meeting, where it was generally agreed that the policy was inadequate and did not meet the needs of these prisoners.
We repeat the recommendation.

2.4 **More consistent use should be made of consultative forums and the personal officer scheme to explain the establishment's processes and improve communication with prisoners. (HP39)**

Not achieved. There was no universal personal officer scheme in operation. The current scheme was out of date and inconsistent in the way it was applied by personal officers and managers. Consultative meetings took place but some prisoners we spoke to were unaware of these forums, and who attended. Generally, staff were unaware of the strategy they were

working to and were unclear of its application (see recommendation 2.41).
We repeat the recommendation.

2.5 **Urgent steps should be taken to improve the quantity and quality of purposeful activity, so that all prisoners are able to spend the working week engaged in purposeful activity. (HP40)**

Partially achieved. The number of available workspaces had substantially increased but was not yet in line with the number of prisoners, following an increase in the prison's roll. However, clear plans were in place to provide enough places for full employment by the end of 2008. The prison recorded 24.15 hours of purposeful activity a week, against a target of 26.5. The proposed course with Travis Perkins, imminently to come on line, offered effective links to resettlement. There was good sequencing of interventions, with prisoners only allowed to stay in some work activities for a limited period of time, to allow them to complete a qualification and then move on, offering the opportunity to other prisoners. For some of the vocational training workshops, prisoners had to achieve a minimum basic skills qualification before they were allowed to work in these areas. There were also good progression opportunities through the variety of workshops available, with prisoners usually starting off in the lower quality workshops and moving on to the more advanced workshops when spaces became free. Although the level of activity had increased, there was limited quality assurance of the provision.

Further recommendation

2.6 Work provision should be more effectively quality assured.

2.7 **There should be more opportunities to accredit learning. (HP41)**

Achieved. Dialogue with the learning and skills council had been successful in maintaining and increasing the portfolio of accreditation in education and vocational areas. There had been particular successes in horticulture and in changing some workshop activities, such as car tyre and exhaust fitting, to bring them into line with employer needs. The timetable had been reviewed to give prisoners the opportunity to participate in education on a part-time basis. Any prisoners participating for more than two sessions had to take classes in English and mathematics until a level 2 qualification was achieved. The recent implementation of outreach provision for literacy and numeracy on residential wings and in workshops had improved participation and achievement.

2.8 **Searching of visitors should be conducted in private and with proper regard for the individual's dignity. (HP42)**

Not achieved. Visitors, including legal visitors, were not searched in private. The search by prison staff and the drug dog search were carried out in full view of all other visitors, even though there was a room available in the search area.
We repeat the recommendation.

Other recommendations

To the Governor

Arrival in custody

Courts, escorts and transfers

2.9 **Reception opening times should be reviewed to ensure that all prisoners are dealt with properly on the day of their reception. (1.5)**

Achieved. The working patterns of reception staff had been changed and now better matched the normal arrival times of escort vans. In particular, reception was staffed during the late afternoon, so that prisoners could be received and moved on to the first night centre in good time. Following the opening of the new residential units, since which time groups of up to 10 prisoners had regularly been transferred to the establishment, a temporary protocol had been agreed with the escort service, whereby escort vans had to arrive before 11.30am or after 1.30pm (when reception was shut), to ensure that prisoners did not spend long periods in reception and received meals at an appropriate time. Based on a four-week sample of the recorded arrival and departure times of escort vans, there was no evidence that prisoners experienced significant waits to be moved from the escort van once it had arrived at the establishment, even on the occasions when the van arrived close to 11.30am.

2.10 **Staff should meet regularly with escort providers in order to improve the level of service provided to prisoners. (1.6)**

Partially achieved. The establishment was not represented at area meetings with the escort providers, and no alternative formal meetings had been arranged. However, in the previous year there had been telephone contact between the governor responsible for reception and the area manager for the escort service to discuss issues of concern. One outcome of these discussions had been the temporary protocol to cover the expansion in prison places (see recommendation 2.9).

First days in custody

2.11 **The reception building should be improved to provide adequate accommodation and facilities fit for purpose, and a clean and welcoming environment for newly received prisoners. (1.25)**

Achieved. The recently extended and refurbished reception building provided a much improved environment. The number of holding rooms had increased but, despite requests from prison managers, had not been fitted with integral sanitation, so prisoners still had to attract staff's attention if they wished to use the toilet. The reception area was clean, spacious and welcoming, with dedicated office and storage space, and a prisoner orderly worked there. There was no prisoner telephone, shower or servery, as these facilities were available on the first night unit to which prisoners were moved as quickly as possible. Staff and prisoners we spoke to estimated that prisoners generally spent less than 90 minutes in reception.

2.12 **Information and facilities should be provided to occupy prisoners while they are held in reception. (1.26)**

Not achieved. Information boards were still on the main walls of the reception area in

locations that were not readily accessible by prisoners. The new holding rooms were designed to hold a television (playing a continuous loop information DVD about the prison, its regime and services) and information notice boards. None of these were in place at the time of the inspection, and the holding rooms were bare.

Further recommendation

2.13 The holding rooms should be properly furnished with televisions and information notice boards.

2.14 The strip-searching area should offer total privacy to the prisoner. (1.27)

Achieved. The new search area was based on a system of full-length curtains that could be pulled around to provide up to four full search cubicles. These provided total privacy from all other areas of reception.

2.15 Information should be provided directly to prisoners about the rules and routines at Stocken. This should be available in different languages. (1.28)

Partially achieved. No such information was provided to prisoners in reception but, once on the designated induction unit (D wing), prisoners received verbal and written information on a one-to-one basis from a member of the induction team, as well as from a prisoner Insider. This was available in at least 13 languages.

2.16 The reception process for prisoners should be improved. In particular, prisoners should be allowed an opportunity to voice their individual needs and concerns, and to have them addressed. (1.29)

Achieved. An average of 80 new prisoners arrived at the establishment each month. This number was likely to reduce slightly now that the new accommodation was full. Normally, no more than five or six prisoners arrived on any one day, and reception staff were able to deal with them individually. The orderly officer attended reception to 'meet and greet' each new arrival and check for any immediate needs or concerns, and a designated member of the induction staff came to collect new prisoners and provide some continuity between the reception and induction processes.

2.17 The cell-sharing risk assessment should be conducted in privacy. (1.30)

Partially achieved. We did not observe any risk assessment interviews. The initial part of the assessment was conducted in an area that could be closed off from the main reception if necessary. This provided privacy from other prisoners but other staff members could be present or within hearing during this interview. Healthcare screenings were now conducted in a separate healthcare interview room. We were satisfied that prisoners had sufficient opportunity to disclose information in privacy during the reception and induction procedures.

2.18 Night staff should be able to identify the names and locations of first-night prisoners. (1.31)

Achieved. There were no designated first night cells; new prisoners were located to any vacant cell on D wing. Night duty staff on D wing were required to photocopy paperwork and prepare files on newly arrived prisoners, so that they were aware of which prisoners were new to the wing. A list of new arrivals and their locations was also provided to these members of staff as part of the formal daily handover.

2.19 **Induction should make provision for prisoners whose first language is not English. (1.32)**

Partially achieved. In addition to the national publications and documents available in translation, the establishment was able to produce translations of a number of its own local policy and information documents. Two life-sentenced prisoners were employed to produce any desired translation using a computer software programme, and this significantly improved the amount and range of information available to prisoners. Although this was an excellent initiative, the 13 available languages did not necessarily cover all the languages represented in the population. Identified prisoner and staff translators assisted in some cases but little use had been made of accredited telephone translation services (see recommendation 2.80). It was therefore possible that some prisoners had not received a proper induction.

Further recommendation

2.20 The establishment should provide translated material to cover all identified languages of prisoners who do not speak English.

2.21 **All prisoners should receive all induction modules. (1.33)**

Achieved. A register was now kept of which modules each prisoner had attended, and any missed sessions were routinely followed up. Prisoners who had been at the establishment within the previous six months were not required to attend the full induction but there was no structured assessment of which modules they needed to attend.

Further recommendation

2.22 Prisoners returning to the establishment should have their resettlement needs fully assessed and be fully briefed on any new rules, procedures or services that have been introduced since they last completed the full induction programme.

2.23 **Induction staff should have sufficient time to cover all induction material. (1.34)**

Achieved. Responsibility for first night and induction processes had been transferred back from F wing to D wing. The induction team were able to concentrate on this task and did not have competing demands on their time. If for any reason new prisoners were located on other wings, they still attended the induction sessions on D wing, and staff there monitored their progress through the modules. Most prisoners spent their first two weeks on D wing and were able to cover all of the induction programme during that time, as induction, in practice, only took one week to complete.

Additional information

2.24 Overall, prisoners' experiences during their arrival and first few days at the establishment had improved, although the accommodation on D wing was inadequate and the conditions of the cells extremely poor. Reception and induction staff took their responsibilities seriously and had responded well to the extra demands on them as a result of the recent increase in prisoner population. The prisoner Insider who worked on the induction wing told us that he was well supported by induction staff. Two prisoners who arrived during the inspection confirmed that

they had been treated well and had received the information they needed to help them settle in.

2.25 Although all prisoners had been transferred from other prisons, where their personal telephone numbers would have been checked and cleared, on arrival at Stocken only one telephone number was authorised for the first 24 hours. Prisoners were told that other numbers were not valid and that they would have to resubmit their desired numbers for security clearance; this was a source of frustration among prisoners. Only 10% of all numbers submitted were actually verified.

2.26 The induction programme contained a good mixture of information-giving sessions and individual assessments. Although there was input from prisoner health trainers (see section on health services) some topics, such as diversity, race equality and safer custody, were delivered mainly by induction staff, rather than by staff or prisoners with the relevant specialist knowledge. There was no manual or set format for these sessions, so neither the content nor quality of the delivery could be guaranteed.

Further recommendations

2.27 Prisoners transferring from other prisons should be allowed to keep their verified telephone numbers unless there are evidenced security or public protection concerns.

2.28 All induction sessions should be delivered by staff or prisoners with specialist knowledge of the topic, or be delivered according to an agreed package to which specialist staff have contributed.

2.29 The condition of the accommodation on D wing should be improved to provide a more welcoming environment to newly arrived prisoners.

Environment and relationships

Residential units

2.30 **In-cell toilets should be adequately screened to provide privacy and separation from the living and dining area. (2.13)**

Not achieved. Some cells remained unscreened, and prisoners in these cells had to eat their meals in-cell. Some attempts had been made to screen toilets in double cells with shower screens but these were not adequate, and the cells were not suitable for double occupancy in their current condition.
We repeat the recommendation.

2.31 **The display of information for prisoners should be consistent across all residential units, and should be suitable for the establishment's population. (2.14)**

Not achieved. The appearance and content of information displayed for prisoners on residential units were not consistent and notice boards generally were poorly maintained. On some boards, information notices were half ripped off or had fallen behind other posters. On some wings, the perspex covers had been broken off. Notice boards were not kept up to date, despite there being a member of staff responsible for the maintenance of each board.
We repeat the recommendation.

2.32 **Wing laundries should be introduced to all wings. (2.15)**

No longer relevant. The establishment was in the process of opening a new central laundry, for which funding had been secured, alongside the opening of the new residential units. Some wings also had their own laundries, which were currently in use.

2.33 **Prisoners should be given the option to wear their own clothing. (2.16)**

Partially achieved. See section on incentives and earned privileges.
We repeat the recommendation.

2.34 **Consultation should take place with HMYOI and RC Glen Parva in order to improve the standard of prison-issue clothing. (2.17)**

Partially achieved. Consultation had taken place with Glen Parva, as evidenced from the minutes of meetings about the kit exchange protocol. However, standards had not improved significantly and the prison continued to have concerns about the service provided by Glen Parva (see recommendation 2.35).
We repeat the recommendation.

2.35 **The system of prison kit exchange should be reviewed to ensure that all prisoners have access to good quality clothing that fits. (2.18)**

Partially achieved. The prison kit exchange system had been reviewed but this had not yet impacted on the quality of clothing that prisoners received. We saw examples of unserviceable kit arriving from Glen Parva, including items such as T-shirts and sweatshirts that bore the Glen Parva identification markings.
We repeat the recommendation.

2.36 **Prisoners' stored property should be held securely at all times. (2.19)**

Not achieved. Prisoners' property was held in three separate locations in the reception building. Personal property that was not allowed in-possession was placed in sealed bags and kept in individual property boxes in the main property store. Bags containing property to be handed out during social visits were stored in a separate room, and incoming items ordered from catalogues were kept in another room pending their collection by prisoners. On the occasions that we were in reception, all three of these rooms were unlocked. Staff and managers told us that the reception orderly did not have unsupervised access to these areas, and that the doors were left open because staff often needed ready access to the rooms.
We repeat the recommendation.

2.37 **Prisoners should be issued with items from reception within one week of their receipt. (2.20)**

Achieved. The new staffing profile provided sufficient time to process incoming catalogue orders. While efforts were made to issue items to prisoners within 24 hours of receiving them, it was more usual for prisoners to be called to reception at the weekend to collect items that had arrived during the week. There was no system of recording the dates on which items were received and despatched but the system appeared reasonable and there were auditable trails in the event of any query or complaint about excessive delays.

2.38 **Time allocated to the civilian cleaning contractor should be sufficient to cover the work required. (2.21)**

Not achieved. Two civilian cleaners each attended the prison for 30 hours a week. However, this was insufficient to meet the demand, and areas such as the healthcare department and visits hall suffered from this practice. Managers told us that they had difficulty in recruiting cleaners and had recently advertised for an additional cleaner to enhance the service.
We repeat the recommendation.

Additional information

2.39 The overall environment was mixed. Some outside areas were badly littered, although considering that the prison had, effectively, been a building site for the previous couple of years, owing to significant expansion, many communal areas were in an acceptable state. The building work had made it impracticable to have a party of prisoners cleaning the grounds. The residential units were also mixed, with some of the newer wings presenting as bright, clean and well maintained, whereas some of the older units, most notably D wing, were scruffy and, in some areas (for example, stairwells) not cleaned to a satisfactory standard.

Further recommendation

2.40 Levels of cleanliness should be improved, particularly in some of the communal areas such as stairwells on the older units.

Personal officers

2.41 **A written personal officer policy should be produced that clearly sets out what is required of staff and what prisoners can expect from their personal officer. (2.27)**

Not achieved. See recommendation 2.5.
We repeat the recommendation.

2.42 **All prisoners should receive an appropriate amount of help and attention from their personal officer, irrespective of their location. (2.28)**

Not achieved. Prisoners told us that the level of support they received depended on which residential unit they lived on. From the wing history sheets we examined, recorded contact with prisoners varied, and in some areas there was no recording of management checks having taken place. The quality of entries on wing history sheets varied; some only recorded observations, with few examples of interaction with the prisoner.
We repeat the recommendation.

Additional information

2.43 There had been no progress in implementing even a basic personal officer scheme. This had been recognised by managers and recent efforts had been made to improve the position. We found two separate pilot schemes being implemented on two different residential units (I and H wings), with neither group of staff aware of what the other was doing.

2.44 Despite the lack of a functioning personal officer scheme, we observed general relationships between staff and prisoners to be reasonable. The high levels of mistrust that existed at the time of the previous inspection appeared to have reduced, and the extremely vocal complaints

and general dissatisfaction expressed by prisoners no longer presented as a serious issue. Although a number of prisoners complained to us that they felt the overall regime was too restrictive, they did not complain about staff.

Duty of care

Bullying and violence reduction

2.45 **Prisoners should be consulted and involved in determining how their lives in the prison can be made safer. (3.8)**

Partially achieved. There was a degree of prisoner consultation via wing meetings but not all prisoners were aware of this process. The violence reduction strategy had not been informed by prisoner consultation (see recommendation 2.4).

2.46 **There should be rigorous and routine monitoring of available intelligence and information to identify potential bullying hotspots and allow pre-emptive action to be taken. (3.9)**

Partially achieved. The violence reduction strategy meeting received reports from each wing and there was some monitoring of data, although analysis of intelligence was underdeveloped and there was no specific report from the security department.

Further recommendation

2.47 Better links should be developed between the security department and the violence reduction meeting to allow for more effective analysis of intelligence.

2.48 **Senior managers should ensure that staff with specialist responsibilities (such as the anti-bullying/violence reduction coordinator) are able to fulfil their duties in an efficient and timely manner. (3.10)**

Not achieved. A residential senior officer on C wing was nominally appointed as violence reduction coordinator. However, she was not given any dedicated time for this role and had to fit any violence reduction duties around her role as a busy line manager. This meant that she was unable to carry out any proactive duties, and in practice her role did not extend beyond offering advice and coordinating completed reports. She was not involved in staff training, investigations of alleged bullying incidents or quality assurance. The establishment was considering combining the roles of violence reduction coordinator and suicide prevention coordinator into one full-time safer custody manager's post.

Further recommendation

2.49 A full-time safer custody coordinator should be appointed with direct oversight of violence reduction and suicide prevention.

Additional information

2.50 Violence reduction and anti-bullying measures were insufficiently coordinated and significantly under-resourced. Levels of violence and bullying overall were not especially high but this did not appear to be a consequence of the effectiveness of the current anti-bullying arrangements. There was an overarching violence reduction strategy but this was overly long and difficult to read, and staff on the residential units were unfamiliar with its contents. The violence reduction coordinator was not given time to carry out proactive violence reduction work, and practice was inconsistent across the establishment.

2.51 A three-tier process was nominally in place but there was little difference between the levels in terms of monitoring arrangements. In theory, when a bullying report was received, the wing senior officer would initially investigate the matter and decide whether it warranted placing a prisoner on anti-bullying measures. However, many of the open violence reduction booklets contained no evidence of any investigation and it sometimes was not clear why they had been opened. The booklets themselves contained space for staff to maintain ongoing observations but the quality of these observations was extremely poor. Regardless of what level the prisoner was on, staff observations consisted of little more than 'no bullying issues today'. There were never any entries concerning whom prisoners associated with, or anything that demonstrated a level of insight and understanding of the issues. At the end of the scheduled period of time, the prisoner was told that he could come off the monitoring process, even from level two, with no review board held. Managers recognised these weaknesses and were in the process of revising the booklet, although this alone would not solve all the problems.

2.52 We also found evidence of under-reporting of the official process, with incidents from security information reports, for example, that had not been subject to any anti-bullying or violence reduction investigation. There was no cross-referencing with the healthcare department about unexplained injuries, and health services staff were not part of the violence reduction strategy team. A log was maintained in the centre office but many staff did not inform the office when booklets were closed, so it was impossible to tell how many booklets were open at one time.

2.53 Some innovative new work was planned with prisoner peer supporters but this had not yet started.

Further recommendations

2.54 The violence reduction strategy should be revised, in consultation with prisoners, relaunched and implemented consistently across all residential units.

2.55 All staff in contact roles should receive training in anti-bullying and violence reduction.

2.56 All incidents involving alleged bullying should be properly investigated and referred to the anti-bullying coordinator.

2.57 Planned peer support work to support violence reduction should be implemented.

2.58 Unexplained injuries should be monitored and referred to the violence reduction coordinator.

Self-harm and suicide

2.59 **The crisis care suite should be relocated to reduce the demands on healthcare staff. (3.19)**

Achieved. There was no longer a crisis suite in the healthcare department (see recommendation 2.107).

2.60 **A safer cell should also be provided on one of the normal house blocks, so that it is not always necessary to relocate those requiring the safer cell into segregated accommodation. (3.20)**

Achieved. There were now several safer, reduced ligature cells around the establishment: one on D wing, two on K wing and four in the newly opened segregation unit. The two on K wing formed part of the establishment's certified normal accommodation. Those in the segregation unit were intended only to be used for prisoners already in segregation. However, since the opening of the new segregation unit there had been some confusion about the exact roles of the different specialist cells there. We found some recent examples where prisoners had inappropriately been moved into one of the safer cells in the segregation unit from normal location, rather than being placed into one of the cells on D or K wing. The establishment had recognised this and taken remedial steps.

Further recommendation

2.61 A protocol should be drawn up covering the precise circumstances and the authorisation required for use of all the establishment's various safer cells.

Additional information

2.62 Suicide and self-harm prevention procedures were reasonable. There was a comprehensive strategy document, which was being reviewed at the time of the inspection. A principal officer was designated as safer custody manager, although he had to fit in this work around other areas that he also covered. There were 30 assessors, of all grades, and all the senior officers were trained as case managers. Twelve Listeners were in post, and they reported being well supported. They attended the monthly suicide prevention management committee. Suicide and self-harm was managed through a different management chain than violence reduction, with different team leaders. The establishment hoped to bring this area of work together under one safer custody manager, which would improve coordination between the two functions.

2.63 There were nine assessment, care in custody and teamwork (ACCT) documents open at the time of the inspection, which was slightly higher than the recent average of around three to four. We reviewed a number of open and recently closed files. The quality of these, on the whole, was reasonable and demonstrated that prisoners were cared for appropriately. There were occasions when quality dropped, and in one case that we looked at there had been no post-closure review. However, the safer custody manager checked all open files regularly, quality assured all closed files and highlighted issues when they arose, as well as in his quarterly report. In the main, the issues we highlighted had already been identified and remedial action put in place.

Diversity

Not inspected at the last inspection.

Additional information

2.64 The prison disability policy (published in December 2007) outlined the support that would be made available to prisoners with a disability. There was no policy covering broader diversity issues for prisoners. Separate diversity and disability committees met quarterly, with the former covering both staff and prisoner issues. We found no evidence of any monitoring through the diversity committee or other means to ensure that disabled, elderly or gay prisoners were not victimised or discriminated against. There were, however, personal evacuation plans for those requiring them, and wing staff we spoke to were aware of the details of these.

2.65 A senior officer combined disability liaison officer (DLO) duties with running the busy induction wing, and therefore told us that his ability to carry out proactive DLO work was severely restricted. All prisoners were asked to complete a questionnaire on induction, and 122 had self-disclosed a disability, including reduced mobility or physical functioning, mental health issues, visual or hearing impairment, and general or specific learning difficulties.

2.66 The DLO reported that he was unable to carry out a full assessment of the needs of all those declaring disabilities, instead concentrating on prisoners with more obvious difficulties and those requesting assistance. Prisoners with special educational needs were seen by the education department, who could offer support to those with specific learning issues, such as dyslexia, and sensory disabilities. We found one prisoner using a wheelchair; he had been at the establishment for six months, and despite having a clear need for cell adaptations, these had not been provided. The prison had also not granted his request for access to an electric wheelchair, which would greatly enhance his mobility.

Further recommendations

2.67 An overarching diversity strategy should be produced, which outlines how the specialist needs of minority groups of prisoners, including disabled, elderly, gay and bisexual prisoners, will be identified, assessed and supported. This should be monitored by managers.

2.68 The disability liaison officer should have sufficient time to carry out individual assessments of needs with any prisoners disclosing a disability. These should result in individual support plans, and all relevant reasonable adjustments should be made without delay.

Race equality

2.69 **All staff should be trained in cultural, racial and diversity issues. (3.29)**

Not achieved. Despite some efforts to increase the percentage of black and minority ethnic staff at the establishment, this remained very low, and managers accepted that cultural and diversity awareness was a training need for many staff. All new staff attended diversity training and had a session with the race equality officer (REO) on induction. However, this covered mainly legal requirements, with little specific information about the population at the establishment or issues of cultural awareness. Refresher diversity training for existing staff had last been delivered in December 2007 but many staff still needed to attend this. Links between the REO and the training department were not strong and the material delivered was not

always fully up to date with current instructions. The REO had produced an information pack relevant to the diverse prisoner population at the establishment but there was some confusion about who was responsible for making this available to staff, and there was no opportunity for staff openly to discuss and consider the issues that the pack raised. The prison had run some diversity events, including a celebration of black history month, and to mark festivals such as Eid.

We repeat the recommendation.

2.70 **Racist incident report forms should be available in all designated areas, together with separate boxes to which only race relations liaison officers have access. (3.30)**

Partially achieved. Racist incident report forms (RIRFs) were readily available on all wings, with each attached to a sealable envelope addressed to the REO. Completed RIRFs were posted in the general complaints boxes located on each wing and emptied by the night orderly officer. The main reasons given for not having separate RIRF boxes opened by the REO were the large number of wings and the length of time it would take for one person to empty all the boxes during the day. Once collected, RIRFs were posted into a locked box in the administration department; the complaints clerk opened this the following morning and passed them to the REO to log and investigate. As the distances between the wings were large, and prisoners had the opportunity to seal their RIRFs in envelopes, thus ensuring confidentiality, the collection process was reasonable.

Additional information

2.71 Nearly 27% of prisoners were from black and minority ethnic backgrounds. There was an up to date race equality policy, and a well attended monthly committee, chaired by the Governor. There was evidence from the minutes that data from RIRFs and ethnic monitoring were analysed and followed up.

2.72 A full-time REO had been in post for nearly a year but also had responsibility for foreign nationals, which diluted his ability to be proactive in developing the race equality agenda. Nevertheless, the RIRF process was well managed; 83 had been dealt with in 2007 and 17 in 2008 to date. We reviewed a sample of recently closed RIRFs and in all cases found that thorough and thoughtful investigations had been carried out by the REO. The Governor and area manager reviewed closed RIRFs. The REO hoped to use an external organisation to quality assure completed complaints.

2.73 Little progress had been made in developing adequate racial impact assessments. There was only one black and minority ethnic prisoner representative, and there was no regular consultation with this prisoner group. Efforts to engage with community-based groups had so far been unsuccessful. The REO had recently written a community engagement policy, which he hoped would develop this agenda.

2.74 The REO did not have designated office space and this caused him significant difficulties. In addition, the deputy REO had resigned and had not been replaced, resulting in no cover for rest days and periods of annual leave.

Further recommendations

2.75 Functional heads should take full responsibility for completing impact assessments in their areas, with input from prisoners.

2.76 Black and minority ethnic prisoner representatives should be appointed or elected on each wing and encouraged to meet regularly to discuss issues of interest or concern. The REO should ensure that any actions from these meetings are taken forward and reported back to all black and minority ethnic prisoners.

2.77 Active steps should be taken to make links with relevant community groups and organisations to the benefit of black and minority ethnic prisoners.

2.78 The REO should be provided with a private office.

2.79 A deputy REO should be appointed.

Foreign national prisoners

2.80 **Prisoners should have access to accredited translation and interpreting services wherever matters of accuracy and/or confidentiality are a factor. (3.36)**

Partially achieved. We could find no evidence of any restrictions on the use of such services but, during the six months before our inspection, accredited translation services had only been used on seven recorded occasions, which seemed very low, although some of these had involved more than one prisoner. A wide range of translated materials was available, and further requests could be dealt with on an ad hoc basis using the translation software available (see recommendation 2.19). Some efforts had been made to identify staff and prisoners with language skills, and these were used to support prisoners with little or no use of English.
We repeat the recommendation.

2.81 **Routine consultation of the foreign national prisoner population should be undertaken, and any significant issues raised should be acted upon. (3.37)**

Not achieved. Seventy-seven prisoners (nearly 10% of the population) were foreign nationals. Some consultation had periodically taken place with groups of prisoners but this had been ad hoc. There were no appointed or elected prisoner representatives, no regular prisoner forum, and foreign national prisoners did not attend the foreign nationals committee meeting. We were told, but saw no evidence, that a foreign nationals survey had been conducted in 2007 to look at communication, and that some action had been taken to improve library provision but little else, despite a quarter of respondents rating a range of areas – such as reception, resettlement and the facilities list – as poor.
We repeat the recommendation.

Additional information

2.82 The foreign national population at the establishment encompassed a wide range of nationalities and cultural backgrounds. In April 2008, the largest group was African (27%), followed by non-UK Europeans (19%), Jamaicans (19%) and Vietnamese (14%). This was not a static population, which meant that prisoners' requirements and perceptions needed regular monitoring and reviewing. The foreign nationals coordinator was unable to be proactive in this work (see section on race equality); he did not see foreign national prisoners during their induction to assess any specific needs, and prisoners we spoke to were unaware of whom to contact if they needed advice or support. Prison managers told us that they were planning to separate the roles of REO and foreign nationals coordinator.

2.83 No successful links had been developed with community-based non-statutory organisations dealing with foreign nationals in custody. The information needs of foreign national prisoners had been enhanced by additional provision of foreign language materials in the prison library, and extracts from newspapers from around the world were provided on request. A free £10 telephone credit was offered to prisoners in lieu of visits not received.

2.84 A foreign nationals clerk managed all immigration work; systems were well developed to identify prisoners who might be subject to deportation and to liaise with the UK Border Agency (UKBA). The establishment held four detainees at the time of the inspection but active steps were being taken to move them on. Four other detainees had been transferred to removal centres in the week before we arrived. Surgeries run by the immigration service at the establishment had become less frequent, and prison staff told us that they were experiencing difficulty in obtaining a commitment from UKBA to facilitate these on a regular monthly basis. This was causing some anxiety for prisoners waiting for information about their status from the immigration department.

Further recommendations

2.85 A dedicated foreign nationals coordinator should be appointed.

2.86 All foreign national prisoners should be interviewed by the coordinator during their induction, to identify any specific needs.

2.87 The services offered by the foreign nationals coordinator should be well publicised throughout the establishment.

2.88 Foreign national representatives should be appointed or elected, and attend the bi-monthly committee meeting.

2.89 The establishment should actively seek out community-based organisations that would be willing to support their work with foreign national prisoners.

2.90 The establishment should liaise with the immigration services to ensure regular surgeries for prisoners.

Applications and complaints

2.91 **A system to log all prisoner applications should be introduced across all wings; timeliness of responses and outcomes should be recorded and monitored. (3.57)**

Not achieved. A system to log prisoners' applications was not used on all wings. There was no evidence of any monitoring of responses, timeliness or outcomes.
We repeat the recommendation.

2.92 **A nominated senior manager should regularly check the quality of complaint responses. The nature of complaints should also be monitored by senior managers. (3.58)**

Partially achieved. A senior manager selected and reviewed a 5% sample of complaints. We were told that feedback was provided to staff if the answers were not adequate but there was no evidence of this. Managers had assessed most of the written responses to prisoners as

adequate. However, we reviewed a sample of recent complaints forms, and some were particularly poor. Little use was made of first names or 'Mr...'; some provided cursory or dismissive responses and others did not answer the complaint being made. In addition, we found examples where complaints had been upheld but prison records indicated that the complaint had been rejected.
We repeat the recommendation.

Further recommendation

2.93 Managers should ensure that the quality of responses provided to prisoners' complaints is improved.

2.94 **Complaints boxes should not be accessible by all wing staff, but only by designated members of staff. (3.59)**

Achieved. Yellow complaints boxes were available on all wings, each with a stock of forms. The boxes were opened by the night orderly officer, who passed them to the complaints clerk for logging and sending on for a response. The timeliness of responses was good, with over 95% made within prescribed deadlines.

Substance use

2.95 **A dedicated mandatory drug testing team should be created. (8.69)**

Not achieved. While 13 staff were trained to undertake mandatory drug testing (MDT), there was no dedicated team. Weekend testing took place, and in 2007/08 to date the positive rate was reported to be 3.4%, against a target of 9%. There had been 10 refusals during this period and a number of adjudication charges relating to prisoners refusing to provide a urine sample for MDT since February 2008.
We repeat the recommendation.

Further recommendation

2.96 The recording of all data relating to drug testing should be reviewed to ensure that accurate information is collected, analysed and reported.

2.97 **An alternative location should be found for the dog handlers and the drugs dog shed. (8.70)**

Achieved. Building work was being carried out to provide a new venue for the dog handlers and their dogs.

Health services

2.98 **The contract cleaning of healthcare facilities should be increased to ensure that a high level of cleanliness is maintained at all times. The cleaner should have a set of keys to access and clean all healthcare rooms. (4.56)**

Not achieved. Although the cleaner had a set of keys to the rooms in the healthcare

department, from our observations and discussions with staff it was obvious that cleaning was not being carried out to a sufficient standard (see recommendation 2.38).

Further recommendation

2.99 The cleaning of healthcare facilities should be improved to ensure that a high level of cleanliness is maintained at all times.

2.100 **Discipline staff should be present to supervise prisoners and control movement during treatment and clinic times. (4.57)**

Not achieved. On weekdays, a member of discipline staff was allocated to supervise prisoners attending the healthcare department at medication time but not for clinics. At weekends, the allocated officer was shared with visits, so supervision was poor. Typically, the officer remained in the corridor, checking which prisoners were listed to attend, but did not actually supervise prisoners in the waiting area outside the department.
We repeat the recommendation.

2.101 **The dispensary should not be used other than for dispensing medications. (4.58)**

Achieved. The dispensary was used only for dispensing medicines. Other offices had been identified for the triage clinics and nurses' office.

2.102 **A service level agreement should be agreed between the prison and the pharmacy, and pharmacist input increased. (4.59)**

Partially achieved. There was a Service Level Agreement (SLA) between the prison and the pharmacy, dated July 2005. Although the SLA stated that a pharmacist would attend the prison weekly and could make appointments to review specific patients' medications, health services staff told us that this did not occur with any regularity, and prisoners were unable to see a pharmacist.

Further recommendation

2.103 Prisoners should be able to see a pharmacist.

2.104 **Procedures should be developed to ensure that prisoners missing doses or with poor compliance are monitored and supported. (4.60)**

Not achieved. We found examples of prisoners who had not collected their medication for several days, despite the fact that it was for a long-term medical condition. There appeared to be no system to ensure that prisoners missing doses or with poor compliance were monitored and supported. Some staff told us that if prisoners missed doses, they just had to remember to collect it at the next available opportunity. The mental health in-reach team was not always alerted when their clients were non-compliant with medication.
We repeat the recommendation.

2.105 **The treatment room should be refurbished to comply with infection control guidelines. (4.61)**

Not achieved. At the time of the inspection, the treatment room had not been refurbished; it

was cluttered and untidy and not well laid out. Work was in hand to improve matters as part of the redevelopment programme for the healthcare department, and the department was expanding into the old segregation unit at the time of the inspection. The infection control lead from Leicestershire County and Rutland Primary Care Trust (PCT) had been consulted about the redevelopment plans and was apparently content that infection control guidelines would be met.
We repeat the recommendation.

Further recommendation

2.106 The decoration and cleanliness of all rooms used for delivering health services should be consistent with the promotion of health and well-being and have appropriate infection control facilities.

2.107 **The healthcare boardroom should be returned to healthcare services, and the crisis suite located elsewhere in the prison. (4.62)**

Achieved. As part of the redevelopment plans, the healthcare boardroom was scheduled to become office accommodation for the healthcare department. There were no crisis suites within the healthcare department (see section on suicide and self-harm).

2.108 **Day-care services should be introduced. (4.63)**

Partially achieved. The occupational therapist, who was part of the mental health in-reach team, ran limited group support and anxiety management sessions for prisoners known to the team, although there was scope to develop services further.
We repeat the recommendation.

2.109 **The practice manager should be a member of the senior management team (SMT). (4.64)**

Not achieved. This recommendation was rejected by the establishment following our previous inspection. The head of health services attended the SMT, while the practice manager attended other prison meetings.

2.110 **There should be mental health-trained nurses in the primary care nursing team. (4.65)**

Partially achieved. A registered mental health nurse had been appointed and was due to commence duties imminently. An induction programme had been compiled for him and it was intended that he would have close links with the mental health in-reach team.

Further recommendation

2.111 Mental health services should include primary, secondary and tertiary services.

2.112 **Prisoners should be able to access simple medications and remedies through the prison shop. (4.66)**

Achieved. The prison shop list included a standard list of simple medications and remedies. Prisoners were also able to obtain a two-day pack of paracetamol or ibuprofen to keep in-possession. However, these packs were not given out to new arrivals. The prisoner health trainers, prisoners with a recognised qualification in public health (see paragraph 2.127),

encouraged new prisoners to obtain a pack of analgesics so that this would be available when health services staff were not on duty.

2.113 The number of external NHS appointments attended by prisoners should be increased. (4.67)

Not achieved. At the time of our previous inspection, only seven prisoners had been able to attend external hospital appointments each week. These were allocated by the detail office. Despite the increase in the prison roll, there had been no apparent increase in this number, although this was in dispute, as health services staff were under the impression that they could schedule 10 a week. This was made worse by the fact that, if a prisoner was required to attend hospital for an overnight stay, two other appointments were cancelled, to facilitate the appointment. Neither the healthcare department nor detail office kept a log of cancellations, to monitor how many appointments were cancelled or to ensure that all patients referred to secondary care consultants met NHS waiting time targets.

Further recommendation

2.114 Sufficient detail time should be profiled to allow external NHS appointments to be scheduled according to demand. Current confusion should be rectified and cancellations should be monitored.

2.115 Medicine distribution times should be reviewed, and patient confidentiality should be improved. (4.68)

Not achieved. Medications were still administered three times a day from the main healthcare department. Prisoners had to provide their identification card when collecting medications. Due to the expansion of the site, there were imminent plans to open a small healthcare treatment annex between E and F wings from which prisoners from some of the wings could collect their medications. Discipline staff did not remain in the healthcare department once main movements had been completed, so there was no supervision of prisoners collecting medications, little confidentiality, and opportunities for prisoners to trade medications and for bullying to take place unobserved.
We repeat the recommendation.

2.116 First aid should be the responsibility of prison staff, not healthcare staff. (4.69)

Achieved. The action plan from the previous inspection stated that the number of first-aid-trained staff had increased. At the time of the inspection, 36 staff were listed as being trained, although four had been trained three years previously.

2.117 The core day should be reviewed with healthcare staff to provide prisoners with better access to healthcare. (4.70)

Not achieved. The core day did not allow prisoners enough time in the morning to wash, have breakfast and attend the healthcare department to collect their medications, particularly from the more distant parts of the establishment. Several prisoners told us that they regularly missed breakfast, in order to collect their medications.
We repeat the recommendation.

2.118 Algorithm-based triage should be introduced, following appropriate training for nursing staff. (4.71)

Achieved. There were three nurse prescribers within the nursing team, and other nurses were being trained in minor injuries by a nurse from the PCT. Staff used triage algorithms for a wide variety of common complaints, as used by general practitioners (GPs) in the community. The algorithms included red flags that highlighted signs and symptoms that needed immediate treatment.

2.119 **Clinical supervision should be implemented. (4.72)**

Not achieved. Staff did not have clinical supervision, although with the increase in staffing levels there were plans to introduce it in the near future.
We repeat the recommendation.

2.120 **Prison staff should have regular mental health awareness training. (4.73)**

Not achieved. A total of 45 prison staff were recorded as having received mental health awareness training. This included chaplaincy staff and psychologists. Some of the training had occurred over three years previously.
We repeat the recommendation.

2.121 **A clinical governance policy should be agreed by the governor and the primary care trust (PCT), and should be implemented. (4.74)**

Achieved. While there was no formal clinical governance policy, the establishment worked closely with the PCT prison clinical governance lead. Healthcare development group meetings were held at the establishment and attended both by PCT commissioners and by prison health services staff, and there was also a quality and governance committee, chaired by a senior nurse from the PCT, and a prison partnership board. Each group had clear terms of reference.

2.122 **An analysis of the dental waiting list and of how it is managed should be made to ensure the most effective use of the dental team. (4.75)**

Achieved. The waiting list was maintained as part of the electronic clinical information system (SystmOne). There were 159 patients on the list, including nine who were considered to be urgent. The longest wait for a routine appointment was just over 12 weeks. The contract for dental services was only for one session per week, despite the increase in the roll of the establishment.

Further recommendation

2.123 A dental needs assessment should be carried out and the dental contract revised to ensure that there are sufficient dental sessions to meet the needs of prisoners.

Additional information

2.124 Prison health services were commissioned by Leicestershire County and Rutland PCT and provided by staff employed by the Prison Service. The department was open from 7.45am until 5pm each day. A nurse was on call each night to provide advice but the local GP out-of-hours service could also be used.

2.125 The head of health services was a joint appointment between HMP Stocken and HMP Ashwell, although it was planned to advertise for a stand-alone manager for Stocken shortly after the inspection, in recognition of the increase in the workload of this post, given the increase in the size of the population. There was a band 6 clinical nurse manager based at the establishment. Two of the band 5 registered general nurses were nurse prescribers and one had previous experience with substance misuse clients. Three of the staff were healthcare support workers; they also undertook clerical tasks, as there were no administration staff. A locum pharmacy technician was in place until the permanent appointment took up post. Staffing appeared to be sparse, with staff working a variety of shifts. The arrangement of work appeared to be organised daily, rather than planned in advance, and the department lacked coordination and was not well integrated with some of the prison's other departments, not helped by the location of some of the facilities and the shortage of staff. The intended developments in the management of the department, along with improved staffing and facilities, would all help to develop services.

2.126 We reviewed a variety of clinical records; while entries on SystmOne appeared reasonable, we found several examples of prescription charts which had not been annotated for several days, so it was unclear whether medications had been administered.

2.127 There were five prisoner health trainers who had undertaken a Royal Institute of Public Health course (level 2). They ran the smoking cessation courses, which had excellent results. They also ran sessions on the induction programme, and prisoners could apply to see them for one-to-one advice about a variety of health issues, such as weight management and in-cell exercise.

2.128 Mental health in-reach services were provided by Leicester Partnership Trust; the team worked between HMP Stocken and HMP Ashwell. There were two full-time members of staff – one band 6 and one band 7 – and an occupational therapist who provided three or four sessions a week. The team's caseload was 34 at the time of the inspection; they received approximately 35 new referrals a month, and these were discussed at a weekly single point referral meeting. The team only accepted those who were eligible for the standard or enhanced care programme approach, who had severe or enduring mental health issues, although the occupational therapist saw some patients with primary mental health issues in group sessions. A consultant forensic psychiatrist had recently been commissioned by the PCT to provide one session a week; her caseload was managed by the mental health in-reach team leader.

Further recommendations

2.129 There should be a skills review to ensure that there are sufficient staff, with the relevant skills and competencies to provide health services. This should include a review of administrative tasks.

2.130 All clinical records should be contemporaneous and conform to professional guidance from regulatory bodies.

Good practice

2.131 *The introduction of health trainers was of benefit both to the individual trainers and to the prison population as a whole.*

Activities

Learning and skills and work activities

2.132 **A coherent plan should be prepared for the development of learning and skills across the prison. (5.17)**

Partially achieved. A development plan had been produced and partially completed to address the need for increased learning opportunities in line with the expanded prison population, and there had been improved liaison and dialogue with the education provider. However, there was not a cohesive strategic plan for improving and continuing to develop the whole of learning and skills across the establishment.
We repeat the recommendation.

2.133 **Quality improvement procedures should be fully and consistently implemented across all areas of learning and skills. (5.18)**

Partially achieved. Although some improvement had taken place, with the production of a quality assurance calendar and manual, the implementation of the procedures had been very slow. Self-assessment across learning and skills had not been completed since 2006. Prisoners had not been surveyed to inform the quality of provision. There was observation of teaching and learning in education classes but not in other areas of the prison. The quality improvement group had been slow in addressing the quality of provision and using and analysing data to inform decision making.
We repeat the recommendation.

2.134 **Individual learning plans should contain clear and measurable targets, which should be linked to sentence-planning targets. (5.19)**

Partially achieved. Two information, advice and guidance workers had been appointed in the previous six months and identified prisoners' initial needs. However, the targets set for prisoners were not always clear and measurable, and education staff did not always find this information useful in establishing specific learning needs. Some joint working took place between the labour and sentence planning boards to inform activity allocation to meet the needs of prisoners. There were no processes to identify if the targets set at the labour board had been achieved.

Further recommendations

2.135 All information, advice and guidance targets should be clear and measurable.

2.136 Systems should be introduced to identify the success of targets set at the labour board.

2.137 **Prisoner access to the library should be improved. (5.20)**

Achieved. Library access had improved, with each wing allocated 45 minutes twice a week. The library was open on three evenings a week, Friday afternoon and Saturday morning for borrowing, so there was no interference with the core working day. There were further plans to open the library on Sunday mornings. Since January 2008, attendance had been consistently over 300 visits a week. During the day, the library was used for a wide variety of activities, including resettlement planning, Storybook Dads and distance learning

2.138 **Prisoners in work should have more opportunity to spend part of their week in educational activities on a day- or part-day-release basis. (5.28)**

Achieved. Classrooms were in use in most workshop areas, embedding literacy and numeracy in the workshop activities. Pay had been realigned so that payment was per session for both education and work, with a maximum potential of £10 per week. Additional pay was available for prisoners with an orderly responsibility. Of the 280 prisoners attending education, 123 did so for between one and five sessions a week while participating in other work activities.

2.139 **The movement to work process should be re-examined to reduce the number of occasions when incorrect rolls are called. (5.29)**

Achieved. A further review was taking place owing to the distance of the new residential wings from some work places. There was evidence of delays in prisoners arriving at activities, especially in the morning. The education department had changed the start and finish times in the afternoon by 10 minutes to take this problem into account. Responsibility for the roll call currently rested with administrative staff, and the intention was to transfer this to principal officers.

Additional information

2.140 Considerable overall progress had been made since the previous full inspection, and the prison was able purposefully to occupy the majority of prisoners. The situation was set to improve further in the weeks after the inspection, with a range of new activity places coming on stream. There were significantly more opportunities for prisoners to participate in work and learning than before.

2.141 There was a better attitude to learning and skills, and occupancy levels in work and education classes were much better than before. A sensible approach to progression had been adopted, with prisoners starting in the lower quality workshops and progressing to the better quality ones. Elements of learning and skills were now embedded into most activity places, often delivered via outreach, and there was evidence of good sequencing, with prisoners required to achieve minimum basic skills levels before being allowed to work in some of the VT workshops. There were also good links with the resettlement department.

2.142 An Ofsted re-inspection in 2006 recognised the progress made, reflected in the overall assessment of satisfactory. There had, however, been insufficient progress since then and insufficient focus on quality. Currently, use of data was weak, as was the self-assessment process overall, and the quality improvement group had been slow in identifying and addressing some quality issues. These were the main areas for development.

Physical education and health promotion

2.143 **Greater access to accredited physical education courses should be provided. (5.36)**

Achieved. An increased range of programmes had been implemented, in line with current industry needs. A yearly plan showed when the various courses ran; these ranged from one- to five-week courses but most were only delivered twice a year. Success rates were satisfactory.

2.144 **The next review of weekend staffing profiles should ensure that there is no disruption to the physical education programme. (5.37)**

Achieved. There had been considerable improvement in reducing the disruption in physical education over the previous 12 months. Since December 2007, there had been just two occasions when staff were removed, and both were for injuries sustained in the gymnasium by a prisoner.

Faith and religious activity

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

Additional information

2.145 A full programme of faith activities was well publicised and there were no impediments to prisoners attending corporate worship. The facilities available, and in particular the large new world-faith room, were very good. Some gaps in the chaplaincy team were in the process of being filled, including a half-time Muslim chaplain, who would replace the current post holder (who only worked on Fridays), provide enhanced support to Muslim prisoners and be fully involved in generic chaplaincy work.

2.146 The chaplaincy team was involved in a range of work, including seeing all prisoners in the segregation unit and those on an open assessment, care in custody and teamwork (ACCT) document every day. Chaplaincy team members met all prisoners within 24 hours of their arrival, and delivered a session in the induction programme. They were involved in supporting prisoners who had experienced bereavement, and families when deaths in custody occurred. They attended a range of prison meetings, and made active contributions to sentence plans and reviews.

Good practice

2.147 *Chaplains saw all prisoners on an open ACCT document daily.*

Time out of cell

2.148 **All prisoners should spend at least 10 hours out of their cell each day, except in exceptional circumstances. (5.50)**

Not achieved. There was some confusion about the length of time that prisoners spent out of cell, and we established that the method by which this was calculated was flawed, resulting in an inflated figure. In fact, prisoners on most wings spent between seven and a half and eight hours out of cell during weekdays, and less at weekends. However, this did not account for the 117 prisoners who were unemployed and spent less than four hours a day out of cell. Time out of cell was greater for those prisoners on G and J enhanced wings, who spent all day unlocked.
We repeat the recommendation.

2.149 **The rota system for the loss of association should be refined so that cancellation does not adversely affect one wing more than any other. (5.51)**

Achieved. Association had last been cancelled in February 2008, which was the first time in over a year. A rota had been developed to ensure that no one wing could be more affected than any other. Exercise in the fresh air was also scheduled daily.

2.150 **A system to monitor the use of association equipment, to ensure that no one group monopolises it, should be introduced. (5.52)**

Partially achieved. There was no formal system to monitor the use of association equipment but this was readily available on wings, and prisoners and staff did not report any difficulties in gaining access to it, or associated bullying. Staff told us that they monitored the use of equipment and prisoner behaviour during normal supervision of association.

Good order

Security and rules

2.151 **The rules governing strip-searching during and after visits should be clarified and published. (6.7)**

Achieved. The previous confusion surrounding local rules about strip-searching during visits had been clarified, and an extract from the local security manual had been published.

Discipline

2.152 **A strategy should be developed to deal with the number of prisoners refusing to lock up on, or relocate to, normal location in the hope of transferring out of the prison. (6.21)**

Partially achieved. No formal strategy had been developed, although there was a policy, which we were told covered all prisons in the area, that any prisoner who refused to return to normal location when ordered to do so was placed on report and initially given a punishment of cellular confinement. If the prisoner still refused to relocate, he was placed on report again and the case was referred to the independent adjudicator, who usually gave added days to the prisoner's sentence as a punishment. Segregation staff always advised prisoners of this likely outcome if they threatened to refuse to leave the segregation unit. The number of prisoners seeking transfer out of the establishment through the segregation unit had fallen significantly.

2.153 **The adjudicating governor should properly complete the safety algorithms before any award is given. (6.22)**

Achieved. We found no evidence that safety algorithms were not completed before adjudication punishments of cellular confinement were given.

2.154 **The use of force should always be legitimate and a last resort. Regular analysis of the use of force should be conducted, in order to identify and deal with any emerging trends. (6.23)**

Achieved. We found no evidence of force being used inappropriately. Quarterly use of force meetings were held, looking at trends and any other emerging findings or issues over the preceding period.

2.155 **Regular cell furniture should normally be provided in cells in the segregation unit, unless a risk assessment indicates that cardboard furniture is necessary. (6.24)**

Achieved. The new segregation unit had fixed wooden furniture and plastic moulded chairs in all the normal cells, and the accommodation was equipped to a good standard. A policy

governing the use of cardboard furniture was still in place, however, stemming back to when the previous segregation unit had been in use, which had not been updated. Staff were unclear as to how they would apply this policy in the new segregation unit.

Further recommendation

2.156 The policy covering the use of cardboard furniture in the segregation unit should be updated to take account of the new segregation unit.

2.157 **Day-to-day management of the segregation unit should be improved to support staff in difficult and challenging situations. (6.25)**

Achieved. There was now a clear management structure, and a senior officer was based in the unit daily, with the role of unit manager.

2.158 **A clear policy should be introduced showing which items of the facilities list are available to segregated prisoners and which off-unit activities segregated prisoners are allowed to attend. The reasons for any restrictions should be explained. (6.26)**

Not achieved. The only measure in place was a notice displayed on the wall of the unit, which contained some out-of-date information.

Further recommendation

2.159 A booklet explaining the segregation unit rules, regime and allowances should be prepared and given to all prisoners on entry to the unit.

2.160 **Formal targets to help reintegrate prisoners onto normal location should be agreed upon GOOD (good order or discipline) reviews. (6.27)**

Not achieved. The good order reviews that we looked at did not evidence any formal target setting, other than extremely simplistic ones, regarding daily behaviour. However, the issue was less significant, as there were far fewer long-term residents of the segregation unit than there had been previously.
We repeat the recommendation.

2.161 **Any relevant issues identified during an adjudication should be taken into consideration and acted upon. (6.28)**

Achieved. We examined a large number of records and found no evidence of relevant information being ignored or not fully taken into consideration.

Additional information

2.162 We reviewed a number of completed adjudication records, which were of reasonable quality and provided assurances about the general fairness of proceedings. Adjudication tariffs were in place and subject to regular review. Use of force was not especially high, having been used on 54 occasions in the six months to March 2008. Staff in the segregation unit were responsible for the collation of all the paperwork after a use of force incident. In a small number of cases there had been unacceptable delays in some staff completing the relevant

statements. The forms that we looked at had been completed reasonably well. Use of the special cell had also fallen since the previous inspection, and had only been used on six occasions to date in 2008 – a significant reduction from the previous inspection, when we had had serious concerns about the use of the special cell. The paperwork associated with the special cell had been completed well, with authorisation clearly recorded. There was clear evidence that prisoners were let out of the special cell as soon as they became compliant and the average length of stay in there was less than one hour.

2.163 A large new segregation unit had recently been opened. It had three spurs and contained 18 regular cells (three of which had a reduced number of ligature points), and a range of specialist cells, including a special cell, de-escalation cell, two dirty protest cells and a gated safer cell. The cell fabric in the normal cells was good and the cells were large and reasonably well equipped. The specialist cells were all located on one spur. The gated safer cell was inappropriately located alongside the cells for refractory and non-compliant prisoners, although the location was mitigated to some extent by the fact that the rooms were used very infrequently. The special cell was completely bare and fairly small. Sight lines into the cell were poor. The de-escalation cell was also completely bare. According to staff, it was not intended for de-escalation purposes but for use as a searching room for prisoners on arrival to the unit, who were already compliant. Staff were not clear as to what would happen in the event of a prisoner needing to be restrained while in this cell, as the cell would become a special cell in the event of a prisoner being locked in there.

2.164 The regime in the segregation unit was basic but adequate. There were six prisoners in the segregation unit during the inspection, mostly serving a punishment. They all understood the reasons why they were segregated. Prisoners who requested segregation for their own protection were normally managed on their own wings, rather than being located on the segregation unit. There were three exercise yards, which were extremely small and austere, with caged roofs.

Further recommendations

2.165 Protocols should be drawn up governing the use, and required levels, of authorisation for all the specialist cells in the segregation unit, including the de-escalation cell.

2.166 Records should be kept in the segregation unit of the usage of all of the specialist cells.

2.167 Efforts should be made to make the segregation unit yards less austere.

Incentives and earned privileges

2.168 **There should be sufficient difference between the standard and enhanced levels of the incentives and earned privileges (IEP) scheme to encourage responsible and compliant behaviour. (6.34)**

Partially achieved. The IEP scheme had been reviewed and additional inducements introduced to provide greater incentive to move from standard to enhanced levels. These included access to play stations, duvets and own clothing, although the latter was restricted to exercise and association and was not perceived by many prisoners as an incentive, particularly as they could not have any items sent or handed in but had to purchase everything through the local catalogue system. Additionally, some prisoners were not even aware of this privilege. The IEP policy stated that if enhanced status was lost, play stations would be taken

away and could not be replaced, even if the status was subsequently regained. Prisoners we spoke to on G and J enhanced wings were positive about the relaxed regimes on offer there, although enhanced level prisoners on other wings told us that this was not an incentive for them, as they did not want to move from their current wing. At the time of the inspection, the establishment was again reviewing the IEP policy, and also looking at options to extend the facility for enhanced level prisoners to wear their own clothes once the new laundry was operational and a new X-ray machine was installed. During the inspection, four prisoners were on basic, 439 on standard and 331 on the enhanced level of the IEP scheme. This was monitored for trends.
We repeat the recommendation.

Further recommendation

2.169 Prisoners should be able to have items of clothing sent in once the X-ray machine has been installed.

2.170 **Discussions should take place with those prisons that regularly send prisoners to Stocken, to ensure that IEP status information is readily available, and that delays do not occur because of staff having to confirm this information. (6.35)**

Achieved. Although prisoners still arrived without clear information about their IEP status, induction staff routinely contacted the sending prison to ensure that there were minimal delays in putting prisoners onto the appropriate level of the scheme.

2.171 **The facilities list should be compared with those of other prisons in the area, and some degree of standardisation achieved. (6.36)**

Achieved. The current facilities list had been published in June 2007; it had been developed with reference to lists at similar prisons, and prisoner views had been taken into account.

Services

Catering

2.172 **There should be some opportunities for prisoners to dine in association. (7.6)**

Partially achieved. Several residential units had areas suitable for communal dining, and it had been trialled on the lifer unit. Following our previous inspection, the prison's action plan said that the facility had not been expanded, as it had been established through prisoner consultation groups that this was not something that prisoners desired. Prisoners told us that on a few occasions they were allowed to eat their evening meals either in another prisoner's cell or outside the cell. Prisoners were still required to eat their meals in cells with unscreened toilets.
We repeat the recommendation.

2.173 **There should be regular and easily accessible ways for prisoners to comment on the choice and quality of the food. (7.7)**

Achieved. Catering staff attended the monthly prisoner forum, and the catering team carried out a prisoner survey bi-annually. Prisoners could complete consumer food comments forms,

which were available on the wings. The completed forms we sampled had received adequate responses.

Additional information

2.174 Prisoners told us that, on occasion, the food was not warm enough. They also highlighted that no separate utensils were provided to serve halal food, and the catering manager confirmed this. In some serveries, we observed prisoners serving food who were not wearing the appropriate protective clothing or gloves.

Further recommendations

2.175 The temperature of all foods should be tested before serving.

2.176 Separate utensils should be used when serving halal food.

2.177 Prisoners and staff should wear the appropriate clothing when serving meals.

Prison shop

2.178 **Shop prices should be reviewed at least annually to ensure that they do not differ significantly from those of other prisons in the area, and are not excessive compared to recommended retail prices. (7.13)**

Not achieved. The prison shop was managed by Aramark. Prison managers had no control over the prices charged but fed back to Aramark complaints from prisoners about the high prices.
We repeat the recommendation.

2.179 **The planned review of the complete list of items should be conducted. Prisoners should be involved in this process. (7.14)**

Achieved. Prisoners were surveyed quarterly about the items available on the prison shop list. This information was regularly discussed at the prisoner consultation group. We saw evidence of items on the list being changed as a result of this feedback.

2.180 **Prisoners arriving from other prisons should be able to purchase items from the prison shop within a week of their arrival. (7.15)**

Partially achieved. Shop orders were distributed to all wings each Wednesday. Prisoners arriving from Thursday to Tuesday morning could make their first purchase within a week but those arriving on Tuesday afternoon or Wednesday had to wait a full week. All newly arrived prisoners were able to purchase a basic smokers' or non-smokers' pack.
We repeat the recommendation.

Resettlement

Strategic management of resettlement

2.181 **The establishment should make more use of release on temporary licence (ROTL) to assist resettlement and incorporate a proactive approach to ROTL into the resettlement strategy. (8.5)**

Not achieved. The resettlement strategy (dated May 2007) made no reference to ROTL. A separate ROTL policy had been produced in March 2008 but this largely duplicated the Prison Service Order and did not specify how ROTL was to be used to support the resettlement work at the establishment. In the previous 12 months, there had been 68 applications for ROTL, of which 21 had been granted; the majority of these were for prisoners to work in the grounds of the prison. During this period, three prisoners had been granted day release for resettlement purposes, which was fewer than before the previous inspection. Resettlement managers had consulted with staff and prisoners in order to inform the racial impact assessment on ROTL and had found a general perception that ROTL was not used.
We repeat the recommendation.

2.182 **The resettlement strategy should include regular updating checks on the average length of stay of prisoners prior to release and be adjusted accordingly to meet prisoner need. (8.37)**

Not achieved. The most recent resettlement needs analysis (which informed the current resettlement strategy) had taken place in November 2006 and showed the average length of stay to be four months for prisoners serving sentences of less than four years and 12 months for those serving over four years. Our analysis of the next 50 prisoners to be released showed a similar pattern. However, there was no evidence that the length of stay was monitored routinely.
We repeat the recommendation.

2.183 **Senior managers should ensure that release on temporary licence (ROTL) supports the resettlement strategy. (8.38)**

Not achieved. See recommendation 2.181.

Additional information

2.184 The resettlement policy was out of date, as it did not reflect fully the current range of resettlement services and processes. It was based on the priorities set in the East Midlands regional reducing reoffending delivery plan but was mainly descriptive; there was no associated action plan or targets, other than the key performance targets. Not all of the resettlement pathways had a nominated strategic lead manager. Although the senior managers we spoke to were able to describe the work in progress and future proposed projects, this was not formally recorded anywhere and was not apparent from the minutes of the resettlement committee; in addition, staff providing resettlement services had limited knowledge of any such strategic plans. This placed too much reliance on the knowledge of a small number of individuals and made it difficult to monitor and measure achievement.

2.185 Although data were available from prisoner passports and offender assessment system (OASys) assessments, they had not been used to inform the development of interventions, and no new needs analysis had been done or planned following the significant increase in the prisoner population.

2.186 The overarching strategic committee was supposed to meet quarterly but had not met since November 2007.

Further recommendations

2.187 The resettlement strategy should be updated based on a current assessment of prisoners' resettlement needs and contributions from service providers, prisoners and offender managers.

2.188 An action plan should be drawn up to ensure that the resettlement strategy is implemented, monitored and reviewed in the most effective way.

2.189 The quarterly strategic resettlement committee should be reinstated.

Offender management and planning

2.190 **Life-sentenced prisoners should be allowed to progress to G and J wings as part of a planned, progressive move. This should be effectively communicated to staff and prisoners. (8.18)**

Achieved. Ten of the 70 places on these enhanced units were now allocated to life-sentenced prisoners and all were filled at the time of the inspection. Staff on the lifer unit (B wing) were clear about the criteria for progression, and a nominated lifer-trained officer was based on G wing to support lifers once they reached the enhanced units. Life-sentenced prisoners also had access to specialist units such as the Kainos community and the STOP drug treatment programme and would normally return to B wing once they had completed the relevant programme.

2.191 **All staff working with life-sentenced prisoners should be appropriately trained. (8.19)**

Not achieved. Five of the lifer-trained staff on B wing were on sickness absence from work, three of whom were potential long-term absences. Other officers were covering the workload in the interim and mentoring new staff in aspects of lifer work. No additional staff could be trained, as the national training programme had been suspended in order to revise and update the course materials; given the growing demand for places, there was likely to be a significant delay in getting staff onto the programme once it restarted.
We repeat the recommendation.

2.192 **The regime and facilities available on the lifer unit should be reviewed to enable life-sentenced prisoners to take increased responsibility and develop more independence. (8.20)**

Achieved. There were 64 life-sentenced prisoners at the establishment at the time of the inspection, and 52 of these were accommodated on B wing. Formal consultation meetings had been held in September and November 2007 but had since stalled owing to staff absences (see recommendation 2.191). However, a number of the issues and suggestions raised by life-

sentenced prisoners at the meetings had been taken forward and changes made to the regime and facilities.

2.193 **Personal officers should attend the bi-monthly lifer meetings and prisoners' annual review boards. (8.21)**

Partially achieved. Personal officers on B wing had previously been known as case managers and had recently been rebranded as key workers. On the days when lifer meetings took place, the unit was closed down early to allow all staff on duty to attend. Officers told us that they always tried to attend sentence planning and other review boards but these were not always scheduled for times when key workers were on duty, and other demands sometimes took priority. Life-sentenced prisoners were now managed under the offender management system and had nominated offender supervisors in the offender management unit (OMU).
We repeat the recommendation

2.194 **The establishment should draw up a public protection policy which incorporates all existing practise and is reviewed annually. (8.42)**

Achieved. We were provided with a copy of a policy document dated January 2008.

Additional information

2.195 An OMU had been set up since our previous inspection and was responsible for the assessment and case management of those prisoners who met the criteria for phases 2 and 3 of the National Offender Management Service model. At the time of the inspection, this workload covered a total of 329 prisoners, including 64 life sentenced prisoners (41% of the total population). All these prisoners had a named offender manager in the community, of which approximately 70% contributed to sentence planning boards, although mostly through teleconferencing. Offender supervisors made formal contact with their prisoners every two to three months and responded to other requests on application. Caseloads were not excessive, at 30–35, but staffing difficulties and the need to catch up with new intakes of prisoners had put the unit under strain.

2.196 The OMU manager was concerned that she had to prioritise her time on operational rather than strategic issues, and believed that the profile of the OMU needed to be raised within the establishment. The OMU was underdeveloped and poorly integrated into the wider work of the prison.

2.197 Since the end of December 2007, responsibility for managing the recategorisation of prisoners had transferred to the OMU. A backlog of assessments had been cleared, and consideration for category D status (and hence a potential move to open prison conditions) was now linked into the sentence planning process.

2.198 The population of life-sentenced prisoners had remained relatively static but since February 2008 there had been a rapid increase in the number of prisoners sentenced to an indeterminate sentence for public protection (IPP). The establishment held 34 IPP prisoners at the time of the inspection. There was no plan for managing the needs of these prisoners.

Further recommendations

2.199 The offender management unit should be adequately resourced to enable assessments and reviews to take place on time, and offender supervisors to maintain more frequent contact with their prisoners.

2.200 Offender management and sentence planning should be well integrated with other functions within the prison, so that decisions about an individual prisoner, and how he will spend his time in custody, always take account of sentence plan targets.

2.201 The resettlement strategy should specifically address how the establishment will address the needs of prisoners sentenced to indeterminate sentences for public protection.

Resettlement pathways

Drugs and alcohol

2.202 **Clear provision should be made for counselling, assessment, referral, advice and throughcare (CARAT) staff to participate in case supervision and training. (8.64)**

Partially achieved. CARAT staff received monthly supervision from their team leader, although training opportunities were limited.
We repeat the recommendation.

2.203 **The CARAT and STOP teams should have access to more computer and telephone facilities. (8.65)**

Partially achieved. As part of the prison expansion, the STOP team had moved to new purpose-built offices, which had sufficient telephones and computer terminals. However, at the time of the inspection, the CARAT team were still waiting for extra cabling in their offices to provide them with more computer terminals.
We repeat the recommendation.

2.204 **Drug information given to prisoners should be made available in other languages. (8.66)**

Achieved. The drug information given to prisoners during their induction was available in 13 different languages.

2.205 **A dual-diagnosis care pathway should be developed for those prisoners with both drug/alcohol and mental health problems. (8.67)**

Achieved. A recognised dual diagnosis care pathway developed between the CARAT and mental health in-reach teams had not been formally used for some time. However, these teams met monthly to discuss cases and share information, and relationships between them were described as good.

2.206 **A dedicated voluntary drug testing team should be created. (8.68)**

Not achieved. There were staff on each wing who were able to undertake drug testing, and

facilities throughout the establishment, but there was no dedicated voluntary drug testing (VDT) team. No prisoners were signed up for voluntary testing, while 452 (57%) were signed up for compliance testing. Compliance testing results were reported as VDT rates; the results supplied for 2007/08 to date were 3.3% positive, although when refusals, failure to supply and dilutions were included, the positive rate was nearer 4%.
We repeat the recommendation.

Children and families

2.207 **The take-up of visits should be increased and prisoners encouraged to maintain good family contact, both during sentence and in preparation for their release. (3.47)**

Not achieved. There was a low uptake of visits, and this had been compounded by the cancellation in December 2007 of the free bus service. The prison had run a number of family days but the use of the resettlement visiting order mentioned in their action plan had not been developed.
We repeat the recommendation.

2.208 **The role of the visitors' reception centre should be reviewed to ensure it meets visitors' needs – for example, to access relevant information and support, and to be able to share any concerns they have about the prisoner. (3.48)**

Not achieved. Domestic visits started at 1.45pm but on one day during the inspection the visitors' centre had not yet been unlocked shortly before the start of visits, and we observed a queue of visitors, some of whom had been waiting outside from 11am. The visitors' centre manager had not arrived for work (which we were told had happened before) and no one had notified the establishment. Visitors complained about visits not starting on time and the delay in getting prisoners into the visits room, both of which we were subsequently able to confirm. Visits staff had little interaction with visitors during the visits sessions, which gave visitors little chance to share any concerns they might have.
We repeat the recommendation.

2.209 **Toilet facilities for visitors and prisoners should be improved. (3.49)**

Partially achieved. Visitors were able to use the adequate toilet facilities before, during and after visits; however, prisoners had to terminate their visit if they wished to use the toilet.

Further recommendation

2.210 Prisoners should have access to a toilet during visits without the need to terminate the visit.

2.211 **Trained staff should be available to run the children's play area during all five visits sessions, but especially at weekends. (3.50)**

Not achieved. The children's play area was not open during visits, and managers told us that they had difficulties in recruiting suitable staff to run the area.
We repeat the recommendation.

Additional information

2.212 Visitors we spoke to expressed their concerns about the difficulty for family and friends in getting to the establishment. The visitors' centre was not secure, yet while there we discovered folders containing personal information about visitors, some of it going back eight years.

2.213 The visits room had low-level furniture, which was not family friendly, and overall it was institutional in appearance. There was a lack of information on display in the room and it appeared unkempt; in fact, staff had made comments in the observations book about how dirty the visits room was. The closed visits booths were very dirty owing to the building work going on next door, and the booths themselves were in full view of the main hall. Prisoners were not called for until their visitor was in the room; this resulted in unnecessary delays to the start of visits and caused stress for staff, visitors and prisoners.

2.214 When we observed legal visits, solicitors complained to us about the lack of tables available for them; late starting times; the noise in the room; and the lack of privacy, due to the absence of booths, and resources to show CD and video evidence. The area was also grubby. Staff supervising legal visits said that they felt overwhelmed with this task, as they had been given no training and were often left understaffed.

2.215 We were approached throughout the inspection by prisoners who expressed their concern about being placed on closed visits. Some of the formal complaints forms we read did not clearly show why prisoners had been placed on closed visits. Approximately 9.3% of the population were currently on closed visits.

Further recommendations

2.216 The free bus service should be reintroduced to assist families and friends in getting to the establishment.

2.217 Personal information stored in the visitors' centre about visitors should not be kept for excessive periods, and should be disposed of appropriately.

2.218 There should be regular consultation with domestic and official visitors and prisoners (through the prisoner forum) to seek their views on the visits experience and how it can be improved.

2.219 There should be an overall review of the visits protocols to address problems such as getting prisoners to the visits room on time and improving facilities for visitors, legal representatives and prisoners.

2.220 The visitors centre should be staffed in order to allow the centre to be opened according to scheduled times.

2.221 Prisoners should not be placed on closed visits unless there is intelligence linking them with trafficking. This should not include being placed on closed visits for a positive drug test alone.

Attitudes, thinking and behaviour

2.222 **The promotional material and information provided to prisoners about offending behaviour courses should accurately reflect the likelihood of prisoners accessing such**

courses while at Stocken. (8.28)

Partially achieved. Promotional material about the enhanced thinking skills (ETS) and controlling anger and learning to manage it (CALM) courses had been altered to make the selection criteria much clearer. The wording of sentence plan targets had also been changed to read 'to be assessed for', rather than 'to attend', a particular programme, which would have helped to structure prisoners' expectations better. The waiting lists, both for assessments and for programmes, were better managed and there was now a more realistic chance of a prisoner completing a programme while at the establishment. Once dates had been set for forthcoming programmes, notices identified which groups of prisoners (prioritised by release date) were eligible to be considered. However, the notices on display at the time of the inspection were out of date and related to programmes that had run in 2007.

Further recommendation

2.223 Promotional notices should be updated.

2.224 **Alternative sentence planning targets should be set for those prisoners who will not complete an accredited offending behaviour programme while at Stocken. (8.29)**

Partially achieved. There was some evidence that alternative interventions, such as the Kainos community, featured in sentence plans but managers acknowledged that targets were still heavily focused on assessment for the accredited programmes. Targets relating to work and skills training or personal development activities were rarely included, which meant that the sentence plan was not the sole or major driver for what happened to the prisoner during his time at Stocken.
We repeat the recommendation.

Additional information

2.225 The new approach to reintegration, introduced shortly before our previous inspection, was well embedded. A team of six officers, a senior officer and a principal officer made up a resettlement team; they saw all new prisoners during induction to identify resettlement needs, made referrals to appropriate services or agencies, and monitored progress through a detailed database. Resettlement officers acted as offender supervisors for those prisoners not covered by the OMU but did not have routine contact with their prisoners, and there was a backlog of outstanding OASys assessments. The team ran a twice-weekly drop-in surgery in the library, or prisoners could access them through application. Prisoners were interviewed again three months before release. Resettlement officers were sometimes cross-deployed to cover staff shortages elsewhere, which impacted adversely on their ability to cover their own duties adequately.

2.226 The provision of the pre-release course had faltered, with only one course having been delivered so far in 2008. The course material was being revised to complement the preparation for work course now run by the education department, and a money management course was being developed in conjunction with Lincolnshire Action Trust. Similarly, the lifer course aimed at preparing lifer-sentenced prisoners for open conditions had not run during the previous two years, despite 17 such prisoners having moved to open prisons in the previous year and three having been released directly to hostels.

2.227 A healthcare support worker ran a 'going home clinic' once a week, at which all prisoners due to be released in the following week were seen. They were given a summary of their clinical records from the electronic clinical records system which they were told to give to their general practitioner (GP). However, they were not given any assistance in how to register with a GP or other health and social care services. Mental health in-reach staff organised care programme approach meetings for those being released, involving community mental health in-reach teams (CMHT) and their patients. They had good relationships with a number of local CMHTs, although the team leader told us that it was more difficult to get CMHT staff from Leicester Partnership Trust to attend than other teams.

2.228 Resettlement staff had been working with Action for Families to develop parenting skills for prisoners and direct work with families. Two family fun days had been run and another was planned for June 2008; these were available for enhanced level prisoners within the last three months of their sentence and involved families working together through structured play activities.

2.229 The establishment had been without a senior psychologist for most of 2007, and in August a number of probation and psychology staff had left, resulting in a serious shortage of tutors for the ETS and CALM programmes, resulting in both programmes being temporarily stopped. This had created delays in getting prisoners onto programmes and had also impacted on assessment and one-to–one work with life-sentenced and high-risk prisoners. The ETS course had now resumed and it was hoped to recommence the CALM course shortly after the inspection. The establishment had been unable to meet requests from the Parole Board to complete assessments and we received complaints, both from staff and from prisoners, about actual or perceived delays to prisoners' progression as a result of this situation. A new senior psychologist was due to start work within the next few weeks.

Further recommendations

2.230 All prisoners should be offered a pre-release resettlement course that is tailored to meet their needs.

2.231 Life-sentenced prisoners moving to open conditions should be given support to reduce their institutional dependence.

2.232 Prisoners should be given information and assistance to access health and social care services on release.

2.233 The backlog of OASys assessments should be cleared.

2.234 The backlog of psychology assessments should be cleared and prisoners should have timely access to group or individual interventions designed to change their attitudes, thinking and behaviour.

Section 3: Summary of recommendations

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

Main recommendations (from the previous report)

To the governor

3.1 The establishment should implement the violence reduction strategy; train staff in identifying potential bullying situations; support those bullied; and confront and isolate those carrying out the bullying. (2.1)

3.2 The establishment should draw up and implement a clear foreign national prisoners' policy, to ensure all prisoners can participate fully in the regime and that foreign national prisoners' needs are addressed. (2.3)

3.3 More consistent use should be made of consultative forums and the personal officer scheme to explain the establishment's processes and improve communication with prisoners. (2.4)

3.4 Searching of visitors should be conducted in private and with proper regard for the individual's dignity. (2.8)

Recommendations

To NOMS

3.5 Shop prices should be reviewed at least annually to ensure that they do not differ significantly from those of other prisons in the area, and are not excessive compared to recommended retail prices. (2.178)

3.6 All staff working with life-sentenced prisoners should be appropriately trained. (2.191)

Recommendation

To UKBA and the governor

3.7 The establishment should liaise with the immigration services to ensure regular surgeries for prisoners. (2.90)

Recommendations

To the governor

First days in custody

3.8 The holding rooms should be properly furnished with televisions and information notice boards. (2.13)

3.9 The establishment should provide translated material to cover all identified languages of prisoners who do not speak English. (2.20)

3.10 Prisoners returning to the establishment should have their resettlement needs fully assessed and be fully briefed on any new rules, procedures or services that have been introduced since they last completed the full induction programme. (2.22)

3.11 Prisoners transferring from other prisons should be allowed to keep their verified telephone numbers unless there are evidenced security or public protection concerns. (2.27)

3.12 All induction sessions should be delivered by staff or prisoners with specialist knowledge of the topic, or be delivered according to an agreed package to which specialist staff have contributed. (2.28)

3.13 The condition of the accommodation on D wing should be improved to provide a more welcoming environment to newly arrived prisoners. (2.29)

Residential units

3.14 In-cell toilets should be adequately screened to provide privacy and separation from the living and dining area. (2.30)

3.15 The display of information for prisoners should be consistent across all residential units, and should be suitable for the establishment's population. (2.31)

3.16 Prisoners should be given the option to wear their own clothing. (2.33)

3.17 Consultation should take place with HMYOI Glen Parva in order to improve the standard of prison-issue clothing. (2.34)

3.18 The system of prison kit exchange should be reviewed to ensure that all prisoners have access to good quality clothing that fits. (2.35)

3.19 Prisoners' stored property should be held securely at all times. (2.36)

3.20 Time allocated to the civilian cleaning contractor should be sufficient to cover the work required. (2.38)

3.21 Levels of cleanliness should be improved, particularly in some of the communal areas such as stairwells on the older units. (2.40)

Personal officers

3.22 A written personal officer policy should be produced that clearly sets out what is required of staff and what prisoners can expect from their personal officer. (2.41)

3.23 All prisoners should receive an appropriate amount of help and attention from their personal officer, irrespective of their location. (2.42)

Bullying and violence reduction

3.24 Better links should be developed between the security department and the violence reduction meeting to allow for more effective analysis of intelligence. (2.47)

3.25 A full-time safer custody coordinator should be appointed with direct oversight of violence reduction and suicide prevention. (2.49)

3.26 The violence reduction strategy should be revised, in consultation with prisoners, relaunched and implemented consistently across all residential units. (2.54)

3.27 All staff in contact roles should receive training in anti-bullying and violence reduction. (2.55)

3.28 All incidents involving alleged bullying should be properly investigated and referred to the anti-bullying coordinator. (2.56)

3.29 Planned peer support work to support violence reduction should be implemented. (2.57)

3.30 Unexplained injuries should be monitored and referred to the violence reduction coordinator. (2.58)

Self-harm and suicide

3.31 A protocol should be drawn up covering the precise circumstances and the authorisation required for use of all of the establishment's various safer cells. (2.61)

Diversity

3.32 An overarching diversity strategy should be produced, which outlines how the specialist needs of minority groups of prisoners, including disabled, elderly, gay and bisexual prisoners, will be identified, assessed and supported. This should be monitored by managers. (2.67)

3.33 The disability liaison officer should have sufficient time to carry out individual assessments of needs with any prisoners disclosing a disability. These should result in individual support plans, and all relevant reasonable adjustments should be made without delay. (2.68)

Race equality

3.34 All staff should be trained in cultural, racial and diversity issues. (2.69)

3.35 Functional heads should take full responsibility for completing impact assessments in their areas, with input from prisoners. (2.75)

3.36 Black and minority ethnic prisoner representatives should be appointed or elected on each wing and encouraged to meet regularly to discuss issues of interest or concern. The REO should ensure that any actions from these meetings are taken forward and reported back to all black and minority ethnic prisoners. (2.76)

3.37 Active steps should be taken to make links with relevant community groups and organisations to the benefit of black and minority ethnic prisoners. (2.77)

3.38 The REO should be provided with a private office. (2.78)

3.39 A deputy REO should be appointed. (2.79)

Foreign national prisoners

3.40 Prisoners should have access to accredited translation and interpreting services wherever matters of accuracy and/or confidentiality are a factor. (2.80)

3.41 Routine consultation of the foreign national prisoner population should be undertaken, and any significant issues raised should be acted upon. (2.81)

3.42 A dedicated foreign nationals coordinator should be appointed. (2.85)

3.43 All foreign national prisoners should be interviewed by the coordinator during their induction, to identify any specific needs. (2.86)

3.44 The services offered by the foreign nationals coordinator should be well publicised throughout the establishment. (2.87)

3.45 Foreign national representatives should be appointed or elected, and attend the bi-monthly committee meeting. (2.88)

3.46 The establishment should actively seek out community-based organisations that would be willing to support their work with foreign national prisoners. (2.89)

Applications and complaints

3.47 A system to log all prisoner applications should be introduced across all wings; timeliness of responses and outcomes should be recorded and monitored. (2.91)

3.48 A nominated senior manager should regularly check the quality of complaint responses. The nature of complaints should also be monitored by senior managers. (2.92)

3.49 Managers should ensure that the quality of responses provided to prisoners' complaints is improved. (2.93)

Substance use

3.50 A dedicated mandatory drug testing team should be created. (2.95)

3.51 The recording of all data relating to drug testing should be reviewed to ensure that accurate information is collected, analysed and reported. (2.96)

Health services

3.52 The cleaning of healthcare facilities should be improved to ensure that a high level of cleanliness is maintained at all times. (2.99)

3.53 Discipline staff should be present to supervise prisoners and control movement during treatment and clinic times. (2.100)

3.54 Prisoners should be able to see a pharmacist. (2.103)

3.55 Procedures should be developed to ensure that prisoners missing doses or with poor compliance are monitored and supported. (2.104)

3.56 The treatment room should be refurbished to comply with infection control guidelines. (2.105)

3.57 The decoration and cleanliness of all rooms used for delivering health services should be consistent with the promotion of health and well-being and have appropriate infection control facilities. (2.106)

3.58 Day-care services should be introduced. (2.108)

3.59 Mental health services should include primary, secondary and tertiary services. (2.111)

3.60 Sufficient detail time should be profiled to allow external NHS appointments to be scheduled according to demand. Current confusion should be rectified and cancellations should be monitored. (2.114)

3.61 Medicine distribution times should be reviewed, and patient confidentiality should be improved. (2.115)

3.62 The core day should be reviewed with healthcare staff to provide prisoners with better access to healthcare. (2.117)

3.63 Clinical supervision should be implemented. (2.119)

3.64 Prison staff should have regular mental health awareness training. (2.120)

3.65 A dental needs assessment should be carried out and the dental contract revised to ensure that there are sufficient dental sessions to meet the needs of prisoners. (2.123)

3.66 There should be a skills review to ensure that there are sufficient staff, with the relevant skills and competencies to provide health services. This should include a review of administrative tasks. (2.129)

3.67 All clinical records should be contemporaneous and conform to professional guidance from regulatory bodies. (2.130)

Learning and skills and work activities

3.68 Work provision should be more effectively quality assured. (2.6)

3.69 A coherent plan should be prepared for the development of learning and skills across the prison. (2.132)

3.70 Quality improvement procedures should be fully and consistently implemented across all areas of learning and skills. (2.133)

3.71 All information, advice and guidance targets should be clear and measurable. (2.135)

3.72 Systems should be introduced to identify the success of targets set at the labour board. (2.136)

Time out of cell

3.73 All prisoners should spend at least 10 hours out of their cell each day, except in exceptional circumstances. (2.148)

Discipline

3.74 The policy covering the use of cardboard furniture in the segregation unit should be updated to take account of the new segregation unit. (2.156)

3.75 A booklet explaining the segregation unit rules, regime and allowances should be prepared and given to all prisoners on entry to the unit. (2.159)

3.76 Formal targets to help reintegrate prisoners onto normal location should be agreed upon GOOD (good order or discipline) reviews. (2.160)

3.77 Protocols should be drawn up governing the use, and required levels, of authorisation for all the specialist cells in the segregation unit, including the de-escalation cell. (2.165)

3.78 Records should be kept in the segregation unit of the usage of all of the specialist cells. (2.166)

3.79 Efforts should be made to make the segregation unit yards less austere. (2.167)

Incentives and earned privileges

3.80 There should be sufficient difference between the standard and enhanced levels of the incentives and earned privileges (IEP) scheme to encourage responsible and compliant behaviour. (2.168)

3.81 Prisoners should be able to have items of clothing sent in once the X-ray machine has been installed. (2.169)

Catering

3.82 There should be some opportunities for prisoners to dine in association. (2.172)

3.83 The temperature of all foods should be tested before serving. (2.175)

3.84 Separate utensils should be used when serving halal food. (2.176)

3.85 Prisoners and staff should wear the appropriate clothing when serving meals. (2.177)

Prison shop

3.86 Prisoners arriving from other prisons should be able to purchase items from the prison shop within a week of their arrival. (2.180)

Strategic management of resettlement

3.87 The establishment should make more use of release on temporary licence (ROTL) to assist resettlement and incorporate a proactive approach to ROTL into the resettlement strategy. (2.181)

3.88 The resettlement strategy should include regular updating checks on the average length of stay of prisoners prior to release and be adjusted accordingly to meet prisoner need. (2.182)

3.89 The resettlement strategy should be updated based on a current assessment of prisoners' resettlement needs and contributions from service providers, prisoners and offender managers. (2.187)

3.90 An action plan should be drawn up to ensure that the resettlement strategy is implemented, monitored and reviewed in the most effective way. (2.188)

3.91 The quarterly strategic resettlement committee should be reinstated. (2.189)

Offender management and planning

3.92 Personal officers should attend the bi-monthly lifer meetings and prisoners' annual review boards. (2.193)

3.93 The offender management unit should be adequately resourced to enable assessments and reviews to take place on time, and offender supervisors to maintain more frequent contact with their prisoners. (2.199)

3.94 Offender management and sentence planning should be well integrated with other functions within the prison, so that decisions about an individual prisoner, and how he will spend his time in custody, always take account of sentence plan targets. (2.200)

3.95 The resettlement strategy should specifically address how the establishment will address the needs of prisoners sentenced to indeterminate sentences for public protection. (2.201)

Resettlement pathways

3.96 Clear provision should be made for counselling, assessment, referral, advice and throughcare (CARAT) staff to participate in case supervision and training. (2.202)

3.97 The CARAT and STOP teams should have access to more computer and telephone facilities. (2.203)

3.98 A dedicated voluntary drug testing team should be created. (2.206)

Children and families

3.99 The take-up of visits should be increased and prisoners encouraged to maintain good family contact, both during sentence and in preparation for their release. (2.207)

3.100 The role of the visitors' reception centre should be reviewed to ensure it meets visitors' needs – for example, to access relevant information and support, and to be able to share any concerns they have about the prisoner. (2.208)

3.101 Prisoners should have access to a toilet during visits without the need to terminate the visit. (2.210)

3.102 Trained staff should be available to run the children's play area during all five visits sessions, but especially at weekends. (2.211)

3.103 The free bus service should be reintroduced to assist families and friends in getting to the establishment. (2.216)

3.104 Personal information stored in the visitors' centre about visitors should not be kept for excessive periods, and should be disposed of appropriately. (2.217)

3.105 There should be regular consultation with domestic and official visitors and prisoners (through the prisoner forum) to seek their views on the visits experience and how it can be improved. (2.218)

3.106 There should be an overall review of the visits protocols to address problems such as getting prisoners to the visits room on time and improving facilities for visitors, legal representatives and prisoners. (2.219)

3.107 The visitors centre should be staffed in order to allow the centre to be opened according to scheduled times. (2.220)

3.108 Prisoners should not be placed on closed visits unless there is intelligence linking them with trafficking. This should not include being placed on closed visits for a positive drug test alone. (2.221)

Attitudes, thinking and behaviour

3.109 Promotional notices should be updated. (2.223)

3.110 Alternative sentence planning targets should be set for those prisoners who will not complete an accredited offending behaviour programme while at Stocken. (2.224)

3.111 All prisoners should be offered a pre-release resettlement course that is tailored to meet their needs. (2.230)

3.112 Life-sentenced prisoners moving to open conditions should be given support to reduce their institutional dependence. (2.231)

3.113 Prisoners should be given information and assistance to access health and social care services on release. (2.232)

3.114 The backlog of OASys assessments should be cleared. (2.233)

3.115 The backlog of psychology assessments should be cleared and prisoners should have timely access to group or individual interventions designed to change their attitudes, thinking and behaviour. (2.234)

Good practice

Healthcare services

3.116 The introduction of health trainers was of benefit both to the individual trainers and to the prison population as a whole. (2.131)

Faith and religious activity

3.117 Chaplains saw all prisoners on an open ACCT document daily. (2.147)

Appendix I: Inspection team

Jonathan French	Team leader
Karen Dillon	Inspector
Gail Hunt	Inspector
John Simpson	Inspector
Sean Sullivan	Inspector
Elizabeth Tysoe	Healthcare inspector
Jane Robinson	Ofsted inspector

Appendix II: Prison population profile

(i) Status	Number	%
Sentenced	792	*99.5*
Detainees (single power status)	4	*0.5*
Detainees (dual power status)		
Total	**796**	***100***

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	2	*0.25*
6 months to less than 12 months	9	*1.13*
12 months to less than 2 years	94	*11.81*
2 years to less than 4 years	289	*36.3*
4 years to less than 10 years	296	*37.19*
10 years and over (not life)	16	*2*
Life	90	*11.31*
Total	**796**	***100***

(iii) Length of stay	Sentenced prisoners	
	Number	%
Less than 1 month	103	*12.94*
1 month to 3 months	155	*19.47*
3 months to 6 months	314	*39.45*
6 months to 1 year	145	*18.22*
1 year to 2 years	59	*7.41*
2 years to 4 years	17	*2.14*
4 years or more	3	*0.38*
Total	**796**	***100***

(iv) Main offence	Number	%
Violence against the person	205	*25.75*
Sexual offences	14	*1.76*
Burglary	128	*16.1*
Robbery	96	*12.1*

Theft and handling	24	*3.3*
Fraud and forgery	7	*0.9*
Drugs offences	198	*24.87*
Other offences	124	*15.58*
Civil offences	0	
Total	**796**	***100***

(v) Age	Number	%
21 years to 29 years	418	*52.51*
30 years to 39 years	253	*31.78*
40 years to 49 years	106	*13.32*
50 years to 59 years	14	*1.76*
60 years to 69 years	5	*0.63*
Total	**796**	***100***

(vi) Home address	**Number**	**%**
No information provided		
Total		

(vii) Nationality	**Number**	**%**
British	725	*91*
Foreign nationals	71	*9*
Total	**796**	***100***

(viii) Ethnicity	**Number of prisoners**	**%**
White:		
British	565	*70.9*
Irish	4	*0.5*
Other White	20	*2.6*
Mixed:		
White and Black Caribbean	25	*3.1*
Other Mixed	11	*1.3*
Asian or Asian British:		
Indian	20	*2.5*
Pakistani	18	*2.2*

Bangladeshi	1	*0.1*
Other Asian	17	*2.1*
Black or Black British:		
Caribbean	61	*7.6*
African	16	*2*
Other Black	21	*2.6*
Chinese or other ethnic group:		
Chinese	7	*0.8*
Other ethnic group	10	*1.2*
Total	**796**	***99.5***

(ix) Religion	Number	%
Baptist		
Church of England	277	*34.8*
Roman Catholic	110	*13.82*
Other Christian denominations		
Muslim	77	*9.67*
Sikh	8	*1*
Buddhist	21	*2.64*
Jewish	5	*0.63*
Other		
No religion	298	*37.44*
Total	**796**	***100***