Report on an unannounced short follow-up inspection of

HMP Wymott

15–17 November 2011

by HM Chief Inspector of Prisons

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Introduction

HMP Wymott is a large category C training prison in Lancashire holding over 1,100 men, including a significant population of vulnerable prisoners. Our last full inspection of Wymott in October 2008 was positive and we found that the prison was achieving good or reasonably good outcomes for prisoners. We were impressed during that inspection that, despite considerable expansion, the prison had managed to continue to improve and functioned as an effective training prison. During this short follow-up inspection we found progress to be mixed, and in some important areas, limited. Short follow-up inspections focus on recommendations made at the last full inspection and so do not provide an assessment of the prison as a whole.

Progress on safety was insufficient. The quality and timeliness of reception processes continued to be poor for some prisoners. Arrangements to support prisoners at risk of self-harm or suicide, which we were concerned about at our last inspection, had progressed but still required further improvement. Levels of violence remained commendably low and violence reduction was well managed, but limited staff resources hampered further development. Use of force levels were not high and were similar to those at the time of our last inspection, but there was insufficient management oversight of the use of force and many reports were incomplete. Scrutiny of adjudication paperwork was similarly poor.

Some improvements had been made to residential areas. The number of telephones had increased and cell toilets had been screened. However, many showers remained unscreened and, although clean, required refurbishment.

Progress on diversity was disappointing. Race issues were dominant although the negative perceptions of black and minority ethnic prisoners had yet to be explored. Wider diversity provision had not been developed and the needs of foreign national prisoners were not being met. The number of older prisoners and prisoners with disabilities remained high and we were pleased to see that there had been significant improvements in their care.

There had been good progress in health care and health care staff were well integrated into the prison. However, prisoners were still negative about health care provision and this was mainly due to long waits to see the GP and dentist.

We had few concerns about prisoners' access to, and the quality of, learning and skills provision at our last inspection. At this inspection we found further progress to be reasonable although record keeping and reviews of prisoner learning required development. Access to the library had improved considerably and use of the gym and participation in fitness activities had increased.

The strategic management of resettlement and offender management had improved since our last visit. Progress along the resettlement pathways was generally sound, with some particularly good links with employers resulting in high numbers of prisoners being released into employment. There had been some progress around improving visits arrangements and engaging with sex offenders in denial, which both caused us concern last time, but more work needed to be done.

Wymott faces the challenge of delivering a purposeful training regime to a diverse prisoner population. The prison has undoubtedly remained an effective training prison and has made notable progress in managing prisoners' sentences and improving resettlement outcomes – both of which had given us cause for concern last time. Progress is less visible in other areas. The prison needed to refocus its efforts to ensure sufficient attention is given to maintaining a

safe and respectful environment and, in particular, to developing its approach to diversity, recognising that it holds a diverse population presenting a range of risks and needs.

Nick Hardwick — January 2012
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Wymott is a category C training prison.

Prison status
Public

Region
North-west

Number held
1,174

Certified normal accommodation
1,103

Operational capacity
1,176

Date of last full inspection
October 2008

Brief history
HMP Wymott was originally opened in 1979 as an open campus, four-wing male adult category C industrial prison for a short-term total prisoner population of 816.

The prison operated successfully throughout its initial years but in 1986 was subject to two serious disturbances, the first of which coincided with prisoner unrest in several other establishments elsewhere across the country as a result of national industrial action. The establishment's buildings then became increasingly unfit for purpose to control the prisoner population, culminating in a major riot in 1993 which resulted in the demolition of two wings (which were then replaced by more effective and appropriate cellular accommodation).

Since that difficult period, the establishment has gradually re-established itself as a training prison, which holds a split-site population of the full range of vulnerable and ordinary category C prisoners, including lifers.

Short description of residential units

Unit/Wing	Use	CNA
A wing	Vulnerable prisoners	191
B wing	Vulnerable prisoners	191
C/D wing	Sentenced prisoners	190
E/F wing This includes 34 vulnerable prisoners	Sentenced prisoners	159
G/H wing G wing has all vulnerable prisoners. H wing has sentenced category C prisoners	Sentenced prisoners	178

I wing	Special unit	68
All are vulnerable prisoners		
J wing	Enhanced unit	40
This unit contains a mixture of vulnerable and sentenced category C prisoners		
K wing	Sentenced prisoners	64

Escort contractor
GeoAmey Security UK

Health service commissioner and provider
Commissioner: Central Lancashire Primary Care Trust
Provider: Lancashire Care Foundation Trust

Learning and skills providers
The Manchester College

Section 1: Summary

Introduction

1.1 Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, immigration detention facilities and police custody.

1.2 All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the UN Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

1.3 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2008 and assess the progress achieved. All full inspection reports include a summary of outcomes for prisoners against the model of a healthy prison. The four criteria of a healthy prison are:

Safety	prisoners, particularly 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.

1.4 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. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected and giving an overall assessment against the following definitions:

Making insufficient progress
Overall progress against our recommendations has been slow or negligible and/or there is little evidence of improvements in outcomes for prisoners.

Making sufficient progress
Overall there is evidence that efforts have been made to respond to our recommendations in a way that is having a discernible positive impact on outcomes for prisoners.

Safety

1.5 At our inspection in 2008 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 32 recommendations in this area, including two main

recommendations, of which 14 had been achieved, five partially achieved, including one main recommendation, and 13 had not been achieved, including one main recommendation. We have made no further recommendations.

1.6 There had been limited progress in the arrangements for prisoners' first days in custody. Prisoners continued to be handcuffed when disembarking in the sterile area. They spent too long in reception when large groups of new prisoners arrived. Some who arrived late, especially on a Friday, were not able to shower and did not always have the opportunity to see a peer supporter or Listener in either reception or on the first night wing. Vulnerable and mainstream prisoners shared first night accommodation and, although a formal review had not been undertaken, we were assured that it operated effectively and safely. A comprehensive and accessible induction booklet was not available in languages other than English.

1.7 The strategic management of suicide and self harm had improved considerably; however, the quality of assessment, care in custody and teamwork (ACCT) procedures still required improvement. Although plans were updated after reviews, and they were often attended by mental health staff, attendance at reviews was not sufficiently multidisciplinary. There was no consistent case manager in most cases. Targets in care plans were sometimes poor and there was insufficient interaction between staff and prisoners on an open ACCT document.

1.8 The level of violence was low. There were clear and comprehensive violence reduction and suicide prevention policies, managed through separate governance meetings, which received and analysed a full range of safer custody information. Meetings were attended by appropriate departments, including health care, and prisoners. Managers and staff told us that there were insufficient resources across the safer custody and violence reduction teams to fully develop the strategy, particularly in regard to staff training and quality assurance. The tackling antisocial behaviour (TAB) system was well used and understood by staff but training had not been available during the current year. There were no interventions to address the attitudes and behaviour of perpetrators or help victims to cope.

1.9 Support from Listeners was well organised, Samaritan telephones were available and there was a clear policy on constant supervision.

1.10 The segregation unit policy clearly identified the usage and governance of the camera cells. However, there had been little progress in other areas of segregation and discipline. Prisoners were routinely strip-searched on location onto the segregation unit, despite the policy stating otherwise. Individual prisoner files did not reflect meaningful interaction between staff and prisoners on the segregation unit. Scrutiny of adjudication paperwork remained poor; there was little evidence of adjudication quality checks and there had been only one standardisation meeting during the current year.

1.11 Use of force documentation was not subject to any quality assurance and many reports were incomplete. There had been no progress on analysis and monitoring of use of force to identify emerging issues or trends, little reference to the use of force at the security committee and there was no established use of force committee.

1.12 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient progress against our recommendations.

Respect

1.13 At our inspection in 2008 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 62 recommendations in this area, including one main recommendation, of which 28 had been achieved, seven partially achieved, including one main recommendation, and 25 had not been achieved. Two recommendations were no longer applicable. We have made a further three recommendations.

1.14 Some improvements had been made to residential areas. The number of telephones had been increased; most of these were in privacy booths or had hoods but some still had no privacy screening. The screening of in-cell toilets by a curtain remained inadequate. Most shower areas in the older units were not screened and, although they were kept clean, were in a poor state of repair. One shower area on B wing had been refurbished to a good standard.

1.15 There had been no improvement in the management of wing-based prisoner meetings but they were followed by monthly prison-wide representatives meetings, which were minuted, with actions allocated to staff and reports of progress received.

1.16 The personal officer policy was comprehensive but staff were not familiar with it. Although a change of cell meant a change of personal officer, entries on prisoner files were regular and of good quality.

1.17 Few prisoners had the opportunity to dine in association, and breakfast packs continued to be issued at lunchtime on the day before consumption.

1.18 Diversity work appeared to have been neglected in recent years. Strategic management was particularly poor and the diversity policy and associated action planning were out of date. Diversity was dominated by race issues. Wider diversity management meetings, diversity complaints and diversity prisoner representatives had not been introduced. The negative perceptions of black and minority ethnic prisoners had yet to be explored. There was some high-quality activity relating to African-Caribbean prisoners but no regular consultation with black and minority ethnic groups and there was little evidence of a prison-wide approach to promoting equality.

1.19 Apart from regular UK Border Agency surgeries, provision for foreign national prisoners had dwindled.

1.20 There had been considerable improvements in the care of older prisoners and those with disabilities. I wing continued to operate as a specialist unit, and older prisoners and those with disabilities were supported by health services staff and specialist social care workers. Formal care plans were drawn up for those who needed them and a range of adjustments had been implemented as required. A day care centre had been developed and provided a range of activities for older prisoners and those with disabilities. Prisoners requiring assistance in an emergency were not easily identifiable on all wings.

1.21 The applications and complaints processes had improved. There was a standardised application system in use across the prison, which enabled outstanding applications to be tracked.

1.22 There had been good progress against our recommendations across health services. Staffing levels were sufficient to meet the workload, and cancellation of clinical activities owing to staff shortages was rare. All clinical areas had been subjected to an infection control audit and were generally fit for purpose. There had been little progress in reducing waiting lists, and prisoners

waited too long to see the GP and dentist. A system of timed appointments had been introduced but escorting practices remained unchanged, which meant that prisoners waited for extensive periods in the waiting rooms in the health centre after their appointments. The health care complaints process had improved and the responses we sampled were timely, courteous and focused.

1.23 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient progress against our recommendations.

Purposeful activity

1.24 At our inspection in 2008 we found that outcomes for prisoners against this healthy prison test were good. We made 10 recommendations in this area, of which five had been achieved and five had not been achieved. We have made no further recommendations.

1.25 The amount of time out of cell for prisoners had not increased. The published core day still allowed a maximum of nine and a half hours out of cell during the week. Our observations showed that in reality prisoners had much less time out of cell than this, as the core day was not always adhered to and prisoners were locked up early. The prison reported a time out of cell of around eight and a half hours a day.

1.26 For prisoners involved in learning, individual learning plans remained underdeveloped. The frequency of prisoner reviews was not consistent and review records were not effective in identifying progress in learning and the development of personal skills.

1.27 Appropriate arrangements had been made for older prisoners and those with disabilities to access library facilities.

1.28 The promotion of PE/fitness facilities had been effective and usage had increased. Promotion had been enhanced through links with the healthy living education course, involvement in health promotion events and the introduction of well-man health checks. Most PE instructors had not received teacher training.

1.29 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Resettlement

1.30 At our inspection in 2008 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 29 recommendations in this area, including three main recommendations, of which 18 had been achieved, including two main recommendations, and ten had not been achieved, including one main recommendation. One recommendation was no longer applicable. We have made one further recommendation.

1.31 The strategic management of reducing reoffending had improved. It was based on a comprehensive needs analysis but did not comment on the role of the offender management unit. There was detailed information on the resettlement pathways and a comprehensive action plan.

1.32 The management and allocation of offender supervisor caseloads had improved. Regular contact was maintained with high-risk offenders but was insufficient for others. Offender manager engagement and attendance at sentence planning boards had improved.

1.33 Links with a wide range of employers had been developed and a large number of prisoners had been placed in jobs with these employers on release.

1.34 A thorough drug interventions needs analysis had been conducted and was being used to inform the new substance misuse strategy. Drugs services were well developed. The therapeutic community (TC) was staffed appropriately, although the unit accommodation was too small to hold full TC community meetings. There was good access to a comprehensive counselling, assessment, referral, advice and throughcare (CARAT) service.

1.35 There had been some progress in the children and families pathway. A comprehensive review of visits had taken place but without consultation with prisoners. While there was good consultation with visitors, it was not possible to see how this informed visits provision. Visits started late but access to the visits booking line had increased. Access to family days remained limited for the standard IEP level prisoner population.

1.36 A strategy had been developed to increase the engagement of sex offenders in treatment programmes; however, it had not been successful in improving engagement and had been subject to a comprehensive review. Some prisoners were transferred to other prisons to complete interventions identified in their sentence plans.

1.37 On the basis of this short follow-up inspection, we considered that the establishment was making sufficient progress against our recommendations.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 A succinct violence reduction strategy covering anti-bullying should be developed, in consultation with prisoners, which all staff understand and implement consistently. (HP39)

Partially achieved. The violence reduction policy had been reviewed and a new version published in April 2011. It contained policy statements, and outlined the principles of a strategy and its governance. The second section was a clear and practical guide for staff in the operation of the tackling antisocial behaviour (TAB) process and the final section was another practical guide for staff, covering cell sharing risk assessments, including the importance of early identification of antisocial or violent prisoners who might be a risk to others. Although the safer custody manager, who wrote the policy, told us that she was in touch with the views of prisoners through her contact with prisoner representatives, they had not been directly involved in the formulation of the policy. Staff we spoke to were familiar with the policy and understood its contents. Implementation was monitored by the safer custody manager and the violence reduction meeting.

2.2 The quality of assessment, care in custody and teamwork (ACCT) procedures for those at risk of suicide and self-harm should improve, to ensure that care and support plans reflect assessed need and that reviews are consistently chaired by the same case manager and involve staff from a range of disciplines. (HP40)

Not achieved. In the six months before the inspection, 110 ACCT documents had been opened, which was not excessive. We examined 10 of these and found some common themes in deficits, reflecting those found at the previous inspection. Some care plans contained appropriate targets but others were too brief and targets were not well developed. The poorest example we found identified the problem of a prisoner who was not motivated to get out of bed in the morning; the objective and the action required were both listed as 'get up'. Reviews for each prisoner were chaired by various case managers, which we were told was because of inconsistency of staff on residential units. While several reviews were attended by members of the mental health team, there was rarely wider attendance from offender supervisors, the chaplaincy, workplace supervisors or personal officers. The quality of ACCT contact records was mostly poor. Most entries were solely observational, and little interaction was recorded, which gave the impression in some cases that there had been no conversation with the prisoner about his mood or feelings over several days. Entries by night staff were repetitive and predictable.
We repeat the recommendation.

2.3 A diversity policy should be developed and implemented, covering all distinct minority groups, including gay prisoners, those with disabilities and older prisoners, and based on an analysis of their needs. (HP41)

Partially achieved. A diversity policy had been introduced in 2010, and covered all the diversity strands, but it was out of date. It was mainly descriptive and not based on an analysis

of prisoner needs. It did not identify how diversity should be managed at the establishment or the range of services and support available to prisoners across each of the strands. The accompanying race equality action plan was out of date, actions in it were not time bounded and, as it was such an unwieldy document, it was not available in hard copy to be monitored at the race equality action team (REAT) meeting.
We repeat the recommendation.

2.4 A new reducing reoffending strategy should be agreed, based on a comprehensive assessment of the needs of all categories of prisoner represented at the prison, with action plans setting out how those needs will be met. (HP42)

Achieved. There was a reducing reoffending strategy, dated November 2009. It had been based on a comprehensive needs analysis but did not distinguish between vulnerable and category C prisoners. Governance arrangements were provided through the resettlement policy committee, resettlement pathway lead meetings and a resettlement strategy group meeting. These quarterly meetings took place routinely, with action points addressed. The strategy did not mention how the offender management model worked and the part it played in the overall strategy to reduce reoffending. It contained detailed information about the resettlement pathways and included a reducing reoffending action plan, which contained relevant objectives, most of which had been progressed to completion. There was work in progress to complete a revised version for 2011, and a needs analysis for this had already been completed but this had yet to be integrated into the strategy document or an updated action plan compiled.

Further recommendation

2.5 The reducing reoffending strategy should take into consideration the differing needs of the general category C prisoners and the sex offender population in relation to treatment and resettlement needs.

2.6 There should be a comprehensive review of the policy, procedures and provision in relation to visits, in consultation with prisoners and their visitors and taking into account good practice at other prisons. (HP43)

Not achieved. The visits policy document was dated November 2011 but was already out of date. It contained, as an annex, a visitors' survey but there was nothing in the policy document to indicate whether a survey had been completed, if there had been any analysis of it or whether it had been used to inform the policy. There was no evidence to show that prisoners had been consulted in the formulation of the policy. Visitors were invited to participate in family forum meetings as part of a consultative process to improve their experiences. Brief minutes of these family forum meetings were taken but there was little evidence of any action points or influence on policy or procedures.
We repeat the recommendation.

2.7 A prison-wide strategy should be developed for increasing the proportion of sex offenders willing to engage in treatment programmes, and appropriately managing those who are not willing or ready to do so. (HP44)

Achieved. A forensic psychologist in training had developed a comprehensive deniers and refusers policy, which had been implemented in January 2010. It explained how prisoners in denial would be encouraged to participate in offending behaviour programmes by developing closer links between the programmes team and incentives and earned privileges (IEP) boards;

by holding quarterly staff meetings to advise and support residential staff in their interactions with deniers; by appointing and training prisoner mentors (under supervision) who had successfully completed offending behaviour programmes and by holding drop-in sessions for prisoners across the vulnerable prisoners wings, hosted by programmes staff. The policy had been initially reviewed in March 2010 and again in June 2011, when analysis showed that the number of deniers had fallen by only 1%, from 32% in 2010 to 31% in 2011. Attendance by prisoners at mentors' forums, facilitators' drop-in sessions and staff meetings was low (13 across all three forums between 2010 and 2011). The key findings from the analysis were: there had been a reduction in the number of deniers/refusers that needed to be targeted (down to 17%) based on release dates and the opportunity to engage in offending behaviour programmes; some training had not been delivered and mentors had been difficult to recruit. A number of recommendations had been made to continue this work, and at the time of the inspection these were being explored.

Recommendations

Courts, escorts and transfers

2.8 Prisoners should not be double cuffed for escorts unless justified by a risk assessment. (1.7)

Not achieved. Most prisoners were disembarked from directly outside the reception and were not required to wear restraints of any kind as they left the escort van. However, in our groups, a number of prisoners told us that they had been double cuffed as they disembarked, as recently as three months before the inspection. We found that it was regular practice to apply double cuffing when prisoners arriving late were disembarked in the sterile area inside the gate and were walked along an enclosed secure walkway to reception.
We repeat the recommendation.

First days in custody

2.9 Sufficient staff should be allocated to reception to minimise waiting times and allow completion of all reception procedures when large groups of prisoners are received. (1.20)

Not achieved. There were two officers allocated to reception duties, assisted by a senior officer. Reception staff told us that the number of prisoners received was unpredictable and that groups of up to 10 could arrive at one time, which led to long delays in reception. Prisoners in our groups told us that they had spent up to five hours in reception, and some that they had been called back from the first night wing during evening association to complete reception processes and collect possessions.
We repeat the recommendation.

2.10 Reception orderlies should have a formal peer support role. (1.21)

Not achieved. There was a full-time prisoner orderly based in reception, who assisted staff with managing new arrivals. He made drinks for prisoners and was a trained Listener. He resided on the first night wing, but he did not have a formal role in providing information and support to prisoners in reception. When prisoners arrived on the first night wing, they had sessions with a prisoner wing representative and a Listener, who ensured that they were settled and had received information about prison routines. However, prisoners arriving late did

not always meet these representatives.
We repeat the recommendation.

2.11 The new first night centre arrangements on F wing should be reviewed after six months to ensure that they are operating effectively and safely. (1.22)

Partially achieved. There had been no formal review of the first night arrangements, which involved vulnerable and category C prisoners sharing a wing and had been introduced at the time of the previous inspection. The arrangements, which had been carefully designed to ensure that vulnerable prisoners had full access to the regime and were kept separate from the rest of the population, were routinely monitored. We spoke to staff and vulnerable prisoners, who all told us that there had been no incidents of violence and only minimal verbal abuse, which had been dealt with robustly. Prisoners told us that they felt safe at all times and that they were able to access all facilities.

2.12 All prisoners should have the opportunity to shower on their first day at the prison. (1.23)

Not achieved. Most prisoners had the opportunity to shower during evening association on the first night centre but some in our groups told us that they had not had this opportunity because they had been uncertain about routines on their first night or had arrived on the wing late (some having waited for long periods in reception; see recommendation 2.9). Prisoners who arrived on a Friday, especially those arriving in the afternoon or in large groups, did not have access to association. There was a shower in the reception area but this was not used.
We repeat the recommendation.

2.13 The race and diversity sessions in the induction programme should actively promote diversity and good race relations, and challenge, in discussion with prisoners, any unacceptable attitudes and behaviour. (1.24)

Achieved. There was a session in the induction programme which dealt with race and diversity. It was led by a prisoner who had had experience of working as a race representative at previous establishments. He told us that he outlined the establishment's approach to diversity, the mechanisms for supporting those from diverse backgrounds and how to make a complaint about discrimination. Prisoners in our groups told us that this session also covered unacceptable behaviour and its consequences. We did not have the opportunity to observe the session.

2.14 The induction booklet should be readily available in relevant foreign languages. (1.25)

Not achieved. There was a well-designed and comprehensive induction booklet, containing colourful illustrations which enhanced the text. However, it was available only in English.
We repeat the recommendation.

Residential units

2.15 Toilets in both single and double occupancy cells should be appropriately screened. (2.17)

Not achieved. With the exception of those in the most modern units, toilets were screened by a curtain, which afforded little privacy. In some cells, the toilet curtain was missing. Staff were aware of the problem of curtains being taken by other prisoners.
We repeat the recommendation.

2.16 Sufficient telephones should be provided on all wings, particularly C and D wings. (2.18)

Achieved. The ratio of telephones to prisoners was greater than one to 20 on all wings, following the installation of new telephones since the previous inspection. Prisoners told us that access to telephones was satisfactory. However, we came across telephones that were not working and were told that they had been inoperative for some time.

Housekeeping point

2.17 Telephones should be repaired promptly when they become inoperative.

2.18 Telephones should be placed in booths for privacy. (2.19)

Partially achieved. A number of telephones had been enclosed in booths, with those in association areas being prioritised. Other telephones had privacy hoods, which were adequate, but there were still a small number with no privacy screening.

Housekeeping point

2.19 There should be adequate privacy screening for prisoner telephones.

2.20 Cell call bells should be answered within five minutes, and managers should regularly monitor response times. (2.20)

Not achieved. Response times were recorded electronically on K wing but were not monitored consistently. On other wings, there was no recording system, so it was not possible to judge how prompt responses had been. In our groups, prisoners on A, B and I wings told us that responses to the bells on their spurs were prompt. Other prisoners told us that responses were slow during the day but better at night.
We repeat the recommendation.

2.21 Showers on A and B wings should be screened. (2.21)

Not achieved. There was generally no screening of showers on A and B wings. The only exception was a refurbished shower unit we saw on B wing (see recommendation 2.22).
We repeat the recommendation.

2.22 All shower areas on the older units should be refurbished and showers should be screened. (2.22)

Not achieved. Shower units on A and B wings were clean but most had peeling paint and missing tiles, and some had mould patches. We saw one shower area on B wing which had been refurbished to a good standard, with modesty screening, modern fittings and damp-proof wall coverings. We were told that such refurbishment work was carried out by the works department when resources were available.
We repeat the recommendation.

2.23 The management of legally privileged mail should be improved to reduce the actual or perceived number of occasions on which such mail is opened in error. (2.23)

Achieved. The number of items of mail opened in error was recorded. In the six months before

the inspection there had been only 39 such instances. Mail room staff made efforts to identify privileged mail which was not externally marked, and when they were unsure, items were X-rayed and sent to the wing to be opened by the prisoner in front of staff. Letters of advice were sent to legal firms who did not mark mail clearly.

Staff–prisoner relationships

2.24 The decency strategy group should develop an action plan to improve relationships, with regular feedback to prisoners about action taken. (2.30)

Partially achieved. A decency strategy had been developed and there was an action plan to implement elements of it. The group that had been convened to develop the strategy had been disbanded and responsibility for different actions had been allocated to existing management groups which covered the area related to the objective. The achievement of the action plan was overseen by the senior management team. There had been some progress in implementing the strategy, including an innovative staff training programme concerned with the balance of authority and care in the prison, but this had not been shared with prisoners.

2.25 Wing consultation meetings should be held to a consistent format, with action points for named individuals, with appropriate report back at subsequent meetings. (2.31)

Partially achieved. Wing meetings were held, usually combining two neighbouring wings, but the minutes we saw reflected a difference in formats and attendance between them. The meeting for A and J wings was held most regularly and was well minuted, with clear action points allocated to individuals. Other wings held meetings irregularly and records were sparse. There was a monthly meeting of prisoner wing representatives, chaired by a governor grade and attended by residential managers and the Independent Monitoring Board. The actions agreed were recorded and allocated to specific members of staff. The minutes of wing-based meetings were well presented but not all wings submitted notes of meetings.
We repeat the recommendation.

Personal officers

2.26 The personal officer policy should be revised to reflect more accurately the actual operation of the scheme, and promoted to staff as a training guide. (2.39)

Partially achieved. The personal officer policy had been reviewed and rewritten in June 2011. It was comprehensive and clearly set out the responsibilities of staff, with advice on best practice. Although staff we spoke to generally understood their responsibilities, they were not aware of the revised policy and practice.

Housekeeping point

2.27 All staff in a personal officer role should be familiar with the revised policy.

2.28 Cell moves should not routinely result in a change of personal officer. (2.40)

Not achieved. Personal officers were allocated according to prisoner location and changed when the prisoner moved cell. The wing files showed that when prisoners moved, their new personal officer quickly introduced him/herself, to ensure continuity of support and care.

2.29 Detailed personal officer entries should be made at least once a month. (2.41)

Achieved. The quality of personal officer entries in the wing records we examined was generally good. They reflected knowledge of the prisoner, progress with important issues and work that had been done by the officer to support the prisoner. In most files there were monthly entries, but some gaps due to staff leave or sickness.

Bullying and violence reduction

2.30 The monthly violence reduction and safer custody meetings should be chaired by a member of the senior management team. (3.12)

Achieved. Monthly safer custody meetings were broken down into violence reduction and suicide prevention sessions, both of which were chaired by a residential governor, who was a member of the senior management team. Membership was suitably representative of appropriate departments and attendance was good. The meetings covered all aspects of safer custody, including reports from the safer custody manager (see recommendation 2.38).

2.31 Work to develop and oversee violence reduction, anti-bullying and safer custody should be adequately resourced. (3.13)

Not achieved. The safer custody manager was a principal officer, who was supported by two officers working shift patterns. This meant that they were often committed to residential duties and occasional outside escorts. Staff and managers told us that the consequence of staff not being reliably available was that training, quality monitoring and policy development were difficult to plan or sustain.
We repeat the recommendation.

2.32 Staff in prisoner contact roles should be trained in the tackling anti-social behaviour (TAB) process, including how to recognise problem behaviour and maintain appropriate records. (3.14)

Partially achieved. A programme of staff training in the TAB process had started and approximately 100 had been trained. However, it had been suspended in December 2010, when training places had been required to implement the P-Nomis recording system.
We repeat the recommendation.

2.33 A comprehensive log should be kept of all investigations into alleged bullying and their outcomes, and TAB books opened and closed. (3.15)

Achieved. A log was kept of all TAB booklets opened and closed. There was also a record of assaults and allegations of bullying which had been investigated by the safer custody team. The details and outcomes of investigations were recorded, including the location and type of incident. The level of violence was low, with just 14 assaults, none classified as serious, and three fights in the three months before the inspection.

2.34 Interventions for bullies and victims should be developed, involving families where appropriate. (3.16)

Not achieved. No interventions had been developed to challenge bullying behaviour and attitudes, or to help victims to cope.
We repeat the recommendation.

Self-harm and suicide

2.35 A briefer safer custody strategy should be developed and promoted to staff. (3.26)

Achieved. The current suicide prevention policy had been published in April 2011. It was comprehensive and pragmatic, and described how the safety of prisoners should be maintained by good management, the use of resources such as safer cells and constant supervision, the application of ACCT procedures and the provision of access to support, including Listeners, the Samaritans and family links. There was a clear guide on ACCT procedures for staff and how to follow up deaths in custody.

2.36 Health services staff should regularly attend the monthly safer custody meeting. (3.27)

Achieved. In the six months before the inspection, health services staff from mental health and/or primary care had been present at every violence reduction and suicide prevention meeting.

2.37 Prisoner representatives should be invited to attend the safer custody meeting. (3.28)

Achieved. Prisoner representatives attended both safer custody meetings and had an allocated space on the meeting agendas.

2.38 A broad range of safer custody management information should be collected and discussed at the safer custody meeting. (3.29)

Achieved. The safer custody manager provided a comprehensive report at each meeting. For the violence reduction meeting, this included information on the type and location of incidents, a description of individual prisoners' behaviour and the TAB documents opened. For the suicide prevention meeting, the report included information about the types of, and reasons for, self-harm, representation of age groups and location, ethnic monitoring information and use of Listeners. The information was discussed and analysed to identify any action which might be required. Since the previous inspection, there had been 12 deaths in custody, one of which had been self-inflicted. Deaths in custody were reported to the suicide prevention meeting but action plans to respond to the Prisons and Probation Ombudsman's enquiries, drawn up by a designated governor, were not monitored by the meeting.

Housekeeping point

2.39 Action plans in response to enquiries into deaths in custody should be reviewed by the suicide prevention meeting.

2.40 Care plans should be updated and revised as appropriate after case reviews. (3.30)

Achieved. In ACCT files which had been open for a long period, action plans had been updated on more than one occasion following a review. New objectives reflected developments in health care and in social or family matters.

2.41 A Listener rota for the whole prison should be used to ensure that individual Listeners are not over-burdened. (3.31)

Achieved. There was a Listener rota, which covered the whole prison, and Listeners told us

that it was mostly adhered to, so that they were not overburdened. The only exceptions were when a prisoner requested time with a particular Listener, and took place by agreement with the Listener and staff.

2.42 A Samaritan telephone and base station should be available in the segregation unit. (3.32)

Achieved. A Samaritans telephone and base station had been installed in the segregation unit. When we tested it, it was operating well.

2.43 There should be a clear policy on the management of constant watches for those at risk of suicide and self-harm. (3.33)

Achieved. There was a current constant supervision policy, written by the safer custody manager, which gave clear guidance on how supervision should be authorised and reviewed. The importance of interacting with the prisoner was emphasised, as was access to the regime; ensuring appropriate levels of privacy and how a period of supervision should be recorded. The annexed guidance for staff was a clear operational guide which outlined best practice.

Applications and complaints

2.44 There should be a single application system for the prison which allows applications to be tracked. (3.88)

Achieved. There was a standardised application system across the prison, based on a triplicate form. Applications could usually be submitted during any evening association period, with the exception of prison shop distribution days.

2.45 Complaint forms should be readily available on all wings. (3.89)

Achieved. The full range of formal complaint forms was available on all of the wings we observed.

Legal rights

2.46 A suitably trained officer should be allocated to legal services work each day and be provided with sufficient time to deal with the demands of the workload. (3.94)

Achieved. There were two trained legal services staff at prison officer grade, both of whom were based between E and F wings. Time for one member of staff was profiled each weekday morning, which equated to approximately 12 hours per week. Legal services staff told us that the available hours were usually sufficient for them to perform their role, and that if their hours were cancelled, they were usually made up later in the day/week.

2.47 Prisoners should be provided with clear and accurate information about the work of the legal services officer and how to access the service. (3.95)

Achieved. All new receptions were seen by a member of the legal services staff within 24 hours of arrival; a log of such contact had been maintained since May 2010. Prisoners were also given information about the role of the legal services staff and this was recorded in hard copy and on P-Nomis. The 'Living at Wymott' booklet issued to new inductions also highlighted the legal services available.

2.48 Suitable facilities should be provided for private legal visits and the use of laptops. (3.96)

Not achieved. Legal visits were held each Tuesday and Thursday morning but took place in the main visits halls, which lacked privacy. Legal visitors were not permitted to take laptop computers into the prison.
We repeat the recommendation.

Faith and religious activity

2.49 Prisoners should be able to access suitable washing facilities before attending Muslim prayers on a Friday. (5.37)

Achieved. Prisoners were allowed to shower on the wings before Friday prayers. There was also an ablution facility provided in the worship area.

2.50 Processes to security-clear chaplains should be expedited to ensure continuity of provision to prisoners. (5.38)

Achieved. There were no longer any delays in obtaining security clearances for any of the chaplaincy team or the volunteers. The coordinating chaplain was satisfied with the processes involved.

Substance use

2.51 The North-West Area Dog Section should ensure adequate drug dog cover for the prison to support the existing security measures that are in place to reduce the supply of drugs. (3.103)

Achieved. The North-West Area drug dog team was responsive to requests from the prison for assistance to carry out specific drug-related operations and was also proportionate in its allocation of visits search dogs in relation to the relatively low levels of visits-related intelligence. They also attended the monthly security committee meetings and provided data on their attendance at the prison and emerging issues.

2.52 Vulnerable prisoners should not be disproportionately represented in random drug testing samples. (3.104)

Achieved. Fifty-five per cent of prisoners subject to random mandatory drug testing were vulnerable, and vulnerable prisoners represented 54.6% of the total prisoner population, so the random sample was proportionate.

Diversity

2.53 A diversity committee should be formed to manage and monitor all aspects of diversity and promote diversity across the prison. (3.42)

Partially achieved. A diversity committee was in place and met bimonthly. The meeting was reasonably well attended and generally included representation from prisoner race representatives. However, there were no prisoner diversity representatives, the meeting still went by the name of 'REAT' and there was little evidence of wider diversity matters being raised or discussed in either the agenda or minutes. There was no diversity action plan to

monitor progress. Diversity-related information on noticeboards, including the identity of diversity committee members and representatives, was out of date. There was some high-quality work that related to African-Caribbean prisoners but there was no regular consultation with black and minority ethnic groups and little evidence of a prison-wide approach to promoting equality.
We repeat the recommendation.

2.54 The diversity complaints system should be reviewed as to its effectiveness in improving outcomes for prisoners. (3.43)

Not achieved. The diversity complaints system was disjointed, with separate racist incident report forms (RIRFs) and out-of-date diversity complaint forms. There was no external scrutiny, and the nature and outcome of complaints were not reviewed at the REAT meeting or monitored for trends.
We repeat the recommendation.

Race equality

2.55 All staff should be trained in diversity, with particular attention paid to race issues. (3.60)

Not achieved. Most staff had received 'challenge it, change it' training but this was aimed at workplace harassment issues rather than prisoner-based race and cultural issues.
We repeat the recommendation.

2.56 The race relations management team should investigate with black and minority ethnic prisoners the reasons for the poorer perceptions, particularly about victimisation, relationships with staff, safety and maintaining family ties. (3.61)

Not achieved. A recent questionnaire aimed at reviewing the experiences and perceptions of black and minority ethnic prisoners had been undertaken but sample sizes for individual ethnic minorities had not been large enough to provide statistically valid results. There were plans to introduce focus groups to explore issues further.
We repeat the recommendation.

2.57 Separate boxes for submitting racist incident report forms (RIRFs) should be provided and they should be emptied daily by the REO or his deputy. (3.62)

Not achieved. Separate boxes had not been provided. RIRFs and diversity complaint forms still shared the general complaints boxes, and these were emptied by the night orderly officer, rather than the diversity manager, which potentially compromised confidentiality.
We repeat the recommendation.

2.58 All RIRFs should be investigated fully, and accompanying documentation completed in full, preferably typed, and prisoners should receive detailed feedback. (3.63)

Not achieved. Governance of complaints was poor. Not all RIRFs were investigated and we found some complaints which had been submitted and logged but subsequently had not been investigated. In some cases, complaints had been logged but the complaint form was missing. When investigations were completed, prisoners were provided with feedback.
We repeat the recommendation.

2.59 The racist and discriminatory prisoner log should include confirmation of when actions have been completed. (3.64)

Not achieved. The diversity manager produced a list of prisoners identified as racist or evidencing discriminatory behaviour and made this available on the shared computer hard drive. However, the list did not identify any required actions.
We repeat the recommendation.

2.60 Effective links should be established between the REO and the offender management team with respect to managing prisoners identified as racist or discriminatory. (3.65)

Not achieved. The offender management team had access to the racist and discriminatory prisoner log on the shared computer hard drive but there was no contact with the diversity manager and no evidence in prisoner sentence planning documentation to indicate that such behaviour was addressed or managed.
We repeat the recommendation.

2.61 The race equality action team should ensure that issues and trends from RIRFs and ethnic monitoring are identified, discussed and acted on. (3.66)

Partially achieved. RIRFs were not analysed at REAT meetings to identify issues or trends. Systematic monitoring and analysing of race equality treatment (SMART) monitoring data were routinely discussed and analysed, and appropriate action was taken.
We repeat the recommendation.

Foreign nationals

2.62 The foreign national policy should include more information relating to support available at the prison. (3.76)

Not achieved. The foreign national policy, dated 2009, was out of date and not available to prisoners. In addition, it referred to HMP Canterbury and services available in Kent, without describing the support available for foreign national prisoners in Wymott. The level of support available to foreign national prisoners had fallen dramatically. There was no dedicated foreign nationals coordinator to act as a support and source of advice and no prisoner forum to raise and resolve issues. There were no links with community-based immigration advisory services. Notices, rules and forms, including those relating specifically to foreign national prisoners, were almost exclusively in English.

Further recommendation

2.63 Provision for foreign national prisoners should be reviewed, to ensure that they are supported by a dedicated member of staff, a regular forum and access to independent advice and translated materials.

2.64 The role of wing foreign national liaison officers should be clarified, with a comprehensive job description. (3.77)

Not achieved. See recommendation 2.62 and further recommendation 2.63.

2.65 Foreign national prisoners should be able to receive 'blue' telephone cards without undue delay. (3.78)

Achieved. Blue international cards were no longer available but any prisoner wishing to make international calls could apply for a foreign national PIN (which had replaced the 'blue card') and were entitled to move up to £50 per week into their PIN account. Prisoners were able to access this service by application, and requests were dealt with swiftly.

2.66 Links should be made with community-based immigration advice services. (3.79)

Not achieved. See recommendation 2.62 and further recommendation 2.63.

2.67 More immigration surgeries should be held, to meet demand. (3.80)

Achieved. Links had been made with the UK Border Agency, representatives who attended the establishment every four to six weeks. Prisoners had advance notice of surgeries and could make an appointment by submitting a request to the foreign nationals clerk.

2.68 Foreign national prisoners should receive a free telephone call home each month, whether or not they receive any visits. (3.81)

Not achieved. Foreign national prisoners could only receive a free five-minute telephone call if they did not receive any visits.
We repeat the recommendation.

Prisoners with disabilities and older prisoners

2.69 Individual care plans should be developed for older prisoners with special needs and those with disabilities. They should be held on wing files and regularly monitored. (3.44)

Achieved. Prisoners requiring individual care plans were identified by health services staff and the diversity liaison officer. The plans drawn up were comprehensive and monitored by health services staff and the social care workers. They were readily available in wing files for staff to access.

2.70 Activities for older prisoners and those with limited mobility should be improved to provide more stimulating and purposeful occupation. (3.45)

Achieved. A day care centre had been opened and provided good-quality activities, including education, living skills, PE, leisure activities and work. This was available for all older prisoners and those with limited mobility or ability.

2.71 Cells for prisoners with a disability or limited mobility should be adapted to meet their needs. (3.46)

Achieved. There was evidence of a range of adjustments provided to prisoners as required. I wing remained unsuitable for prisoners using a wheelchair because of its narrow doors. However, there were two purpose-built cells for those with disabilities on G wing, which were in use and suitable for those using a wheelchair. A further five cells had been adapted in the annexe and were also suitable for use by those using a wheelchair. This area had however, been closed owing to pressures on staffing.

2.72 All prisoners requiring assistance in an emergency should be easily identifiable to all staff and have individual evacuation plans. (3.47)

Not achieved. Personal evacuation plans were initially drawn up for all prisoners requiring assistance in an emergency; however, the lists identifying these prisoners, held in wing offices, were out of date and inaccurate.
We repeat the recommendation.

Health services

2.73 Appropriate cover should be provided to ensure that staff annual leave or sickness does not have a negative impact on the delivery of patient care. (4.36)

Achieved. We were told that it was rare to cancel clinical activities because of staffing problems. There was a full complement of staff and this was sufficient to respond to the workload and provide 24-hour cover. Sickness and absence were managed effectively and the prison had access to the Lancashire Care NHS Trust nursing bank to supplement staffing as necessary. New funding had been acquired to recruit a nurse, to improve the management of escorts and bed watches for HMPs Garth, Preston and Wymott.

2.74 Complaints about health services should be answered properly, with appropriate management quality checks. (4.37)

Achieved. There had been an average of 77 complaints a month between April and October 2011. Complaints mainly concerned waiting times for the GP and dentist, and individuals' concerns about medication. Complaints were answered within NHS target times and registered in the Trust Datix system (an electronic incident monitoring system, with inbuilt flagging for management quality checks). The complaint responses we sampled were courteous and focused. Around one in 10 complaints were upheld. A revised first-stage complaints/enquiries system was being introduced at the time of the inspection.

2.75 The healthcare centre and all rooms used for delivery of healthcare should be in a good state of repair, clean and fit for purpose. (4.38)

Achieved. All clinical areas had been subjected to an infection control audit in January 2011 and remedial works to ensure compliance were almost complete, with only the taps in the treatment rooms on A and B wings requiring replacement. Cleanliness was maintained by a health care housekeeper and team. The rooms were fit for purpose, although some had limited space and capacity for development.

2.76 All staff should have access to clinical supervision, and records of this maintained. (4.39)

Partially achieved. All staff had access to peer group supervision, which was factored into a monthly half-day health care training event. There were plans to start individual recording of the supervision received.

2.77 A system of timed appointments should be introduced. (4.40)

Achieved. SystmOne was used to allocate timed appointments for patients attending clinics. Appointment times were notified to prisoners at the time the appointment was made and followed up with a reminder, delivered to the prisoner on the evening before the appointment day.

2.78 Waiting times for general practitioner (GP) appointments should be reduced significantly, and vulnerable prisoners should not have to wait longer than others. (4.41)

Not achieved. Waiting times to see the GP had reduced over the previous three months but 102 patients remained on the list; 72 had been waiting over two weeks. Triage nurses could be seen within an hour and GP appointment slots were reserved at each clinic for patients with urgent problems, who were seen within 24 hours. Recruitment was under way to recruit permanent GP staff as part of the long-term solution to increasing GP capacity, although responses to recruitment drives had not been fruitful to date.
We repeat the recommendation.

2.79 Prisoners should be returned to house blocks, education or work promptly following healthcare appointments. (4.42)

Not achieved. We saw patients waiting for 40–60 minutes in congested waiting rooms waiting for escort staff to take them away from the health care centre following their appointments. We were told by prisoners and staff that escort waiting times could be even longer. A uniformed 'runner' had been allocated to the health care centre to alleviate the congestion, although he/she could not assist all of the patients waiting to leave.
We repeat the recommendation.

2.80 Medicines should be administered directly from the original dispensed container. (4.43)

Achieved. Medicines were supplied and issued in named patient dispensing containers.

2.81 The in-possession policy should be reviewed to ensure that there is robust, documented risk assessment underpinning all in-possession supplies, including special sick. The policy should give clear guidance on how to determine the appropriate term of in-possession supply, and decisions should take into account the nature of the individual patient, as well as the nature of the medication. (4.44)

Achieved. Around 90% of patients had medicines in possession. The in-possession policy had been reviewed following the previous inspection and gave appropriate guidance. A robust risk assessment had been introduced and was located in a template on SystmOne.

2.82 The medicines and therapeutics committee should introduce a special sick policy, with an agreed formulary of medicines available for supply by nurses. This should be reviewed regularly to ensure that all appropriate medicines can be supplied. (4.45)

Achieved. A special sick policy and associated formulary had been approved by the medicines and therapeutics committee (MTC). The policy had been reviewed and was subject to further review before assimilation into the Trust portfolio.

2.83 GPs should attend the medicines and therapeutics committee. (4.46)

Partially achieved. A lead GP had been appointed for HMPs Garth, Preston and Wymott and he attended the tri-prison MTC. There were plans to have GP representation at the Wymott MTC when a GP had been recruited.

2.84 Health services staff should adhere to Nursing and Midwifery Council guidelines for the safe administration of medications. (4.47)

Achieved. All registered nurses and nursing assistants had been trained in the safe

administration of medicines in the previous 12 months. Training materials were based on Nursing and Midwifery Council (NMC) guidelines. There were plans to introduce the Trust e-learning medicines management modules for training updates. We observed the administration of medicines, and practices complied with NMC guidance.

2.85 A dual-labelling system should be introduced for pre-packs to allow the pharmacist to check that the prescription is appropriate and that the correct item has been supplied. (4.48)

No longer relevant. At the time of the inspection, the pharmacist was consulting on how to replace the dual-labelling system with one that provided an equally effective audit trail.

2.86 The length of the waiting list and waiting time for dental appointments should be reduced and reviewed frequently until satisfactory. (4.49)

Not achieved. Waiting times to see the dentist had been reducing since August 2011 but 178 patients remained on the list; 42 had been waiting over six weeks and 36 over 12 weeks.
We repeat the recommendation.

2.87 Cover for dentists' annual leave and sick leave should be provided. (4.50)

Achieved. The dentists' annual leave and other absences were covered as appropriate, so that clinical sessions were not lost.

2.88 The dental triaging facility should be expanded. (4.51)

Achieved. The dental nurse offered triage daily and patients requiring urgent treatment were given appointments in reserved slots at the next clinic.

Time out of cell

2.89 The times stated for unlock in the published core day should be adhered to. (5.43)

Not achieved. Staff we spoke to told us that lock-up times in the core day coincided with their 'off-duty' time at the gate, so in reality the core day could not be adhered to. Wing observation records supported this; for example, on E/F wings the teatime lock-up times ranged from 4.55pm to 5.05pm, against a published time of 5.15pm (see recommendation 2.90).
We repeat the recommendation.

2.90 Prisoners should spend at least 10 hours out of cell on weekdays. (5.44)

Not achieved. The prison reported time out of cell of around eight and a half hours a day both on weekdays and at weekends. The published core day indicated a maximum of nine and a half hours during the week (not on Fridays, when there was no evening association period), and eight hours at weekends. Prisoners in our groups and also staff we spoke to told us that the reality was more likely to be around seven and a half hours. Wing observation records routinely showed the afternoon period finishing around 15 minutes before staff were due to be off duty.
We repeat the recommendation.

Learning and skills and work activities

2.91 Individual learning plans should be improved and prisoners' progress reviewed at a frequency appropriate to the course of study and level, and individual needs. (5.16)

Not achieved. Individual learning plans (ILPs) were insufficiently developed to plan and support learning activities fully. Targets were not sufficiently specific or measurable. The frequency of progress reviews was not consistent. Most progress review records did not clearly identify the progress made by individuals, in terms of their learning or the development of vocational or personal skills. Quality monitoring had been introduced but was not effective in identifying and promoting improvements in ILPs or reviews. However, in the small number of information and communications technology courses, a recently introduced electronic ILP was being well implemented, with clear targets for learning and personal development, and detailed records of progress.
We repeat the recommendation.

2.92 Prisoners' understanding of equality and diversity should be checked and reinforced at progress reviews. (5.17)

Not achieved. Equality and diversity was promoted well in education, training and employment activities and through celebrations of diversity. However, actions had not been taken systematically to check and reinforce individual prisoners' understanding of equality and diversity issues at progress reviews.
We repeat the recommendation.

Library

2.93 Access to the library for prisoners not involved in education should be improved, so that they all have the opportunity to attend for a half-hour session at least once a week. (5.18)

Achieved. Timetabled access to the library had improved for prisoners not involved in education. All prisoners had the opportunity to attend for a half-hour session at least once a week.

2.94 Access to the library for older prisoners and those with a disability should be improved, taking due account of their needs. (5.19)

Achieved. Implementation of the library service plan 2011 had improved access to the library for older prisoners and those with a disability. Such prisoners still had timetabled access to the library for one session a week but, in addition, a trolley service was provided on the wing every few weeks; this included delivery of book orders.

2.95 Access to legal textbooks and Prison Service Orders in the library should be improved. (5.20)

Achieved. The range of legal textbooks available in the library had improved and met the requirements of the library specifications 2010. Prisoners had good access to these, and to Prison Service Orders (PSOs), and could request an additional library session to study them. Extra copies of some legal textbooks were available for loan. The librarian provided photocopies of PSOs on request.

Physical education and health promotion

2.96 Opportunities in the gym should be promoted more actively to increase participation rates. (5.29).

Achieved. Promotion of opportunities in the gym had been effective and the participation rate had increased from 35% at the time of the previous inspection to 48%. Measures used to promote participation in gym and fitness activities included PE instructor input into the healthy living education course and in health promotion events, and the introduction of well-man health checks for prisoner groups in 2010.

2.97 The installation of gym equipment in the therapeutic community facility should be completed. (5.30)

Achieved. The installation of equipment in the therapeutic community facility had been completed. The facility included separate rooms for cardiovascular and weights equipment and was staffed by a PE instructor for eight sessions a week. Prisoners had good access to the cardiovascular room, without supervision.

2.98 All PE staff should receive teacher training. (5.31)

Not achieved. Although actions had been taken to increase the number of PE staff with teaching qualifications, some trained staff had left the establishment. At the time of the inspection, the number of PE instructors had increased to nine, and three of these had teaching qualifications. There were plans for two PE instructors to receive teacher training in the near future.
We repeat the recommendation.

Security and rules

2.99 Rules should be displayed on all the residential wings. (6.13)

Achieved. All prisoners received a clear briefing of the rules that applied to them. This was further reinforced by written instructions and an effective standardised noticeboard across the prison. Prisoners in our groups also confirmed that the induction process had outlined what was expected of them.

Discipline

2.100 Thorough quality checks of adjudications should take place and be discussed with adjudicators to encourage good practice and identify training needs. (6.31)

Partially achieved. The deputy governor reviewed 5% of adjudications but quality assurance was limited to checking the laying of charges under the correct rule. Adjudicators we spoke to told us that they only received feedback following an adjudication being quashed by headquarters. There had only been one adjudication standardisation meeting during the current year, in February 2011, which had not included any comment on quality assurance.
We repeat the recommendation.

2.101 Use of force should be monitored and analysed at the security meetings, records should be quality checked, and emerging patterns or issues of quality should be

communicated to staff. (6.32)

Not achieved. Use of force was a standing agenda item at the security committee meeting but there was no ongoing monitoring beyond an occasional comparison with the previous month's total. There was no use of force committee and we found many of the report dossiers to be incomplete.
We repeat the recommendation.

2.102 Prisoners located on the segregation unit should not be strip searched on entry without an individual risk assessment. (6.33)

Not achieved. Although the segregation unit policy document stated that strip-searches should be dependent on risk assessment, segregation unit staff told us that all prisoners underwent such searches; this was recorded in the individual wing records.
We repeat the recommendation.

2.103 The segregation unit policy document should clearly outline the use of the cells with a camera. (6.34)

Achieved. The recently updated segregation unit policy clearly identified the procedures and conditions for using the two camera cells on the unit. Staff on the unit demonstrated a good understanding of the policy.

2.104 Staff on the segregation unit should receive mental health training and diversity training. (6.35)

Not achieved. None of the three staff on duty on the segregation unit had undergone diversity or mental health training, despite having been on the unit for between six months and two years.
We repeat the recommendation.

2.105 There should be meaningful interaction with prisoners on the segregation unit, and this should be reflected in wing history files. (6.36)

Not achieved. Entries in wing files were simplistic and repetitive, mainly relating to wing activities, such as 'seen by the governor, offered exercise'. There was little evidence of ongoing interaction or reintegration planning in the documents viewed.
We repeat the recommendation.

Incentives and earned privileges

2.106 Induction staff should be responsible for confirming prisoners' incentives and earned privileges (IEP) status. (6.44)

Achieved. Induction unit staff retained a record of prisoners arriving at the establishment, which included the IEP level that prisoners had declared themselves to be on and the name of the officer who had confirmed this with the sending establishment. This was on display in the staff office, enabling any of the staff to take action to clarify IEP status issues as they arose.

2.107 Voluntary drug testing should not be linked to the IEP scheme. (6.45)

No longer relevant. Voluntary drug testing was no longer operated as an element of the IEP

scheme and had been replaced by compliance-based testing, which was required if identified as a sentence plan target.

2.108 The IEP scheme should be monitored, and trends analysed. (6.46)

Not achieved. Wing managers had oversight of individual prisoners' promotions and demotions on the IEP scheme but there was no strategic oversight of trends across the prison.
We repeat the recommendation.

Catering

2.109 Prisoners should be able to eat together communally. (7.9)

Not achieved. Only prisoners on K wing (the therapeutic community) had the facility to dine out of cell.
We repeat the recommendation.

2.110 Breakfast should be served on the day it is eaten. (7.10)

Not achieved. With the exception of prisoners located on the segregation unit, breakfast packs were issued at lunchtime on the day before consumption.
We repeat the recommendation.

Prison shop

2.111 Prisoners should have the opportunity to buy items from the prison shop within 24 hours of arrival. (7.17)

Not achieved. There was no provision for prisoners to place an order with the prison shop on arrival. Prisoners could receive either a smoker's or non-smoker's pack.
We repeat the recommendation.

Strategic management of resettlement

2.112 There should be a clear management structure to provide effective overview and direction to implement, monitor and review the reducing reoffending strategy. (8.6)

Achieved. A head of reducing reoffending had been in post for almost three years and was line-managed by the governor. We were not provided with a documented management structure, other than for the offender management unit (OMU) but we were satisfied that strategic direction and governance arrangements were robust and that outcomes for prisoners had improved.

Offender management and planning

2.113 The system for allocating prisoners to offender supervisors should ensure an equal distribution of workload for the offender supervisors and continuity for prisoners. (8.19)

Achieved. Prisoners were no longer allocated to an offender supervisor on an alphabetical basis, and more account was taken of individual offender supervisors' caseloads. All high-risk offenders were allocated to one of the offender supervisors within the 'high-risk' offender

management unit pod. Caseloads were now more equitable, with most offender supervisors being responsible for, on average, 70 cases, including 15 lifers or prisoners serving indeterminate sentences for public protection (IPP).

2.114 Offender supervisors should have regular contact with all prisoners, prioritised according to need, and this should be recorded and monitored. (8.20)

Not achieved. There was evidence to show that regular contact, at least monthly, was maintained with high-risk offenders. This group, comprising 180 prisoners, was managed by four offender supervisors, two of whom were probation officers, within a dedicated offender management pod. Contact with other prisoners among the remaining seven pods was mixed. Some offender supervisors met the locally set target of maintaining contact at least quarterly but in other cases there were long gaps (longer than six months) between contacts and we noted yet other cases in which the offender supervisor had made no contact, even though the prisoner had been at the prison for several months.
We repeat the recommendation.

2.115 Offender managers should have a better level of engagement with in-scope prisoners, including attending sentence planning boards. (8.21)

Achieved. Engagement with offender managers had improved. In the 27 sentence boards/reviews held for prisoners in the high-risk pod over the previous three months, offender managers had attended in person on 17 occasions, with the remainder participating by video-link or telephone conference. In the 75 boards/reviews held by a generic pod, the offender manager had attended on 36 occasions and contributed by video-link or telephone conference on 37 other occasions.

2.116 Prisoners subject to public protection measures should have their telephone calls monitored regularly. (8.23)

Achieved. High-risk multi-agency public protection arrangements (MAPPA) cases and prisoners subject to the Harassment Act (26 in total) had their telephone calls monitored, as did another 96 prisoners subject to public protection measures. In total, we sampled seven cases and found that monitoring took place daily and that, with the exception of one prisoner, all authorisations were up to date.

2.117 Prisoners should be notified in writing how to appeal against categorisation decisions. (6.14)

Partially achieved. Prisoners who attended a recategorisation board in person received a written decision which identified the request and complaints procedure to appeal against decisions. The letter for prisoners refused recategorisation at the pre-sifting stage did not include advice on appealing decisions.
We repeat the recommendation.

2.118 Prisoners should not be prevented from moving to an open prison because of outstanding medical appointments. (6.15)

Achieved. Prisoners were not prevented from transferring to open conditions because of health issues. We saw evidence of effective liaison between the OMU and health care departments in other prisons to resolve treatment issues.

Resettlement pathways

2.119 Information regarding approval for child visits should accompany prisoners on transfer or be quickly available to receiving prisons, to reduce any delay in maintaining appropriate family contact. (8.22)

Achieved. We were satisfied that child contact was not routinely withheld and that public protection staff were proactive in chasing up requests for information in cases where issues or concerns had been raised.

2.120 Links with external employers should be further developed to increase the chances of prisoners finding work on release. (8.38)

Achieved. A wide range of links with external employers had been developed. Since November 2010, 77 released prisoners had been placed in jobs with 17 of these employers. In addition, 195 prisoners had progressed into further education or training. There was a pilot scheme for a small number of prisoners to be released on temporary license. This involved four prisoners working full time on the prison farm, and one prisoner had progressed from the farm into full-time employment with an external landscaping company. A second prisoner had worked for this company on licence and also progressed into employment there on release.

2.121 Prisoners who are not registered with a GP in the community should be given information advising them how to do this. (8.39)

Achieved. Each prisoner was offered a pre-release health interview and given guidance on how to become registered with a GP. The guidance information was contained on a SystmOne pre-discharge template and printed off for the prisoner to take away.

2.122 There should be formal systems for discharge planning in relation to healthcare needs, particularly for those with complex needs. (8.40)

Achieved. Night nurses used P-Nomis to identify prisoners being discharged in the following week. The nurses arranged pre-release interviews and the supply of general well-man health information packs, harm minimisation packs and take-home medications, as necessary. A dedicated reception/pre-release nurse used a template to ensure that a systematic approach was taken to preparing each individual for discharge.

2.123 The substance use strategy should be informed by regular population needs assessments and contain detailed action plans and performance measures. (8.51)

Achieved. There was a comprehensive drug interventions needs analysis (2011) and draft revised substance misuse strategy (2011–2013). The strategy contained a consultation plan, which, we were told, would result in the formation of a detailed action plan for implementation following consultation.

2.124 The prison should ensure that prisoners are able to attend their appointments with the counselling, assessment, referral, advice and throughcare (CARAT) team during the working day. (8.52)

Achieved. CARAT staff told us that there were no problems in securing the attendance of prisoners at their CARAT appointments. Additionally, CARAT workers were flexible in their approaches and saw prisoners on the wings or in their places of work, as appropriate.

2.125 A suitable facility to accommodate the therapeutic community (TC) communal meetings should be provided. (8.53)

Not achieved. There was no room on K wing capable of housing the TC communal meeting. Members of the TC congregated in the well of one of the landings, bringing their chairs with them, to hold such meetings. The landing well was acoustically poor and unsuitable for such gatherings.
We repeat the recommendation.

2.126 The TC should be appropriately staffed to ensure that all aspects of the programme delivery, including end of therapy reports, are carried out appropriately. (8.54)

Achieved. The senior manager of the TC told us that the staffing level was sufficient to meet the workload. End of therapy reports were completed.

2.127 Psychometric test results taken pre- and post-TC programme should be annotated to individual prisoners as a measure of progress. (8.55)

Not achieved. Prisoners did not receive annotated feedback on psychometric tests taken pre- or post-programme, in spite of repeated requests from the treatment manager to the operational services and interventions group (OSIG) to provide this information.
We repeat the recommendation.

2.128 Prisoners who consistently fail to supply a sample for voluntary drug testing (VDT) should be referred to CARAT services. (8.56)

No longer relevant. Compact-based drug testing (CBDT) had superseded voluntary drug testing. There was a documented CARAT referral system for those failing to supply a sample for CBDT. CBDT staff were members of the CARAT team.

2.129 Managers and staff involved in visits should be involved in the development of the children and families pathway. (8.67)

Partially achieved. A working group to consider how managers and staff involved in visits could contribute towards the development of the children and families pathway was in place but no minutes of these meetings were available. Discussion also took place with the Partners of Prisoners (POPs) staff, who had direct contact with visitors before and after visits, to inform the pathway lead on family issues.

2.130 A qualified family support worker should be appointed. (8.68)

Achieved. A directly employed qualified family support worker had not been appointed. However, a confidential support line for families was available, as well as referral to a family support worker via the POPs scheme. These were advertised in the visitors centre.

2.131 Family members should be invited to participate in key aspects of the sentence plan, where appropriate. (8.69)

Not achieved. Family members were routinely invited to attend post-programme reviews, in accordance with the requirement of accredited programmes audit criteria; however, they were not invited to sentence plan reviews.
We repeat the recommendation.

2.132 Prisoners with an identified need should have access to interventions aimed at improving parenting skills and relationships. (8.70)

Achieved. The prison had intended to run four parenting skills courses per business year but only two had taken place during 2011; we were told that a further course was planned for December 2011 or January 2012. The course was open to all prisoners, and acceptance followed a one-to-one assessment based on need, age of children and parenting responsibilities. Eighteen learners had completed the course in 2011 and completion included the opportunity to participate in a family day.

2.133 Children and family days should be run for all prisoners. (8.71)

Not achieved. Family days were available and run routinely for all enhanced prisoners, lifer/IPP prisoners on the standard level of the IEP scheme, and also for Listeners, those on the TC and those who had completed a parenting skills programme. They were not widely available to the rest of the standard level prisoner population.

2.134 Children under 18 should not be treated as adults for the purposes of visits. (8.72)

Achieved. We contacted the visits booking line and were advised that three adults were allowed to visit, and up to four children under the age of 18.

2.135 Visitors should be able to contact the booking line without undue delays. (8.73)

Achieved. Prisoners and visitors complained to us about delays in accessing the booking line. However, we rang the number on four separate occasions and, apart from the first occasion, when it was engaged, our other calls were answered swiftly. Contact times had been extended to between 8.45am and 4.45pm from Monday to Friday. Visitors could also email a request for a visit and were asked to provide three choices of date. Replies were emailed and included a booking reference number if one of the choices could be accommodated. Details of how to use the service were provided on the reverse side of visiting orders.

2.136 Prisoners should be able to receive their first visit within one week of arriving at the prison. (8.74)

Achieved. We contacted the booking line on a Wednesday and were offered visiting times for the following Monday and Tuesday. There were no available slots for the upcoming weekend but there were for the weekend after that. We were told that the visiting orders issued by previous establishments would be honoured, provided that they were within 28 days from the date of issue.

2.137 All documents containing information about visits should be checked and cross-referenced to ensure that information provided to prisoners and visitors is accurate. (8.75)

Not achieved. The visits policy document, dated November 2011, was over-long and inaccurate. For example, the visits booking line opening times did not reflect current arrangements and there was no mention of the family forum group or the ability to request a visit by email. The policy was not on display for the benefit of visitors or prisoners. In the visitors centre, there was a useful 'information for families' booklet but this was also out of date, in relation to booking line opening times and information on the amount of money that a visitor could take into the prison for buying refreshments.
We repeat the recommendation.

2.138 Visits should start on time and last for the published time. (8.76)

Not achieved. We spoke to a number of visitors, who said that they had rarely had a visit which started on time and that it was not unusual to experience a 30-minute delay, in spite of arriving at the visitors centre in good time. We observed one party of adults arriving in the visits room at 2.20pm for a 2pm visit, even though they had arrived at 1pm. Visitors also told us that delays were worse at weekends. Staff in the visitors centre confirmed that visitors could experience long delays.
We repeat the recommendation.

2.139 Prisoners should be transferred to prisons able to deliver the interventions identified in their sentence plans. (8.82)

Achieved. Where appropriate, prisoners were transferred to other prisons to complete courses, particularly controlling anger and learning to manage it (CALM) and the rolling sex offender treatment programme.

Section 3: Summary of recommendations

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

Recommendations

To the governor

Courts, escorts and transfers

3.1 Prisoners should not be double cuffed for escorts unless justified by a risk assessment. (2.8)

First days in custody

3.2 Sufficient staff should be allocated to reception to minimise waiting times and allow completion of all reception procedures when large groups of prisoners are received. (2.9)

3.3 Reception orderlies should have a formal peer support role. (2.10)

3.4 All prisoners should have the opportunity to shower on their first day at the prison. (2.12)

3.5 The induction booklet should be readily available in relevant foreign languages. (2.14)

Residential units

3.6 Toilets in both single and double occupancy cells should be appropriately screened. (2.15)

3.7 Cell call bells should be answered within five minutes, and managers should regularly monitor response times. (2.20)

3.8 Showers on A and B wings should be screened. (2.21)

3.9 All shower areas on the older units should be refurbished and showers should be screened. (2.22)

Staff–prisoner relationships

3.10 Wing consultation meetings should be held to a consistent format, with action points for named individuals, with appropriate report back at subsequent meetings. (2.25)

Bullying and violence reduction

3.11 Work to develop and oversee violence reduction, anti-bullying and safer custody should be adequately resourced. (2.31)

3.12 Staff in prisoner contact roles should be trained in the tackling anti-social behaviour (TAB) process, including how to recognise problem behaviour and maintain appropriate records. (2.32)

3.13 Interventions for bullies and victims should be developed, involving families where appropriate. (2.34)

Self-harm and suicide

3.14 The quality of assessment, care in custody and teamwork (ACCT) procedures for those at risk of suicide and self-harm should improve, to ensure that care and support plans reflect assessed need and that reviews are consistently chaired by the same case manager and involve staff from a range of disciplines. (2.2)

Legal rights

3.15 Suitable facilities should be provided for private legal visits and the use of laptops. (2.48)

Diversity

3.16 A diversity policy should be developed and implemented, covering all distinct minority groups, including gay prisoners, those with disabilities and older prisoners, and based on an analysis of their needs. (2.3)

3.17 A diversity committee should be formed to manage and monitor all aspects of diversity and promote diversity across the prison. (2.53)

3.18 The diversity complaints system should be reviewed as to its effectiveness in improving outcomes for prisoners. (2.54)

Race equality

3.19 All staff should be trained in diversity, with particular attention paid to race issues. (2.55)

3.20 The race relations management team should investigate with black and minority ethnic prisoners the reasons for the poorer perceptions, particularly about victimisation, relationships with staff, safety and maintaining family ties. (2.56)

3.21 Separate boxes for submitting racist incident report forms (RIRFs) should be provided and they should be emptied daily by the REO or his deputy. (2.57)

3.22 All RIRFs should be investigated fully, and accompanying documentation completed in full, preferably typed, and prisoners should receive detailed feedback. (2.58)

3.23 The racist and discriminatory prisoner log should include confirmation of when actions have been completed. (2.59)

3.24 Effective links should be established between the REO and the offender management team with respect to managing prisoners identified as racist or discriminatory. (2.60)

3.25 The race equality action team should ensure that issues and trends from RIRFs and ethnic monitoring are identified, discussed and acted on. (2.61)

Foreign nationals

3.26 Provision for foreign national prisoners should be reviewed, to ensure that they are supported by a dedicated member of staff, a regular forum and access to independent advice and translated materials. (2.63)

3.27 Foreign national prisoners should receive a free telephone call home each month, whether or not they receive any visits. (2.68)

Disability and older prisoners

3.28 All prisoners requiring assistance in an emergency should be easily identifiable to all staff and have individual evacuation plans. (2.72)

Health services

3.29 Waiting times for general practitioner (GP) appointments should be reduced significantly, and vulnerable prisoners should not have to wait longer than others. (2.78)

3.30 Prisoners should be returned to house blocks, education or work promptly following healthcare appointments. (2.79)

3.31 The length of the waiting list and waiting time for dental appointments should be reduced and reviewed frequently until satisfactory. (2.86)

Time out of cell

3.32 The times stated for unlock in the published core day should be adhered to. (2.89)

3.33 Prisoners should spend at least 10 hours out of cell on weekdays. (2.90)

Learning and skills and work activities

3.34 Individual learning plans should be improved and prisoners' progress reviewed at a frequency appropriate to the course of study and level, and individual needs. (2.91)

3.35 Prisoners' understanding of equality and diversity should be checked and reinforced at progress reviews. (2.92)

Physical education and health promotion

3.36 All PE staff should receive teacher training. (2.98)

Discipline

3.37 Thorough quality checks of adjudications should take place and be discussed with adjudicators to encourage good practice and identify training needs. (2.100)

3.38 Use of force should be monitored and analysed at the security meetings, records should be quality checked, and emerging patterns or issues of quality should be communicated to staff. (2.101)

3.39 Prisoners located on the segregation unit should not be strip searched on entry without an individual risk assessment. (2.102)

3.40 Staff on the segregation unit should receive mental health training and diversity training. (2.104)

3.41 There should be meaningful interaction with prisoners on the segregation unit, and this should be reflected in wing history files. (2.105)

Incentives and earned privileges

3.42 The IEP scheme should be monitored, and trends analysed. (2.108)

Catering

3.43 Prisoners should be able to eat together communally. (2.109)

3.44 Breakfast should be served on the day it is eaten. (2.110)

Prison shop

3.45 Prisoners should have the opportunity to buy items from the prison shop within 24 hours of arrival. (2.111)

Strategic management of resettlement

3.46 The reducing reoffending strategy should take into consideration the differing needs of the general category C prisoners and the sex offender population in relation to treatment and resettlement needs. (2.5)

Offender management and planning

3.47 Offender supervisors should have regular contact with all prisoners, prioritised according to need, and this should be recorded and monitored. (2.114)

3.48 Prisoners should be notified in writing how to appeal against categorisation decisions. (2.117)

Resettlement pathways

3.49 There should be a comprehensive review of the policy, procedures and provision in relation to visits, in consultation with prisoners and their visitors and taking into account good practice at other prisons. (2.6)

3.50 A suitable facility to accommodate the therapeutic community (TC) communal meetings should be provided. (2.125)

3.51 Psychometric test results taken pre- and post-TC programme should be annotated to individual prisoners as a measure of progress. (2.127)

3.52 Family members should be invited to participate in key aspects of the sentence plan, where appropriate. (2.131)

3.53 All documents containing information about visits should be checked and cross-referenced to ensure that information provided to prisoners and visitors is accurate. (2.137)

3.54 Visits should start on time and last for the published time. (2.138)

Housekeeping points

Residential units

3.55 Telephones should be repaired promptly when they become inoperative. (2.17)

3.56 There should be adequate privacy screening for prisoner telephones. (2.19)

Personal officers

3.57 All staff in a personal officer role should be familiar with the revised policy. (2.27)

Self-harm and suicide

3.58 Action plans in response to enquiries into deaths in custody should be reviewed by the suicide prevention meeting. (2.39)

Appendix I: Inspection team

Alison Perry	Team leader
Paul Rowlands	Inspector
Andrew Rooke	Inspector
Michael Calvert	Inspector
Paul Tarbuck	Health/substance use inspector
Margaret Hobson	Ofsted inspector

Appendix II: Prison population profile

Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

Status	18–20-year-olds	21 and over	%
Sentenced		1007	86.51
Recall		156	13.40
Convicted unsentenced			
Remand			
Civil prisoners			
Detainees		1	0.08
Other			
Total		1,164	100

Sentence	18–20-year-olds	21 and over	%
Unsentenced			
Less than 6 months		0	
6 months to less than 12 months		3	0.25
12 months to less than 2 years		68	5.84
2 years to less than 3 years		107	9.19
3 years to less than 4 years		150	12.88
4 years to less than 10 years		600	51.54
10 years and over (not life)		163	5.41
ISPP		104	8.93
Life		68	5.84
Total		1,163	100

Age	Number of prisoners	%
Minimum age;	21	
21 years to 29 years	388	33.33
30 years to 39 years	315	27.06
40 years to 49 years	229	19.67
50 years to 59 years	121	10.40
60 years to 69 years	78	6.70
70 plus years	33	2.83
Under 21	0	0
Maximum age;	82	
Total	1,164	100

Nationality	18–20-year-olds	21 and over	%
British		1098	94.33
Foreign nationals		46	3.95
Not stated		20	1.72
Total		1,164	100

Security category	18–20-year olds	21 and over	%
Category A exceptional			
Category A high risk			
Category A provisional			

Category A standard			
Category B		3	0.25
Category C		1106	95.01
Category D		31	2.66
Female closed			
Female open			
Female semi			
Other			
Uncategorised sentenced			
Uncategorised sentenced male		3	0.25
Uncategorised unsentenced			
Unclassified		5	0.42
Unsentenced		7	0.60
YOI closed		8	0.68
YOI open		1	0.08
Total		1,164	100

Religion	18–20-year-olds	21 and over	%
Baptist		1	0.08
Buddhist		27	2.31
Church of England		335	28.78
Hindu			
Jewish			
Muslim		80	6.87
No religion		380	32.64
Not Stated		5	0.42
Other		82	7.04
Roman Catholic		252	21.64
Sikh		2	0.17
Total		1,164	100

Ethnicity	18–20-year-olds	21 and over	%
Asian or Asian British			
Bangladeshi		2	0.17
Indian		8	0.68
Other		26	2.23
Pakistani		24	2.06
Total		60	5.14
Black or black British			
African		9	0.77
Caribbean		14	1.20
Other black		10	0.85
Total		33	2.82
Chinese or other ethnic group			
Chinese		1	0.08
Total		1	0.08
Mixed			
African			
Asian		2	0.17
Caribbean		11	0.94

Other mixed		7	0.60
Total		20	1.71
Not stated; code missing		93	7.98
Total		93	7.98
White			
British		932	80.13
Irish		14	1.20
Other white		11	0.94
Total		957	82.27
Total		1,164	100

Sentenced prisoners only

Length of stay	18–20-year-olds		21 and over	
	Number	%	Number	%
1 month to 3 months			0	
1 year to 2 years			93	8
2 years to 4 years			278	23.9
3 months to 6 months			0	
4 years or more			790	67.9
6 months to 1 year			3	0.3
Less than 1 month			0	
Total			1,164	100