HM Chief Inspector of Prisons for England and Wales

Annual Report 2011–12

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Our purpose

To ensure independent inspection of places of detention to report on conditions and treatment, and promote positive outcomes for those detained and the public.

Our values

- Independence, impartiality and integrity are the foundations of our work.
- Respect for human rights underpins our expectations.
- The experience of the detainee is at the heart of our inspections.
- We believe in the capacity of both individuals and organisations to change and improve, and that we have a part to play in initiating and encouraging change.
- We embrace diversity and are committed to ensuring the equality of outcomes for all.

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INTRODUCTION

by the Chief Inspector of Prisons

In my first annual report in 2010–11, I aimed to set a baseline for both the work of the Inspectorate itself and for the establishments it inspects. I intended this to act as a point of comparison as the work of the Inspectorate develops, and as the government's reforms and spending reductions take effect. This year's report aims to describe the progress, or lack of it, that inspected establishments have made and how the Inspectorate has adapted to the new policy and funding environment in which it operates.

This report paints a general picture of improved outcomes for detainees across the different types of establishment we inspect, despite decreasing resources and, in most cases, rising custodial populations. However, this improvement was inconsistent and in each type of custody we inspect, outcomes were still not good enough in too many establishments. Detainees whose needs differed from the majority population did not always receive appropriate management and care. In addition, in some cases, thinly stretched resources appeared to create an increased level of risk. There were more adverse incidents in prisons, and difficulties with contracted escort arrangements across all custodial types illustrated the challenge of delivering consistent and accountable commissioning arrangements.

These challenges reinforce the importance of independent inspection. This year, the Inspectorate has built on its past achievements and sharpened its inspection approach. However, some aspects of the Inspectorate's relationship with our sponsoring department, the Ministry of Justice, require high levels of vigilance to avoid having at least our perceived independence being compromised.

Prisons

Care should be taken in comparing inspection findings from one year to the next as different establishments were inspected in each year. However, with that caveat, the overall picture painted by inspection reports was positive, despite the squeeze applied by budget reductions on one side and an increased prison population on the other. There has been a trend of improving outcomes for some years and in 2011–12, improvement continued in purposeful activity and resettlement as establishments responded positively to the government's determination to introduce a 'rehabilitation revolution' (see Table 1). Across the prison estate, this improvement reflected the impressive efforts of many staff and managers.

Table 1: Outcomes for prisoners are positive[1]

	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12
	%	%	%	%	%	%	%
Safety	75	57	69	72	78	84	82
Respect	65	63	69	69	76	74	73
Purposeful activity	48	53	65	71	68	69	73
Resettlement	68	62	75	75	76	71	84

However, there are two significant areas of concern. First, as this report reveals, progress has been uneven and there was too much inconsistency between establishments that appeared to have similar functions, budgets and populations. Outcomes were not at an acceptable level in too many establishments. For instance, while it is welcome that the proportion of prisons achieving good or reasonably good purposeful activity outcomes had risen from 69% to 73%, it still means that outcomes in this priority area were not sufficiently good or poor in one out of four prisons.

Our report on Wandsworth, published in August 2011, revealed very serious concerns; six months later, our report on Manchester described one of the best performing local prisons we have inspected recently. The two prisons did not have identical functions, but both held predominantly remand and short-term prisoners in Victorian inner city sites. Workshops in Manchester were busy and purposeful and wing staff knew exactly who was not at work and why. In contrast, excellent workshop facilities at Wandsworth stood almost empty and too many staff appeared indifferent about the prisoners in their care. We could find no good reason for such wide variations in outcomes.

Second, our healthy prison tests each cover a wide area and provide a judgement about outcomes for most prisoners. This can obscure shortcomings in the individual components of a healthy prison test or poor outcomes for a minority of prisoners. This report illustrates that against the overall trend of improvement, there was a strong counter current of individual adverse incidents and concerns.

Progress on safety and respect appeared to have stalled. As we finalised this report, the National Offender Management Service (NOMS) published its own data on safety in prisons which appeared consistent with our concerns. The number of self-inflicted deaths in prison rose from 54 (0.64 per 1,000 prisoners) in 2010–11 to 66 (0.76 per 1,000 prisoners) in 2011–12. It remains to be seen whether this rise is an anomaly, or whether it heralds the reversal of a downward trend in the number of self-inflicted deaths in prison. Incidents of self-harm are, however, also rising in men's prisons – from 14,768 in 2010–11 to 16,146 in 2011–12 (the number fell in women's prisons) – as are the number of recorded assaults, from 13,804 to 14,858. Taken together, these figures are a matter of real concern. When we compared survey results for prisons inspected this year with those from their previous inspections, prisoners' perceptions of their safety had significantly worsened in twice as many prisons as those where they had significantly improved.

One factor that had improved safety in prisons was the continued development of the integrated drug treatment system (IDTS) which had improved the clinical management of substance misuse. During 2011–12, we welcomed a shift in emphasis from long-term methadone maintenance

1 'Positive' refers to outcomes assessed as being good or reasonably good, or where establishments were judged to be making sufficient progress against our recommendations.

prescribing towards a recovery-orientated drug treatment approach. Reducing demand through better treatment must go hand in hand with reducing supply. We have previously reported on the diversion of prescription drugs in high security and vulnerable prisoner populations. This year, we saw this problem spreading to mainstream populations and it has become a major concern. These prescription drugs are not routinely detected under current mandatory drug testing procedures which therefore understate the availability of abused drugs in prison. Diverted medication is now reported in the majority of prisons we inspect, resulting in problems such as drug debts, bullying, unknown interactions with other prescribed drugs and the risk of overdose.

Prisoners from black and minority ethnic backgrounds and Muslim and foreign national prisoners continued to have poorer perceptions of their treatment and conditions than the prison population as a whole. NOMS changed its approach to tackling diversity and equality issues during the year, moving away from prescriptive processes to an emphasis on responsibility for delivering equality of outcomes. At the same time, greater weight was given to all protected characteristics, not just race. There are some good reasons for this change in approach. Too often in the past, specialist posts and processes became an excuse for equality and diversity issues not being part of the everyday work of all staff. However, the aspirations of the new approach have not yet been realised – outcomes were not consistently monitored across the range of protected characteristics and when disparities were found, there was insufficient accountability or effective action to address them.

One issue not sufficiently addressed was the strikingly high proportion of prisoners who described themselves in our surveys as being of Gypsy, Romany or Traveller background – almost one in 10 in Wormwood Scrubs and frequently as high as 5% elsewhere. Not enough is understood about how best to meet their needs and address their offending behaviour.

Physical and mental health care had generally improved. The need had grown too as the prison population has become older and the visible extent of mental health need, even to an untrained eye, was still a matter of real concern. Care for common mental health problems remained underdeveloped and the training of uniformed officers in the recognition and support of prisoners with mental health issues was generally inadequate. Patients with more complex mental health needs had good access to mental health staff and transfer times to secure mental health hospitals had generally improved, although they remained too long in London. I reported in 2011 that concerned staff in Brixton had made a point of introducing me to a very distressed prisoner in health care who had been waiting months for a secure bed. He appeared unable to care for himself in even the most basic way and was in an extremely disordered cell. It was a disgraceful way to hold someone who was little more than a boy and very sick.

The improved focus on providing work opportunities for prisoners that we found in many prisons was very welcome. However, in local prisons we found that the time prisoners spent out of their cells had declined dramatically as association was reduced and prisoners were locked up earlier in the day.

We have recorded improvements in resettlement outcomes in the prisons we visited. This mainly reflects improvements in practical resettlement support in areas like accommodation and finding a job – all of which are essential to reducing the risk that a prisoner will reoffend. However, offender management processes to address the attitudes and behaviours that underpinned a prisoner's offending behaviour were still not sufficiently embedded, available or resourced.

The voluntary organisations that work in prisons have an important role to play in delivering resettlement outcomes. Some of the larger organisations compete successfully for contracts, deliver services on a national basis and have played a big part in achieving the improved outcomes we see. However, many smaller organisations, often reliant on volunteers to deliver projects and often working in the arts or with families where outcomes may be more difficult to measure, nonetheless play an important part in the rehabilitation process and in making prisons a safe and decent environment. There is also a wider benefit for society from the involvement of local communities in prisons which reflects the government's own ideas about the 'big society'. However, in my own visits to prisons and in discussions with many of these organisations, I have been concerned about how difficult it is for them to obtain funding. The involvement of volunteers and community groups in prisons has a long tradition and it is important to ensure that funding processes and criteria recognise their value and do not inadvertently exclude them.

Working with voluntary organisations is just one aspect of the increasingly complex set of contracting and provider arrangements that prison governors manage. As a consequence, some areas that are critical to the outcomes prisons achieve are outside their direct control. New national escort contracts introduced in August 2011, for example, caused real problems which remained unresolved for too long and, to some extent, persist even now. It is a particular concern that men, women and children may be transported in the same vehicle even if they are kept separated. The commissioning of health services is particularly complex. Prison health will become the responsibility of the new NHS Commissioning Board in 2013. This has the potential to promote consistency in health services across the prison estate but it will also be necessary to ensure that provision remains responsive to local needs. Learning and skills contracts will also be reallocated in 2012 and will have a greater emphasis on improving prisoners' employability. Birmingham became the first prison to move from the public to the private sector in October 2011 and it is certain that others will follow. This is uncharted territory and the long-term implications for both individual services and the wider prison economy are not yet clear. However, what can be said in the short-term is that managing these changes is challenging and it is important that however complex the commissioning arrangements, lines of accountability and responsibility do not become muddled.

In March 2011, the prison population was 85,400; by March 2012, it had grown by 2,131 to 87,531. The operational capacity of prisons had grown over the same period by 3,532 to 90,622. Apart from the exceptional circumstances of the August 2011 riots, the issue was not how many prisoners could be squeezed into the available cells. In fact, the establishments we inspected this year were less overcrowded than the year before. The issue was whether there were the resources available to hold all detainees safely and securely and do anything useful with them when they were there. Resources are now stretched very thinly. There was plenty of scope for efficiency and some prisons had risen to that challenge very well, genuinely delivering more for less. In others, poor management appeared to have exacerbated the adverse effects of funding reductions. Nevertheless, in my view overall, our inspection findings suggest that there is a risk of undermining the progress that has been made in recent years and threatening the delivery of the government's rehabilitation revolution. If a rehabilitation revolution is to be delivered, with all the economic and social benefits that promises, there is a pretty clear choice for politicians and policy makers – reduce prison populations or increase prison budgets.

Women

We reported on seven women's prisons in 2011–12 and published a thematic report on the use of alternatives to custody for women offenders with HM Inspectorate of Probation.

There is no doubt that women's prisons had improved. None of the healthy prison assessments we made in a full inspection of a women's prison in 2011–12 were less than reasonably good. However, we were concerned to find in our short follow-up inspection of Downview that management problems had adversely affected the prison and it was making insufficient progress in two areas.

March 2012 marked the fifth anniversary of Baroness Corston's powerful report about women with particular vulnerabilities in the criminal justice system. Her recommendations have led to significant improvements. The prisons we inspected were safer and more respectful places than before with a better focus on promoting purposeful activity and resettlement. Better drug treatment and mental health services and better first night arrangements had made women's prisons safer.

The statistics bear this out. The number of self-harm incidents fell from 11,517 in 2010–11 to 7,879 in 2011–12. Welcome though that is, women still account for a staggering one-third of all self-harm incidents, although they make up less than 5% of the prison population.

It is quite clear when I visit a women's prison that the needs and challenges of most of those held are very different from those in a male prison. Women are imprisoned for different reasons from men, their family responsibilities are greater and they are more likely to have substance abuse or mental health problems. Around 40% of new arrivals at Send, Styal and Peterborough, and over 50% at Low Newton, were dependent on drugs and/or alcohol. Fifty-two per cent of women felt that they had emotional wellbeing or mental health issues, compared with an average of 29% across male prisons. Many women prisoners were themselves the victims of abuse, rape and other crimes. Levels of self-harm were high overall but some women made repeated and severe attempts to self-harm. Six deaths at Styal prison between 2002 and 2003 led to the commissioning of Baroness Corston's review. When inspectors returned to the prison this year, they noted bleakly that officers often had to use force to remove ligatures from women intent on harming themselves.

Despite these differences, all too often women's prisons appear to be run to meet the requirements of the 95% of the prison population that is male. Most women pose different security risks to men and while routine strip-searching of women on their entry to prison has now ended, some measures remain disproportionate and degrading. Health inspectors found that one woman at Send attending an external hospital appointment had remained cuffed to an officer while getting undressed and undergoing an intimate examination.

Leaving aside the most egregious examples, there is a limit to what women's prisons can achieve. They are too big, too far away from women's homes (there are no women's prisons in Wales, for example) and cannot provide the levels of care many women in prison require.

Baroness Corston called for the creation of dispersed, small, multi-functional centres to replace large existing prisons, but these and other recommendations require leadership to deliver and sustain them. She suggested the establishment of a Commission with senior leadership to drive these changes through. Other models have been suggested but what they all have in common is the need to create a distinct leadership and structure to drive a reduction in population and improvements in women's custody. The evidence of the need for that approach remains as clear today as when Baroness Corston published her report.

Children and young people

The riots in August 2011 had more impact on young offender institutions (YOIs) for children and young people than on adult prisons. In our inspections, we found that young people were moved from Feltham in the south-east to Hindley in the north-west to make room for new arrivals. This was inevitably disruptive. Some promising long-term work with the most challenging young people had to be put on hold and staff sometimes struggled to get the information they needed about the young people they were dealing with. 'Gangs' or groups of young people reformed to create new geographical allegiances. There was an increase in assaults and the use of restraint. Feltham saw a 200% increase in the number of young people placed on suicide and self-harm procedures. It is a credit to the staff involved that more serious difficulties were not experienced.

The decision not to abolish the Youth Justice Board (YJB) in November 2011 was welcome. The YJB has presided over a drop in the number of young people held in custody from an annual average of 2,807 in 2000–01 to 2,040 in 2010–11. While other factors were involved, the YJB should take a great deal of credit for this.

The young people who remain in custody, however, are both more troubled and more troubling. The vulnerability of some of the young people held was tragically brought home by the apparent self-inflicted deaths of three young people during the year – two aged 17 and one aged 15.

The circumstances of these tragedies are still being investigated but a quarter of the young people we surveyed said they had felt unsafe at some time with threats and abuse shouted out of windows often cited as a problem. Although we observed generally positive relationships between young people and staff, young people's own perceptions of their relationships with staff continued to deteriorate this year. The contraction of the juvenile estate meant young people were held further away from home and it was difficult for their families to visit.

These problems are exacerbated for looked after children in custody. Our thematic review estimated that about 400 looked after children are in custody at any one time. We found that there was a lack of clarity about who was responsible for looking after these children, as well as a lack of coordination between the agencies involved. Young people themselves were often pessimistic about their resettlement prospects and outcomes were indeed poor for those we were able to follow up. We were pleased that the YJB accepted our recommendations to reinstate social workers in YOIs to try to tackle some of these issues. Nevertheless, it remains unacceptable that children who are so at risk that they need to be taken into the state's care also remain low among our national priorities.

Our resettlement thematic review found more general problems. YOIs themselves did little to monitor resettlement outcomes but when we followed up young people just one month after they left their YOI, some were already homeless, others were in very unsuitable accommodation and half had dropped out of their education or work placement. Others were back in custody or on the run. It is hard to see how the YJB and YOIs can develop and deliver effective resettlement if they do not themselves monitor outcomes.

The very small YOIs for young women we inspected were particularly impressive. Each was holding fewer than 10 17-year-olds and staff provided a high level of care and support to which the young women responded positively.

Immigration detention

We inspected six immigration removal centres (IRCs) in 2011–12. As in other types of detention, we found a general pattern of welcome but uneven improvement. The number of people held in immigration detention rose by 14% over the year to 3,034 – the highest level since comparable data was first published in 2001.

For most detainees, being detained and anxiety about their case were the biggest concerns. Restricted access to good quality legal advice and some poor casework by the UK Border Agency added to these tensions. The care and management of vulnerable groups was still not good enough in too many cases. Facilities for older and disabled detainees were often inadequate. We found 'Rule 35' processes – intended to safeguard detainees who might be unsuitable for detention because of past torture, ill-treatment or risk of suicide – were often applied in a dismissive and careless way.

Pregnant women should only be detained in the most exceptional cases. There were seven pregnant women at Yarl's Wood at the time of our inspection. In only one case had the woman's pregnancy been considered as part of her monthly review. One pregnant woman had been transferred over the course of four days from Northern Ireland to Scotland to Manchester – where she had collapsed and been treated – and finally to Yarl's Wood in Bedfordshire.

We welcomed the decision to end the detention of children. However, there were circumstances in which children were still detained. Age dispute cases were not always appropriately managed. In one case at Haslar, a child was unnecessarily detained before his status as a minor was confirmed. We published a thematic review of short-term holding facilities which found that their environment and management, while still too variable, had improved overall. However, at the Heathrow Terminal 3 facility, 100 children had been detained in the three months prior to our inspection with a dozen detained for over 18 hours. A small number of children had also been held for long periods at Terminals 1 and 4. At Terminal 4, we found that one child had been detained without the necessary authority. None of these facilities were suitably designed or staffed to hold children. It may sometimes be necessary to detain children on arrival – for example, to establish their relationship with the adults accompanying them and ensure they are not being trafficked – but this should only be in exceptional circumstances, for the shortest time possible and in facilities that safeguard the child's welfare. Cedars, a new unit to hold families being detained prior to removal, opened during the year and our first inspection of the unit took place as this report was being prepared.

We carried out our first overseas escort inspections in 2011–12. We accompanied two removals from the collection points at IRCs in England to disembarkation in Jamaica and Nigeria. They were both reasonably ordered and well managed. However, we were disturbed by the unprofessional attitude of some G4S staff, excessive staffing levels and the practice of overbooking flights without telling the detainees concerned. Overbooking meant that some detainees experienced the trauma of preparing to be removed only to be told at the last minute they would not be going and being returned to an IRC. We gave evidence about our findings to the Home Affairs Select Committee in November 2011 which agreed with our view that the practice of overbooking flights should cease.

Police custody

We have inspected police custody jointly with HM Inspectorate of Constabulary (HMIC) since April 2008. We published our 50th police custody inspection report this year and 17 reports, including our first three follow-ups, in 2011–12 itself.

We used these milestones to review our inspection process. We revised our police custody expectations and moved to an entirely unannounced inspection programme. Like other services, the police had to respond to both pressure on its budgets and significant policy change as preparations for the introduction of Police and Crime Commissioners got underway.

Despite these pressures, we found evidence of investment in custody facilities and effective partnership working within the custody environment. Like other custody environments, police custody depends on the effective management of a variety of relationships and the quality of these relationships was a determining factor in the outcome for detainees.

Crucial among these has been the relationship between the force and the police authority. This worked best where the authority had a designated lead for custody and it is hoped that Police and Crime Commissioners make arrangements to provide a similar focus and expertise.

As in every other custody environment, escort arrangements were problematic. In some cases, we found delays in escorts had led to detainees being locked out of prisons and inappropriately held overnight or during the weekend in police custody. A critical role of any escort is the transfer of information about the risk a detainee poses to themselves or others. We began work during the year for the Ministerial Board on Deaths in Custody to review the effectiveness of the Person Escort Record (PER) by which such information is conveyed.

Many forces were reviewing the use of police constable gaolers. We found private sector detention officers engaged in a range of roles from traditional detainee care to booking in detainees with a custody sergeant providing oversight. Most forces used private health service suppliers but in others, such as the Metropolitan Police Service, these services were provided in-house. We welcome work to prepare police forces for NHS-led commissioning of health care provision in police custody, which we hope will improve clinical standards.

Support and diversion services for detainees with substance abuse and mental health problems were variable. Detainees in most custody suites had access to substance abuse services and in larger urban suites specialist drug and alcohol services were available. Onsite mental health services were less available and police custody was still used too frequently as a place of safety under section 136 of the Mental Health Act 1983. The Inspectorate began a thematic review of the use of section 136 in partnership with HMIC and the Care Quality Commission.

In a similar way, police custody was too frequently used as a place of safety for children who had been charged and were awaiting a court appearance. We worked with HMIC to review the provision of appropriate adults and local authority accommodation for children and young people in police custody. We found the emphasis was on compliance with the Police and Criminal Evidence Act 1984 rather than the welfare of the child. Children and young people were detained in police cells for longer than necessary. Few were transferred to local authority accommodation after being charged and yet almost two-thirds of those in our sample were granted bail or conditional bail at their first court appearance. The provision of appropriate adults for vulnerable adults was mostly poor and depended on local initiatives.

The Inspectorate

This report draws on the findings of 100 individual inspection reports that we published during the year and five thematic reports that we published singly or jointly with other inspectorates. We continue to have real impact: 65% of the recommendations we followed up in the course of this year's inspections had been achieved or partially achieved.

We have maintained the quality and quantity of our work despite a real reduction in our baseline funding of 7.1% between 2010–11 and 2011–12, and a reduction of 14.4% across the whole of the current comprehensive spending review period. We achieved this by deploying inspectors more efficiently and by significantly reducing our non-inspection costs. We also produced and consulted on the Inspectorate's first strategic plan for the period 2012–13 to 2014–15. Despite funding reductions, the plan sets out a very full programme to further strengthen the work of the Inspectorate.

Maintaining an independent, rigorous and human rights-based inspection process is at the heart of the plan's objectives. During 2011–12, we revised our inspection criteria, known as 'expectations', for adult prisons and police custody. We also published, for the first time, expectations for the Military Corrective Training Centre. The new expectations are more focused on the outcomes establishments achieve rather than the processes they use; will lead to clearer inspection reports; and will ensure that our recommendations provide a real basis for improvement. We will continue this process with revisions to our expectations for children and young people in custody and immigration detention in 2012–13. The strategic plan also commits us to delivering a fully unannounced inspection programme in 2013–14 and we will publish a revised inspection manual which describes how we conduct inspections. We will continue to work with Ofsted to develop a joint inspection regime for secure training centres. The contribution of partner inspectorates is vital to effective inspections and I am grateful to our partners for their support and cooperation.

The UK is obligated to ensure the regular and independent monitoring of all places of detention under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). In the UK, this monitoring is performed by 18 bodies which make up the required 'National Preventive Mechanism' (NPM) that together inspect all places of detention. In our role as the coordinating body of the NPM, the Inspectorate has promoted full compliance with OPCAT, including completing plans to inspect court custody in England and Wales from 2012–13. The UK is unusual in having a multi-body NPM: in most countries, the NPM is made up of a single monitoring body. The NPM model in the UK has many strengths but it can also be cumbersome. To address this, we established a steering group of NPM members this year to help identify common themes and priorities arising from members' work and to promote a shared understanding of OPCAT principles.

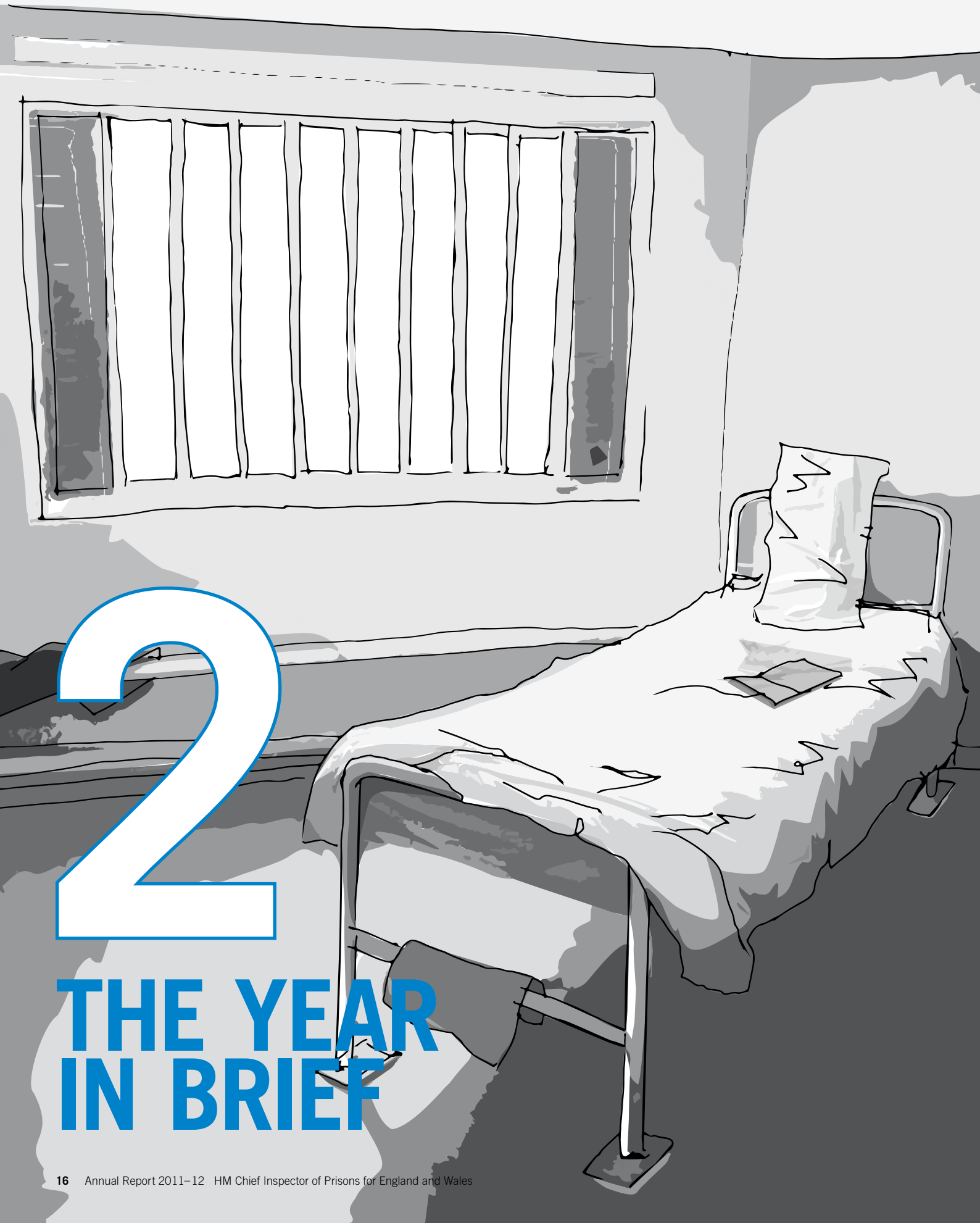
The reputation of the Inspectorate is such that we receive many requests to support or advise other nations and international bodies regarding independent inspection. The UK government is keen to promote the ratification of OPCAT by other states and we try to meet requests to explain our work and the principles that underpin it to international visitors. In 2012, we delivered an awareness raising and training programme to Russian justice officials in Moscow. We also inspect by invitation a number of establishments that are not within our statutory remit. In 2011–12, these included the prison on the Isle of Man, Maghaberry prison in Northern Ireland and the custody facilities in the British Sovereign Base Area in Dhekelia, Cyprus. In our 2011–12 annual report, I noted that we had been invited to consider the possibility of inspecting British military detention facilities in Afghanistan. The independent inspection of military detention facilities was

a recommendation arising from Sir William Gage's inquiry into the death of Baha Mousa in Iraq. After visiting the facilities, I stated that we were willing to undertake such inspections and believed it was feasible to do so. Nevertheless, these proposals have not progressed.

Independence is crucial to the Inspectorate's work and reputation. It was rightly the main concern of the Justice Select Committee at the time of my appointment. Our relationship to government is one of the features of our work that is of most interest to our international visitors. It is not acceptable, therefore, that despite generally good relationships with our sponsoring department, the Ministry of Justice, some aspects of their requirements compromise at least our perceived independence. In particular, the loss of our own website and the requirement to become part of the government's 'Justice' website is at best confusing for those who use it and at worst damaging to our reputation. Restrictions on how and where we recruit staff to fill vacancies that are within our agreed staff complement inhibit our ability to meet the OPCAT requirement of a balanced staff group with the necessary expertise. Along with the Prisons and Probation Ombudsman and HM Inspectorate of Probation, we made a submission to the Justice Select Committee in March 2012 setting out our shared concerns about these and other matters. As it was for my predecessors, preserving the Inspectorate's independence has been a time-consuming and frustrating battle throughout the year. It is perhaps time to consider whether the independence of bodies such as the Inspectorate could be better preserved by a more direct relationship to Parliament and its institutions.

2011–12 was a challenging year. We saw improvements in treatment and conditions across the entire custody environment we inspect but threats to this progress were becoming more apparent. There was no excuse for some of the inconsistency and poor practice we found. However, as resources were stretched thinly and commissioning arrangements became more complex, the level of risk increased. The increase in adverse incidents in prisons and the problems with new escort arrangements across the custody environment were examples of this. Detainees whose needs differ from the population as a whole – such as women prisoners or children in any form of custody – are likely to have less positive outcomes than the majority population even now and they are likely to be most adversely affected by any overall decline in standards. The role of the Inspectorate in preventing poor treatment, as required by OPCAT, will be more important than ever and I hope the changes we are making will ensure we are as well equipped as possible to meet that challenge.

Nick Hardwick
Chief Inspector of Prisons



2 THE YEAR IN BRIEF

Between 1 April 2011 and 31 March 2012, we published inspection reports on 100 custodial establishments including:

- 46 prisons holding adult men
- seven prisons holding adult women
- nine establishments for children and young people under the age of 18
- one detainee unit at Long Lartin
- six immigration removal centres, eight short-term holding facilities and two inspections of overseas escorts
- 17 police custody suites, in conjunction with HM Inspectorate of Constabulary
- two prisons in Northern Ireland, in partnership with Criminal Justice Inspection Northern Ireland
- one prison on the Isle of Man
- one prison for the Sovereign Base Areas in Cyprus.

Of the 63 prison inspections in England and Wales, 38 were unannounced. Two of the immigration removal centres were full announced inspections while the remaining four were unannounced follow-ups. Last year, almost half of our police custody inspections were unannounced. In 2011–12, this proportion increased to almost three-quarters.

The majority of our inspections are carried out with the assistance of partner organisations. All inspections of prisons and immigration removal centres were carried out jointly with Ofsted in England, Estyn in Wales or the Education and Training Inspectorate in Northern Ireland. All full inspections were carried out with the assistance of the Care Quality Commission in England, Healthcare Inspectorate Wales and the Regulation and Quality Improvement Authority in Northern Ireland.

Our inspections also benefited from input from the General Pharmaceutical Council. The Care Quality Commission participated in inspections of police custody suites which we conducted in partnership with HM Inspectorate of Constabulary. Offender management was inspected jointly with HM Inspectorate of Probation. Our work with the police and probation inspectorates forms part of the Criminal Justice Joint Inspection programme through which the work of the criminal justice inspectorates is coordinated. This coordinated approach to inspection minimises the impact on the inspected organisations and allows us to develop a full picture of the custodial environment in which education, health care and offender management should be integral parts.

In 2011–12, we published thematic reports on:

- the care of looked after children in custody
- resettlement provision for children and young people, focusing on accommodation and education, training and employment
- the use of alternatives to custody for women offenders, jointly with HM Inspectorate of Probation and HM Crown Prosecution Service Inspectorate
- appropriate adult and local authority accommodation provision for children in police custody, in association with HM Inspectorates of Constabulary and Probation, the Care Quality Commission, Healthcare Inspectorate Wales and the Care and Social Services Inspectorate Wales
- a review of short-term holding facility inspections.

We also began work on several more thematic reviews, including reviews of:

- the experience of remand prisoners
- the use of restorative justice in the criminal justice system, led by HM Inspectorate of Constabulary
- the transition of young people from youth to adult-based services in the community and in custody, led by HM Inspectorate of Probation
- the effectiveness and impact of immigration detainee casework, with the Independent Chief Inspector of Borders and Immigration.

We published our annual report on the self-reported experience of 15–18-year-olds in custody.

We embarked on a programme to revise our 'expectations', the independent criteria we use to assess the treatment of and conditions for prisoners and detainees. We published revised expectations for adult prisoners and for detainees in police custody, and began work on revising the criteria for children and young people in custody, and for immigration detention. For the first time, we published expectations for the Military Corrective Training Centre at Colchester.

We have been invited by Ministers to inspect court custody facilities and have developed expectations specific to this context as well as carrying out two pilot inspections. A regular programme of inspection will begin in 2012–13. In conjunction with HM Inspectorate of Constabulary, we have also been invited to inspect customs custody facilities operated by the Border Force. These facilities are used to hold people for short periods of time at entry points to the UK and are operated under the Police and Criminal Evidence Act 1984. Inspections of these facilities will begin in 2012–13.

We continued to act as the coordinating body for the UK's National Preventive Mechanism (NPM), the group of organisations designated under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment to monitor all places of detention. We published the second annual report of the NPM, reflecting the activities and findings of the 18 member organisations, in 2012.

Of the 63 prisons in England and Wales inspected in 2011–12, the outcomes for prisoners were assessed as being good across all four tests of a healthy prison at only one prison: Kirklevington Grange. Kirklevington Grange is a small, specialist resettlement prison preparing men coming to the end of long sentences for their return to the community. We concluded that it performed this specialist function very well. Our report noted, 'Kirklevington carefully selected its prisoners and so, of course, in that and in other ways, a comparison with many other prisons might seem unfair. However, the principles that Kirklevington successfully applied – of men making progress by working hard to put something back into the community and to acquire the skills, experience and confidence they will need to get and hold down a job on release – are principles that have a wider application in the prison system.'

Focus: aftermath of disturbances

The violent disturbances in UK cities in August 2011 saw significant numbers of people across the country being arrested, held in police custody and then remanded or sentenced to prison. We were able to examine the impact of this sudden influx of prisoners on some key prisons across the country and on police custody suites in Nottinghamshire. In the aftermath of the disturbances, we visited Wandsworth, Manchester, Belmarsh, The Mount and Isis prisons holding adult males, and Feltham and Hindley holding children and young people under the age of 18.

Overall, adult prisons coped with the influx well. There were, however, some negative consequences. There was some increase in overcrowding and, at The Mount, some prisoners were doubled up in unsuitable single cells. At Belmarsh, the already inadequate number of activity places was stretched even further and all prisoners spent longer locked up in their cells each day. Some double cells were used to accommodate three prisoners. In the prisons we visited, we found no increase in the use of segregation, violent incidents or the number of prisoners thought likely to harm themselves.

The impact of the disturbances for some children and young people at Hindley and Feltham was greater. Young people were transferred to Hindley, in the north-west, to create space in establishments in the south of England for those involved in the disturbances. Twenty per cent of young people arrived at Hindley over a seven-day period in August without any accompanying information and an even larger proportion arrived with no medical records. One young person was transferred even though he was at risk of self-harm and another was transferred just prior to a critical hospital appointment. The establishment accepted that it was unable to offer a comprehensive risk assessment and induction due to the unprecedented number of new arrivals.

Hindley experienced an increase in group fights as young people arrived from London, formed gangs and 'looked after each other'. Some of those involved in the disturbances glorified their actions and became heroes to others. More young people than normal were restrained and the number of young people thought to be at risk of self-harm increased by almost one-third. Many of those who had been transferred no longer received visits from family and friends due to the distance they were being held from home.

Feltham's task was to quickly move a large number of young people to other establishments in order to make room for a new intake of those directly involved in the disturbances. In one week, Feltham received the number of new arrivals it would normally expect in a month. Many young people arrived at the prison after midnight and without any personal information. It was therefore difficult to assess whether they posed a risk to themselves or to others, or whether they were at risk from other young people. Staff had to rely on the young people to tell them about their gang affiliation. Youth offending teams were unable to provide information quickly to assist with risk assessments and to instigate bail applications. Induction periods for the new arrivals had to be shortened.

Some young people already at Feltham were angry with the 'rioters' for causing their friends to be transferred from the establishment and for attacking their home communities and putting family and friends in danger. Some of the new arrivals were assaulted. Young people formed gangs and some young people with no previous history of being involved in gangs joined them to protect themselves. The number of young people thought to be at risk of self-harm increased by 200%.

Some excellent work in progress with some of Feltham's most troublesome young people was disrupted as staff instead managed the difficulties resulting from the new intake.

Police custody suites in the city of Nottingham were heavily affected but senior managers were confident they had dealt with the challenge. One suite, which was never normally full, spilled into the court cells on the same site. The closed suite in Newark was reopened and detainees from the city were also placed in Mansfield. The permanent custody staff were supplemented by trained officers from response teams.

3 PRISONS

The inspection process

All inspections of prisons are conducted against published criteria known as 'expectations', which draw on and are referenced against international human rights standards. Expectations are also based on the four tests of a healthy prison, which were first introduced by this inspectorate's thematic review, Suicide is everyone's concern, published in 1999. The four tests 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.

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. These range from good to poor as follows:

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

Outcomes for prisoners are reasonably good against this healthy prison test
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

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

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

Our assessments are based on five sources of evidence:

- prisoner surveys[2]
- discussions with prisoners in groups and individually
- discussions with staff, managers and visitors
- records, policies and data
- observation.

2 A survey of a random sample of prisoners, which is representative of the total population in each establishment, is carried out for all full inspections (this includes full announced, full unannounced and full follow-up inspections). The survey results provide one source of evidence for the inspection but, when combined, also provide comparative information for each functional type of establishment.

In January 2012, we published revised expectations for adult prisoners which take account of our growing experience and changes to the prison environment. We began to use the new expectations in inspections of adult prisons from January 2012 and reports of those inspections will be published in 2012–13. The findings described in this report relate to inspections carried out under our previous set of expectations and it is those expectations that are described in the body of this annual report.

Prisons receive a full inspection every five years and a follow-up inspection in the intervening period. Follow-up inspections are based on an assessment of risk and may be 'full', in which the prison as a whole is assessed, or 'short'. Short follow-up inspections focus on reviewing the progress a prison has made in implementing the recommendations made at the last full inspection. In 2011, we introduced a new method of assessing prisons subject to short follow-up inspections. We had concluded that short follow-ups did not provide sufficient evidence to make a robust assessment of every aspect of a prison. Prisons receiving short follow-up inspections are now assessed as follows:

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.

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.

Prisons in 2011–12

In 2011–12, we published the reports of 63 prison inspections, of which seven were inspections of women's prisons and nine were of establishments for children and young people under the age of 18. One inspection was of the Detainee Unit at Long Lartin. In addition, we inspected Hydebank Wood Young Offenders Centre and Ash House in Northern Ireland on behalf of Criminal Justice Inspection Northern Ireland, and the Isle of Man Prison at the invitation of the Manx government. The healthy prison assessments for each of the prisons inspected are included in Appendix 2. In our unannounced follow-up inspections, we assessed the outcome of 4,924 recommendations made across the prison estate in England and Wales, finding that 67% had been achieved or partially achieved.

Prisons in England and Wales assessed negatively[3] against at least one of the four tests of a healthy prison:

- 23 out of 40 adult male prisons
- 5 out of 6 young adult prisons
- 1 out of 2 male open prisons
- 1 out of 7 women's prisons
- 3 out of 9 establishments for children and young people.

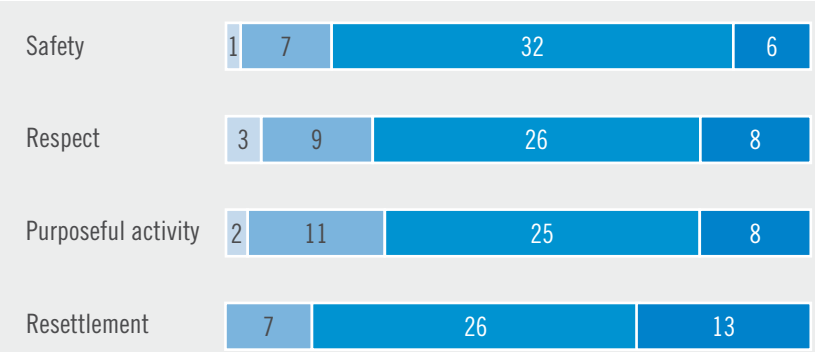
Outcomes for prisoners were most often poor in relation to respect.

Outcomes for prisoners were most often good in relation to resettlement.

3 'Negatively' refers to outcomes that were assessed as poor or not sufficiently good in inspections, or to establishments assessed as not making sufficient progress in short follow-up inspections.

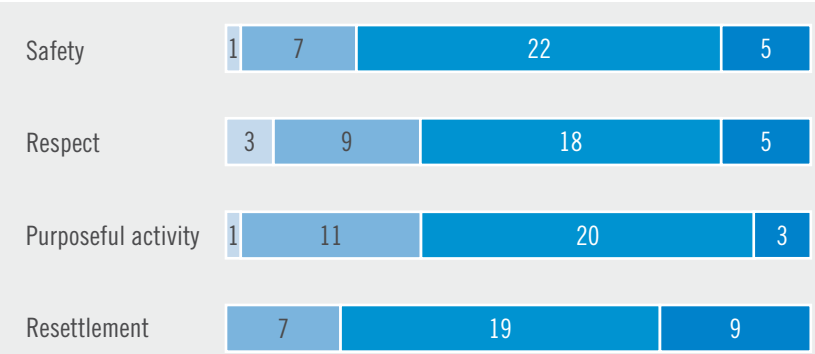
Healthy prison assessments

All prisons

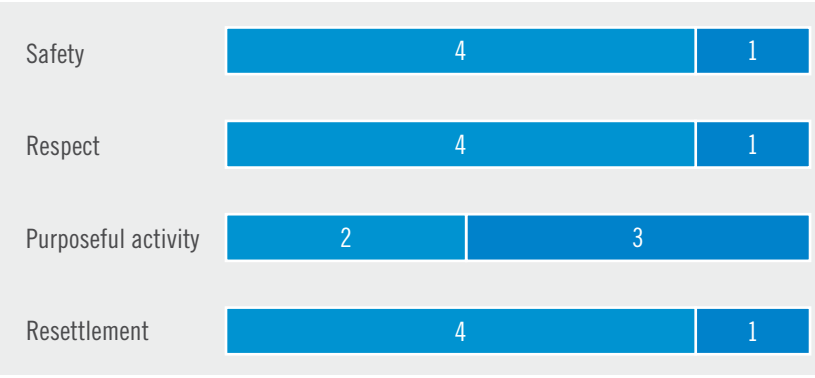


Key

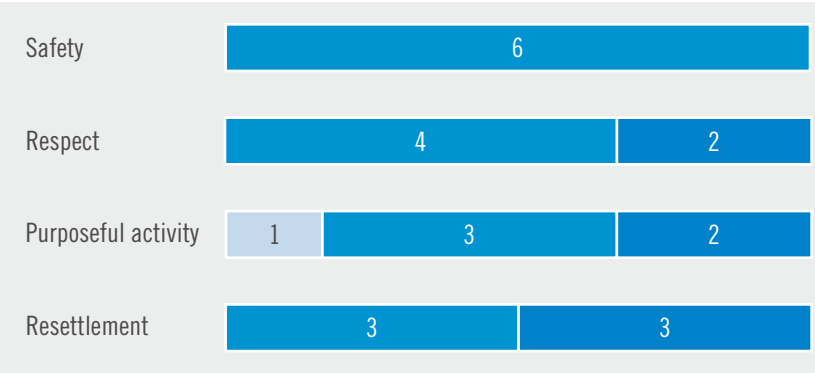
Adult male prisons



Women



Children and young people



Safety

Prisoners, particularly the most vulnerable, are held safely.

Of the 46 establishments holding adult males which we inspected in 2011–12, the outcomes for prisoners in relation to safety were good at five prisons, reasonably good at 22 and not sufficiently good at seven. Just one prison (Wandsworth) was assessed as having poor safety outcomes overall. Of the 11 short follow-up inspections carried out under our new methodology, nine prisons were making sufficient progress and two were not. In our unannounced follow-up inspections, we found that 68% of our recommendations relating to safety had been achieved or partially achieved.

Table 2: Safety outcomes in adult male establishments

	Outcomes poor	Outcomes not sufficiently good	Outcomes reasonably good	Outcomes good
Locals	1	1	8	1
Trainers	0	3	9	3
Young adults	0	3	2	0
High security	0	0	2	0
Open/resettlement	0	0	1	1
Total	**1**	**7**	**22**	**5**

Courts, escorts and transfers

We expect that prisoners travel in safe, decent conditions to and from court and between prisons. During movement, prisoners' individual needs are recognised and given proper attention.

In our inspections, we continued to find that few prisons provided sufficient information to prisoners before their arrival about what they could expect from their first few days in custody.

Although most prisoners reported a reasonable experience of transfers and escort arrangements, they also reported spending long periods in court cells or in transit before arriving at their prison. Comfort breaks were not routinely offered despite the often long distances travelled. Escort staff at Wayland told us that if prisoners asked for a comfort break, they would be offered a bag to urinate into by the escort contractor, rather than delay the journey by making a stop. At a number of prisons, we found that vehicles were often admitted to the prison quickly but prisoners waited for long periods of time before being taken to reception. At Northallerton and Stocken, for example, prisoners remained locked in vans for more than an hour because reception was closed over the staff lunch period.

Some of the vans we inspected were in poor condition. Some were dirty with broken steps. There were no hand rails to help prisoners with mobility problems get on or off larger vehicles.

Some security procedures were overly restrictive. All prisoners transferred to Hatfield, for example, arrived in secure vans, despite having been deemed suitable for open conditions. We also observed some prisoners being handcuffed while they disembarked from vehicles and walked the short distance to reception. This was disproportionate to the risk presented.

We observed that escort and reception staff were generally courteous to prisoners. Prisoners' property was treated correctly and the officers we spoke to were appropriately focused on prisoner safety. On the whole, information about prisoners was shared systematically and reception staff made appropriate use of it to inform their initial risk assessments about the prisoner. We did, however, come across person escort records that were either blank or incomplete. In this small number of cases, we were not confident that prisoners' safety could be assured.[4]

4 The Inspectorate also carried out a more detailed review of person escort records in 2011-12. For further information, see page 90.

Focus: escorts

Arrangements to escort prisoners to and from court and on inter-prison transfer changed significantly in 2011. All escorts, aside from the escorting of Category A prisoners, were initially carried out by Serco, Reliance and G4S. From 29 August 2011, prisoner escort contracts were awarded to two new providers. Serco Wincanton now supplies escorts for London and the east, while GeoAmey supplies the rest of England and Wales. These contracts provide for the escorting of around 80,000 prisoners to court each month.

There have been difficulties with the implementation of the new contracts across England and Wales. NOMS officials told us that these difficulties were exacerbated by the public disorder in August 2011 and the consequent rise in the prison population. In the early days of the new contracts, both contractors experienced difficulties with staffing issues, the scheduling of vehicles and their technology. This resulted in late arrivals to prison from court and prisoners, particularly in London, being 'locked out' and diverted to other prisons or police custody suites. Even where late arriving prisoners were admitted to a prison, additional pressures were placed on the establishment's reception and first night procedures. Under the new contracts, escort vehicles picked up prisoners from a number of points before taking them to court or prison, meaning that the prisoner picked up first often had a protracted journey.

At local prisons, we observed delays in moving prisoners through reception caused by large groups arriving together late in the afternoon. We found disproportionate security procedures and some vehicles in poor condition. Prisoners often said they felt unsafe during their journey. Some vehicles had limited capacity to transport a prisoner's property and items were sometimes mislaid or damaged when they were separated from the prisoner.

We were particularly concerned that the new contracts permitted women and children under the age of 18 to be transported in the same vehicles as adult men. Protocols to separate them within vehicles appeared underdeveloped and some escort staff told us that mixing men and women on the same van was problematic. Removable partitions that could be used to divide vehicles into separate compartments for men, women and children were not effective and hampered the ability of staff to supervise all prisoners.

First days in custody

Prisoners are most vulnerable in the early days of custody. We therefore expect that they should feel safe on their reception into prison and risks should be mitigated through effective reception, first night and induction procedures. The individual needs of prisoners, both during and after custody, should be identified and plans developed to meet them. During their induction into the prison, we expect prisoners to be made aware of prison routines, how to access available services and how to cope with imprisonment.

In our surveys, 74% of prisoners reported feeling safe on their first night at the prison. The proportion of prisoners who felt safe on their first night was lowest in high security prisons (only 62%) and highest in open prisons (95%).

In many prisons, we found reception officers to be professional and aware that new prisoners were particularly vulnerable. We observed that first night and induction policies were generally implemented effectively and officers were supported to identify and address prisoners' needs. Prisoners were interviewed by staff in private where reasons for committal to custody were confirmed and initial assessments were carried out. At Chelmsford and Stafford, for example, prisoners were asked about any special needs or problems with which they needed immediate help and any issues raised were dealt with quickly by knowledgeable staff.

Good use was made of peer support in many prisons. Listeners or other peer supporters, including Insiders, attended most receptions and saw new arrivals individually and in groups to explain, from a prisoner perspective, prison systems and how to access help.

Many prisons had designated first night accommodation but this was not always clean or properly prepared. It was unacceptable that many new arrivals at Wayland, for example, were unable to shower or make telephone calls to inform their families of their whereabouts.

We were concerned that in a small number of prisons, including Wandsworth and Stocken, procedures for assessing vulnerability were weak and first night procedures and induction were not sufficiently supportive for new arrivals, particularly those with no previous experience of prison. Cell sharing risk assessments were not always reviewed, prisoners in reception were not always interviewed in private and, occasionally, there was no formal first night interview. At Lindholme, individual interviews were carried out in an open area which was not conducive to sharing confidential information.

We saw many prisons where nominated induction officers interviewed all new prisoners the day after their arrival to explain written induction packs and the prison's procedures and rules. Prisoners were encouraged to ask questions and were given the opportunity to discuss matters they felt were important. Individual needs were assessed again, and recorded.

In many prisons, including Moorland, induction programmes were delivered in dedicated induction units to all new prisoners and began the morning after their arrival. These programmes consisted of several modules delivered over the course of around five days by a multidisciplinary team of prison staff, peer support workers and service providers, including education and resettlement staff. Nominated officers were responsible for ensuring that the induction programme was delivered to all prisoners. Programmes provided relevant information about prison life and prisoners were encouraged to ask questions.

However, in some prisons, induction was not clearly structured or consistently

delivered and prisoners on induction were not usefully occupied. We found induction programmes that ranged from a perfunctory two-hour presentation at Wealstun to a seven-day programme at Deerbolt which, despite its length, did not fully engage prisoners. At Blundeston, a number of specialists delivered useful induction sessions but prisoners were not provided with enough basic information: only 56% of prisoners who had undergone induction said that it had covered everything they needed to know about the prison. At some prisons, including Whitemoor and Aylesbury, prisoners spent too much time locked in their cells when they were not engaged with structured induction sessions or any other purposeful activity.

There was limited input into induction from many key departments in the prison and many prisoners we spoke to were unaware of many of the basic routines and rules of the establishment. *(Wandsworth)*

Bullying and violence reduction

Bullying and violence in prisons can take many forms and include verbal and racial abuse, theft, threats of violence and assault. We expect all prisoners to feel safe from bullying and victimisation. Active and fair systems to prevent and respond to violence and intimidation should be known to staff, prisoners and visitors, and inform all aspects of the regime.

In 2011–12, 41% of prisoners who responded to our survey reported feeling unsafe. Feelings of safety were poorest at high security prisons, followed by local prisons. At Long Lartin, a high security prison, 64% of prisoners felt unsafe, while 58% felt unsafe at Pentonville, a local prison. At both types of prisons, the proportion of prisoners feeling unsafe was higher than at the same types last year. Just 6% of prisoners at Kirklevington Grange, a small resettlement prison, had ever felt unsafe.

Prisoners regarded Kirklevington as a very safe place, and this was reflected in positive responses to our survey and internal surveys. The careful selection criteria and prisoners' personal investment in their progress contributed to safety. Very few respondents said that they had witnessed any bullying in the prison. *(Kirklevington Grange)*

Resources applied to, and understanding of, violence reduction varied widely. Some prisons identified key concerns and developed a whole prison approach to tackling them. Belmarsh and Deerbolt, for example, had developed effective systems to collect data, monitor patterns of violence and implement effective violence reduction strategies. At Isis, a multidisciplinary committee reviewed a wide range of data to identify trends and hotspots to help develop strategies to reduce violence. The

Table 3: Have you ever felt unsafe in this prison?

Prison type	Highest %	Lowest %	Overall %
Local prisons	58 (Pentonville)	25 (Shrewsbury)	45
Category B trainers	35 (Rye Hill)	32 (Lowdham Grange)	33
Category C trainers	42 (Haverigg)	8 (Northallerton)	36
High security prisons	64 (Long Lartin)	60 (Whitemoor)	62
Young adults	45 (Isis)	24 (Northallerton)	38
Open/resettlement	12 (Hatfield)	6 (Kirklevington Grange)	9

prison identified repeated incidents of violence during prisoner mass movement and responded by stationing additional staff along routes to work and education and rearranging some movement and free flow times.

At other prisons, a wide range of data was collected but it was insufficiently analysed to identify problem areas, develop actions and inform strategy.

> The collection of data for the number and nature of violent incidents was underdeveloped and we were not assured that all information about suspected incidents was being investigated. *(Stafford)*

In most prisons, the security department appropriately shared information about violent or antisocial behaviour. In others, including Brixton and Wandsworth, links between the violence reduction and security teams were insufficiently developed. The addition of CCTV in some prisons, including Whitemoor, contributed to prisoners feeling safer.

There was not always a correlation between sound violence reduction structures and processes and the actual levels of violence or bullying in a prison.

Wandsworth was the only prison where we judged that safety outcomes were poor and where none of the elements that contribute to a safe prison were in place. Structures and processes were underdeveloped with erratic attendance at the violence reduction committee and inadequate links between security and the violence reduction departments. There was evidence of a significant number of violent and antisocial incidents as well as under-reporting of incidents.

Most prisons operated a staged response when responding to and monitoring perpetrators of violent or antisocial behaviour, which generally involved closer observation by staff. Sanctions included incentives and earned privileges (IEP) scheme warnings or reviews, often resulting in a downgrade to the basic level, as well as formal disciplinary procedures, wing moves or transfers to another prison. Beyond disciplinary procedures, responses to acts of violence by prisoners were often inadequate and we noted that violence reduction procedures at many prisons required improvement.

Only a few prisons delivered direct interventions to perpetrators of violence. Some prisons required perpetrators to take part in pro-social modelling or conflict resolution modules which required them to demonstrate and promote positive behaviour and encouraged socially acceptable confrontation techniques. At Chelmsford, perpetrators were expected to complete exercises designed to deal with the consequences and impact of their behaviour and to develop strategies to deal with anger. They were also expected to attend sessions addressing antisocial behaviour delivered by the violence reduction team.

Structured support for victims of violent or antisocial behaviour was not always well developed. Support was offered in some prisons, including targeted gym sessions at Dovegate for prisoners with low self-esteem. In many other prisons, however, victims were simply moved within the prison. In some prisons, including Wealstun, victims were moved to the segregation unit for their own protection to await transfer to another prison.

No training was provided centrally to prison officers and only a few prisons delivered local bullying or violence awareness sessions. At Swaleside, however, 59% of staff had undergone locally developed and delivered training on violence reduction. Other prisons told us they had training packages available, but there was very little evidence to show that these were ever delivered.

Self-harm and suicide

We expect prisons to reduce the risks of self-harm and suicide through a whole-prison approach. Prisoners at risk of self-harm or suicide should be identified at an early stage, and a care and support plan drawn up, implemented and monitored. Prisoners who have been identified as vulnerable should be encouraged to participate in all purposeful activity. All staff should be aware of and alert to vulnerability issues, be appropriately trained and have access to proper equipment and support.

In challenging circumstances, most prisons managed to care for and protect prisoners from harm. However, too many prisoners were still able to take their own lives. In 2011–12, there were 66 self-inflicted deaths in prisons across England and Wales.[5] Eighteen prisons experienced multiple self-inflicted deaths.[6]

A further 129 prisoners died of natural causes, one as a result of homicide and one from other non-natural causes, while 14 deaths remain unclassified.[7] Tragically, January 2012 saw a spike of 13 self-inflicted deaths in prisons, including two children and one young adult. At the time of writing, there is insufficient evidence to draw any conclusions about this sharp increase. The death of a prisoner is particularly traumatic for the prisoner's family and friends, but also for fellow prisoners and prison staff.

Whereas the number of self-harm incidents fell in women's prisons in 2011–12, self-harm incidents in men's prisons rose from 14,768 to 16,146.

Learning from deaths in custody is vital. We work closely with the Prisons and Probation Ombudsman whose role includes investigating all deaths in prison. During our inspections, we assess progress against recommendations made by the Ombudsman following his investigation into a death in prison. At all prisons where a death had occurred, we found that action plans had been put in place. In some establishments, however, recommendations were not regularly reviewed or reinforced and we saw examples, including at Risley and Long Lartin, where repeated concerns were not dealt with satisfactorily. At Manchester we found that there was insufficient priority and focus given to ensuring lessons were learnt from previous cases and, where possible, that causal factors were eliminated and not repeated.

We were not convinced that all staff understood that the preservation of life took precedence over security. This point was frequently emphasised in the Ombudsman's reports, yet we were concerned that some prisons were not consistently reinforcing this message to staff.

> We were not convinced that all staff understood that the preservation of life, over security, should be the primary consideration. This was also a recommendation from a previous investigation and highlighted the importance of periodically reviewing action plans. *(Risley)*

Some night staff who were in sole charge of a wing told us they would not enter a cell before backup arrived and they believed it was safe for them to do so, even if a prisoner's life was at risk.

Of the prisons we inspected where there had been self-inflicted deaths, strategic management of suicide and self-harm prevention was mostly reasonable. Most had comprehensive suicide prevention strategies and regular, well-attended committee meetings where trends and patterns of self-harm were analysed and where outcomes from death in custody investigations were discussed. Despite this,

5 Ministry of Justice, Safety in Custody Statistics Quarterly Bulletin January to March 2012 England and Wales (July 2012).
6 Figure from Prisons and Probation Ombudsman.
7 Unclassified deaths may later be classified as self-inflicted, natural causes or other non-natural causes.

however, in too many prisons, the day to day care of those at risk was inadequate and there was insufficient training to appropriately equip staff to care for and manage prisoners at risk.

Suicide and self-harm monitoring (ACCT) documents are used to observe prisoners identified as being at risk of suicide or self-harm. We were concerned by inconsistencies in individual case management. At Northallerton and Grendon, we found good examples of prisoners at risk being well cared for.

The quality of written entries in most of the ACCT documents we examined was very good and demonstrated that staff were aware of the personal circumstances of their prisoners. *(Haverigg)*

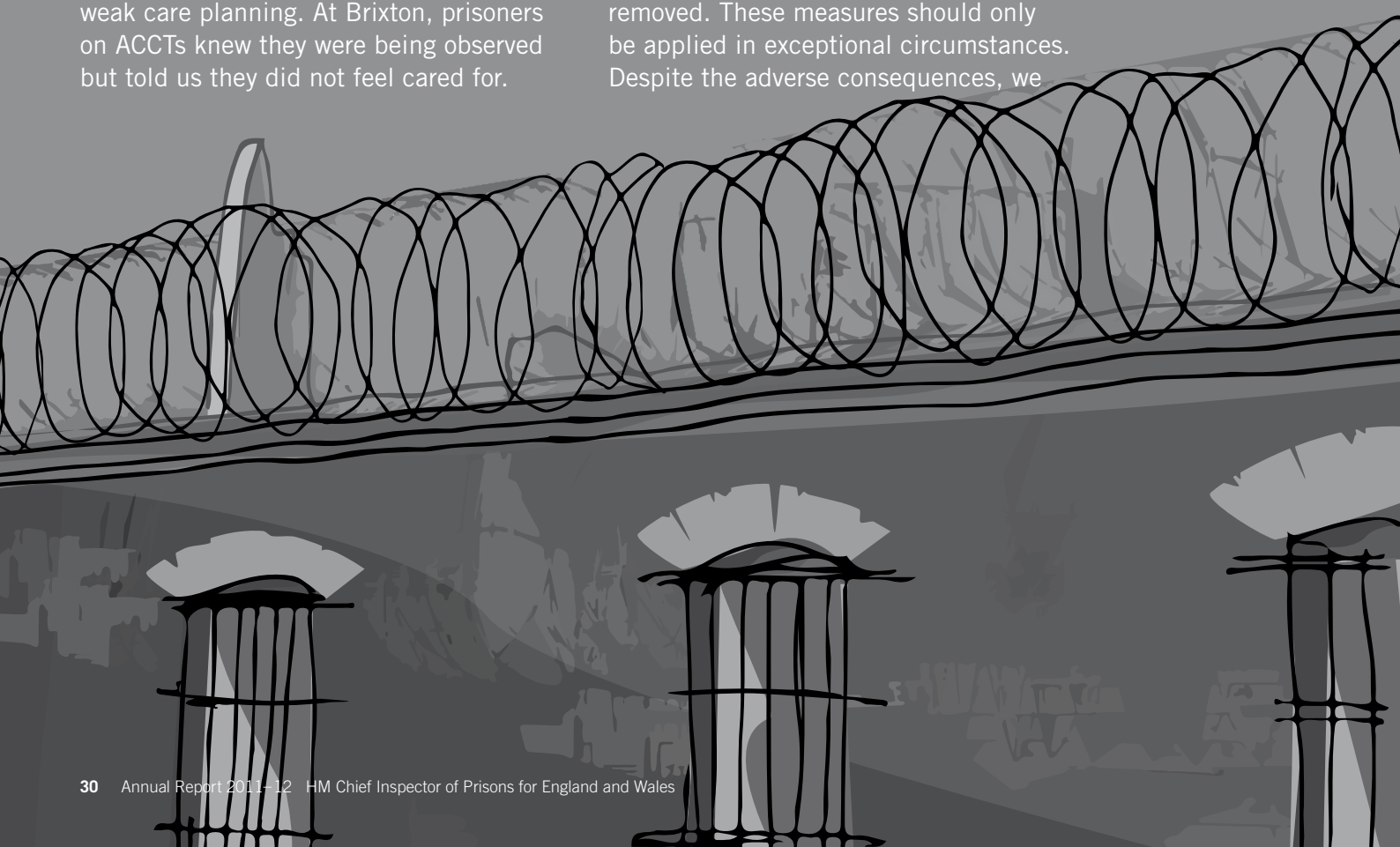
However, we experienced the converse at other prisons, including Long Lartin and Pentonville, where ACCT documents were poor or inconsistent and did not reflect good levels of care or engagement with prisoners. At these prisons, there was often a lack of multidisciplinary involvement and weak care planning. At Brixton, prisoners on ACCTs knew they were being observed but told us they did not feel cared for.

Many prisons had quality assurance measures in place, but too many were ineffective and did not result in necessary improvements in practice.

A review of closed and current ACCT documents revealed some frailties and reviews were rarely multidisciplinary; interactions did not always happen in line with the recommended frequency; written entries lacked evidence of meaningful interaction with prisoners. *(Stocken)*

We were pleased to see cases where those at risk had involvement and support from mental health professionals and where complex cases were subject to enhanced reviews. In a small number of prisons inspected, including Deerbolt, Risley and Peterborough, we found a range of particularly supportive interventions used to engage those at risk.

The distress of those at risk of self-harm or suicide may be increased by the segregation of prisoners already at risk, removal of their own clothing or placement in special accommodation cells from which all furniture and normal fittings have been removed. These measures should only be applied in exceptional circumstances. Despite the adverse consequences, we



observed such practice in several prisons without the necessary justification. We saw too many prisoners on ACCT documents being segregated, often in the absence of exceptional circumstances to justify this. In some prisons, constant observation cells, used to monitor those who pose an active and serious risk of suicide or self-harm, were inappropriately located in segregation units. These units were often austere environments which were not conducive to providing the necessary care and support for those in crisis. At several prisons, including Rochester and Blundeston, a number of prisoners on ACCTs had their clothing removed and replaced with strip clothing as a routine measure and without justification.

Listeners or other similar peer support schemes were available in all the prisons we inspected and continued to offer a highly valued service to prisoners at risk. In most prisons, access to peer support was good, even at night. We were disappointed to find that in a minority of prisons, Listeners did not feel valued or supported by some officers.

Vulnerable prisoners

Vulnerable prisoners are those who need protection from other prisoners for a variety of reasons, including the nature of their offence, debt or conflicts outside or within the prison. Practice varies across the prison estate: some sex offenders are placed in specialist prisons; some vulnerable prisoners are accommodated on specialist wings within a prison; and others are integrated with the general population. In some prisons, there was not enough space on specialist wings to accommodate all vulnerable prisoners, resulting in them being placed with the general population. At Brixton, vulnerable prisoners held on the overspill landing said they felt unsafe due to mainstream prisoners continually banging on their doors, taunting them and subjecting them to abuse. Some prisons inappropriately held vulnerable prisoners in the segregation unit due to a lack of space on vulnerable prisoner wings. At Doncaster, vulnerable prisoners were held on a wing adjacent to a unit holding mainstream young adult prisoners and were subject to abuse when taking exercise in the yard. As at a number of prisons, vulnerable prisoners at Doncaster had poor access to purposeful activity and were locked in their cells for most of the day.

It was surprising to find that some prisons, such as Stocken, did not have a reception and first night strategy setting out how vulnerable prisoners would be identified and supported. In too many prisons, reception and first night arrangements for vulnerable prisoners were inadequate. At Peterborough, only 53% of vulnerable prisoners, compared with 77% of the main population, said they had felt safe on their first night.

Security and rules

Security and good order should be maintained through positive staff-prisoner relationships as well as attention to physical and procedural matters. Physical security was sound in all establishments and while there were variations in the quality of dynamic security, it was rarely less than adequate. Dynamic security relies on positive staff-prisoner relationships, good intelligence about what is happening in the prison, effective processes for resolving complaints, prisoners being purposefully occupied with plenty of activity and achievable resettlement or long-term objectives. One of the best examples of dynamic security we found was at The Verne. Good staff-prisoner relationships, excellent time out of cell, sufficient employment and effective channels for prisoners to resolve complaints contributed to a stable environment and a consistent flow of security intelligence.

Most establishments were carrying out identified actions from assessed intelligence within appropriate timescales but, at a significant number of prisons, the quality of security analysis was inadequate. At Moorland, there was a more than 20% increase in security information reports (SIRs) in the six months prior to a major disturbance. This increase had not been identified or discussed at security meetings by senior managers. Security should

be proportionate and we were pleased that fewer establishments were placing prisoners on closed visits for reasons not directly linked to visiting arrangements.

Links between prisons and local police forces that led to effective joint work were improving. At Pentonville, for example, additional police monitoring around the perimeter walls had significantly reduced the amount of drugs thrown into the prison.

Segregation

Prisoners may be held in segregation as a punishment, for their own protection or because it is believed their behaviour is likely to be so disruptive that keeping them on ordinary location would be unsafe. We expect prisoners to be held in segregation for the shortest possible period under the supervision and care of appropriately trained and experienced staff. There should be a decent physical environment and, subject to the constraints of security or unless properly denied as part of an adjudicated punishment, prisoners in the segregation unit should have access to the same facilities and activities as prisoners on normal location. Good governance is essential. Overall, 11% of prisoners reported having spent a night in the segregation unit. This was highest for young adults (23%) and those in high security prisons (22%).

Most segregation units were clean, decent environments but there were some exceptions, notably at Chelmsford and Haverigg. Exercise yards remained austere and, despite the controlled conditions in segregation units, we often saw cells disfigured by graffiti.

> The exercise yards consisted of four individual cages in poor condition – they were stark and featureless with no seating or greenery. Prisoners could not participate in shared exercise regardless of their risk, so only a maximum of four prisoners (one in each cage) could exercise at a time. This meant that they had to press their faces against the metal cage and shout in order to talk to each other. *(Long Lartin)*

Regimes were invariably limited but usually appropriate for short-term prisoners serving punishments. However, too many prisons did not provide basic entitlements for segregated prisoners such as daily access to showers. It was rarely acknowledged that such regimes were inappropriate for those held in segregation for their own safety or that they had limited impact on changing the behaviour of those held for longer periods due to consistently poor behaviour.

> Prisoners who refused to return to residential units had their access to telephones and showers restricted to three times a week and one resident had gone eight days without a shower. The well-equipped association room was not used. In-cell electricity had been installed but televisions had been removed from all residents in an attempt to reduce the amount of time that they stayed on the unit. *(Wandsworth)*

Staff-prisoner relationships were very positive in most segregation units and were often the best examples of good relationships that we saw in each prison. Staff at Chelmsford and Wormwood Scrubs described their role as being predominantly about care. This description was borne out when we observed their interactions with prisoners.

> Relationships between staff and prisoners were very good. Officers dealt with difficult individuals respectfully, using high levels of care, and were clearly comfortable when dealing with prisoners. There was extensive use of preferred names and titles, and all residents we spoke to said that staff were kind and helpful. *(Chelmsford)*

In the majority of prisons, authorisation records completed by operational managers often did not support decisions to segregate prisoners. At Wandsworth, even the initial health care screening which determines whether segregation is appropriate had not been completed.

Despite reasonable multidisciplinary input at most prisons, routine reviews for prisoners remaining in units for longer than 14 days lacked sufficient depth. Subsequent targets for prisoners to achieve reintegration on mainstream wings were too generic, with little focus on underlying issues relating to prisoners' continued segregation. We often came across cases where, following a period of stabilised behaviour in the segregation unit, prisoners would be returned to mainstream wings and their behaviour would deteriorate, resulting in a return to segregated conditions. This cycle would repeat itself as the underlying causes of poor behaviour were not addressed. This was despite Prison Service Order 1700 which required formal care and reintegration planning processes. One notable exception was at Stafford where we saw reintegration planning at its most developed.

Personal officers visited segregated prisoners weekly and prisoners could attend activities off the unit to aid their progression to normal location. Each prisoner had a clear management plan. Reviews of segregation clearly showed prisoners' progress against targets and new targets set. All prisoners were reviewed 28 days after leaving the unit; issues were identified and dealt with swiftly and had resulted in a reduction in the number of prisoners held in segregation. *(Stafford)*

In some prisons, prisoners were too readily transferred from the segregation unit to other establishments without sufficient efforts to tackle the underlying reasons for their segregation and reintegrate them back on the wings.

There was a disturbing perception among prisoners and staff that victims of bullying were deliberately self-harming so that they would be placed on suicide and self-harm monitoring, moved to the segregation unit and then transferred out of the prison. We found examples that appeared to validate this perception. *(Wealstun)*

Strategic governance of segregation required improvement in many prisons. Senior managers often did not collate and analyse data on a routine basis. Where they did, analysis lacked sufficient depth to adequately inform strategic policy decisions relating to segregation arrangements.

Use of force

For the use of force to be lawful, it must be reasonable in the circumstances, necessary and proportionate. We expect all incidents of the use of force to be subject to rigorous scrutiny. Such rigorous scrutiny was, however, absent from most prisons inspected. Few senior managers reviewed use of force documentation and reviews of video recordings of planned interventions, such as barricading, were even less common.

Use of force documentation was reasonable but too often lacked detail and did not record efforts to de-escalate. Although planned interventions were video recorded they were not routinely reviewed. The use of force committee met regularly but governance and the quality and depth of scrutiny required improvement. *(Deerbolt)*

Strategic oversight was lacking in most prisons. Use of force data was either not routinely reviewed in any formal forum or not reviewed with sufficient depth or sophistication. In our surveys, 18% of young adults said they had been physically restrained by staff in the last six months, compared to no more than 7% in local, training, high security and open prisons.

Special accommodation

Special accommodation, from which normal furniture and fittings have been removed, should only be used when no other alternative is available and for the minimum period of time until a prisoner no longer poses an immediate risk to themselves or others. This is the most extreme form of custody and so it was unacceptable that effective governance was often lacking, both in terms of initial authorisation for the use of special accommodation and in continued oversight. Many establishments, such as Rochester and Blundeston, used special accommodation frequently but an analysis of records revealed its use was not always justified. Even in those establishments where the use of special accommodation was justified, supporting records and logs were often poorly completed.

> The use of special accommodation had increased considerably. It was usually used for short periods, although we came across one example of a prisoner who had been inappropriately held overnight. All prisoners who were placed in special accommodation were strip-searched, some by force, and placed in strip clothing. Governance was insufficiently robust and managers had missed major shortcomings in the application of procedures. *(Blundeston)*

A number of prisons continued to routinely strip-search prisoners when placing them in a special cell. This searching was always carried out by force. The routine placement of prisoners in anti-ligature clothing still occurred in some prisons even though few of the prisoners concerned had a history of self-harm and fewer still of using ligatures.

> Special accommodation was little used and usually only for short periods but prisoners were inappropriately placed in protective clothing when it was not necessary to prevent injury to themselves or others. *(Wormwood Scrubs)*

There was a small number of prisons where the use of special accommodation was either very low or non-existent. This included Doncaster, Peterborough, Lancaster Farms and Stafford. The defining characteristic of these prisons was a clear expectation from the governor or director that all managers and staff must provide strong justification for removing furniture and clothing from a prisoner.

Close supervision centres

Close supervision centres (CSCs) are managed centrally by the Directorate of High Security at NOMS. The CSC system provides a multidisciplinary approach to managing high risk prisoners who have demonstrated, or expressed a desire to demonstrate, violent and/or highly disruptive behaviour. The overall aim of the CSC system is to remove these prisoners from normal location, manage them within small and highly supervised units with appropriate interventions and specialist input, and then return the prisoners to normal or a more appropriate location as their risk reduces.

In 2011–12, we inspected one CSC at Whitemoor housing nine prisoners. Five men had reasonable time out of cell and intensive interactions with operational and specialist staff, as well as daily interaction with other CSC prisoners. Four men, who for disciplinary reasons or an unwillingness to engage with the regime, had a much reduced regime similar to that offered in segregation. Efforts were made to engage with these men to help them progress to the regime experienced by other prisoners on the unit.

The CSC was self-contained, small and claustrophobic. Prisoners rarely left the unit. The regime was limited in comparison to ordinary residential units and educational input was lacking. Visits were closely supervised by staff and afforded little privacy. Staff were, however, specially selected and trained to work on the unit.

Adjudications

Adjudications are formal disciplinary processes that should be conducted fairly. Any sanctions should be applied for a good reason that the prisoner understands. In 2011–12, we found that adjudication processes were appropriately followed in the majority of prisons, although we noted weaknesses where prisoners refused to attend proceedings. Of more concern was the number of establishments where adjudications recorded poor levels of enquiry before reaching a verdict. In many prisons, there was no formal quality assurance of adjudications by senior managers.

Incentives and earned privileges

We expect that incentives and earned privileges (IEP) schemes should be well-publicised, designed to improve behaviour and be applied fairly, transparently and consistently. All prisons are required to operate an IEP scheme which aims to encourage responsible behaviour by prisoners as well as their participation in work and activities. An IEP scheme generally has three levels: basic, standard and enhanced. The scheme rewards good behaviour and performance and removes privileges if expected standards are not achieved. Each prison decides what incentives it will offer to encourage prisoners to engage with the scheme and progress through the levels. Incentives can include additional visits, eligibility for higher rates of pay, access to in-cell television and increased time out of cell for association.

Some incentives were counter-productive or ineffective. It was unacceptable that prisoners could earn different levels of pay for the same job. Prisoners often told us that the differences between the standard and enhanced levels were not sufficiently meaningful to encourage them to progress. In addition, it could sometimes take too long for prisoners to progress to the enhanced level: at Pentonville, for example, prisoners had to demonstrate good behaviour for at least three months before they were considered for progression. This was ineffective given that the average length of stay at Pentonville was two and a half months.

In some prisons, we found that the application of the scheme was inconsistent and at others it was unfair or overly harsh. At Rochester, prisoners on the basic level were denied association. We also found that reviews of prisoners' status on the scheme were not always carried out as required. Too many prisoners on the basic level of the IEP scheme were set perfunctory targets.

In our surveys:

- 50% of prisoners said they felt they had been treated fairly under the IEP scheme
- only 46% said the different levels of the scheme encouraged them to change their behaviour
- 43% reported that they were on the enhanced (top) level of the IEP scheme.

Substance misuse – clinical management

Overall, clinical management continued to improve under the integrated drug treatment system (IDTS), but we still saw inconsistencies and some poor practice. First night treatment was inadequate at Belmarsh, Brixton and Wandsworth, yet at Chelmsford, a GP was available on the designated drug treatment unit until 9pm to provide first night prescribing, treatment was flexible and needs-led, and prisoners were offered an impressive range of activities and support services. At Wormwood Scrubs, we found a much improved service and prompt access to clinical support and, at Pentonville, it was evident that prisoners were fully involved in their treatment plan and a new substance misuse unit provided a much improved environment.

During 2011, we welcomed a shift in emphasis from long-term methadone maintenance prescribing towards a recovery-orientated drug treatment approach. In prisons such as Chelmsford and Lowdham Grange, prisoners were encouraged but not pressurised to reduce their dosage, they participated in regular treatment reviews, received a good level of support and their care was well coordinated. At Wayland, however, we reported serious concerns about the management of a recently imposed inflexible and non-individualised opiate dose reduction regime, which caused frustration and anxiety to prisoners. As a result, four prisoners had been placed on ACCT monitoring and there was a risk of overdose with illicitly procured drugs.

Prisoners experiencing substance and mental health-related problems still had difficulty accessing specialist services. The mental health team at Belmarsh was, for example, reluctant to see drug users. However, we saw good practice at Chelmsford and at Wormwood Scrubs, where a dual diagnosis nurse had found that 42% of prisoners admitted to the drug support unit also experienced mental health problems.

Substance misuse – supply reduction

In our last annual report, we highlighted the diversion of prescription drugs, such as Tramadol, Gabapentin and Pregabalin, in high security and vulnerable prisoner populations. This year, we saw this trend spreading to mainstream populations and it has become a major concern. These prescription drugs are not routinely detected under current mandatory drug testing (MDT) procedures. At Brixton, we found that the MDT rate had fallen but the availability of drugs was the most frequently identified safety issue. Diverted medication is now reported in the majority of prisons we inspect, resulting in problems such as drug debts, bullying, unknown interactions with other prescribed drugs and the risk of overdose. At Long Lartin, a trial was run to determine the effectiveness of random tests for Tramadol and Gabapentin. The roll-out of this pilot will have a significant effect on MDT rates, which do not currently reflect actual prevalence.

In terms of illicit drugs, MDT figures and finds pointed to the use of cannabis and Subutex, rather than heroin. Subutex use was more evident at prisons in the north of the country. At Wealstun, the MDT rate stood at 16.5%, 45% of prisoners said it was easy to get illegal drugs and 17% reported having developed a problem with drugs in prison. The prison had cancelled 79 MDT sessions in the previous six months, resulting in little suspicion or risk testing. At Belmarsh, less than 50% of requests for suspicion tests were met and at Haverigg it was less than 20%. Haverigg did not even manage to consistently test 5% of the population under random MDT.

> In our surveys overall, 29% of prisoners reported having a drug problem when they arrived at the prison and 6% said they had developed a drug problem since their arrival. Twenty-four per cent of prisoners reported that it was easy or very easy to get drugs in their prison.

We found good practice at Rye Hill where security staff linked well with the drug strategy, drug-related SIRs were shared with health and counselling, assessment, referral, advice and throughcare (CARAT) services, and the establishment had developed a detailed supply reduction action plan which was reviewed regularly.

Respect

Prisoners are treated with respect for their human dignity.

In 23 establishments holding adult male prisoners, outcomes relating to respect were good or reasonably good. Outcomes were not sufficiently good at nine prisons and poor at three. We carried out 11 short follow-up inspections where eight prisons were judged to be making sufficient progress on respect-related issues, and three were making insufficient progress. During our follow-up inspections, we found that more than two-thirds of our respect-related recommendations had been achieved or partially achieved.

Table 4: Respect in adult male establishments

	Outcomes poor	Outcomes not sufficiently good	Outcomes reasonably good	Outcomes good
Locals	1	2	5	3
Trainers	1	5	8	1
Young adults	0	1	4	0
High security	0	1	1	0
Open/resettlement	1	0	0	1
Total	**3**	**9**	**18**	**5**

Staff-prisoner relationships

We expect that prisoners are treated respectfully by all staff and are encouraged to take responsibility for their own actions and decisions. At the majority of prisons inspected, relationships between staff and prisoners were reasonably positive and many had improved in this area.

In our surveys, 70% of prisoners said that most staff treated them with respect. This ranged from 85% of prisoners in Category B trainers to only 64% in young adult establishments. Overall, 72% of prisoners said they had a member of staff they could turn to for help if they had a problem, with prisoners in Category B trainers again reporting most positively (82%), compared with only 69% of those in high security prisons. At Manchester, where the governor actively modelled the behaviour he expected of staff and prisoners, our follow-up inspection found that 73% of prisoners said staff treated them with respect, compared with 56% at the previous inspection, and 78% compared with 68% said they had a member of staff they could turn to with a problem.

It is striking that in the small number of prisons where staff-prisoner relationships were not as positive, outcomes were not sufficiently good across at least two of our four healthy prison tests. At Wandsworth, for example, where outcomes were poor or not sufficiently good in three areas, we observed indifference and disinterest from staff and, on a few occasions, abusive language towards prisoners. Isis was a new prison and had not been able to recruit sufficient permanent staff. A combination of relatively inexperienced new recruits who lacked confidence, and detached duty staff drafted in from other prisons – too many of whom had low expectations and a dismissive attitude towards prisoners – meant that managers struggled to embed the positive culture and relationships they were keen to develop. The structure of the core day meant that officers and prisoners could avoid each other and minimise their interaction. During our inspections of both Wandsworth and Isis, we were at times overwhelmed by the number of prisoners who wanted to complain to us about poor treatment by officers.

We often find prisoners reporting that most staff are respectful but that a minority of staff members damage relationships overall. At Long Lartin, prisoner perceptions of staff varied in different parts of the establishment. At some prisons, such as Aylesbury, staff were respectful but distant.

Personal officers

The personal officer scheme, giving each prisoner a named member of staff to turn to for help, was being maintained at a reasonable level in many establishments, although the quality of the scheme's implementation was patchy. In some places, such as Kennet and Dovegate, the scheme was working effectively.

The Prison Service P-Nomis IT system enables personal officers to make regular entries on a prisoner's record and allows managers to check those entries. The system was being well used at some prisons but at others, there was inconsistency in the frequency and quality of entries. Management checking of entries was not always reliable and we noted that managers in most prisons could do more to improve the quality of personal officer work.

In some establishments, the personal officer scheme existed on paper only and barely at all in reality. This was especially true of prisons in London, including Brixton and Wandsworth. In other prisons, prisoners knew who their personal officer was but had little contact with them.

Environment

We expect to find prisoners living in a safe, clean and decent environment within which they are encouraged to take personal responsibility for themselves and their possessions. Of the 46 adult male establishments inspected in 2011–12, 29 were overcrowded at the time of our inspection. In a substantial number of prisons, cells housed more prisoners than the number for which they were designed. For example, cells at Featherstone designed for one prisoner were occupied by two and cells at Belmarsh designed for two prisoners were occupied by three. Many cells in the prison estate were too small and cramped. These conditions were not limited to older buildings. Against this trend, Swaleside had, commendably, moved to single occupancy throughout.

On the whole, the condition and cleanliness of residential areas was reasonable and, in some establishments, the wings were very clean. However, there were still too many exceptions. At Brinsford, the quality of accommodation on most house blocks was extremely poor. Many of the older wings were dirty with damaged floors, burnt windows and high levels of graffiti. At several prisons, there was an inconsistent standard of accommodation: at Wayland and Blundeston, conditions on older wings contrasted sharply with much better accommodation on newer wings. There was graffiti in many cells at Wandsworth and those at Brixton were often dirty and shabby. Similarly, some old cells at Maidstone were cramped and dark while unrepaired broken windows were a problem at Manchester and Wormwood Scrubs. It was not inevitable, however, that older buildings were in poor condition – at The Verne, residential units were showing their age but were kept clean.

Secure lockers in cells, especially shared cells, are important for preventing theft and promoting good order, yet they were absent in shared cells at several prisons. The extent to which published rules on offensive displays in cells were followed was an indicator of the levels of staff supervision in residential areas. On the whole, standards were good but at Wealstun, for example, there was a large amount of offensive material.

We expect that prisoners are able to use both communal and in-cell toilets in private. However, screening of in-cell toilets was inadequate in many prisons, even in the newly built Isis. At Belmarsh, where cells were mainly clean, toilets were dirty and scaled. At Long Lartin, the residential wings for vulnerable prisoners were older than the rest of the prison and still operated night sanitation arrangements, which limited and delayed prisoners' access to the most basic sanitation. Some prisoners were forced to use buckets and

'slop out' when they were unlocked. Similar night sanitation systems were still in use at Grendon and Blundeston.

Most prisoners had reasonable (though not always daily) access to showers. Prisoners were not always able to shower in privacy at some establishments and Deerbolt lacked a sufficient number of showers for the population. In our surveys, only 69% of young adults said they could have a shower every day against an average of 82% across all prisons. Showers at Brinsford were dirty and unhygienic while those at Wealstun were poorly ventilated. Showers at many other prisons were substandard.

The supply of prison clothing was generally adequate but was insufficient at Featherstone and Pentonville and in poor condition at Brinsford. At some training or open establishments, too many prisoners were wearing prison clothing rather than their own.

Mail and telephones

Access to telephones in residential units was reasonable in most prisons. Some had improved in this respect, such as Featherstone, but there was a shortage of telephones at Manchester and other prisons. Telephones were still sited in noisy areas and without privacy hoods in some prisons. In-cell telephones had been installed at a few establishments, including Lowdham Grange and Dovegate. At these two prisons, as well as a few others, electronic kiosks on wings enabled prisoners to take direct responsibility for many routine tasks such as booking visits, ordering purchases and buying telephone credits.

Focus: Wandsworth

There were large amounts of graffiti in cells, and although we were told that staff were aware of this, little had been done to rectify it. There was an offensive display policy posted on wings but during the inspection we saw a number of examples of material on display in cells which did not conform to the policy. We were told that cells were inspected by staff but there was evidence that this was ineffective in many cases.

In our survey, only 54% of prisoners said that they could shower every day, which was significantly worse than at comparator establishments (80%) and than at our previous inspection (79%). Fifty-one per cent of prisoners (against a comparator of 31%) said that they had problems accessing telephones. For most prisoners, access to telephones and showers was limited by the short amount of time out of cell every day. Many had to choose between using the telephone or showering during their social and domestic periods. Because of queues, there was often insufficient time to do both.

Although there were generally sufficient telephones on the wings, a number did not work at the time of the inspection and, on some landings, despite queues to use them, the telephones were not turned on. Even where telephones were working, they were often poorly sited and lacked privacy hoods.

Food and shop

In many prisons, prisoners had poor perceptions of the food, but what we saw was of a reasonable quality. The quality and quantity of food was clearly uneven at Isis and Pentonville. Only 14% of those in high security prisons thought that the food was good, against an average of 27% in all other prisons. Rising food prices and static budgets have led to some food, such as some meat products, being available less often. In the great majority of prisons, breakfast packs were distributed the previous evening, which was poor practice. Other meals were served too early (for example, lunch before noon or dinner before 5pm) at several prisons, including Pentonville and Whitemoor. There were few opportunities for communal dining; most prisoners ate their meals in their cells which, in many cases, were shared and had inadequately screened toilets.

A good standard of food hygiene was generally observed in kitchens and serveries. However, at Manchester hot food was sometimes cold by the time it was served. At Lindholme, the kitchen facility was poor and not adequate to provide for the number of prisoners held. Many items of equipment were out of order. The food trolleys were filthy and food was left on the wings overnight.

The options for prisoner purchases became more uniform in 2011–12 as a national supply contract covered all public sector prisons. The contract limited the number of items stocked locally but provided an opportunity to review stock quarterly. Prisoners were affected by the rising cost of their purchases and static pay rates. The needs of different groups of prisoners were largely provided for and regular consultation fed into the quarterly stock review in most establishments. In some prisons, however, prisoners from minority groups were not happy with the range of goods available. Prisoners could also purchase some goods from catalogues but there was often an administration fee which, for just one item, could equate to 20% of the weekly allowance of a retired prisoner.

Equality and diversity

We expect that prisons demonstrate a clear and coordinated approach to eliminating discrimination, promoting equality of opportunity and fostering good relations, ensuring that no prisoner is unfairly disadvantaged. Prisons should develop, implement and monitor policies and plans to meet the specific needs of minority groups. Multiple diversity needs should be recognised and met.

At the beginning of this reporting year, NOMS issued a Prison Service Instruction on ‘Ensuring Equality’ which significantly changed the diversity regime that had developed over the preceding 10 years. The emphasis moved from detailed prescription of process to a focus on the responsibility of local managers to ensure delivery of a range of required outcomes. At the same time, NOMS and individual establishments were coming to terms with the implications of the Equality Act 2010 which gives equal weight to a wider range of diverse groups, or ‘protected characteristics’.

Some establishments were taking this new context as an opportunity to move forward. At Featherstone and Dovegate, senior managers were allocated to specific diversity strands and were taking action. In other prisons, responsibility for particular diversity strands had been devolved to less senior staff who sometimes did not have sufficient time or support to be effective. It remained the case that in many prisons, the focus on race equality significantly outweighed that of other protected characteristics.

Prisoner diversity representatives were increasingly covering a number of different protected characteristics and were working well in several establishments. In some prisons, these representatives had become

the main focus so that the wider population was less involved. At Manchester for example, there were regular cultural awareness events but they were largely aimed at the representatives themselves. Most prisons lacked regular focus groups for members of specific minorities. Where equality action teams met regularly with good attendance from both staff and prisoners, they were often effective. At Rochester, an enthusiastic diversity team was making a real impact.

> Provision for diversity was good and had a high profile across the prison. There was a comprehensive diversity policy, informed by a thorough analysis of the population. The diversity, race and equality action team was effective in addressing issues through an equality action plan. A wide range of support groups was led by the equality manager. *(Shrewsbury)*

The use of equality impact assessments, in which much effort had previously been invested as a way of testing and addressing the potential for discrimination in prisons, had fallen as the pressure for them from NOMS had eased. Ethnic monitoring continued to generate useful local data but the need for monitoring across other protected characteristics was clear. We regretted that the short-term monitoring tool introduced by NOMS for this purpose was scarcely being used.

In a number of prisons, equality and diversity work was simply underdeveloped and had a low profile. A lack of overarching policies and up-to-date action plans at some prisons indicated a lack of attention to these issues. In contrast, at Belmarsh and Brixton, well thought out strategy documents were providing a good basis for progress. A lone equalities manager was responsible for both Hatfield and Moorland prisons and, consequently, was only able to give a patchy and reactive service.

Race equality

While the traditional focus on race equality issues in prisons had broadened to cover other aspects of equality, there were no grounds for complacency in relation to race and ethnicity. At Erlestoke, for example, training on race and cultural awareness for staff was no longer provided and positive race relations were not promoted strongly enough.

Our surveys continued to show more negative perceptions on the part of black and minority ethnic prisoners across a range of issues, including feelings of safety and victimisation by staff. Perceptions were poor at Manchester, where some consultation with black and minority ethnic prisoners had been attempted but with little outcome. The cultural awareness of many staff was questioned by prisoners in several prisons, especially those where the black and minority ethnic population was low.

Prisoners' perceptions were not intrinsically negative. The perceptions of black and minority ethnic prisoners at some prisons were broadly equivalent to or more positive than those of white prisoners. At The Mount, a prison which we have criticised before in relation to race equality, just over half of the prisoners were from black and minority ethnic backgrounds and this group reported more favourably than white prisoners across many areas (though not on relationships with staff). The prison had dedicated resettlement and mentoring provision for black and minority ethnic prisoners.

> Prisoners from a black and minority ethnic background did not complain of unequal treatment. Systematic monitoring and analysing of race equality treatment (SMART) monitoring was undertaken monthly and appropriate action taken. Racist complaints were investigated appropriately and a thorough set of quality checks was in place. There was a regular group for Gypsy and Traveller prisoners. *(Wealstun)*

Ethnic monitoring showed that proportionally more black and minority ethnic than other prisoners were segregated, subject to the use of force and adjudications and on the basic level of the IEP scheme at some establishments. These establishments included Chelmsford, although it was responding actively to the problem. At some prisons, a number of black and minority ethnic prisoners felt that the better jobs were more often allocated to white prisoners. Work allocations were monitored by race in some prisons but not others.

The investigation of alleged racist incidents was sound in many establishments but not in others. The requirement for external scrutiny of these investigations had been withdrawn nationally and the practice had fallen away in some prisons but was carried on in others. Aylesbury had imaginatively introduced 'racist incident report forums' where prisoners reviewed anonymised cases to help build confidence in the system. In a number of establishments, reports of racist incidents were falling but the reasons for this were unclear.

> Black and minority ethnic prisoners gave us examples of what they perceived to be racist behaviour by staff. We were not assured that these issues had been responded to or investigated with sufficient rigour. *(Isis)*

Work to support members of the Gypsy and Traveller communities was taking shape in a few prisons. At Wormwood Scrubs, although 9% of those responding to our survey were from these communities, there was no specific support for them. At Wayland, some prisoners from a Gypsy or Traveller background complained that inappropriate name calling by staff and prisoners was not challenged.

A regular programme of cultural events to promote good relations between groups of prisoners was in place at Pentonville, Brixton and Whitemoor. Generally, however, this type of activity was not on the increase.

Foreign nationals

As at 31 March 2012, there were 10,337 foreign nationals in prison in England and Wales, almost 12% of the prison population. In our last annual report, we noted the establishment of 'hub' prisons where foreign nationals were to be concentrated, and 'spoke' prisons. Hub prisons would have permanent UK Border Agency (UKBA) staff while spokes would have regular visits from them. The purpose of this hub and spoke system was to facilitate deportation, removal or early release and to reduce the number of foreign nationals held.

At Risley, a hub, there was good UKBA presence but no independent immigration advice and a generally low level of support for foreign national prisoners. At two spoke prisons, Maidstone and Haverigg, there was inadequate provision for foreign national prisoners but UKBA did attend regularly. UKBA staff were better engaged than previously in number of prisons inspected this year. However, outside the hub and spoke system, the service had deteriorated or was simply unsatisfactory.

> The prison was not maintaining a reliable record of foreign national prisoners and we were not assured that their needs were being met. UKBA had not been to the prison in the previous 12 months and decisions from UKBA regarding intention to deport were not readily forthcoming and had delayed re-categorisation decisions. *(Wealstun)*

In our surveys, the perceptions of foreign nationals were generally more negative than those of British prisoners, including at Risley where a greater proportion of foreign nationals than British nationals felt unsafe at the time of our survey (27% compared with 13%). At another hub, Wormwood Scrubs, foreign national prisoners reported more positively than British prisoners on most aspects of their experience. This largely resulted from the establishment of good peer support networks. At Bedford,

there had been considerable progress with the appointment of a dedicated liaison officer, weekly meetings with UKBA and prisoner representatives and effective consultation. In a few prisons, including Belmarsh, foreign national coordinators with sufficient time to perform their role were proving effective.

However, almost no prison had carried out any analysis of the needs of foreign nationals in their population. Regular immigration advice surgeries were held at some prisons, including High Down, and UKBA staff were regularly available, but provision had declined at Wymott. Independent immigration advice was not available at several prisons.

There was an up-to-date and reasonably comprehensive foreign nationals policy. A comprehensive action plan, drawing on issues identified in monthly foreign national forums and an annual questionnaire, was managed by the foreign national coordinator. There were good systems to identify foreign national prisoners and ensure links to UK Border Agency. *(Chelmsford)*

Many prisoners were still being held under immigration powers beyond the end of their sentence. This included 55 men at Wandsworth, one of whom had been held in prison for more than three years beyond the end of his sentence. It was still too common for prisoners to be given very short notice of continued detention, with the intention to remove, beyond the end of their sentence.

The use of telephone interpretation for a variety of purposes, not just the most formal interactions, is vital to decent treatment of foreign national prisoners who are not fluent in English. Telephone interpretation was underused at several prisons. The only prison where we found fully appropriate use of telephone interpretation was Rochester, where its use was closely monitored and promoted and where it could also be accessed by peer support workers. In some prisons, such as The Verne, prisoners were used inappropriately to interpret for their peers, including during health care interviews. The provision of translated written materials was inadequate in several prisons.

'I was given no information where I was, why and for how long. I wasn't informed how to use the telephone or canteen. I was given no information about visits or how my bed sheets would be changed.' *(One of the 578 foreign national prisoners at Wandsworth)*

Faith and religious activity

Across the establishments inspected this year, 54% of prisoners believed that their religious beliefs were respected. Chaplaincy continued to be one of the areas of provision most appreciated by prisoners. The coverage of different faiths was good across almost all prisons, and chaplaincy staff were engaged in the mainstream life of the establishments, as well as catering for their own constituencies. In many places, especially Risley, chaplains were very involved in the care and support of those at risk of self-harm and, at Northallerton, chaplains worked with victims of bullying. At The Verne, chaplains had done some good work in contacting the families of foreign national prisoners.

The chaplaincy team provided a full range of weekly services for all the main faiths and pastoral support for prisoners and their families, as well as running a range of faith-based and other courses. Chaplains were well integrated into the life of the prison and made regular entries in history sheets that showed they had a good knowledge of prisoners and actively engaged with them. *(Whitemoor)*

Chaplaincy services had improved at several prisons and the increased number of hours provided for Muslim chaplaincy may have

contributed to more positive perceptions of access to chaplains on the part of Muslim prisoners. At Lowdham Grange, the experience of Muslim prisoners was particularly positive but this was far from universal. Muslim prisoners were much more likely than those from other faiths to report that they had been victimised by staff (39% compared with 23%). At Wandsworth, Muslim prisoners reported overwhelmingly negative experiences compared with non-Muslim prisoners, particularly in relation to safety and respect: 60% of Muslim prisoners, compared with 31% of non-Muslim prisoners, said they had been victimised by staff and nearly half (47%) said they had felt threatened or intimidated by staff, compared with 25%. Muslim prisoners at Wandsworth felt significantly less respected by staff (37% compared with 60% of non-Muslim prisoners) and fewer felt there was a member of staff to whom they could turn for help (45% compared with 60%). At Whitemoor, Muslim prisoners said that many staff were unsure how to relate to them without resorting to assumptions about extremism.

The religious diversity of the prison population was generally reflected in the evolution of faith provision, but space for Muslim worship was still inadequate in several prisons and approaching capacity at others. At Rochester, some prisoners were excluded from workshops through disproportionate security measures. Provision for ablutions was not always satisfactory. Prisons had, however, become more competent in catering for the observance of Ramadan.

A well-integrated chaplaincy team offered a range of services and faith classes in a suitable multi-faith venue. Prisoner access to the chapel and facilities was good with a large number attending weekly events and services. The Muslim chaplain and the establishment as a whole offered impressive support to Muslim prisoners and promoted Islamic awareness. The resettlement chaplain offered good links with community faith groups for prisoners on release. *(Belmarsh)*

Facilities for other faiths were not always as good as for Christians and Muslims. At Pentonville, the mosque and chapel were well equipped but the synagogue had become a multi-faith room and was small, shabby and lacked a toilet. In our surveys, those belonging to minority religions reported more negatively across many areas of prison life than Christian denominations or those with no religious affiliation. This was particularly true of the very small Jewish population surveyed.

Chaplaincies were developing better through-the-gate links with community faith groups at several prisons. At Wayland, there was a designated resettlement chaplain who linked prisoners due for release with faith communities in their area and community chaplaincy groups. This work was less developed elsewhere.

Faith awareness courses for staff and prisoners were a useful part of the training programme at Isis and Whitemoor, while at Shrewsbury a new course for Muslim prisoners had been introduced to support reintegration into their communities.

Sexual orientation and transgender prisoners

Few prisons we inspected had effective strategies for combating homophobia. Sexual orientation and gender remained generally the least well protected characteristic in prisons under the Equality Act 2010, though most prisons accepted our recommendations that these characteristics should be included in their diversity and equality policies and the subject of action plans.

Some prisons had established support and consultation groups for gay, lesbian, bisexual and transgender prisoners but their development remained patchy. Prisons reported that such groups were difficult to sustain because gay prisoners were reluctant to be visible. Monitoring of sexual orientation could encourage gay prisoners to come forward. At Brixton, the prison was unaware of the number of gay prisoners but, in our survey, 5% of prisoners described themselves as gay or bisexual. A support group for gay prisoners was no longer running.

Often there was only one transgender prisoner at a time in each establishment, a situation which could result in them feeling isolated and unsafe. We sometimes found good services being offered, usually where there was an effective policy. These included the opportunity to wear clothes and make-up appropriate to the gender to which the prisoner was transitioning, information about sources of support, and strategies to combat transphobia among staff and prisoners. A new Prison Service Instruction (PSI) had come into effect in March 2011, providing guidance to prisons on the care and management of transsexual prisoners. It seems likely that this had a positive impact: in the period following publication of the PSI, two transsexual prisoners reported to us that diversity staff had shown interest in how they felt they had been treated and wanted to learn from their experience.

Disability and older prisoners

Disability liaison officers were in place in some establishments but many lacked sufficient time to develop work with disabled and older prisoners. In our survey, disabled prisoners continued to report less access to the regime – including education, exercise and association – than non-disabled prisoners. We sometimes found that questionable security imperatives got in the way of making the reasonable adjustments required by the Equality Act 2010. At Stocken, one prisoner had his own electric wheelchair but was unable to retain it in his cell overnight as the security department thought he might use the battery to charge a mobile telephone, even though the prisoner had no history of using a mobile phone in the prison.

Care plans for disabled prisoners were sometimes developed by health care staff but not shared with residential officers. Many night staff did not know about prisoners' personal emergency evacuation plans (PEEPs). At some establishments, the picture was better: the disability liaison officer at The Verne interviewed all prisoners who identified themselves as having a disability, talked through their specific needs and agreed action to support them. There were good examples of specific individualised care and prisoners with disabilities felt they received good support. However, at Whitemoor, two wheelchair users received inconsistent support. Staff would not push them on the grounds that they had not been trained to do so and, if prisoners attempted to do without their wheelchairs, comments were made about them feigning disability.

The proportion of older prisoners (those aged 50 and over) in the adult male prison estate has grown significantly: in 2002, they represented 7% of the population but this had risen to 11% in 2011. The number of prisoners aged 60 and over almost doubled between 2002 and 2011.[8] Despite this, prisons did not

8 Ministry of Justice, Offender management caseload statistics 2011 – Table A1.4.

always pay sufficient attention to the needs of older prisoners. We often found that retired prisoners had to pay for their in-cell television despite the low rates of retirement pay. At some establishments, retired prisoners were unlocked during the working day but there were often no structured activities for them. Wayland held 74 prisoners over the age of 50 at the time of our inspection but there was little consideration of their needs apart from a dedicated session in the gym for older prisoners. There was no specific policy addressing the needs of older prisoners and no mechanism for regular consultation.

Applications and complaints

Nearly half of all prisoners in our surveys had made a complaint. Eighty-two per cent of high security prisoners reported making a complaint, compared with only a quarter of those in open prisons. Some complaints were low-level and could have been dealt with informally or through applications, but at Long Lartin prisoners told us that this was not encouraged.

Prisoners had little faith in complaints procedures. Only 28% who had made a complaint in our surveys said their complaints were treated fairly and 36% that their complaints were answered promptly. The quality of replies varied between establishments. At Lowdham Grange, we found prompt and respectful responses to complaints but 12% were withdrawn before they were investigated, with no recorded reasons. The prison had developed an excellent training package to improve the quality of replies but it had reached few prisoners.

Prisoners at High Down told us they were reluctant to complain because of potential repercussions. Despite this, the number of complaints was high.

Black and minority ethnic prisoners perceived complaints systems more negatively than white prisoners. In our surveys, more black than white prisoners said they had made a complaint (49% compared with 47%). Fewer black than white prisoners said their complaints were dealt with fairly (24% compared with 30%) and promptly (34% compared with 37%).

Legal rights

Legal services varied between establishments. At Featherstone, Lindholme and Peterborough, legal services officers saw all new arrivals. We found improved services at Chelmsford and, at The Mount, legal services provision was good but not widely advertised. Prisoners appealing against their conviction or their sentence could borrow laptops through the access to justice scheme at some prisons.

Other prisons offered less effective services. There were no trained legal services officers at Blundeston, Pentonville and High Down. Whitemoor lacked legal visits rooms to conduct confidential interviews. Legal visits were only allowed two days a week at Aylesbury and at Manchester there was a backlog in legal services applications.

In our surveys, 43% of prisoners said it was easy to communicate with their legal representative. However, this fell to 38% in local prisons where efficient communication with legal representatives was required due to the number of remand prisoners and appeals against sentencing and conviction. Only one-fifth of those held in local prisons said it was easy to obtain bail information. Forty-one per cent of prisoners said confidential legal mail had been opened without them being present. In high security prisons, this proportion rose to 63%.

Black and minority ethnic prisoners reported negatively in our surveys in relation to legal rights. Fewer black and minority ethnic than white prisoners said it was easy to communicate with their solicitor, attend legal visits or obtain bail information.

Health care

We expect that prisoners should be cared for by a health service that assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. The standard of health service provided should be equivalent to that which prisoners could expect to receive in the community.

The Inspectorate has established effective working relationships with the Care Quality Commission, as well as other health care professional and regulatory bodies in England, Wales and Northern Ireland, to assure standards of care.

Commissioning, provision and governance

Primary Care Trusts (PCTs) commissioned prison health care services. The infrastructure was being developed to begin national commissioning of offender health. In prisons where tendering for services was underway, there was uncertainty; we observed periods of paralysis until the outcome of the contracting round was known. This led to lack of development and reluctance to fill vacancies, sometimes over protracted periods. In some prisons, particularly those with services provided by non-NHS suppliers, contractual arrangements were complex with multiple providers. While governance had generally improved, some prisons continued with fragmented and unsatisfactory arrangements.

All prisons had services that had developed as a result of health needs analyses. In some cases, the analyses were insufficiently comprehensive and many were out of date. Few included the social care needs of dependant and older prisoners.

We saw improvements in the employment of nurses and doctors but there were areas of the country where failure to attract permanent staff had become a chronic issue. This led to an over-reliance on agency staff which affected the continuity of care. Many prisons had introduced their own nurse banks to alleviate the problem and some had taken steps to better manage sickness and absence. Most prisons had well developed on-call arrangements. At Kennet prisoners had no access to pain relief out-of-hours except for those permitted in-possession medication.

Complaints and service user participation

Prisoners could sometimes only make health care complaints through the general complaints system which did not provide sufficient patient confidentiality. Prisons used both prison and PCT complaints systems but few used the PCT Patient Advice and Liaison Service (PALS) effectively. Some prisons had arranged access for prisoners to the Independent Complaints Advisory Service, though neither this nor PALS were well advertised. Prisons employed a variety of methods to consult with service users but consultation was problematic in prisons with a high turnover of prisoners. A few prisons, such as Manchester and Long Lartin, adopted the 'you said – we did' system which was effective, with feedback prominently posted outside the health care room on the wings.

Environment of care

Prisons continued to improve the physical environment of care, yet we still found rooms that were unfit for purpose in many. At Rye Hill, the range of therapeutic activities offered to patients had outgrown the capacity of the physical environment. The majority of prisons had infection control audits and consequent action plans to ensure compliance with standards. At Long Lartin, we observed systematic infection control and high standards.

All prisons had introduced SystmOne, an electronic system for the management of clinical information. The standard of record keeping had improved with appointments made more efficiently and better monitoring of issues such as waiting times. Although most prisons monitored and managed

non-attendance rates, they were still too high in some. In a minority of prisons, we found that health care beds were still being used for non-clinical purposes as part of prisons' certified normal accommodation. This practice should cease.

Treatment and care

All prisoners received health screening on reception to prison. A few prisons, including Rye Hill, had introduced the Learning Disability Screening Questionnaire which was good practice. Secondary health assessment was being more consistently undertaken. Standards of patient care were generally good, but in some prisons there was an absence of care plans for patients with long-term conditions. Some clinics were provided inconsistently due to staffing shortages. There was an increased trend for advanced nurses to lead clinics that were once GP-led. At Isis, we saw nurses running immunisation and vaccination clinics who had not received additional training. We welcome nurse-led initiatives as long as nurses are appropriately trained and competent.

Dental services continued to offer a generally good standard of care, but waiting times and non-attendance rates were problematic in some prisons. In our surveys, only 12% of prisoners across the estate said it was easy or very easy to see the dentist. This ranged from 7% in Category B trainers to 45% in open prisons. Pharmacy services continued to improve but attention was required at several prisons to ensure that standard operating procedures were adhered to, processes were audited, and patients were able to access and take advice from qualified pharmacists. We welcomed the publication by the Royal College of General Practitioners and others of 'Safer Prescribing in Prisons', which we hope to see more widely used in the coming year.

Clinical supervision was available to nurses but in some prisons it was inconsistent and in the majority not recorded. There was good attention to the mandatory training of staff and, in a handful of prisons, the prisoners also participated. For example, at Kirklevington Grange, prisoners were trained to use automated external defibrillators alongside health professionals.

Many more prisons had developed excellent evidence-based approaches to palliative care and the care of lifelong incapacitating illnesses. We saw good and caring practices in several prisons to ease the suffering of terminally ill patients and their relatives. At Manchester, a dedicated care room had been created on the inpatient unit and families were allowed to visit.

Mental health

Patients with more complex mental health problems had good access to mental health staff, but services for patients with common mental health problems were less developed. In some prisons, daytime therapeutic support services and access to counselling were limited. However, in a handful of prisons, we saw the introduction of Improving Access to Psychological Therapies (IAPT) workers to develop cognitive therapies. Leyhill offered a comprehensive mental health service.

The training of uniformed officers in the recognition and support of prisoners with mental health issues was generally inadequate. Mental health staff had received Department of Health guidance on the care and management of prisoners with personality disorders and some had begun to offer localised training to groups of staff. Transfer times for patients accessing secure NHS facilities continued to improve but in certain areas of the country, including London, they remained problematic. At the time of our inspection of Brixton, for example, 14 patients were awaiting transfer to NHS mental health beds, one of whom had been waiting over six months. This was unacceptable.

Purposeful activity

Prisoners are able, and expected, to engage in activity that is likely to benefit them.

We assessed purposeful activity in 46 prisons holding adult males. In three of these prisons, outcomes for prisoners in relation to purposeful activity were good and in 20 outcomes were reasonably good. However, in 12 prisons outcomes were not sufficiently good or poor. In our short follow-up inspections, seven prisons were making sufficient progress in relation to purposeful activity but four were not. Of the 298 purposeful activity recommendations assessed during our follow-up inspections, 67% had been achieved or partially achieved.

The proportion of prisons where outcomes were positive was similar to last year, but it was still the case that in over a third of prisons, outcomes for prisoners were not sufficiently good.

Table 5: Purposeful activity in adult male establishments

	Outcomes poor	Outcomes not sufficiently good	Outcomes reasonably good	Outcomes good
Locals	0	7	3	1
Trainers	0	3	11	1
Young adults	1	1	3	0
High security	0	0	2	0
Open/resettlement	0	0	1	1
Total	**1**	**11**	**20**	**3**

Time out of cell

We expect that all prisoners are actively encouraged to engage in out of cell activities, and that prisons offer a timetable of regular and varied extra-mural activities.

We found that time out of cell varied enormously. In general, prisoners in local and young adult establishments spent the most time locked up. In some prisons, the data held was inaccurate and overstated prisoners' time out of cell. We expect that prisoners spend at least 10 hours out of their cells on weekdays but this was rarely achieved, particularly among young adults: only 5% of young adults were unlocked for the expected length of time. Notable exceptions included Manchester, Shrewsbury, Grendon and Featherstone. In local prisons, time out of cell this year was dramatically lower than those inspected last year, mostly due to a reduction of evening association from four to just two or three nights a week or an earlier lock up time in an effort to reduce costs. In high security, Category B trainers and open prisons, however, time out of cell had improved.

Table 6: Time out of cell (as reported by prisoners)

	Spend more than 10 hours out of cell (weekday) (%)	Spend less than two hours out of cell (weekday) (%)
Locals	8	27
Category B trainers	25	6
Category C trainers	11	13
Young adults	5	20
High security	10	7
Open/resettlement	56	1

Table 7: Association (as reported by prisoners)

	Have association 5 times or more per week (%)	Have association less than twice a week (%)
Locals	42	20
Category B trainers	87	5
Category C trainers	75	6
Young adults	51	6
High security	84	5
Open/resettlement	84	3

In spot checks, inspectors repeatedly found at least 25% of a prison's population locked up during the day with nothing to do. Many of these prisoners were unemployed or not required for work, despite wishing to do so, and were out of their cells for substantially fewer hours each day than their employed peers, often for as little as three hours a day. Inspectors' observations were reflected in prisoners' own perceptions of the amount of time they spent out of their cells (Table 6).

In five establishments, over 40% of prisoners were locked in their cells for at least part of the working day. Four of these were local prisons and one was Isis, a new Category C training prison which held 504 men under the age of 25.

> The core day indicated that a fully employed prisoner could achieve about nine hours out of cell on Monday to Thursday and about seven hours on Fridays. Our observations, however, indicated that in practice the average time out of cell was nearer to six hours – and could be as little as two to three hours for the significant number of prisoners who did not work. During a roll check one morning, we found about 48% of the population locked in their cells. *(Isis)*

Contrary to our expectations, many prisoners did not have the opportunity to spend one hour in the open air every day. Some exercise areas had benches but few had exercise equipment.

> Unlocked time remained limited and very poor for some. Association was limited and frequently cancelled and exercise was offered for only 30 minutes a day first thing in the morning. Slippage in the regime appeared routine. Exercise yards were bleak, some were small and none had any equipment. *(Aylesbury)*

Sometimes, association was too short to enable prisoners to shower, exercise in the open air and use the phone. In a minority of prisons, evening lock up after association was as early as 6.30pm.

Learning and skills and work

Inspection of learning and skills and work in prisons and young offender institutions is conducted jointly with Ofsted in England, Estyn in Wales and the Education and Training Inspectorate in Northern Ireland. We expect that there should be sufficient purposeful activity for the total prisoner population. Prisoners should be encouraged and enabled to work and learn during and after sentence and should have access to good library facilities.

Local prisons have historically struggled to provide meaningful activity for their transient populations and they continued to do so, with just over a third achieving reasonably good or good outcomes. The main barriers to more positive outcomes continued to be a lack of activity places and poor management of the places which did exist.

Outcomes were better in training prisons, over two-thirds of which were judged as being good or reasonably good. The best performers had a prison-wide commitment to their training function, an understanding of the importance of learning and skills, high levels of participation and sufficient good quality provision.

In only one establishment – Rochester, holding young adults – were outcomes poor. This compared with five establishments assessed as poor last year. Even in other young adult establishments where outcomes were better, we too often found that activity places were under-used.

Prisoners were insufficiently engaged in purposeful activity and there was significant under-employment. Punctuality and attendance were problematic, and we found more than a quarter of the population locked in their cell during the working part of the day. Too many work opportunities were mundane, unchallenging and lacked a training element. There were too few vocational training places. *(Rochester)*

Outcomes for prisoners were good or reasonably good in the two open prisons we inspected. In both, learning and skills and work were suitably focused on resettlement with good links to the community. At one of these prisons – Kirklevington Grange – we found a clear strategic direction for learning and skills with a focus on resettlement. Provision was based on a good needs analysis and there was effective work with external partners which provided prisoners with a wide range of employment, education and training opportunities. Over 50 prisoners were in paid employment outside the prison and more than 80 were engaged in unpaid community work. Projects had a clear restorative justice theme which promoted positive community engagement as well as good quality work.

This year, although there had once again been an overall increase in the number of places available in work, education and training, including at Stafford and Bedford, some of the additional places were for low-grade wing work which offered limited skill development. At Risley, the number of activity places had improved since our previous inspection but, in practice, those working as wing cleaners and orderlies were not sufficiently or purposefully occupied.

Many prisons still had insufficient purposeful activity places for all their prisoners.

There were still too few activity places to keep prisoners purposefully occupied and little use of part-time work to spread activity more equitably. Half of prisoners were formally unemployed. *(Pentonville)*

Frustratingly, in a significant number of prisons where there was adequate provision, activity places were under-utilised leaving prisoners on wings, often locked up, with nothing meaningful to do. At Wealstun, prisoner attendance at activities was poor and staff did not adequately monitor or challenge attendance. In contrast, attendance was very good at Manchester and Stafford. Staff encouraged prisoner attendance and could provide an explanation for each prisoner who remained on the wings during the working day.

There was a variety of reasons for why some prisons, which had sufficient activity places, failed to get prisoners into work and learning activities. Some had poor allocation processes or overly restrictive security assessments, but often it was because work, learning and skills were not given a high enough priority and other regime activities got in the way. A number of establishments, including Moorland, routinely provided recreational physical education (PE) during the working day which cut across any attempt to provide a realistic full working day and work ethic.

Learning and skills provision was good where the range of provision met prisoner need and where both the provider and prison management worked collaboratively to ensure attendance at activity was maximised.

We saw improvements in the way individual prisoner needs were identified and managed. The quality and timeliness of individual assessments on induction was generally good and although the quality of individual learning plans still varied, the links between learning plans and sentence planning had improved and sentence plan targets generally informed allocation.

In education, the quantity of provision was generally sufficient but the range was just satisfactory. A few establishments had extended the range of education provision. For example, at Wormwood Scrubs, a wide range of education courses from pre-entry to level 3 and higher education opportunities provided prisoners with good progress routes. However, all too often, the range of courses met the needs of low entry learners and not enough was done for the more able. At Rochester, the range of education courses was adequate but there were limited opportunities to progress, particularly for the more able or those serving longer sentences, and only a small number of prisoners were completing Open University distance learning courses.

Vocational training and work was a mixed picture. We often found insufficient vocational training opportunities, including at Stocken, Northallerton and Aylesbury. Even where provision had increased, as at Bedford and Deerbolt, it remained insufficient. We were concerned this year to see a number of prisons reducing their vocational training provision. At Rye Hill, there was little provision and this had fallen substantially since our previous inspection from about 250 participants to fewer than 25.

Where vocational training was available, much of it did not offer sufficient opportunity for progression. At Stafford, the variety of accredited vocational courses was good but the range was mainly limited to level 1 courses, with little opportunity to progress to a higher level qualification and further enhance employment prospects on release.

The range of available work varied and included workshop activities such as packaging and assembly, cleaning, catering and laundry work. We found too many prisoners under-employed in low skill roles. At Belmarsh, for example, with a population of just under 1,000 prisoners, there were around 200 low skill cleaner and orderly posts. While such work allowed prisoners to gain some skills, these were often unaccredited.

> Prisoners developed good employability skills in workshops and prison work, such as team working and problem solving, but they were not formally recognised or recorded. *(Stafford)*

We did, however, see a few good examples of employability skills training. At Haverigg, a wide variety of work was available and the prison had carefully selected and increased the range of qualifications that prisoners could aim for while at work. Prisoners developed high levels of skill and experience that could be used in employment on release and employability skills in some workshops were recognised and recorded effectively. A number of prisons had introduced shift working and longer working days with prisoners staying at work and having packed lunches to provide more realistic working hours and structures. At Manchester, the introduction of an extended working day in print workshops and the laundry provided a more realistic working environment and wider key skills accreditation in workshops effectively recorded the development of prisoners' employability skills.

Libraries

As reported last year, most prisoners had no access to the internet and relied on libraries to provide support and facilities for learning and recreation. We saw some excellent library provision: at Chelmsford, provision had been significantly improved and the library supported a good range of initiatives, such as Toe-by-Toe and Storybook Dads. There was an adequate range of materials for foreign nationals, as well as easy reads, talking books and satisfactory learning materials for vocational courses.

Libraries were generally welcoming and well resourced, but usage was often low. Sometimes this was because the facility was not well promoted, but frequently it was because access was poor and many libraries were not open during evenings and weekends.

Physical education and health promotion

Access to physical education facilities is important for prisoners to stay healthy, as an outlet for excess energy, to manage stress and to build self-esteem. We expect that prisoners are encouraged and enabled to take part in recreational PE in safe and decent surroundings. We also expect prisons to offer each prisoner at least two opportunities to use PE facilities each week.

Most prisons had good gym facilities, although too many still had no useable outside exercise areas, and a few required some renovation. In young adult facilities, high security and in most Category B training prisons, between 60% and 70% of prisoners were able to attend the gym three times a week. However, in local and Category C training prisons, the figures were disappointingly low, at 38% and 54% respectively. In four establishments, prisoners were unable to access even two sessions a week for reasons including insufficient facilities for the population, poor coordination and allocation, and staffing shortages.

Encouragingly, many prisons were promoting healthy lifestyles. There were some effective links with health care as well as offending behaviour programme teams where physical activity was used to complement and support these interventions. Increasingly, gymnasium staff were trained to deliver accredited courses, which were generally of good quality and had high success rates. Most PE departments dedicated some sessions to parts of the prison population which were harder to engage and there were some peer health trainer schemes.

There was a range of accredited PE programmes and achievement of qualifications was outstanding, with many courses achieving 100%. Over 80% of the population took part in a range of recreational PE. The PE department had useful links with health care and CARATs, including a programme for tackling drugs through PE. *(Deerbolt)*

Resettlement

Prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending.

Of the 46 establishments holding adult male prisoners inspected this year, 28 were assessed as having either good or reasonably good resettlement outcomes. Outcomes were not sufficiently good in seven prisons but no establishments had poor resettlement outcomes. Ten prisons were assessed as making sufficient progress in our short follow-up inspections and only one was not. Of the 680 recommendations relating to resettlement assessed in follow-up inspections, we found that almost two-thirds had been achieved or partially achieved.

Table 8: Resettlement in adult male establishments

	Outcomes poor	Outcomes not sufficiently good	Outcomes reasonably good	Outcomes good
Locals	0	2	5	4
Trainers	0	2	13	0
Young adults	0	2	3	0
High security	0	0	2	0
Open/resettlement	0	1	0	1
Total	**0**	**7**	**23**	**5**

Strategic management of resettlement

Since the vast majority of prisoners are released back into the community at some point, the significance of resettlement cannot be underestimated. To be effective, resettlement must underpin the work of the whole establishment. We expect that it is supported by strategic partnerships in the community and is informed by an assessment of prisoners' risks and needs. Planning for a prisoner's resettlement should begin at the point of sentence, not in the few weeks before his release. Strategically, most prisons managed resettlement as part of their overarching reducing reoffending strategy and, in doing so, gave it appropriate weight.

It was, however, disappointing that a number of prisons lacked any systematic needs analysis on which to base their resettlement service. At Doncaster, although there was a good range of provision under each resettlement pathway, there was no needs analysis to help gauge demand. Although it was encouraging that most prisons undertook a needs analysis, the quality varied considerably. At Northallerton and Risley, for example, the needs analysis did not take into account issues of diversity or differentiate between the needs of different groups, such as foreign national prisoners. Some prisons based their needs analyses purely on prisoners self-reporting their needs against the resettlement pathways, but this was not always reliable or accurate. At High Down, however, a needs analysis was undertaken twice a year and incorporated both self-reporting and information from OASys (Offender Assessment System, the standard assessment tool). This provided a comprehensive picture of the needs of the population.

All prisons had some form of resettlement committee that met regularly and were usually multidisciplinary. Where action plans and development objectives were in place, these were regularly reviewed but some establishments lacked clear direction. At The Verne, there was no action plan and therefore little against which to review progress. Some establishments continued to operate with few community partnerships, and therefore missed valuable opportunities to access specialist support and guidance.

Prisons with the most effective overall strategies were those with clearly defined objectives, based on a regular analysis of the population's needs and risks, where progress was regularly reviewed and a wide range of support services were accessed to facilitate links back to the community.

Offender management and planning

The national offender management model was designed to meet the needs of punishment and rehabilitation by managing offenders throughout their journey through the criminal justice system. An assessment of risk and need is used to identify interventions which would reduce the likelihood of reoffending and the harm caused. The model is delivered by a community-based offender manager with assistance from prison-based offender supervisors who maintain contact with the offender while in prison and manage the delivery of interventions. Since its introduction, there have been insufficient resources to apply the model to all prisoners. The model's introduction has therefore been phased and currently applies to higher-risk prisoners, including prolific offenders, indeterminate sentence prisoners and some prisoners with determinate sentences. Prisoners who fall outside the scope of the model may have assessments and plans prepared and delivered by prison-based offender supervisors.

All establishments inspected had offender management units in place with teams providing, to varying degrees, assessments of prisoners and plans to address their offending behaviour and resettlement needs. OASys was applied to prisoners sentenced to 12 months or more; assessments addressed the likelihood of reoffending as well as the risk of harm presented by the prisoner. Where the offender management model operated as intended, prisoners were given clear direction and opportunities to address factors which had contributed to their offending, and there was a centrally managed plan of work phased through their sentence. However, we found that direction from the offender manager was often lacking, contact with the prisoner was not sufficiently regular and targets for interventions were not always appropriate.

In a number of establishments, there were also assessments of prisoners serving shorter sentences and those remanded into custody, either as a local arrangement or as part of the introduction of 'layered offender management' which was a less detailed version of OASys. We found layered offender management operating in some Yorkshire prisons, while London prisons had the local custody planning tool known as LISARRT (local initial screening and reducing reoffending tool). These could provide structured planning for short-term prisoners which was not available in many other prisons. Some local custody planning was not effective and we found it to be tokenistic at Lancaster Farms.

We continued to find prisons where a significant number of assessments were delayed beyond the 12 months required in the offender management model. This was due to a combination of factors including under-resourcing of offender management units, reassignment of prison officer offender supervisors to residential duties and, in training prisons,

reception of prisoners from local prisons without completed assessments. At The Mount, there was no strategy of regular engagement between offender supervisors and prisoners between official reviews, which was mainly due to large caseloads – some staff had over 100 prisoners in their caseload. At Belmarsh, offender supervisors complained of regular reallocation to other duties and, at Whitemoor, we found that 26 hours a week were lost through redeployment. Some local prisons, including Pentonville, transferred prisoners before completion of OASys. This practice led to delays in some training prisons such as Kennet and Maidstone where there were many outstanding OASys assessments, the majority of which should have been completed at local prisons to inform appropriate allocation to training establishments.

Many officer offender supervisors continued to express their frustration over their regular use for other functions across the prison. Offender supervisors were used to cover free flow daily and this had been built into the level of staffing for the department. More recently, staff had been drawn upon to cover other functions, such as visits and general wing supervision. As a consequence, on one day during the inspection the department was effectively closed. *(Belmarsh)*

The quality of assessments varied and we found examples of inadequate risk management plans, poor identification of offending-related factors and insufficient attention to protective factors.

Assessments should inform targets for prisoners to work towards but in a number of cases we found that targets were more likely to reflect what was available in the prison, rather than the priorities identified in the assessment.

Support to help prisoners achieve their targets varied. Many lower-risk prisoners did not have further contact with their offender supervisor once the assessment had been completed and nobody had responsibility for overseeing delivery of the interventions. Support for higher-risk prisoners from offender supervisors was better and there was usually regular contact to review progress.

In most prisons, recategorisation processes were satisfactory but did not always involve the prisoner sufficiently. We continued to find prisoners held inappropriately in closed conditions after they had been recategorised as suitable for an open establishment. This was sometimes because of a lack of places but sometimes because prisoners had been retained at Category C establishments (prisoners could be retained for compassionate reasons, such as proximity to family, or because those with a lower security category could perform certain jobs within the prison, such as working in the visitor centre or in the staff mess). There were 28 Category D prisoners held in Lowdham Grange, a Category B trainer, and opportunities for transfer to open conditions were scarce.

At the time of the inspection, there were six category D prisoners. Waiting times for transfers ranged from one month to just under a year. Another prisoner was being held at the establishment to continue his work placement in the community. He had been recategorised over a year previously and we were not assured that the opportunity to continue this from a category D establishment had been explored fully. *(Shrewsbury)*

Public protection

Public protection processes to identify and determine restrictions for prisoners who presented an ongoing risk were well established and child protection procedures were robust. At Long Lartin, we found monthly interdepartmental risk management team meetings that were appropriately constituted and coordinated. A good range of staff attended meetings and reviews were appropriate. Links with community offender managers on public protection arrangements were generally good. At Chelmsford and Deerbolt, we found some poor communication with offender management units which meant important risk information was not shared.

Indeterminate sentence prisoners

The management of indeterminate sentence prisoners was integrated into offender management units in most prisons, often with a specialist group of offender supervisors. Progress for those sentenced to an Indeterminate Sentence for Public Protection (IPP) was often difficult to achieve. At Wealstun, IPP prisoners were prioritised for attendance on offending behaviour programmes but there were few specific facilities for them and most were well beyond their tariff date. At Lindholme and Dovegate, there were shortages of psychologists for the individual work required by the Parole Board with both IPP and life sentence prisoners.

Most Category C training prisons did not provide sufficient release on temporary licence (ROTL) to support resettlement, even for the Category D prisoners they held. For example, in the six months prior to our inspection at Wayland, there had been 116 applications for ROTL but only 15 were granted. No Category C prisoners had had their application approved. Only two of the 15 licences awarded were for overnight release to promote family ties.

Resettlement pathways

We expect that prisoners' resettlement needs are met under the seven pathways outlined in the Reducing Reoffending National Action Plan. An effective multi-agency response should meet the specific needs of each individual offender in order to maximise the likelihood of successful reintegration into the community. Despite the fact that resettlement provision was developing and was good or reasonably good in many establishments, only 52% of sentenced prisoners who responded to our survey thought they had done something, or that something had happened to them while in prison, that would make them less likely to offend in future.

Accommodation

Most prisons provided some form of accommodation support and advice to prisoners but finding appropriate and permanent accommodation continued to be a significant challenge and more than a third of prisoners in our surveys anticipated problems with finding accommodation on release. Some establishments continued to rely on their own staff, who had often received little or no training in helping prisoners to find accommodation. This was the case at Haverigg where accommodation advice was provided by prisoner orderlies with no specialist support. This contrasted significantly with other prisons where accommodation advice and support was provided by dedicated specialist organisations. At Brixton and Wandsworth, the St Giles Trust provided a comprehensive range of support and guidance and also trained prisoners as peer advisers. This bolstered the accommodation support to prisoners and offered valuable work experience to those prisoners working as advisers.

Although all prisons had a target for releasing prisoners to settled accommodation, we continued to find that many establishments, including Bedford, maintained poor records and did not consistently differentiate

between settled and temporary accommodation. Although the number of prisoners reporting release without any accommodation was fairly low (usually below 10% of the population), we remained concerned that in too many cases release addresses were not stable and that prisons made insufficient attempts to interrogate arrangements prior to release.

Education, training and employment

In most establishments, reasonable links existed to support prisoners in finding employment and further education provision on release. At Brixton, a weekly resettlement board involved Jobcentre Plus and other agencies, as well as key workers in the prison, and a labour market coordinator was employed to identify job vacancies in the community. Where prisons had good links with local employers and community organisations, support for prisoners on discharge was significantly better.

> The prison had developed excellent contacts with a range of employers to improve opportunities for employment. An impressive 70% of prisoners left with employment. *(Kirklevington Grange)*

A number of prisons also delivered pre-release courses and job clubs orientated to skills that would help prisoners find employment and training once back in the community. At Wormwood Scrubs such provision resulted in around 20% of attendees entering employment and a further 20% entering education and training on release each month. Some employers, such as Timpson, provided good quality training workshops in prisons and linked these to employment opportunities after release.

Mental and physical health

The standard, consistency and quality of discharge advice and support continued to vary considerably across the prisons we visited. At most, arrangements were reasonable but at The Verne and Blundeston, for example, staff were given too short notice of discharge to be able to consistently provide the necessary pre-discharge advice. Where they operated, multidisciplinary care programming approaches usually worked well. Advice and community links for those with mental health issues were generally better.

Drugs and alcohol

The re-commissioning of counselling, assessment, referral, advice and throughcare (CARAT) services has resulted in comprehensive needs analyses in many prisons. However, at some, including Moorland and Lowdham Grange, the lack of effective performance measures to address identified concerns undermined the value of the needs analyses. CARAT teams were generally well integrated and many prisons provided good quality one-to-one and group work modules helped, at least in part, by the move away from a focus on assessment. In our inspections, we found an appropriate range of accredited programmes including the short duration programme (SDP), the prison addressing substance-related offending (P-ASRO) programme and the building skills for recovery programme that was gradually replacing P-ASRO. At Brixton, a monthly continuity of care meeting monitored all prisoners within six weeks of release, ensuring that drug-related work was properly coordinated with community agencies. However, these meetings did not receive regular contributions from mental health, psychology and sentence planning staff.

Links to community-based services were often good and were excellent at Belmarsh and Wandsworth. Manchester prison had set up a drug recovery programme which worked closely with community-based service providers to offer an integrated six-week programme prior to discharge.

Peer mentor work linked to CARATs was positive where available. At High Down, a Category B prison, two RAPt graduates had voluntarily transferred from a Category C establishment to run the peer advisor scheme.[9]

Many establishments were developing better provision to address alcohol users. At Doncaster and Wayland, there were dedicated alcohol workers, while at Stafford and other establishments, CARAT workers could work with alcohol-only users. However, many other prisons continued to provide relatively little support, including Wandsworth, where only the Alcoholics Anonymous programme was available. Although 30% of the population at Lowdham Grange were identified as having a drug or alcohol problem related directly to their offending, prisoners were unable to access an accredited alcohol or drug programme.

Finance, benefit and debt

Of all resettlement pathways, work in relation to finance, benefit and debt consistently remained the weakest. In our surveys, 27% of prisoners anticipated financial and benefit-related problems on release. Most establishments offered prisoners the opportunity to open bank accounts prior to release and some form of budgeting and money management programme, often as part of the education department's life and social skills programme. However, provision for individual debt management was inconsistent.

Although Hatfield prison's own analysis indicated significant issues of debt among its population, little direct support was available. In contrast, Rochester had managed to consolidate and freeze over £100,000 of debt in the six months before the inspection, and Deerbolt identified around £30,000 of debt held by prisoners every quarter. At Doncaster, a weekly debt advice surgery and fortnightly debt and financial management advice were provided by external agencies, and prisoners were also able to save money prior to release via the use of credit unions.

Children and families of offenders

Most prisons we visited offered a range of support to encourage and support prisoners maintaining contact with their families and friends. Visitors' centres were usually available and offered a good range of information to visiting families. In the north-east, NEPACS, a charity promoting family ties and resettlement, managed a number of centres, including those at Deerbolt and Durham. It provided a range of support services, including links to community services across the region and training for other professionals working in prisons. Other organisations developing positive initiatives with community-based services in relation to family support included the Ormiston Trust, Nacro and HALOW.

Most establishments we visited offered wider family support, often including family visits, although sometimes these were inappropriately limited to those prisoners on the enhanced standard of the incentives and earned privileges scheme. At Rochester, the prison had developed a partnership with local Sure Start services which helped deliver family sessions.

At some prisons, including Wandsworth, we continued to receive complaints about access to visits telephone booking lines and these were borne out by inspectors' own attempts to book a visit. However, in many other prisons, bookings could be made via email, which was more flexible. Arrangements for visitors to get to the visits hall were generally appropriate but in some prisons, including Chelmsford and Peterborough, we noted delays in visit start times.

9 The RAPt programme was set up by the Rehabilitation of Addicted Prisoners Trust and is based on the 12 steps model which requires total abstinence from drugs and alcohol.

Most visits halls we saw over the last year were bright and welcoming with an appropriate range of refreshments and facilities. However, in some cases, children's play areas were not staffed, even at weekends. Too many prisons still used fixed furniture and prisoners often had to wear coloured bibs, which were a disproportionate security measure.

Attitudes, thinking and behaviour

Too often, we found that the demand for offending behaviour programmes outstripped availability and many prisons had lengthy waiting lists. This was unsurprising given the number of prisons with limited or no needs analyses. While access to programmes was appropriately prioritised for higher-risk prisoners and those closest to release, many continued to be released without having completed sufficient offending behaviour work. We were particularly concerned about the lack of sex offender treatment programmes and some significant delays in transferring prisoners to establishments where such programmes were provided. At Maidstone, a specialist delivery centre for sex offenders, there was an inadequate number of programmes to meet the demands of the population. Even though we were unable to quantify the shortfall (and neither was NOMS), the lack of treatment meant that many sex offenders were released into the community having undertaken little or no work to address their offending.

> Offending behaviour programme delivery was not based on any needs analysis and there were no programmes to meet the specific needs of sex offenders, including those in denial. *(Shrewsbury)*

Overall, the range of accredited programmes at inspected prisons was generally appropriate, even if the number delivered was insufficient. Delivery was severely impeded in some prisons, such as Blundeston and Pentonville, due to staff shortages. At a few prisons, we saw examples of good partnership working with community-based probation services to deliver courses to prisoners.

Some prisons, in recognition of the limited availability of accredited programmes, offered a range of approved, rather than accredited, programmes. High Down had delivered in excess of 500 offending behaviour sessions, including stress and anger management, as well as programmes on restorative justice and 'living on licence' which supported post-release engagement. A number of prisons also delivered victim awareness programmes, including Sycamore Tree, which was invariably delivered in partnership with chaplaincies.

Women

In 2011–12, we inspected seven women's prisons. Three of these were announced full inspections while four were unannounced follow-up inspections. During our follow-up inspections, we found that 62% of recommendations made at the previous inspection had been achieved or partially achieved.

Table 9a: Outcomes for women prisoners

	Safety	Respect	Purposeful activity	Resettlement
Low Newton (closed local)	3	3	4	4
Morton Hall (semi-open)[10]	4	3	4	3
Peterborough (local)	3	4	3	3
Send (closed training)	3	3	3	3
Styal (closed local)	3	3	4	3

Key
4: Outcomes good
3: Outcomes reasonably good
2: Outcomes not sufficiently good
1: Outcomes poor

Table 9b: Progress against recommendations in women's prisons inspected using revised short follow-up methodology

	Safety	Respect	Purposeful activity	Resettlement
Askham Grange (open)	Making sufficient progress	Making sufficient progress	Making sufficient progress	Making sufficient progress
Downview (closed training)	Making sufficient progress	Not making sufficient progress	Making sufficient progress	Not making sufficient progress

Safety

In relation to safety, outcomes for women prisoners were good at Morton Hall and reasonably good at Low Newton, Peterborough, Send and Styal. Both Askham Grange and Downview were assessed as making sufficient progress on safety.

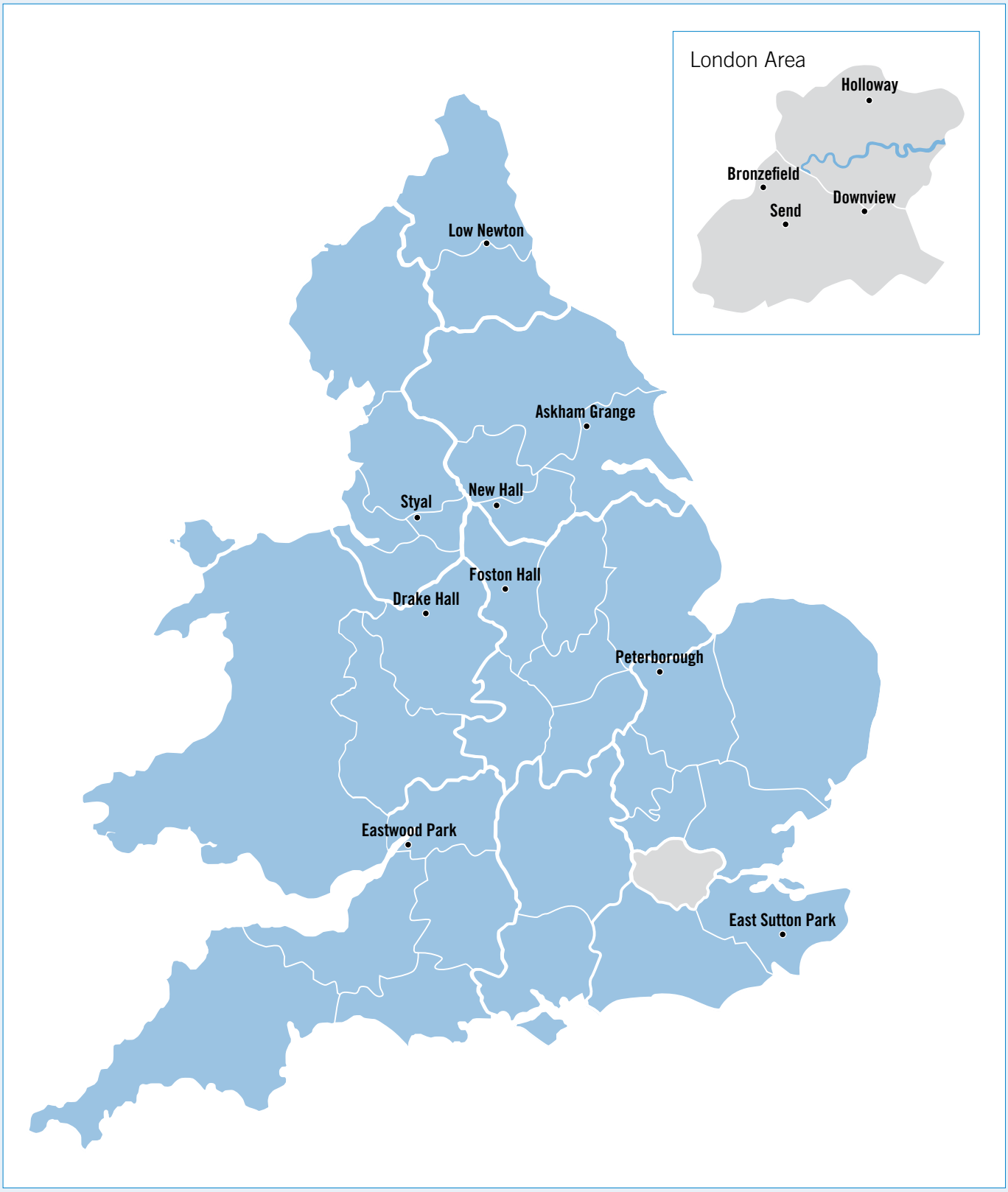
Arrival and early days in custody

Most women prisoners did not experience long journeys to their establishments but Peterborough served 11 court areas, which was twice the number for men accommodated on the same site. Some women arriving at Peterborough had therefore had long journeys and arrived late in the evening. One woman had completed her court appearance at 11.25am and was recorded as leaving court at 3.40pm, but did not arrive at the prison until after 7.00pm because the van had stopped at two other courts en-route.

10 Since our inspection, Morton Hall has been re-roled as an immigration removal centre.

Location of women's prisons

There are no women's prisons in Wales. The limited number of women's prisons means women are often held further from home than male prisoners. This results in longer journeys to the allocated prison from court or on transfer, and longer journeys for visitors.



Some women complained of a lack of toilet breaks during transfers and escort staff at Send and Morton Hall told us they had difficulties offering breaks because of the challenges involved in finding a suitable stopping place. We were concerned that the new escort contract permitted women to travel in vehicles with men.

The majority of women who responded to our survey said they felt safe on their first night in custody. However, a lack of space in the first night centre at Styal sometimes meant women shared rooms on their first night with women withdrawing from drugs or alcohol. In addition, the first night centre was so busy that staff were absorbed in dealing with issues in the office instead of regularly interacting with and supporting new arrivals. The late arrival of women at Styal compromised first night procedures and meant women were not always able to see a doctor, make a telephone call or have a shower.

> First night centre staff were clearly ready to help women who came to the office with concerns but some vulnerable women were too nervous to do this and there was a need for a more active approach. *(Styal)*

Suicide and self-harm

Although serious self-harm remained a major concern in local prisons, we cautiously welcomed a reduction in the number of open suicide and self-harm monitoring documents (ACCTs) at some prisons. There were high levels of self-harm at Peterborough, with an average of 225 incidents reported each month involving 33 women.

At Styal, a small number of women on the Waite wing and Keller Unit accounted for a high proportion of self-harm incidents. The Keller Unit was intended to accommodate women whose behaviour could not be adequately managed on the wings. In practice, these women were often severely ill and vulnerable. Staff on the Keller Unit provided good care but its role was still unclear: there was confusion about whether it was a behaviour management unit or a unit for women with mental health problems. If the latter, it was not a sufficiently therapeutic environment. During a night visit to the unit, we found staff to be stretched too thin, despite the high levels of risk. The use of male staff for constant supervision throughout the night was inappropriate and could have caused additional anxiety for the women, many of whom had previously been abused by men.

We reported good support for women at risk of suicide and self-harm at Send and ACCT documents at Peterborough indicated some of the best levels of care we had found in a local women's prison. Assessments at Peterborough were detailed, most reviews were attended by mental health nurses, many care maps had clear targets and daily support records showed good levels of care.

At other prisons, improvements to ACCT procedures were required and there was a need for multidisciplinary case reviews at some. Good support was provided by Listeners. Staff training varied: at some prisons, not enough staff were trained in first aid and resuscitation. At Send, an investigation into the most recent self-inflicted death had raised concerns about the availability of first aid-trained staff at night and the absence of defibrillators, issues that had not yet been addressed at the time of our inspection.

Violence reduction

There was little evidence that antisocial behaviour was a serious problem, and there was little physical violence; bullying often took the form of name-calling and intimidation about petty differences and relationship issues. There were generally good investigations into bullying, and action had been taken to address bullying for, and trading in, medication at Peterborough.

At Send, overall feelings of safety were similar to the comparator, but many women reported victimisation by other prisoners and were reluctant to report incidents as they did not believe they would be taken seriously. The quality of investigations was poor and not enough action had been taken to monitor and challenge the behaviour of alleged perpetrators. Similarly, there was too much reliance on observations rather than active challenging of poor behaviour at Downview and Styal. Conflict resolution was used at Morton Hall at an early stage in disputes to bring affected parties together and provided a safe forum for women to air grievances.

Security and discipline

There was a proportionate approach to security at all prisons and adjudications were generally well conducted with reasonable punishments, but records at Low Newton and Downview did not show sufficient enquiry before reaching findings of guilt. Efforts had been made in Low Newton to make the adjudication environment less intimidating and formal.

Use of force was low but there had been a large increase at Send in the months leading up to our inspection. A high incidence of the use of force on the Keller Unit at Styal underlined the real difficulties of managing the women there; officers often had to use force to remove ligatures from women intent on harming themselves.

Segregation and special accommodation

Not all prisons had a segregation unit but where they existed they tended to be well managed. However, the segregation unit at Low Newton was austere and the regime was basic. There was low use of special accommodation across the establishments inspected, but the 'calm down room' at Send was inappropriately located next to a gated cell used to supervise women at risk of suicide and self-harm.

Substance misuse

Around 40% of new arrivals at Send, Styal and Peterborough, and over 50% at Low Newton, were dependent on drugs and/or alcohol and there had been a large increase in the number of women requiring alcohol detoxification at Styal. In most prisons, the integrated drug treatment system (IDTS) was well established and integrated with CARATs. Mandatory drug testing rates were generally low but at Low Newton, for example, there was evidence of diverted prescription medication and some illicit drugs.

Respect

We found that respect-related outcomes for women were good at Peterborough and reasonably good at Low Newton, Morton Hall, Send and Styal. Askham Grange was making sufficient progress on respect but Downview was not.

Accommodation

All prisons were generally clean. Single cells at Peterborough and Styal, which continued to accommodate two women, were cramped and dormitories in Askham Grange provided little privacy. In-cell toilets were insufficiently screened and some had no screening at all at Downview. In shared cells at Peterborough we found the ventilation was poor and women made toilet lids out of cardboard.

Most telephones could not be used in private. Laundry facilities were generally adequate and women wore their own clothes. Women could shower daily and in private. Every wing in Peterborough had a free-standing electronic kiosk where women could buy items from the shop, telephone credits, check their accounts, order meals and check activity timetables.

> Many baths had had the taps removed or the bathrooms had been locked off, which we were told by some managers was due to damage caused by overflowing baths. Others said it was a cost saving measure. *(Styal)*

Young adult women were now fully integrated with older women throughout the prison estate and there was a need to ensure the specific needs of young women were considered and met.

Staff-prisoner relationships

Staff-prisoner relationships were generally good, and most women had a member of staff they could turn to for help. At Peterborough, 90% of women said most staff treated them with respect. The women at Styal, however, were less positive (69%). Despite this, we observed positive interactions between staff and prisoners at the prison and a lower proportion of women said they had been victimised by staff.

At Downview, some staff and prisoners said allegations of staff misconduct, some of which had resulted in criminal charges and convictions, had caused distrust on both sides and had affected the quality of relationships. At Send, 81% of women said they had a member of staff they could turn to for help but 27% also said that they had been victimised and threatened by a member of staff. Many women identified a small number of staff who made life difficult for them but did not believe they would be taken seriously if they complained. Managers said they knew the staff involved but there was little evidence of the officers being challenged.

The ratio of male to female staff was too high in some prisons (63:37 at Peterborough and 42:58 at Send). At Peterborough, only about 40% of officers had undertaken training on working with women prisoners.

Many staff at both Styal and Low Newton continued to refer to adult women prisoners as girls.

Most women found their personal officer helpful and entries in prisoner custody records were good at Send, Morton Hall and Peterborough. At Styal and Downview most comments were observational and simply about behaviour. At Downview, the personal officer policy made no mention of the specific circumstances of women prisoners.

Mother and baby units

Mother and baby units continued to be safe and stimulating environments, although the unit at Styal was old and required updating. At our previous inspection of Askham Grange, we made a recommendation that officers should not wear uniforms, but discipline staff working on the unit had chosen to remain in uniform, which was at odds with the overall ethos of creating the most natural environment possible for babies. There was no designated officer on the unit at night and only seven of the 35 discipline staff had completed any childcare training, most several years previously.

Mothers could cook for their babies at Styal and Peterborough but were unable to do so at Askham Grange, which was a missed opportunity for women to learn good nutritional habits and build self-confidence in managing and cooking food on a budget.

Diversity

Diversity work was in place in all establishments to varying degrees. There was generally good support for those prisoners with a disability but support for lesbian and bisexual prisoners required further development across the estate. At Low Newton and Styal, lesbian and bisexual women were less positive than others about their treatment by staff. At Styal, the diversity policy was being used to over-regulate affectionate, non-sexual behaviour between women, rather than to support and protect lesbian and bisexual prisoners.

Some black and minority ethnic women had poorer perceptions of their treatment than white women. Except at Send, racist incidents were generally well investigated. Many prisons only monitored those areas required by NOMS for potential discrimination, but Peterborough monitored other areas which prisoners often identified as an issue, including allocation to jobs.

As reported last year, support for foreign national women varied. At Downview, still nominally a designated centre for foreign national women, support structures remained underdeveloped and the well-regarded Hibiscus service had been withdrawn. Although the diversity teams at Styal and Peterborough supported foreign national women well, there was a lack of engagement between wing staff and women who did not speak English. Good use was made of the telephone translation facility at Morton Hall, and 14 dedicated handsets had been purchased at Low Newton where invoices indicated that telephone interpreters were used routinely to communicate with the one Vietnamese woman who did not speak or understand English well. At some other prisons though, this facility was poorly used, leaving women isolated. Lack of interpretation at Styal was mitigated somewhat by the formal diversity buddy system through which women who spoke little or no English were, where possible, assigned a prisoner who spoke both English and their language to help them.

Most foreign national women could only have a free monthly telephone call abroad if they had not had a domestic visit. This could restrict contact with close family. At Low Newton, however, foreign national women received a free 10-minute monthly telephone call, as did British women whose close families were abroad, irrespective of visits. UKBA caseworkers supported prisoners at Send, Low Newton and Morton Hall and a new service for independent immigration advice had just been introduced at Styal.

Health care

Primary physical health care services were excellent at Askham Grange and Low Newton. At Send, health services were beginning to improve from a very poor baseline, although prisoners were negative about nearly all aspects of health care. Only 13% of women surveyed who had accessed health care, compared with 46% at comparable prisons, rated health services positively. At Send, recruitment and retention of permanent nursing staff remained a significant challenge. Most women could see a female GP but this was restricted to one clinic a week at Styal. At Peterborough, no female GP was available.

In our surveys, 69% of women were currently taking medication, compared with an overall average of 46% across adult male prisons. The high proportion of women receiving medication at Styal made administration challenging, and dispensing arrangements for medication on one wing at Downview were badly organised and supervised, and potentially unsafe.

Women attending hospital appointments at Send were routinely handcuffed (in some cases to male officers), and treatment often took place with restraints still applied.

> One woman had remained cuffed to a female officer during an intimate examination and while getting undressed, which she said had made the whole procedure very distressing and difficult. These measures were disproportionate, did not always appear to be based on an assessment of individual risk and compromised a basic right to privacy and dignity. *(Send)*

Good mental health provision is much needed in women's prisons: in our surveys, 52% of women felt that they had emotional wellbeing or mental health issues, compared with an average of 29% across male prisons.

Mental health provision was reasonably good at Send and Morton Hall and very good at Peterborough. The resource centre at Styal provided good support for a small number of women with low level mental health needs, but there was a gap in service provision for women with common mental health problems such as anxiety and depression. Weekly review meetings on Styal's Keller Unit were detailed and comprehensive and staff provided some good support, but the environment was inappropriate for mentally ill women. All women on the unit were mental health patients but it was still not led by a clinical manager.

Purposeful activity

Outcomes relating to purposeful activity were good at Low Newton, Morton Hall and Styal and reasonably good at Peterborough and Send. Askham Grange and Downview were judged to be making sufficient progress in our follow-up inspections.

Time out of cell was generally good across all prisons. However, at Peterborough, many unemployed prisoners, including women on the initial stages of IDTS, were only able to spend about three hours a day out of their cell. Most women could spend time in the open air but the duration varied. Women at Send were able to have over an hour in the fresh air during the evenings in the summer months (but not during the winter), while women at Peterborough were restricted to about 30 minutes a day – less for working prisoners. At Low Newton, the daily scheduled exercise periods were early and clashed with breakfast, other domestic tasks and medication distribution.

Evening association on one wing at Styal was restricted to a maximum of four days (Monday to Thursday). Even then, association on Thursdays was restricted to enable the distribution of shop orders. At Downview, staffing shortages severely affected association time and evening association was cancelled frequently and unpredictably and with little notice.

There were sufficient activity places at most prisons. At Peterborough, the learning and skills strategic plan had clear objectives that were monitored. However, the plan covered both the women and men's prison with no focus on the specific and different needs of women, including young women and those beginning life sentences.

Education provision was generally good but, at Peterborough and Send, the range of learning and skills places was limited and most education and training was at a low level, with little for the more able women and those who spent longer periods at the prison, such as life-sentenced women. Staff shortages at Send meant there was insufficient cover for some classes and some vocational training had stopped.

Work at Send and Peterborough was generally of good quality but there was insufficient accredited training. At Styal, work and vocational training opportunities had generally improved and included good initiatives, such as the prison radio station, but there were missed opportunities to accredit skills in some areas. At Low Newton, some relevant work was provided to match the needs of the employment market with links to vocational qualifications but other jobs had no qualifications or training.

Although in 2008 we recommended improved arrangements for women returning to Askham Grange from outside work, women returning after dark continued to walk along unlit roads from the bus stop to the prison.

Resettlement

In our surveys, most sentenced women said they had a sentence plan, but only 37% said this was the case at Peterborough (compared with 89% at Send). Most women felt involved in the development of their plan. Our surveys showed that, on release, women expected to have problems with their finances and in finding a job and accommodation. However, not all women knew where to find help with

these issues in the prison. Only 25% of women at Peterborough and 28% at Styal felt a member of staff had helped them to prepare for release.

Resettlement outcomes were good at Low Newton and reasonably good at Morton Hall, Peterborough, Send and Styal. While Askham Grange was making sufficient progress on recommendations made at its last inspection, Downview was not.

All prisoners had resettlement strategies, most of which were up to date, but those at Peterborough and Styal were not based on a needs analysis of their population. Strategic oversight of resettlement at Downview required attention and there had been no reducing reoffending meeting, and therefore no strategic management, in the seven months leading up to our inspection.

Styal planned to introduce a 'community house' accommodating women suitable for open conditions and working in the community. While this appeared to be a positive initiative, it had not been developed as part of a national approach to the women's estate. Instead it was a local initiative designed to give women from the north-west the opportunity to stay in their home area rather than being moved to Askham Grange in York, the nearest open prison.

The Styal drop-in centre continued to provide very good support to women. Prisoners could drop in for information or attend appointments with representatives of approximately 24 voluntary sector groups who attended weekly. Similarly, at Peterborough, resettlement services were delivered in a central area of the prison known as the Link, which provided an excellent one-stop-shop approach to accessing services in a positive and relaxed environment.

Offender management

All prisons had well established offender management units and most OASys assessments and sentence plans were up to date. Nonetheless, there was no custody planning for the majority of the remanded and short-term sentence women at Styal and Peterborough, although, at the latter, a pilot project to help meet the resettlement needs of such women was just beginning. In contrast, the offender management unit at Low Newton managed all sentenced women, irrespective of sentence length.

Prisoner contact with offender supervisors was generally frequent for women serving sentences of more than 12 months, but less so for others. At Peterborough and Send, women serving less than 12 months had no offender supervisor contact following the creation of an initial plan until an annual review. In contrast, offender supervisors at Styal had quarterly contact with this group of women.

Women serving indeterminate sentences were effectively managed at most prisons but Peterborough and Send lacked sufficient forensic psychology input as part of a multidisciplinary lifer team.

Drugs and alcohol

All prisons had good counselling, assessment, referral, advice and throughcare (CARAT) provision, providing valuable support to prisoners, and there was increasing support to address alcohol misuse at all establishments except Morton Hall. Styal had introduced a pilot alcohol programme for women and the 'building skills for recovery' course had recently replaced the short duration programme for drug users at Peterborough, usefully including women who had a primary problem with alcohol. A much needed local alcohol programme had recently been introduced at Low Newton but there was a need to develop services further to meet the high level of demand.

At Send, the well-managed 20-bed RAPt 12-step programme, the only one in a women's prison, provided good peer support and aftercare provision. Although it had become better used as a national resource, it was still difficult to attract sufficient numbers and a change of criteria to include women with alcohol-only problems would have helped.

Offender behaviour programmes

Existing programmes met the needs of most women but staff identified a need for anger management programmes at both Styal and Low Newton, and for interventions for women sex offenders at Peterborough. Psychologists provided one-to-one sessions for women convicted of sex offences at Low Newton. There was an insufficient number of Sycamore Tree victim awareness courses to meet demand at Send and Styal. Some women at Styal were benefiting from a recently introduced life coaching course which offered one-to-one sessions and helped increase their confidence and develop skills.

At the Primrose Unit at Low Newton, a national treatment programme continued to successfully treat and support up to 12 women with dangerous and severe personality disorders. Women were involved in up to three years of specialised, psychologically informed interventions tailored to individual need.

Additional resettlement pathways for women who had experienced domestic violence or prostitution meant that relevant services were available and generally promoted, but this was not the case at Low Newton, where women's needs were not assessed under these gender-specific pathways. Despite the high level of identified need, a Rape Crisis counselling service had ended at Peterborough, leaving a significant gap, and it was not clear whether a proposed replacement service would replicate this provision.

Children and families

Many women prisoners were mothers; 53% of women in our surveys had children under the age of 18.

> According to the 2009 prison needs analysis, two-thirds of prisoners had children. Half of the women in the analysis said they had been the primary carer before imprisonment but only 35% expected to be the primary carer on release. A quarter of prisoners' children were in local authority care. Thirty per cent of prisoners said they had problems with visits, citing distance and cost as the main problems followed by difficulties in booking visits. *(Send)*

There was good provision at Peterborough to help women maintain contact with children and families, including family visits, counselling, advocacy, mediation and Storybook Mums, helped by partnerships with external agencies. However, both prisoners and visitors reported difficulties in booking visits. Family liaison workers provided valuable support to women at some prisons but had unfortunately been withdrawn at Downview.

At Send, there was no qualified or experienced family liaison officer to help and support women to maintain or regain contact with their families or come to terms with separation from them.

Visits did not start at the published time at four prisons and women at three prisons had to wear coloured sashes or bibs in the visits room, some of which were dirty. Security arrangements in the Styal visits room were too restrictive and included a prohibition on kissing or holding visitors' hands. The arrangements caused many women and their families anxiety and distress about what contact was allowed. Extended visits for children were available at six establishments.

At Low Newton, this included weekly and monthly children's visits and quarterly family days which were open to a prisoner's wider family. The Stepping Stones flats just outside Downview prison enabled some women to spend quality time with their children. Women at Askham Grange continued to be the only female prisoners to benefit from incoming call facilities.

Equal but different? An inspection of the use of alternatives to custody for women offenders

This joint thematic report, led by HM Inspectorate of Probation, looked at the extent to which non-custodial options were being taken up for women offenders, recognising that to achieve equitable outcomes for male and female offenders, different approaches need to be taken.

There were some positive initiatives: there had been a strategic government drive to develop a framework for working with women offenders and the women's community centres were a valuable resource. However, these initiatives needed to be better embedded into the direct work conducted with women offenders, with more attention given to the promotion of compliance by Probation Trusts.

The report concluded, *'Despite these efforts, in our view the size of the female prison population is still a matter of concern. Too many women are still serving short prison sentences, often for breach of community orders imposed for offences which would not normally of themselves have attracted a custodial sentence.'*

Children and young people

In 2011–12, we inspected nine establishments holding children and young people under the age of 18. Six of these were unannounced follow-up inspections, in which we found that 69% of our previous recommendations had been achieved or partially achieved.

In addition to our inspections, we carried out our annual survey of the views of children and young people in custody. Surveys were carried out at every establishment holding those aged 15 to 18 and 1,092 responses were received. The vast majority of these responses were from young men. Survey findings for each establishment are analysed in its inspection report, but an annual digest of survey findings from across the estate is also published.[11]

Table 10: Outcomes for children and young people in custody

	Outcomes poor	Outcomes not sufficiently good	Outcomes reasonably good	Outcomes good
Safety	0	0	6	0
Respect	0	0	4	2
Purposeful activity	1	0	3	2
Resettlement	0	0	3	3
Total	1	0	16	7

Safety

Young people often had to wait for a long time in court cells before starting their journey and very few were given information about the establishment in which they were being placed. Long and uncomfortable journeys remained a problem for some, and many young people arrived late at the establishment. In most instances, good information was provided to the establishment prior to the young person's arrival and was used effectively by reception staff to record initial vulnerability assessments, though most risk management plans, drawn up as part of these initial assessments, were inadequate.

> 'In the court, cells are dirty. It is not safe in the van because if the driver has an accident there is no seatbelt so there is nothing to protect you.' *(Young person, Hindley)*

Reception staff continued to welcome young people sensitively although, overall, fewer young men than last year reported that on arrival they had received meals, showers, a telephone call to family, a reception pack or information about what to do if they were feeling low. Young women were more positive about their experience.

All young men continued to be routinely strip-searched on arrival at the establishment, contrary to our expectations. Commendably at Werrington, however, managers adopted a risk-assessed approach to strip-searching when particularly vulnerable young people were identified on reception. We were pleased to see that strip-searching in young women's units was intelligence-led.

11 HM Inspectorate of Prisons/Youth Justice Board, Children and Young People in Custody 2010–11: An analysis of the experiences of 15–18-year-olds in prison (2011).

The vast majority of young people – 79% of young men and 85% of young women – said that they felt safe on their first night, although those entering custody for the first time were more daunted by the experience. While all establishments had a clear induction process, young people often reported that it was too long and did not always provide the information they needed. Not surprisingly, young people with learning disabilities struggled to take in new information because it was not communicated in a way they could easily understand.

All establishments had dedicated safeguarding managers and teams, but in most, internal attendance at safeguarding meetings was erratic. While there were still incidences of poor involvement from Local Safeguarding Children Boards, there was also some improved engagement. However, we continued to find that the independent oversight of safeguarding arrangements in establishments was inadequate.

Establishments had comprehensive child protection policies and procedures. We still found many staff who did not fully understand child protection, but in most establishments all allegations were sent out to the local authority designated officer (LADO), strategy meetings were held when appropriate and internal investigations, requested by the LADO, were rigorous.

The care of particularly vulnerable young people was given significant attention in all establishments, all of which arranged specific multidisciplinary meetings to plan services and interventions. However, the coordination of a wide range of assessments and care plans for different purposes continued to be poor, resulting in a disjointed approach to caring for the most challenging young people.

Bullying in young women's establishments was not a problem, but for many young men it was a significant concern. Overall, just over a quarter of young men said that they had felt unsafe at some point during their time in custody, which is a small improvement from last year. Slightly less than a quarter of young men reported that they had been victimised by others, with the most common form of bullying being insulting remarks. In our annual survey, 40% of young men said that shouting out of windows was a problem in their establishment. Young people's membership of gangs in the community continued to create problems for them while in custody.

'It happens all the time. There are a lot of gang issues and people trying to earn respect from each other. It's all down to how long we're banged up – there's a lot of shouting through the doors and it winds people up which leads to fights.' *(Young person, Feltham)*

'It depends what area you are from, problems can come in from the outside. You can keep your head down if you want to and staff will try to keep you away from them but there is still the risk that you will see them on social visits. Staff are aware. Really it's an accepted part of prison life.' *(Young person, Feltham)*

In most male establishments, the use of force continued to be high but there was increasing evidence that de-escalation techniques were being used more frequently. Debriefing young people after restraint was becoming commonplace but the overall quality of debriefs was poor.

In our survey, 21% of young men told us that they had spent a night in a care and separation unit. Of these, only half said they were treated well or very well by staff. The physical environment in such units was usually poor and young people spent long periods in their cells without any constructive activity. Generally, planning for reintegration to mainstream accommodation was inadequate.

Establishments were effective in keeping drugs out of custody and the demands for clinical interventions were low. When it was required, there was generally good therapeutic support.

Respect

Over the years, our surveys of both young men and women have showed a steady decline in the proportion of young people who felt that the majority of staff treated them with respect. Significantly, the perception of black and minority ethnic young people remained worse than their white peers. Nonetheless, during inspections, we continued to observe good staff engagement with young people and many young people said that they could go to someone if they had a problem. This was particularly true of young women: 84% said they felt that they could go to a member of staff with their problems. The majority of staff still did not wear their names on their uniforms, which was a safeguarding issue as well as an important element in developing good relationships.

The majority of personal officer and key worker activity continued to be inadequate and, overall, a smaller proportion of young people than last year reported that they were being seen by staff on a regular basis. Only 45% of young women said they were checked on a regular basis, compared with 67% last year. As in previous years, we continued to find that personal officers were not attending meetings relating to the care of the young people to whom they had been assigned.

Living environments continued to be clean and well maintained, particularly in the young women's units. There had been an overall improvement in young people's access to showers. Young people reported that the quality of the food had deteriorated from last year and although we found the portions of food to be adequate, many young men in particular complained that they often felt hungry.

There had been some improvements in the management of complaints systems with some establishments scrutinising complaints effectively for patterns and trends. However, there was still a considerable amount of dissatisfaction from young people regarding the responses they received; in our survey, only a third of young men who had made a complaint said that they felt it had been addressed properly.

> 'Complaints aren't sorted out fairly, the prison just say they are going to look into it.' *(Young person in custody)*

> 'Most times complaints take too long to be dealt with. It does get sorted within seven days, but sometimes, it feels it's not taken seriously.' *(Young person in custody)*

Race issues continued to be the primary focus of establishments' diversity initiatives and more attention was being given to young people from Gypsy and Traveller communities. Issues of sexuality and disability were still not being properly addressed. While there was an increased recognition of the needs of young people with speech and language difficulties, further work was required. Chaplaincy teams continued to offer valued pastoral support.

Overall health care services were good, though in some instances the environment required improvement. In many of the establishments inspected, we commented on the excellence of mental health services.

Purposeful activity

Although some came close, none of the establishments inspected holding young men met our expectation to provide 10 hours out of cell each day. It was possible for some young people, such as those on the lowest level of the rewards and sanctions scheme and those in segregated conditions, to experience considerably less

time out of cell than 10 hours. At Feltham, young people in these circumstances could spend as much as 22 hours a day locked up.

The proportion of young men who told us they usually had association every day was significantly higher than the previous year (70% in 2010–11 compared with 59% in 2009–10). This year, more young men also said they could usually go outside for exercise every day (40% compared with 31%).

Young women located on small units benefited consistently from more time unlocked than their male counterparts. This sometimes exceeded our 10-hour minimum standard. Young women were also more likely to get the opportunity to take exercise in the fresh air every day.

All young women and the majority of young men undertook some form of education or training and most felt this would be of some benefit to them on release. The educational experience of young women in small units was consistently positive. They generally worked hard, engaged well with staff and their behaviour was good. The standard of work they produced was often high. In the hairdressing, beauty therapy and cookery classes at the Mary Carpenter Unit, the work produced by young women was easily equivalent to that found in mainstream colleges.

The provision of education and training for young men was more problematic. Most establishments provided a balanced curriculum but the quality of teaching was uneven. Attendance and punctuality at classes were sometimes problematic and lessons were more likely to be disrupted because of poor behaviour, resulting in young people being returned to their unit. Some establishments provided effective learning support for individuals who needed extra help and, at Hindley, valuable links had been established with a speech and language therapist. The range of vocational training provided was mostly adequate, with some examples of high quality provision, such as the excellent catering course for young people at Ashfield.

> 'I'm joining the armed forces when I leave and will have something to fall back on in the future thanks to the plumbing course.' *(Young person, Ashfield)*

Most young people across the estate had access to good PE and library facilities.

Resettlement

The three main problems with which young men in custody thought they would experience difficulty on release were employment (49% of young men anticipated this would be a problem), finances (39%) and accommodation (27%). This was broadly in line with what we had found previously but this year a smaller proportion of young men said they would know who to contact for help regarding each of these issues. The proportion was even smaller among those who said it was their first time in custody.

> 'I'm worried about money because I don't know how to get it without offending.' *(Young person, Hindley)*

Young women identified the same major problems, but their level of expressed need was markedly higher. In our survey, 72% of young women said they thought they would have difficulties obtaining employment, 46% anticipated problems with money and finances and 42% with finding accommodation. Over half of sentenced young women (56%) said they had done something or something had happened to them during their time in custody that would make them less likely to offend in the future (compared with 47% of young men).

The provision of professional careers advice for young people in custody was inconsistent. Good quality input was provided at the Rivendell Unit but the services available at the Mary Carpenter Unit and Warren Hill were limited. There was no specialist careers advice available at Feltham.

Work to help young people manage their finances, benefits and debt was being developed across the estate, but was still not an area which received sufficient priority.

Securing and sustaining suitable accommodation for young people leaving custody continued to be extremely difficult. Prison-based staff tended to identify these difficulties early on but were dependent on community-based colleagues to provide resources. Young people at Hindley who had problems with accommodation benefited from input by a Nacro housing worker. At Werrington, there were particularly good links between the prison and local housing providers.

Release on temporary licence was being used well across the juvenile estate. In many establishments, increasing numbers of young people were being given the opportunity to spend time constructively in the community in order to help them resettle. Exceptional work was being carried out at Werrington and the Heron Unit at Feltham, where young people were able to participate in high quality placements.

The standard of visiting facilities was mostly quite good. However, the contraction of the juvenile estate inevitably resulted in a higher proportion of young people being located further away from home, making it more difficult for family members to visit. Only 43% of young men and 44% of young women said that it was easy for their family and friends to visit. Four per cent of young men said they had never received a visit. Some establishments organised regular family days and tried to support family members to visit, but these practices were not widespread.

There was still very little work carried out by staff based within the juvenile estate to track the progress of young people after they were released. If we are to understand what works in children and young people's establishments, then this issue requires much greater investigation and attention.

Resettlement provision for young people

The Inspectorate published a thematic review of resettlement provision for young people in 2011, focusing on accommodation and education, training and employment (ETE).[12] We carried out fieldwork at six male young offender institutions (YOIs), including interviews with 61 sentenced young men approaching release. More than 80% of the young men had an identified accommodation and/or ETE need.

We found that it was unclear how establishments' resettlement work was monitored; the necessary data were not collected. Training plan targets were often broad and placed the onus only on the young person, and did not specify how they would be helped to achieve them. At the time of interview, only 14 of the 48 young men who said they wanted to continue education had a place arranged. Of the 42 who wanted to work, only nine said they had a job arranged on release. For seven of them, it had been arranged through family and without help from the YOI or youth offending team.

We received follow-up information on the young men in our sample on release and one month later. Only 32% had suitable accommodation and ETE on release. Two were forced to report as homeless. One in five were placed in accommodation assessed as unsuitable. Of the third of young men who had an ETE placement arranged on release, only half were still attending one month later. One month after release, six of the young men were in custody and one was on the run. No information was available on the two young men released homeless.

Overall, the outcomes in our sample were very disappointing. The type of follow-up information obtained during our review was not routinely collected by establishments. One of our recommendations was therefore that the YJB should develop procedures to effectively monitor resettlement outcomes for young people following their release. YOIs should receive guidance on how to collect the necessary data and how to use the data to develop and improve resettlement strategies. Better joint work across government departments and agencies is needed and there should be an acceptance that vulnerable young people released from custody are children in need.

12 HMI Prisons, Resettlement provision for children and young people: accommodation and education, training and employment (June 2011).

The care of looked after children in custody

In 2011, we published a thematic review of the care of looked after children in custody.[13] While there are no centrally held data on the number of looked after children in custody, it is recognised that they are over-represented. Based on a total population of 1,500 children and young people in custody, we estimated that, at any one time, there are around 400 children in custody who have spent time in care. We reviewed how well YOIs work with local authorities and youth offending services to ensure the needs of looked after children are met during their time in custody and in preparation for release. Our review was based on interviews with 12 looked after children and a survey of 623 children, as well as interviews with case supervisors, advocates and representatives of safeguarding teams at each of the 12 YOIs.

To meet the complex needs of looked after children in custody, there should be collaboration between everyone involved in supporting them, which must include the involvement of social workers from the looked after children service of the local authorities responsible for their care. The looked after child's social worker should support them during their time in custody and be involved in preparation for their release.

Our review identified the following issues:

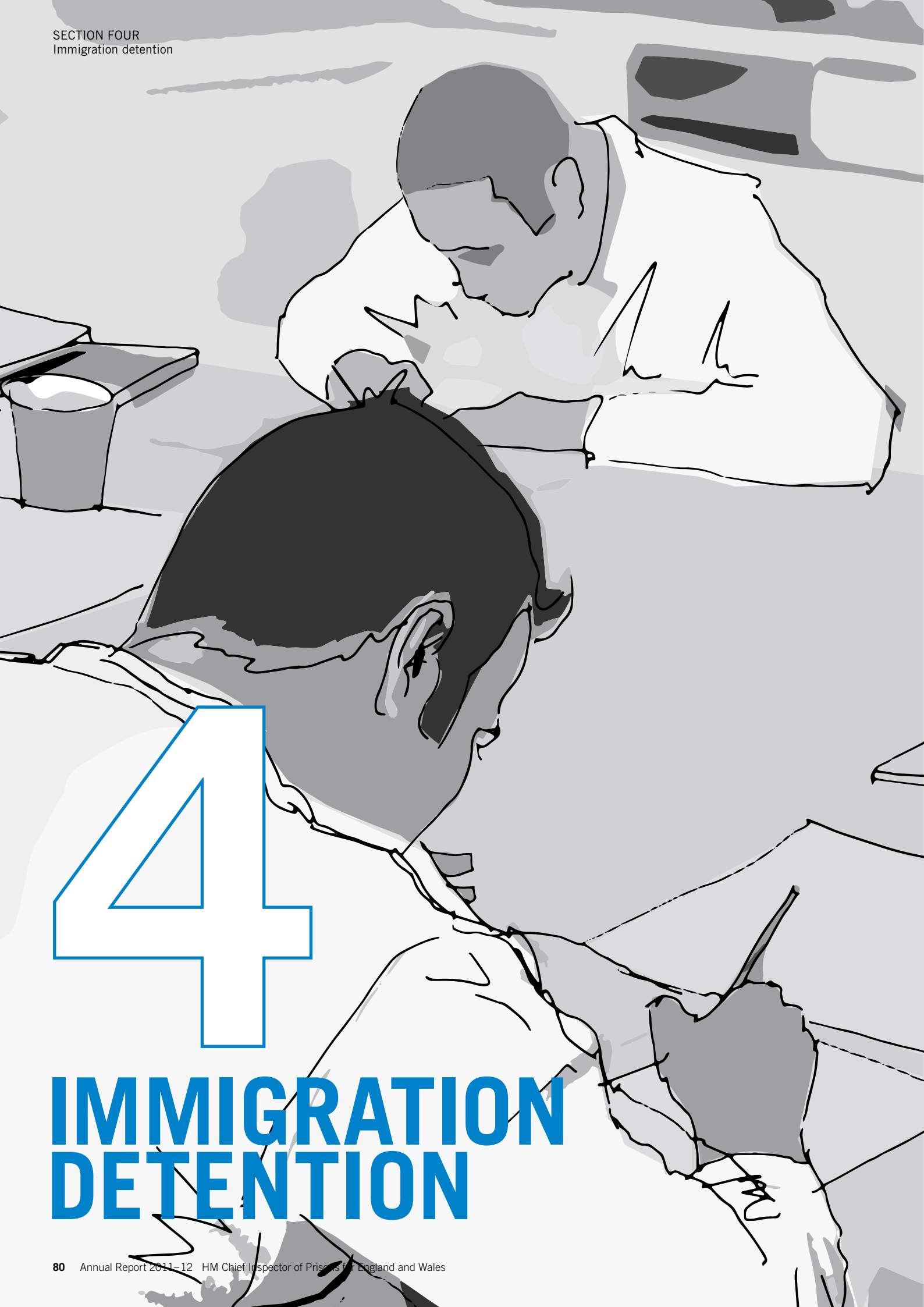
- There was a lack of clarity in most establishments about where the responsibility for looked after children should lie.
- Three-quarters of safeguarding teams said there were barriers which prevented effective communication between the YOI and the local authority. They said the involvement of local authorities was often dependent on the commitment of individual social workers. A third felt some social workers tried to end their involvement while the young person was in custody.
- Less than half the safeguarding teams said they would routinely keep a looked after child's social worker informed of their wellbeing and progress in custody.
- A third of safeguarding teams said looked after children reviews only took place as required because of the tenacity of establishment staff.
- Only half of young people interviewing said they had received a visit from their social worker during their time in custody. The frequency of these visits ranged from weekly to once in three months.

In relation to resettlement, young people who said they had been in care were more likely to think they would have a problem finding accommodation and getting a job on release. Adequate and early planning for release was therefore a key concern of establishment staff and young people. Accommodation was often not confirmed until close to the young person's release or, occasionally, on the day of release. This affected young people's opportunity for early release and meant that some ended up in unsuitable accommodation. Only two of the 12 young people we interviewed had employment and/or education plans confirmed for their release.

Follow-up information about the looked after children we interviewed was concerning: one of the 12 was released without an address and one to unsuitable bed and breakfast accommodation. Two had an education or employment placement to start on release. A month later, only one child was attending education and three were back in custody.

We made four recommendations as a result of our review of the care of looked after children in custody, two of which were addressed to the YJB and two to NOMS. One of these concerned the need for a designated social worker within each YOI with responsibility for looked after children. We were therefore pleased that the YJB announced a commitment to fund social worker posts in YOIs until 2014 and hope that their remit will specifically include addressing the needs of looked after children. Our other recommendations remain outstanding.

13 HMI Prisons, The care of looked after children in custody (May 2011).



4 IMMIGRATION DETENTION

In 2011–12, we carried out six inspections of immigration removal centres (IRCs), two of which were short follow-up inspections in which we focused solely on whether sufficient progress was being made.

Overall, outcomes for detainees had improved at most of the immigration removal centres (IRCs) inspected this year, but significant concerns remained about some aspects of casework and the treatment of the most vulnerable detainees. Brook House had recovered from a low base and neither Tinsley House nor Yarl's Wood were holding children during our visits. Good progress was being made at Haslar but not enough was being done to implement our previous recommendations at Campsfield House and Lindholme. UKBA has subsequently announced the closure of Lindholme as an immigration removal centre.

Table 11a: Outcomes in immigration removal centres

	Safety	Respect	Purposeful activity	Preparation for release
Brook House	3	3	2	2
Lindholme	2	3	3	2
Tinsley House	3	3	3	4
Yarl's Wood	3	4	3	3

Key
4: Outcomes good
3: Outcomes reasonably good
2: Outcomes not sufficiently good
1: Outcomes poor

Table 11b: Progress against recommendations in immigration removal centres inspected using revised short follow-up methodology

	Safety	Respect	Purposeful activity	Preparation for release
Campsfield House	Not making sufficient progress	Not making sufficient progress	Not making sufficient progress	Not making sufficient progress
Haslar	Not making sufficient progress	Making sufficient progress	Making sufficient progress	Making sufficient progress

Safety

Detainees are held in safety and with due regard to the insecurity of their position.

Safety outcomes were reasonably good at all of the centres subject to full inspections. Brook House, which in 2010 was one of the least safe IRCs we had seen, now provided a stable and ordered environment. Detainees told us they felt safe and the amount of violence, bullying and use of force had all reduced substantially. However, concerns remained about the excessive, and in many cases illegitimate, use of separation, which was in sharp contrast to the relatively sparing use of separation in other IRCs.

While detainees at the short follow-up inspections of Lindholme and Campsfield House generally said they felt safe, insufficient progress had been made on implementing previous recommendations. The situation at Haslar was unusual in that the good progress made by the centre contractors was not matched by UKBA, which had achieved none of the recommendations we made at the previous inspection.

Levels of self-harm were not high and assessment, care in detention and teamwork (ACDT) documentation and procedures were generally of a reasonable standard, though some detainees at risk of self-harm were held in depressing separation cells.

Detainee feedback on escorts was generally positive, though too many were still moved around the estate in the middle of the night or subject to frequent transfers. Prison files did not always arrive with ex-prisoners and detainees were routinely handcuffed for outside appointments in line with an inappropriate presumption in favour of handcuffing all detainees.

The inspection of Yarl's Wood was the first since the government's decision to stop detaining children there; a decision we welcomed given our longstanding concerns about the detention of children. This allowed managers to focus more on the needs of the adult population and we saw significant improvements in many areas. Concerns remained about the management of some vulnerable groups, including older detainees, detainees with disabilities and, in particular, pregnant women, who should only be detained in the most exceptional circumstances. There were seven pregnant women at the centre at the time of the inspection and not enough attention was given by UKBA to their condition.

Only one of the UKBA monthly review letters mentioned pregnancy. In one case, a pregnant woman had been transferred over the course of four days from Northern Ireland to Scotland to Manchester, where she had collapsed and been treated, and finally on to Yarl's Wood. *(Yarl's Wood)*

Although Tinsley House held no children at the time of our inspection, a new children's unit was under construction and has subsequently opened. We will inspect it in due course. Age disputes continued to occur across the estate. At Tinsley House, the local and UKBA national age dispute policies were not followed and at Haslar we found some especially poor practice.

UKBA caseworkers did not respond promptly to new documentary evidence showing that a detainee was under 18, which led to a child being unnecessarily detained. He was subsequently confirmed as a minor and moved to social services care. *(Haslar)*

A familiar finding was that initial Rule 35 reports[14] were often poor, reflecting a lack of training and understanding in health care teams as to their purpose. UKBA caseworker responses were often insubstantial and dismissive. Given the importance of the Rule 35 process as a safeguard for detainees who are not fit to be detained and/or have experienced torture, this was an unacceptable state of affairs.

Many detainees were worried about the progress of their cases and needed help to navigate UKBA policy and complex immigration legislation. However, access to legal advice and representation was problematic, with legal aid restrictions and poor quality advice regularly cited as major difficulties. In our surveys, only 31% of detainees said they were getting free legal advice. Although detention duty advice surgeries were in place in all centres, they were commonly oversubscribed. The Inspectorate is currently conducting a thematic inspection on the impact and quality of immigration casework jointly with the Independent Chief Inspector of Borders and Immigration. This will help us to better understand detainees' concerns about casework.

Respect

Detainees are treated with respect for their human dignity and the circumstances of their detention.

Outcomes relating to the healthy establishment test of respect were reasonably good or good in all centres where we made new judgements. Notable progress had been made at two centres. At Yarl's Wood, the vast majority of detainees described respectful and helpful staff. At Haslar, some of the worst accommodation found in any custodial environment we had inspected had been transformed through much needed investment. Previously unacceptable noise levels had abated and the centre was calmer and more decent.

14 Detention Centre Rule 35 requires the centre's medical practitioner to report to the UKBA where a detainee's health is likely to be injuriously affected by detention; where a detainee has suicidal intentions; or where a detainee may have been a victim of torture. Rule 33 defines a 'medical practitioner' as a general practitioner.

While the cleanliness and general condition of most centres was adequate, Lindholme was an exception. The condition of the bedrooms and ventilation were still poor, some toilets were in need of repair and detainees could not wash their own clothes. Poor ventilation was also an issue at Tinsley House and Brook House. The prison-like design of Brook House remained an inappropriate environment for detainees, and developments such as an incentives and earned privileges scheme modelled on prisons were inappropriate.

Staff-detainee relationships were generally good and the improvement was most noticeable at Brook House, where more confident and better supported staff were usually engaging positively with the population. For the largely female population at Yarl's Wood, the proportion of male residential staff was too high. In our surveys, 79% of detainees felt most staff treated them with respect and 62% reported having a member of staff they could turn to for help with a problem.

Faith provision remained good across all centres and was appreciated by detainees. There was little evidence of tension between different nationality groups. Diversity work varied across centres but was underdeveloped, with too little recognition given to language needs. Telephone interpreting was generally underused, except at Yarl's Wood. Most centres made insufficient use of group meetings to help increase communication and support, and ensure that staff were able to keep abreast of detainee concerns.

> Meetings with different nationality groups to encourage dialogue and information sharing did not take place regularly. Only one had been held in the year to date and there was no evidence that issues were followed up or resolved. *(Campsfield House)*

Complaint forms were generally easily accessible but while they could be submitted in any language, replies from UKBA were always in English. The quality of investigations and replies ranged from excellent at Yarl's Wood to sometimes unhelpful and failing to resolve underlying issues at Brook House.

Detainees generally complained about the quality and quantity of food. The ability to cook for themselves was important but only Brook House and Yarl's Wood provided this opportunity, in popular 'cultural kitchens'.

Health care services were generally reasonable but there were significant concerns about provision for detainees with mental health problems at some centres. At Campsfield House, detainees with low level anxiety had no counselling services and there was little structured support for detainees with significant mental distress. There was also no mental health awareness training for custody staff. At Brook House, mental health services were underdeveloped and there was no care planning. The way that UKBA manages detainees with mental health problems has come under increased scrutiny. On three recent occasions, the High Court has ruled that people with mental health problems have been unlawfully detained and that their treatment violated Article 3 of the European Convention on Human Rights (prohibition on inhuman and degrading treatment). One of these cases concerned a detainee who spent time at Brook House.

Telephone interpretation for health care consultations was insufficiently used. At Tinsley House, there was an inappropriate reliance on detainees' friends to interpret during consultations and professional interpretation was underused.

Purposeful activity

Detainees are able to be purposefully occupied while they are in detention.

There was recognition at most centres of the importance of activities in creating a calm environment, given that detainees are regularly held for long periods across the estate. Outcomes for detainees against our healthy establishment test of purposeful activity were reasonably good, except for at Brook House. Insufficient progress was being made against recommendations at Campsfield House, but outcomes had been reasonably good at the previous full inspection.

Detainees had reasonable freedom of movement around centres but, at Brook House, detainees were locked in their rooms for around 11 hours a day, more than at most other IRCs. They were also locked up earlier than at most IRCs, at around 9.00pm. At Tinsley House and Yarl's Wood, our detainee surveys suggested that detainees had enough to do to fill their time.

> For most detainees, there was a wide variety of well-planned and well-attended recreational activity, as well as regular cultural, religious and learning day events. *(Yarl's Wood)*

At Tinsley House, educational facilities were good and the education department at Haslar continued to provide an excellent resource for detainees, though the picture was very different at Brook House, where only 6% of respondents to our survey said they were in education, half the proportion at the last inspection and much worse than the comparator of 29%. There was now only one tutor and currently no arts and crafts provision.

The number of work roles generally varied, with sufficient numbers at Tinsley House and high numbers at Campsfield, but too few at the other centres. Work was generally mundane and wages were low. Detainees who were judged to be non-compliant with UKBA were barred from working, which inappropriately conflated management of centres with the needs of UKBA.

Detainees generally had access to good libraries, but the range of books in languages other than English could be limited and opening hours were sometimes restrictive. PE and sports provision was a generally positive aspect of life at centres.

Preparation for release

Detainees are able to keep in contact with the outside world and are prepared for their release, transfer or removal.

Welfare services are vital for detainees, helping them to resolve practical matters and progress legal cases. Provision was reasonably good at most centres but varied from very good at Tinsley House, where there was an efficient, accessible and valued welfare service, to being particularly weak at Lindholme.

There was still no dedicated welfare officer; staff were allocated the role in rotation for part of each weekday morning, without training or continuity in the role. *(Lindholme)*

Visits provision was generally good, with long hours available at most places, and at Tinsley House and Lindholme, visitors did not have to pre-arrange a visit. We were concerned, however, to find that visitors' personal data, including fingerprints, was used for reasons other than those advertised, without their knowledge. At Campsfield House, all visitors had their fingerprints scanned on arrival and contact management files showed that criminal casework directorate caseworkers regularly requested details of detainees' visitors. Visitors' biometric data were retained indefinitely unless the visitor explicitly requested that it be deleted.

Detainees had good access to telephones and fax machines, though access to the internet and email varied between centres and legitimate websites were sometimes inappropriately blocked.

There was generally a lack of systematic assessment of needs and provision of help to prepare detainees for removal or release. It was largely down to detainees to raise issues with staff. Those leaving Campsfield House with removal directions were seen by the welfare officer but those without removal directions were not. External third-sector organisations such as the Gatwick Detainee Welfare Group at Brook House and Tinsley House provided useful assistance to detainees across the estate.

Short-term holding facilities

The number of people passing through the eight short-term holding facilities we inspected varied greatly, ranging from 34 at Glasgow Festival Court to over 1,000 at Heathrow Terminals 3 and 4. Airport facilities were not suitable for overnight stays but a number of detainees were held for long periods of up to 24 hours. Holding rooms were generally clean but basic, and did not always allow for separation of unrelated men and women and families.

Children, including unaccompanied minors, were regularly held at airports. At Heathrow Terminal 3, nearly 100 children had been held in the three months prior to our inspection, with a dozen detained for over 18 hours. The same number of children were held for over 18 hours at Terminal 4 and, in Terminal 1, two children were held for over 24 hours. None of these facilities were designed or equipped to hold children or adults for such long periods.

At Terminal 4, we saw some particularly poor practice in relation to one child, an EU national, who was held alongside his father without the necessary authority. The child was booked in as a visitor at the direction of immigration staff despite initial challenge by detention staff, and was searched. The father was not offered a telephone call and was not made aware that he could make one. Staff told us that some detainees had also been held without the legal authority in Terminal 1.

UKBA staff were generally trained in child protection, but it was a concern that knowledge of the interagency national referral mechanism for identifying victims of human trafficking was often weak. A number of detention staff had received child safeguarding training.

Staff usually had good sight of the holding rooms, minimising the opportunity for bullying and self-harm. However, most detainee custody officers did not routinely carry anti-ligature knives, which may have caused critical delay in an emergency.

UKBA oversight of the facilities varied. Those at airports received daily checks from an immigration officer, but checks were patchy at Eaton House and Waterside Court. The airport facilities had regular oversight from independent monitoring boards.

One of the most positive aspects was the efforts made by detention staff to treat detainees with respect. We witnessed and were told of many respectful interactions during our entirely unannounced inspections, though not enough was done by staff at Waterside Court in Leeds to engage proactively with detainees.

Detainees usually had good access to telephones but could not use email, except at the residential Pennine House, which in most respects continued to provide good care for detainees held for a number of days.

Escorts

We conducted our first overseas escort inspections to Jamaica and Nigeria. These entailed accompanying an escorted overseas removal from the point of collection from an immigration removal centre in England to the point that detainees disembarked from the aircraft in the destination country.

Both flights were orderly and, in most respects, reasonably well managed. Most escorts performed their duties well and dealt sensitively with the needs of individual detainees. However, we were concerned about the lax and unprofessional approach of a minority who, in the earshot of detainees, swore freely, used offensive and racist language, and made sweeping generalisations about national characteristics. They were unchallenged by colleagues or managers. Overseas removals are inevitably stressful events and the vulnerability of detainees during the process of removal was clearly taken too lightly.

Staff numbers were excessive, with more than three times as many escorts as detainees on one of the flights. There was no accredited training for the use of force on aircraft. In one case, a detainee continued to have his head restrained when he had become compliant. Handcuffs and force should be used only as a last resort and for the minimum time necessary, but we found evidence of shortcomings in relation to both requirements. In one case, a detainee was kept in handcuffs for more than two hours, even though detention staff acknowledged that she was upset rather than 'kicking off'.

The inhumane use of 'reserve' detainees for charter flight removals also continued. This entailed over-booking flights with detainees who had said last goodbyes in the UK or were looking forward to returning home, and at the last minute telling some that they were not flying after all. Detainees were not notified that they were on this reserve list. A recent report by the Home Affairs Select Committee on enforced removals agreed with our view that the practice of using reserves should cease.[15]

15 Home Affairs Select Committee, Rules governing enforced removals from the UK – Eighteenth Report of Session 2010–12 (January 2012).

5 POLICE CUSTODY

The programme of joint inspection of police custody undertaken with HM Inspectorate of Constabulary continued in 2011–12 with reports of 17 inspections published and a number of milestones reached. For the first time, we carried out follow-up inspections of three police forces which we had previously inspected and found that each had implemented clear improvements. The 50th inspection report since the police custody inspection programme began was also published. We reviewed the operation of the first two years of the programme and decided to make all future inspections unannounced and to revise our expectations so that they focused more on key outcomes for detainees.

Strategy

There is a strategic focus on custody that drives the development and application of custody-specific policies and procedures to protect the wellbeing of detainees.

As the police custody inspection programme has progressed, we have seen greater strategic attention to custody issues. We saw ownership of custody at Association of Chief Police Officer (ACPO) level, with clear estates strategies and governance of custody delivery. ACPO involvement in local criminal justice boards (LCJBs) had provided opportunities for improved partnership working within the custody environment.

Many forces continued with a process of rationalisation and investment in their custody estate. We found more efficient use of resources and improvements in custody conditions. Examples included Northumbria, where a 40-cell suite had recently opened in North Tyneside, and the Metropolitan Police Service (MPS) command of Heathrow where a 30-cell complex opened in April 2011. However, we continued to see custody suites that were old, out of date or poorly maintained.

Many forces were reviewing the use of police constable gaolers within custody suites. Detention officers were mainly non-police officer staff, sometimes employed by private companies. The duties of these detention officers varied between forces. For example, in South Wales and Humberside, detention officers undertook the majority of the booking-in process with custody sergeant overview, while in other forces detention officers only undertook the traditional detainee care role. During inspections of MPS boroughs, we often found minimally trained police officers undertaking the role of detention officer, usually during short-term absences of permanent detention officers. This practice was significantly less common elsewhere.

Most custody staff had received initial training in the safer detention and handling of prisoners, although refresher training was patchy. There was, however, regular – usually annual – refresher training in first aid and the use of force.

The ‘Learning the Lessons’ bulletin published by the Independent Police Complaints Commission was provided to all forces and disseminated to custody staff by email. However, staff knowledge of this bulletin was frequently vague.

Police Authority oversight in the implementation of custody inspection recommendations tended to be better where there had been an identified Police Authority lead for custody. With the transition to Police and Crime Commissioners in late 2012, providing this governance will give added focus to police forces’ custody provision.

Treatment and conditions

Detainees are held in a clean and decent environment in which their safety is protected and their multiple and diverse needs are met.

Difficulties with the new escort contractors for London and the South East resulted in detainees at Hounslow and Heathrow experiencing problems being transported to and from court and prison. Consequently, detainees were locked out of prisons and inappropriately held overnight and over the weekend in police custody suites. Some of these detainees were particularly vulnerable and the conditions in police custody suites were unsuitable. We were pleased that this issue was being taken seriously by the MPS and it was working on a solution with the new escort contractors.

The Ministerial Board on Deaths in Custody asked HM Inspectorate of Prisons to review the extent to which Person Escort Records (PERs) were an effective means of alerting courts, escort contractors and prisons to the needs of detainees vulnerable to self-harm. We completed the first stage of this thematic review in December 2011. Findings from the first stage were that information recorded on the PER was, in many instances, inconsistent with information in the police custody risk assessment. Sources of information about self-harm were often not specified. There was a lack of contextual information in PERs about the nature of the self-harm and when it took place. Some sections of the PER were often not completed and many of the PER copies retained by the police were illegible, making quality assurance by the police impossible and raising doubts about how useful the original could have been.

As in previous years, we found custody staff generally dealt with detainees in a professional manner. At Cambridgeshire and Lincolnshire, staff were very responsive and ensured that detainees were clear about what was happening to them.

> We observed instances of custody staff going out of their way to be responsive to detainees' needs by carefully explaining why potentially unwelcome procedures were necessary and answering their questions fully. Use of first names was usual. Most detainees we spoke to told us they felt they had been treated well by custody staff. *(Cambridgeshire)*

There had been little improvement in responding to the diverse needs of detainees, but we did identify some good practice. In Sussex, the force had published guidance outlining the issues facing young people in custody. At most of the custody centres in Sussex, young people were located in a separate corridor away from adults but close to the booking-in desk and were allowed to wait with appropriate adults in waiting rooms instead of cells. Sussex also had good provision for detainees with disabilities and responded well to the religious needs of detainees. The multi-faith room at Nottingham Bridewell was an excellent initiative.

The response to female detainees rarely extended beyond giving them an opportunity to speak to a female member of staff. Provision for older detainees and those with disabilities was mixed. Some custody suites had adapted cells, thick mattresses, widened doors and access to a wheelchair but others were totally unsuitable for detainees with any kind of mobility issue. Hearing loops were provided in some suites or staff had access to British Sign Language interpreters.

The lack of privacy at booking-in desks was consistently an issue. Detainees were required to disclose personal, and sometimes very sensitive, information in the immediate vicinity of other detainees and staff.

There was a fundamental lack of privacy in the booking in area at Fulham. While only one detainee could be booked in at a time, other detainees left in the area could easily listen to conversations between staff and detainees. *(Hammersmith and Fulham)*

Most initial risk assessments were completed thoroughly, drawing on relevant information and observations of detainees, and were updated during the detainee's period in custody. Despite thorough risk assessments, we found risk management plans were not always proportionate. In many custody suites, spectacles, shoelaces and belts were routinely removed. In others, detainees were placed on 30-minute observations for no obvious reason. A padded cell at Nottingham Bridewell used for constant observations was in such disrepair we considered it dangerous and fundamentally inappropriate for holding the most vulnerable detainees. When we pointed this out, senior managers took it out of use immediately. At most custody suites, closed circuit television was not used as a substitute for one-to-one interaction with detainees on constant observations. Staff continued to be attuned to issues around the rousing of detainees, although there were exceptions.

Procedures for checks and rousing detainees under the influence of drugs or drink were effective. New guidance on rousing had been issued, custody staff had received training, and there was a prominent sign on the cell door of each detainee who required rousing. *(Croydon)*

We were not convinced that some staff understood the importance of obtaining full responses to questions when they made rousing checks on detainees. Our custody record analysis identified deficiencies in rousing, with entries such as 'appeared asleep' about detainees subject to rousing checks. *(Cambridgeshire)*

We continued to see little progress in the governance arrangements for the use of force on detainees. Although processes were in place in most forces for the recording of such incidents, little use was made of the data.

The practice of handcuffing detainees was inconsistent and a cause for concern. Although there is ACPO guidance on the use of handcuffs, we found little understanding of this among many operational officers. Detainees were often handcuffed as a matter of course and regardless of their demeanour or antecedents.

Graffiti and overall cleanliness continued to be a challenge for a small number of forces, with large variations in the conditions of custody suites. The physical conditions of two of the three floors of cells at Nottingham Bridewell were very poor. Cells were filthy, with evidence of bodily fluids, food and other materials on the walls, floors and ceilings. We were invited to view the suite some weeks after the inspection and conditions were much improved. There had also been improvements in forces that were re-inspected. In Cambridgeshire and Tower Hamlets, the physical environment was much better than at our previous inspection.

Many elements of care were provided only at the request of the detainee, including toilet paper. Showers and exercise were rarely offered but were provided on request. There was a lack of privacy in shower cubicles, especially for female detainees. Some custody suites held a good stock of hygiene products, including products for women, but detainees were not routinely informed of this. Too many detainees were placed in paper suits instead of being provided with replacement clothing.

> Overall, the suite was well equipped but many services were on 'request only'; in the words of one custody officer: 'I suppose by asking "do you want a shower" you are making work for yourself, as they would need to be supervised and we would not do that if we were busy'. *(Heathrow)*

Refreshments were regularly provided although the quality and variety of microwave meals was mixed. Reading material was available across most forces but there was a lack of suitable material for those under 18 and insufficient books available in large print or in languages other than English, even at those custody suites that held a large number of immigration detainees.

Individual rights

Detainees are informed of their legal rights on arrival and can freely exercise those rights while in custody.

Most forces had a positive approach to balancing the progression of investigations with the rights of detainees. There was also an increasingly positive focus on alternatives to custody, such as voluntary attendance, community resolutions and fixed penalties. Nonetheless, there was still some work to be done at a small number of forces regarding the necessity to detain an individual, as opposed to alternative approaches. Adherence to the Police and Criminal Evidence Act 1984 (PACE) remained good and information was provided to detainees about their rights and entitlements at most custody suites. We found, in many forces, that detainees were not routinely asked about any dependents but most were permitted to have someone informed of their arrest.

Telephone and face-to-face translation services were available in all forces inspected and were mainly used when needed. In most forces, relationships with UKBA were developed and immigration detainees were typically held in custody for 24 hours, but there were exceptions. In Lancashire, many immigration detainees were held for two to three days before they were collected by UKBA and, in most forces, we found examples of immigration detainees being held in custody for excessive periods.

Pre-release risk assessments were completed, but they were basic and many were poor. The assessments rarely resulted in sufficient action being taken to assist the most vulnerable detainees. An exception was in Sutton, where the force carried out detailed pre-release assessments which prompted sergeants to consider a range of relevant issues, particularly for vulnerable detainees being released.

Appropriate adult provision for vulnerable adults was mostly poor and relied on locally developed initiatives. Detained children and young people had better local provision but the out-of-hours service continued to be poor. However, some forces were making progress in addressing these issues. Sussex had invested in appropriate adult services and they worked well for both children and vulnerable adults. In South Wales, the force had contracted a private company to provide an appropriate adult service for vulnerable adults, which did excellent work.

Police continued to adhere to the PACE definition of a child which meant that 17-year-olds were not automatically provided with an appropriate adult. In most other domestic and international law, 17-year-olds are regarded as children and in need of additional protection and support. Place of safety beds to accommodate children who were charged before their attendance at court were rarely supplied. This meant that those who could not be bailed were kept in police custody overnight.

Court cut-off times varied but too many were early and resulted in detainees spending long periods in custody. At weekends, most courts expected detainees to be at court before 9.00am which was too early. We found mostly good management of forensic and DNA samples in custody and effective processes to transport detainee samples, with some exceptions. In Hammersmith and Fulham, we found samples that were almost a year out of date and the registers for recording samples were incomplete, thereby compromising the continuity and integrity of the samples.

The management of complaints continued to be an area of concern. With the exception of allegations of assaults, we found that it was rare for a complaint to be made while a detainee remained in custody. Most custody suites did not have readily available information for detainees about the complaints process.

Health care

Detainees have access to competent health care professionals who meet their physical health, mental health and substance use needs in a timely way.

The majority of health care providers in police custody were private companies, though some forces, including the MPS, continued to directly provide health care. In some areas, service performance monitoring was insufficiently robust, but we saw especially good practice in Humberside. The time it took health care professionals to respond to calls was problematic. In the worst cases, commonly in rural or dense inner city areas, detainees waited between four and seven hours.

Not all doctors were qualified forensic medical examiners (FMEs). Clinical governance of staffing was usually adequate, as checking of the credentials of staff had generally improved. However, maintenance and monitoring of continuous professional development was patchy and clinical supervision was not always available.

We visited several forces where health care rooms were new or purpose-built and of a high standard. However, many were not fit for purpose due to inadequate environmental or infection control standards. The ownership and auditing of the clinical supplies in the majority of services was vague. In most areas, there was significant overstocking and retention of out-of-date items. Automated external defibrillators were available in all custody suites and custody staff were trained to use them. There was a confusing array of other life support equipment and, in many places, equipment was overstocked, incomplete or irregularly checked. We welcome work that has begun to prepare police forces for NHS-led commissioning of health care provision in police custody, which we hope will improve clinical standards.

Medicines management was generally better than we have previously reported with stock auditing and reporting of stock anomalies. We found particularly good practices in Nottinghamshire and Northumbria. However, we still found some custody suites where stock storage and management was weak and discrepancies in some drug registers.

Patient care was generally satisfactory and most detainees we spoke with were happy with their consultations with health care professionals. Detainees reported being able to receive previously prescribed medications, although this was less so for opiate substitutes. Symptomatic relief was available for those withdrawing from alcohol or drugs. Clinical records were usually appropriate and health care professionals gave relevant instructions to custody staff. We found the storage of clinical records to have improved, but there

were still instances where the security of stored records gave rise to concern and not all staff obtained patient consent for the sharing of information.

Detainees in police custody had access to substance misuse workers in most suites. In busier suites, workers were available for extended hours and offered intensive programmes of support. There were a variety of service providers and contract management could be very complex. For example, in Greater Manchester there were different drug and alcohol action teams at each custody suite. Some services offered both drug and alcohol support but the presence of alcohol workers in custody suites was mostly lacking. Detainees were usually signposted to community services to obtain harm minimisation supplies.

Not all police forces had mental health workers on site, but they were usually available to provide telephone support during office hours. Diversion from custody arrangements were in place in some areas and we saw particularly good practice in Lancashire. The process of Mental Health Act assessment was usually efficient during the day, but most forces were dissatisfied with the service in the evenings and at weekends. In some areas, such as Lincolnshire, there appeared to be overuse of police custody to detain people under section 136 of the Mental Health Act and, in some, such as South Wales, NHS suites for section 136 detainees were unavailable. At the time of our inspection in early December, 329 section 136 detainees had been taken to custody suites in South Wales in 2011 due to the absence of NHS suites. There was good practice in the use of section 136 in most MPS boroughs. The Inspectorate has begun work, alongside the Care Quality Commission and HM Inspectorate of Constabulary, to inform a Joint Ministerial Review of the use of section 136 in England and Wales.

Children in police custody

The Inspectorate contributed to a thematic review, led by HM Inspectorate of Constabulary, on the provision of appropriate adults and local authority accommodation for children and young people in police custody.[16] We found that while the provision of appropriate adults had evolved, there was an emphasis on PACE compliance rather than on safeguarding and promoting the welfare of young people. As a result, young people were being detained in police cells for longer than was necessary. In addition, few young people were transferred to local authority accommodation after being charged and denied bail, yet almost two-thirds in our sample who remained in police custody were granted conditional or unconditional bail at their first court appearance.

16 HM Inspectorate of Constabulary, Who's looking out for the children? A joint inspection of appropriate adult provision and children in detention after charge (December 2011).

6 COURT CUSTODY

In light of the UK's obligations under the Optional Protocol to the Convention against Torture to ensure that all places of detention receive independent and regular monitoring, the Inspectorate was invited by Ministers in 2011 to inspect court custody facilities. While this programme of inspections will, in the first instance, be carried out at the invitation of Ministers, it is intended that legislation will soon be brought forward granting the Inspectorate the necessary statutory duties and powers to inspect court custody.

In preparation for this new area of work, we convened a stakeholder group with representatives from various organisations to contribute their ideas and expertise to the development of our inspection methodology. We prepared a set of expectations specific to the inspection of court custody facilities which mirror those for police custody. Expectations are divided into four sections: strategy; treatment and conditions; health care; and individual rights. We also carried out two pilot inspections – of seven courts in Humberside and 11 in Greater Manchester – in early 2012. These pilot inspections proved the value of independent inspection as we identified a number of areas of concern. Because these pilot inspections were designed to test and refine our methodology and inspection criteria, formal inspection reports were not published. Nonetheless, we did make a number of observations to help HM Courts and Tribunal Service (HMCTS) and court custody contractors to make improvements.

Contractors and HMCTS staff welcomed their courts being included in the pilot inspections. We were grateful for their willingness to contribute to the pilots, which were a learning experience for all concerned, and we were impressed by the way in which staff embraced our observations and the speed with which they put plans in place to address our concerns. Now the pilot phase has concluded, our programme of inspections for 2012–13 includes the full inspection of three large court areas encompassing up to 50 courts. The Inspectorate now has the opportunity to inspect custodial conditions from arrest to appearance in court, the transfer to prison, and the period of remand or sentence through to release.

7

APPENDICES

Inspection reports published 1 April 2011 to 31 March 2012

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Kent police custody suites	Announced	5 April 2011
Dhekelia	Announced	13 April 2011
Doncaster	Full unannounced	14 April 2011
Stocken	Full announced	15 April 2011
Send	Full announced	19 April 2011
The Verne	Short follow-up	21 April 2011
Morton Hall	Short follow-up	28 April 2011
Lindholme IRC	Short follow-up	10 May 2011
Stoke Heath (juvenile)	Short follow-up	17 May 2011
Brixton	Full follow-up	18 May 2011
Eastwood Park (Mary Carpenter Unit)	Full announced	25 May 2011
Lincolnshire police custody suites	Unannounced	27 May 2011
Sussex police custody suites	Announced	2 June 2011
Northallerton	Full announced	7 June 2011
Whitemoor	Full unannounced	8 June 2011
Rochester	Full announced	14 June 2011
Sutton police custody suites	Announced	15 June 2011
Lindholme	Short follow-up	22 June 2011
Risley	Full announced	29 June 2011
Croydon police custody suites	Announced	5 July 2011
Heathrow Terminal 3 STHF	Full unannounced	6 July 2011
Heathrow Terminal 4 STHF	Full unannounced	6 July 2011
Blundeston	Full announced	13 July 2011
Moorland	Full announced	15 July 2011
Hatfield	Full announced	15 July 2011
West Yorkshire police custody suites	Unannounced follow-up	20 July 2011
Tinsley House IRC	Full announced	26 July 2011
Werrington	Full announced	27 July 2011
Lowdham Grange	Full announced	28 July 2011
Wandsworth	Full follow-up	10 August 2011
Pentonville	Full follow-up	17 August 2011
Long Lartin Detainee Unit	Full follow-up	18 August 2011
Lancashire police custody suites	Unannounced	1 September 2011
Jamaica overseas escorts	Announced	6 September 2011
Nigeria overseas escorts	Announced	6 September 2011
Belmarsh	Full unannounced	13 September 2011
Haverigg	Full follow-up	13 September 2011
Cleveland police custody suites	Unannounced	19 September 2011
Bedford	Short follow-up	20 September 2011
Chelmsford	Full announced	21 September 2011
Peterborough (men)	Full announced	27 September 2011
Peterborough (women)	Full announced	27 September 2011
Cambridgeshire police custody suites	Unannounced follow-up	28 September 2011
Kirklevington Grange	Full announced	29 September 2011
Askham Grange	Short follow-up	30 September 2011

Inspection reports published 1 April 2011 to 31 March 2012 *(Continued)*

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Heathrow Terminal 1 STHF	Full unannounced	3 October 2011
Warren Hill	Full follow-up	4 October 2011
Isle of Man	Full announced	5 October 2011
Campsfield House IRC	Short follow-up	5 October 2011
Ash House	Short follow-up	10 October 2011
Hydebank Wood	Short follow-up	10 October 2011
Wayland	Full announced	11 October 2011
Haslar	Short follow-up	12 October 2011
Aylesbury	Short follow-up	20 October 2011
Exeter	Short follow-up	21 October 2011
New Hall (Rivendell Unit)	Full announced	25 October 2011
Deerbolt	Full announced	8 November 2011
Swaleside	Short follow-up	15 November 2011
Wormwood Scrubs	Full follow-up	18 November 2011
Lancaster Farms	Full follow-up	22 November 2011
Hammersmith and Fulham police custody suites	Unannounced	23 November 2011
Grendon	Short follow-up	1 December 2011
Yarl's Wood IRC	Full announced	7 December 2011
Kennet	Short follow-up	13 December 2011
Erlestoke	Short follow-up	13 December 2011
Stafford	Full announced	14 December 2011
Feltham	Full follow-up	20 December 2011
Rye Hill	Full announced	23 December 2011
Northumbria police custody suites	Unannounced	4 January 2012
High Down	Full announced	5 January 2012
Eaton House STHF	Full unannounced	6 January 2012
Long Lartin	Full follow-up	10 January 2012
Nottingham police custody suites	Unannounced	11 January 2012
Glasgow Airport STHF	Full unannounced	16 January 2012
Festival Court, Glasgow STHF	Full unannounced	16 January 2012
Shrewsbury	Full announced	17 January 2012
Isis	Full announced	19 January 2012
Styal	Full follow-up	20 January 2012
Hindley	Short follow-up	24 January 2012
Downview	Short follow-up	26 January 2012
Downview (Josephine Butler Unit)	Short follow-up	26 January 2012
Wealstun	Full follow-up	27 January 2012
Brook House IRC	Full follow-up	31 January 2012
Heathrow police custody suites	Unannounced	7 February 2012
Hounslow police custody suites	Unannounced	7 February 2012
Pennine House STHF	Full unannounced	14 February 2012
Leeds Waterside Court STHF	Full unannounced	14 February 2012
The Mount	Full follow-up	15 February 2012
Ashfield	Short follow-up	17 February 2012
Manchester	Full follow-up	22 February 2012
Maidstone	Full announced	23 February 2012
Northamptonshire police custody suites	Unannounced	28 February 2012

Inspection reports published 1 April 2011 to 31 March 2012 *(Continued)*

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Dovegate	Short follow-up	7 March 2012
Dovegate Therapeutic Community	Short follow-up	7 March 2012
Featherstone	Short follow-up	16 March 2012
Tower Hamlets police custody suites	Announced follow-up	20 March 2012
Brinsford	Full follow-up	21 March 2012
South Wales police custody suites	Unannounced	27 March 2012
Low Newton	Full announced	28 March 2012
Wymott	Short follow-up	29 March 2012

Other publications – 1 April 2011 to 31 March 2012

TITLE	DATE PUBLISHED
A review of short-term holding facility inspections 2004–10	7 April 2011
Business Plan 2011–12	20 April 2011
The care of looked after children in custody	26 May 2011
Resettlement provision for children and young people	21 June 2011
HM Chief Inspector of Prisons for England and Wales Annual Report 2010–11	14 September 2011
Equal but different? An inspection of the use of alternatives to custody for women offenders	13 October 2011
Children and young people in custody 2010–11	26 October 2011
Who's looking out for the children? (Appropriate adults/PACE)	13 December 2011
Monitoring places of detention: Second annual report of the UK NPM 2010–11	8 February 2012

Table 1 – Healthy prison and establishment assessments – 1 April 2011 to 31 March 2012

Includes all full inspections and short-follow up inspections assessed on a 1 (poor) to 4 (good) scale

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
LOCAL PRISONS					
Belmarsh	FU	3	2	2	3
Brixton	FFU	3	2	2	3
Chelmsford	FA	3	4	3	3
Doncaster	FU	3	3	2	4
High Down	FA	3	3	2	4
Manchester	FFU	3	3	4	4
Pentonville	FFU	2	3	2	2
Peterborough	FA	3	4	3	4
Shrewsbury	FA	4	4	3	2
Wandsworth	FFU	1	1	2	3
Wormwood Scrubs	FFU	3	3	2	3
HIGH SECURITY					
Long Lartin	FFU	3	3	3	3
Whitemoor	FU	3	2	3	3
TRAINER PRISONS – CAT B					
Lowdham Grange	FA	4	3	3	3
Rye Hill	FA	3	3	2	3
TRAINER PRISONS – CAT C					
Blundeston	FA	2	2	3	2
Haverigg	FFU	2	2	3	3
Lindholme	SFU	3	2	3	3
Maidstone	FA	3	3	2	3
Moorland	FA	3	1	3	2
Northallerton	FA	4	4	3	3
Risley	FA	3	3	3	3
Stafford	FA	3	3	4	3
Stocken	FA	3	2	2	3
The Mount	FFU	4	3	3	3
The Verne	SFU	3	3	3	3
Wayland	FA	3	2	3	3
Wealstun	FFU	2	3	3	3
YOUNG ADULT ESTABLISHMENTS					
Brinsford	FFU	2	3	3	2
Deerbolt	FA	3	3	3	3
Isis	FA	2	2	2	3
Lancaster Farms	FFU	3	3	3	2
Rochester	FA	2	3	1	3

Table 1 – Healthy prison and establishment assessments – 1 April 2011 to 31 March 2012 *(Continued)*

Includes all full inspections and short-follow up inspections assessed on a 1 (poor) to 4 (good) scale

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
OPEN/RESETTLEMENT PRISONS					
Hatfield	FA	3	1	3	2
Kirklevington Grange	FA	4	4	4	4
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS					
Eastwood Park (Mary Carpenter Unit)	FA	3	4	4	4
Feltham	FFU	3	3	1	3
New Hall (Rivendell Unit)	FA	3	4	4	4
Stoke Heath	SFU	3	3	3	3
Warren Hill	FFU	3	3	3	3
Werrington	FA	3	3	3	4
WOMEN'S PRISONS					
Low Newton	FA	3	3	4	4
Morton Hall	SFU	4	3	4	3
Peterborough	FA	3	4	3	3
Send	FA	3	3	3	3
Styal	FFU	3	3	4	3
EXTRA-JURISDICTION					
Isle of Man Prison	FA	3	3	2	1
IMMIGRATION REMOVAL CENTRES					
Brook House	FFU	3	3	2	2
Lindholme	SFU	2	3	3	2
Tinsley House	FA	3	3	3	4
Yarl's Wood	FA	3	4	3	3
MILITARY					
Dhekelia	FA	3	3	3	4

KEY TO TABLE

Numeric:
1 – Outcomes for prisoners/detainees are poor
2 – Outcomes for prisoners/detainees are not sufficiently good
3 – Outcomes for prisoners/detainees are reasonably good
4 – Outcomes for prisoners/detainees are good

Type of inspection:
FFU – Full follow-up
SFU – Short follow-up
FA – Full announced
FU – Full unannounced

Table 2 – Healthy prison and establishment assessments – 1 April 2011 to 31 March 2012

Includes short-follow up inspections assessed on a 1 (insufficient progress) to 2 (sufficient progress) scale.
We adopted this new assessment scale for short follow-up inspections during 2011–12.

		HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
PRISON/ESTABLISHMENT	TYPE OF INSPECTION	SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
LOCAL PRISONS					
Bedford	SFU	2	2	2	2
Exeter	SFU	2	1	1	1
TRAINER PRISONS – CAT B					
Dovegate	SFU	2	2	2	2
Swaleside	SFU	2	2	1	2
TRAINER PRISONS – CAT C					
Erlestoke	SFU	2	2	2	2
Featherstone	SFU	2	2	2	2
Kennet	SFU	2	2	2	2
Wymott	SFU	1	1	2	2
YOUNG ADULT ESTABLISHMENTS					
Aylesbury	SFU	1	1	1	2
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS					
Ashfield	SFU	1	2	2	2
Downview (Josephine Butler Unit)	SFU	2	1	2	1
Hindley	SFU	2	2	2	2
WOMEN'S PRISONS					
Askham Grange	SFU	2	2	2	2
Downview	SFU	2	1	2	1
THERAPAUTIC COMMUNITIES					
Dovegate (TC)	SFU	2	2	1	2
Grendon (TC)	SFU	2	2	2	2
EXTRA-JURISDICTION					
Hydebank Wood – Ash House	SFU	2	2	1	2
Hydebank Wood – YOI	SFU	2	2	1	2
IMMIGRATION REMOVAL CENTRES					
Campsfield House	SFU	1	1	1	1
Haslar	SFU	1	2	2	2

KEY TO TABLE

Healthy Prison Assessment: **1** – Insufficient progress has been made
2 – Sufficient progress has been made

Type of inspection: **SFU** – Short follow-up

Recommendations accepted in full inspection reports published 1 April 2011 to 31 March 2012

PRISONS				
ESTABLISHMENT	**RECOMMENDATIONS** (excluding recommendations no longer relevant)	**ACCEPTED**	**PARTIALLY ACCEPTED**	**REJECTED**
LOCAL PRISONS				
Belmarsh	192	157	22	13
Chelmsford	92	83	9	0
Doncaster	148	138	9	1
High Down	-	-	-	-
Peterborough	120	90	27	3
Shrewsbury	96	81	14	1
Total	**648**	**549 (85%)**	**81 (13%)**	**18 (3%)**
TRAINER PRISONS				
Blundeston	171	157	9	5
Lowdham Grange	135	122	10	3
Maidstone	-	-	-	-
Moorland	168	158	8	2
Northallerton	104	81	20	3
Risley	119	89	26	4
Rye Hill	138	101	29	8
Stafford	130	120	7	3
Stocken	172	146	19	7
Wayland	165	126	30	9
Total	**1,302**	**1,100 (85%)**	**158 (12%)**	**44 (3%)**
OPEN PRISONS				
Kirklevington Grange	43	38	2	3
Hatfield	131	112	16	3
Total	**174**	**150 (86%)**	**18 (10%)**	**6 (3%)**
HIGH SECURITY PRISONS				
Whitemoor	112	93	15	4
Total	**112**	**93 (83%)**	**15 (13%)**	**4 (4%)**
YOUNG ADULT ESTABLISHMENTS				
Deerbolt	107	91	13	3
Isis	119	100	16	3
Northallerton	104	81	20	3
Rochester	159	118	36	5
Total	**489**	**390 (80%)**	**85 (17%)**	**14 (3%)**
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS				
Eastwood Park (Mary Carpenter Unit)	59	45	12	2
New Hall (Rivendell Unit)	45	36	7	2
Werrington	120	104	15	1
Total	**224**	**185 (83%)**	**34 (15%)**	**5 (2%)**

Recommendations accepted in full inspection reports published 1 April 2011 to 31 March 2012 *(Continued)*

PRISONS				
ESTABLISHMENT	**RECOMMENDATIONS** (excluding recommendations no longer relevant)	**ACCEPTED**	**PARTIALLY ACCEPTED**	**REJECTED**
WOMEN'S PRISONS				
Low Newton	-	-	-	-
Peterborough	122	95	23	4
Send	113	80	26	7
Total	**235**	**175 (75%)**	**49 (21%)**	**11 (5%)**
PRISON TOTAL	**3,184**	**2,642 (83%)**	**440 (14%)**	**102 (3%)**
IMMIGRATION REMOVAL CENTRES				
Tinsley House	63	37	13	13
Yarl's Wood	63	41	18	4
Total	**126**	**78 (62%)**	**31 (25%)**	**17 (13%)**
ESCORTS AND REMOVALS				
Jamaica	19	12	5	2
Nigeria	25	12	10	3
Total	**44**	**24 (55%)**	**15 (34%)**	**5 (11%)**
IMMIGRATION TOTAL	**170**	**102 (60%)**	**46 (27%)**	**22 (13%)**
OTHER JURISDICTION				
Isle of Man	-	-	-	-
OVERALL TOTAL	**3,354**	**2,774 (83%)**	**486 (14%)**	**124 (4%)**

KEY TO TABLE

Hyphen (-) – Indicates that outstanding action plans were not returned within the deadline.

Recommendations achieved in follow-up inspection reports published 1 April 2011 to 31 March 2012

PRISONS				
ESTABLISHMENT	**RECOMMENDATIONS** (excluding recommendations no longer relevant)	**ACHIEVED**	**PARTIALLY ACHIEVED**	**NOT ACHIEVED**
LOCAL PRISONS				
Bedford	167	92	17	58
Brixton	162	72	33	57
Exeter	146	70	20	56
Manchester	212	103	40	69
Pentonville	173	61	31	81
Wandsworth	189	60	37	92
Wormwood Scrubs	164	75	29	60
Total	**1,213**	**533 (43%)**	**207 (17%)**	**473 (39%)**
TRAINER PRISONS				
Dovegate	159	100	32	24
Erlestoke	171	101	25	45
Featherstone	140	96	25	19
Haverigg	184	70	47	67
Kennet	131	64	38	29
Lindholme	155	79	21	55
The Mount	193	107	29	57
The Verne	107	55	25	27
Swaleside	110	56	22	32
Wealstun	162	63	32	67
Wymott	130	65	15	50
Total	**1,642**	**856 (52%)**	**311 (19%)**	**472 (29%)**
THERAPEUTIC COMMUNITIES				
Dovegate TC	133	69	23	41
Grendon TC	103	48	25	30
Total	**236**	**117 (50%)**	**48 (20%)**	**71 (30%)**
HIGH SECURITY				
Long Lartin	141	65	35	41
Total	**141**	**65 (46%)**	**35 (25%)**	**41 (29%)**
YOUNG ADULT ESTABLISHMENTS				
Aylesbury	156	41	32	83
Brinsford	192	91	30	71
Lancaster Farms	162	112	29	21
Total	**510**	**244 (48%)**	**91 (18%)**	**175 (34%)**
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS				
Ashfield	77	34	16	27
Downview (Josephine Butler Unit)	55	30	4	21
Feltham	121	46	23	52
Hindley	113	72	19	22
Stoke Heath	130	71	26	33
Warren Hill	153	74	33	46
Total	**649**	**327 (50%)**	**121 (19%)**	**201 (31%)**

Recommendations achieved in follow-up inspection reports published 1 April 2011 to 31 March 2012 *(Continued)*

PRISONS				
ESTABLISHMENT	**RECOMMENDATIONS** (excluding recommendations no longer relevant)	**ACHIEVED**	**PARTIALLY ACHIEVED**	**NOT ACHIEVED**
WOMEN'S PRISONS				
Askham Grange	77	33	15	29
Downview	153	64	19	70
Morton Hall	127	74	27	26
Styal	176	61	38	77
Total	**533**	**232 (44%)**	**99 (19%)**	**202 (38%)**
TOTAL	4,924	2,374 (48%)	912 (19%)	1,635 (33%)
IMMIGRATION REMOVAL CENTRES				
Brook House	185	57	50	78
Campsfield House	96	23	15	58
Haslar	110	59	14	37
Lindholme	146	38	33	75
Total	**537**	**177 (33%)**	**112 (21%)**	**248 (46%)**
SHORT-TERM HOLDING FACILITIES				
Heathrow Airport Terminal 3	20	10	2	8
Heathrow Airport Terminal 4	20	9	5	6
Heathrow Airport Terminal 1	25	15	6	4
Eaton House	19	12	4	3
Glasgow International Airport	18	8	6	4
Festival Court	14	6	4	4
Pennine House	14	8	4	2
Waterside Court	16	9	3	4
Total	**146**	**77 (53%)**	**34 (23%)**	**35 (24%)**
IMMIGRATION TOTAL	683	254 (37%)	146 (21%)	283 (41%)
OTHER				
Hydebank Wood YOI	159	49	32	78
Hydebank Wood Ash House	145	41	41	63
Long Lartin Detainee Unit	30	8	6	16
Total	**334**	**98 (29%)**	**79 (24%)**	**157 (47%)**
OVERALL TOTAL	5,941	2,726 (46%)	1,137 (19%)	2,075 (35%)

2011–12 prisoner survey responses across all functional types: diversity analysis – ethnicity/religion/nationality/disability/age

	Total prisoner survey responses	Black and minority ethnic prisoners	White prisoners	Muslim prisoners	Non-Muslim prisoners	Foreign national prisoners	British national prisoners	Consider selves to have a disability	Do not consider selves to have a disability	Under 21	Over 21
Number of completed questionnaires returned	6,324	1,938	4,265	899	5,262	760	5,352	1,055	5,166	1,160	5,111
	%	%	%	%	%	%	%	%	%		%
When you were in the van: was the attention paid to your health needs good/very good?	30	28	30	28	30	34	29	27	30	32	29
Were you treated well/very well by the escort staff?	62	60	63	55	63	60	62	59	63	60	62
Did you know where you were going when you left court or when transferred from another prison?	79	75	81	75	80	66	81	74	80	83	78
In the first 24 hours, did staff ask you if you needed help/support with the following:											
Problems contacting family?	47	45	48	45	47	49	47	42	48	52	46
Problems of feeling depressed/suicidal?	47	42	49	38	48	43	47	47	47	49	46
Health problems?	58	57	58	54	58	58	58	59	58	58	58
When you first arrived:											
Did you have any problems?	70	73	69	74	69	75	69	82	67	62	71
Were you seen by a member of health services in reception?	87	87	87	86	87	84	88	84	88	89	87
When you were searched in reception, was this carried out in a respectful way?	76	69	79	63	78	71	77	72	77	78	75
Were you treated well/very well in reception?	59	54	62	50	61	58	59	58	60	61	59
Within the first 24 hours did you meet any of the following people:											
Someone from health services?	75	73	76	69	76	72	76	73	75	75	75
Did you feel safe on your first night here?	74	67	78	66	76	69	75	66	76	76	74
Have you been on an induction course?	87	88	87	87	87	86	87	82	88	90	86
In terms of your legal rights, is it easy/very easy to:											
Communicate with your solicitor or legal representative?	43	40	44	43	43	40	43	39	43	36	44
For the wing/unit you are currently on:											
Are you normally offered enough clean, suitable clothes for the week?	52	50	52	50	52	61	50	51	52	46	53
Are you normally able to have a shower every day?	82	79	83	81	82	81	82	79	83	70	84
Is your cell call bell normally answered within five minutes?	38	36	39	36	38	44	37	39	38	38	38
Is the food in this prison good/very good?	27	24	28	23	28	30	26	27	27	23	27
Does the shop/canteen sell a wide enough range of goods to meet your needs?	47	38	51	36	49	46	47	47	47	46	47
Is it easy/very easy to get a complaints form?	81	76	83	74	82	73	82	79	81	81	80
Is it easy/very easy to get an application form?	85	81	87	79	86	80	86	83	85	83	85
Have you made a complaint?	47	49	47	53	46	41	49	54	46	42	48
Are you on the enhanced (top) level of the IEP scheme?	43	42	43	43	43	39	43	37	44	27	45
Do you feel you have been treated fairly in your experience of the IEP scheme?	50	42	54	39	52	38	52	46	51	46	50
Do the different levels of the IEP scheme encourage you to change your behaviour?	46	45	47	45	46	37	48	40	48	53	45
In the last six months have any members of staff physically restrained you (C&R)?	7	8	7	12	7	8	7	8	7	17	6
In the last six months have you spent a night in the segregation/ care and separation unit?	11	12	11	16	10	8	12	12	11	23	9
Do you feel your religious beliefs are respected?	54	59	52	61	53	63	53	54	54	50	55
Are you able to speak to a religious leader of your faith in private if you want to?	57	63	54	75	54	58	57	59	57	54	58
Are you able to speak to a Listener at any time, if you want to?	53	45	57	43	56	41	55	56	53	43	55
Is there a member of staff, in this prison, that you can turn to for help if you have a problem?	72	69	73	64	73	71	72	71	72	68	72
Do most staff, in this prison, treat you with respect?	70	64	73	60	72	71	70	70	70	64	71
Have you ever felt unsafe in this prison?	41	44	39	46	39	44	40	55	37	40	41
Do you feel unsafe in this prison at the moment?	18	21	16	21	17	22	17	28	16	17	18
Have you been victimised by another prisoner?	21	20	21	20	21	25	20	35	18	21	21
Since you have been here, has another prisoner:											
Made insulting remarks about you, your family or friends?	10	7	11	7	10	9	10	18	8	10	10
Hit, kicked or assaulted you?	6	5	7	5	6	5	6	11	5	8	6
Sexually abused you?	1	1	1	0	1	1	1	3	1	1	1
Victimised you because of your race or ethnic origin?	4	7	2	8	3	9	3	7	3	3	4
Victimised you because of drugs?	3	1	3	2	3	1	3	6	2	1	3
Taken your canteen/property?	5	4	5	4	5	5	5	11	4	7	5
Victimised you because you were new here?	6	6	6	6	6	7	6	9	5	8	5

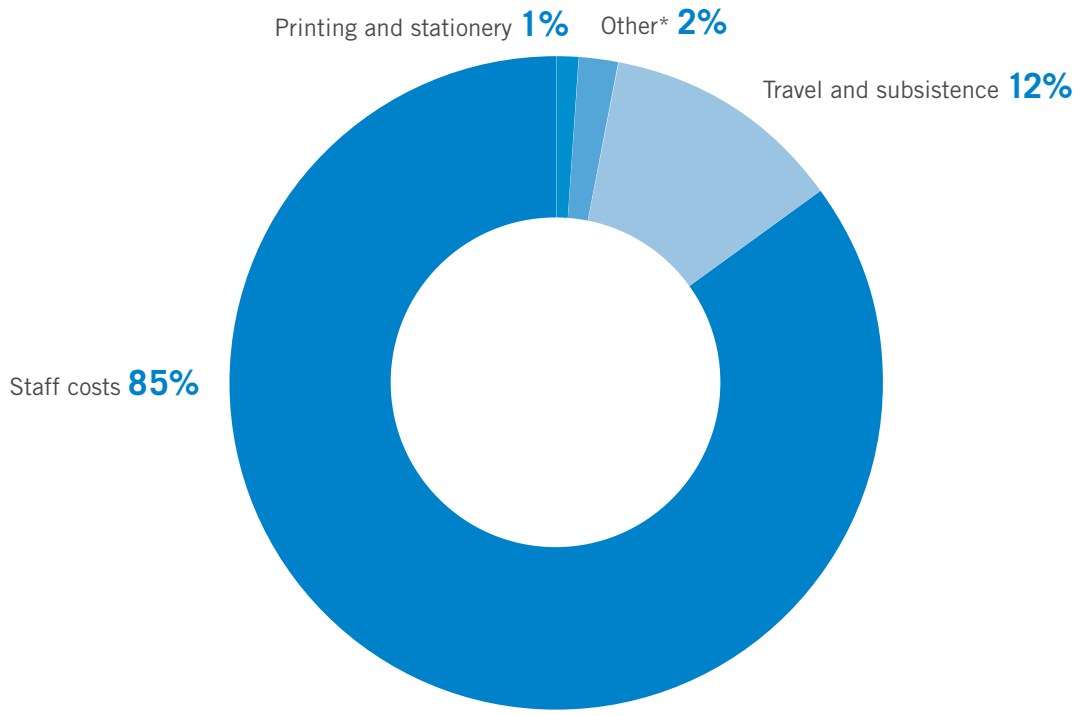
2011–12 prisoner survey responses across all functional types: diversity analysis – ethnicity/religion/nationality/disability/age *(Continued)*

	Total prisoner survey responses	Black and minority ethnic prisoners	White prisoners	Muslim prisoners	Non-Muslim prisoners	Foreign national prisoners	British national prisoners	Consider selves to have a disability	Do not consider selves to have a disability	Under 21	Over 21
Number of completed questionnaires returned	6,324	1,938	4,265	899	5,262	760	5,352	1,055	5,166	1,160	5,111
	%	%	%	%	%	%	%	%	%	%	%
Victimised you because of your sexuality?	1	1	1	1	1	0	1	2	1	1	1
Victimised you because you have a disability?	2	2	2	2	2	2	2	10	0	2	2
Victimised you because of your religion/religious beliefs?	2	4	2	7	2	4	2	4	2	2	3
Victimised you because of your age?	2	2	2	2	2	2	2	5	1	2	2
Victimised you because you were from a different part of the country?	4	3	4	4	4	6	4	6	4	6	4
Victimised you because of your offence/crime?	4	2	5	2	4	3	4	8	3	2	4
Victimised you because of gang related issues?	4	4	4	3	4	2	4	6	3	6	3
Have you been victimised by a member of staff?	26	33	22	39	23	24	26	32	24	22	26
Since you have been here, has a member of staff:											
Made insulting remarks about you, your family or friends?	11	12	10	13	10	6	11	14	10	10	11
Hit, kicked or assaulted you?	4	4	3	5	3	2	4	6	3	6	3
Sexually abused you?	1	1	1	1	1	1	1	2	1	1	1
Victimised you because of your race or ethnic origin?	6	14	2	16	5	11	6	7	6	4	7
Victimised you because of drugs?	3	2	4	2	3	0	4	6	3	2	4
Victimised you because you were new here?	6	9	5	10	6	6	7	6	7	6	7
Victimised you because of your sexuality?	1	1	1	0	1	0	1	1	1	1	1
Victimised you because you have a disability?	2	2	2	2	2	1	2	8	1	1	2
Victimised you because of your religion/religious beliefs?	4	8	2	16	2	3	4	4	4	3	4
Victimised you because of your age?	2	3	2	3	2	1	2	3	2	2	2
Victimised you because you were from a different part of the country?	3	4	3	5	3	5	3	3	4	4	3
Victimised you because of your offence/crime?	4	5	4	4	4	4	4	5	4	3	4
Victimised you because of gang related issues?	2	3	1	3	2	0	2	2	2	3	2
For those who have been victimised by staff or other prisoners:											
Did you report any victimisation that you have experienced?	37	39	36	40	36	40	36	46	35	33	37
Have you ever felt threatened or intimidated by another prisoner/ group of prisoners in here?	24	22	25	23	24	22	24	39	21	25	24
Have you ever felt threatened or intimidated by a member of staff in here?	24	29	20	34	21	20	24	31	22	20	24
Is it easy/very easy to get illegal drugs in this prison?	24	16	28	19	25	15	25	31	22	18	25
Is it easy/very easy to see the doctor?	32	28	34	28	33	29	32	33	32	37	31
Is it easy/very easy to see the nurse?	57	56	58	58	57	56	57	62	56	61	57
Are you able to see a pharmacist?	46	45	46	43	46	50	45	39	47	45	45
Are you currently taking medication?	46	37	51	39	48	37	48	76	40	24	50
Do you feel you have any emotional wellbeing/mental health issues?	29	21	33	22	30	24	30	57	23	23	30
Are you currently involved in any of the following activities:											
A prison job?	53	47	57	47	55	47	55	50	54	38	56
Vocational or skills training?	15	17	14	15	15	14	15	12	16	14	15
Education (including basic skills)?	30	37	26	37	28	44	28	28	30	35	29
Offending behaviour programmes?	13	13	13	14	13	9	14	12	13	9	14
Do you go to the library at least once a week?	38	39	38	36	39	42	38	37	38	30	39
On average, do you go to the gym at least twice a week?	49	56	45	55	47	46	49	31	52	58	47
On average, do you go outside for exercise three or more times a week?	45	44	46	49	44	45	45	39	46	50	44
On average, do you spend 10 or more hours out of your cell on a weekday?	11	9	12	9	11	8	12	8	12	6	12
On average, do you go on association more than five times each week?	59	53	63	54	61	49	61	54	61	48	61
Do staff normally speak to you most of the time/all of the time during association?	19	16	20	16	20	17	19	20	19	18	19
Do you have a personal officer?	61	56	64	58	62	56	62	61	61	59	61
Have you had any problems with sending or receiving mail?	43	42	43	41	43	35	44	44	43	48	42
Have you had any problems getting access to the telephones?	31	34	30	37	30	32	31	32	31	35	31

KEY TO TABLE

- Significantly better than the comparator
- Significantly worse than the comparator
- There is no significant difference

Expenditure 1 April 2011 to 31 March 2012



* Includes information technology and telecommunications, translators, meetings and refreshments, recruitment, conferences, training and development

PURPOSE	EXPENDITURE (£)
Staff costs[1]	3,698,515
Travel, accommodation and subsistence	511,932
Printing and stationery	59,874
Information technology and telecommunications	18,667
Translators	12,694
Meetings and refreshments	22,285
Recruitment	12,750
Conferences	5,039
Training and development	20,174
Total	4,361,930

1 Includes fee-paid inspectors, secondees and joint inspection/partner organisation costs, for example, General Pharmaceutical Council and contribution to secretariat support of the Joint Criminal Justice Inspection Chief Inspectors Group.

Inspectorate staff – 1 April 2011 to 31 March 2012

The Inspectorate staff come from a range of professional backgrounds. While many have experience of working in prisons, others have expertise in social work, probation, law, youth justice, health care and drug treatment, social research and policy. The majority of staff are permanent, but the Inspectorate also takes inspectors on secondment from NOMS and other organisations. Currently, 12 staff are seconded from NOMS and one from Greater Manchester West Mental Health NHS Foundation Trust. Their experience and familiarity with current practice is invaluable.

The Inspectorate conducts an annual diversity survey of our staff in order to monitor diversity within our workforce and to gather feedback on our approach to equality issues. The results of the survey are acted upon but are not published due to the small size of the staff group and the possibility that individual staff members may be identified.

	Nick Hardwick	Chief Inspector
	Martin Lomas	Deputy Chief Inspector
	Barbara Buchanan	Senior Personal Secretary to the Chief Inspector
	Joan Nash	Personal Secretary to the Deputy Chief Inspector
A TEAM (adult males)	Alison Perry	Team Leader
	Michael Calvert	Inspector
	Sandra Fieldhouse	Inspector
	Andrew Rooke	Inspector
	Paul Rowlands	Inspector
O TEAM (women)	Sean Sullivan	Team Leader
	Rosemarie Bugdale	Inspector
	Joss Crosbie	Inspector
	Paul Fenning	Inspector
	Jeanette Hall	Inspector
	Martin Owens	Inspector
N TEAM (young adults)	Kieron Taylor	Team Leader
	Keith McInnis	Inspector
	Kevin Parkinson	Inspector
	Kellie Reeve	Inspector
J TEAM (juveniles)	Fay Deadman	Team Leader
	Angela Johnson	Inspector
	Ian Macfadyen	Inspector
	Ian Thomson	Inspector
I TEAM (immigration detention)	Hindpal Singh Bhui	Team Leader
	Beverley Alden	Inspector
	Colin Carroll	Inspector

(continued on next page)

P TEAM (police custody)	Martin Kettle	Acting Team Leader
	Gary Boughen	Inspector
	Peter Dunn	Inspector
	Vinnett Pearcy	Inspector
PART-TIME INSPECTORS	Karen Dillon	Inspector (part-time)
	Gordon Riach	Inspector (part-time)
	Fiona Shearlaw	Inspector (part-time)
HEALTH SERVICES TEAM	Elizabeth Tysoe	Head of Health Services Inspection
	Paul Tarbuck	Deputy Head of Health Services Inspection
	Michael Bowen	Health Inspector (part-time)
	Helen Carter	Health Inspector (part-time)
	Nicola Rabjohns	Health Inspector (part-time)
	Sigrid Engelen	Drugs and Alcohol Inspector (part-time)
	Paul Roberts	Drugs and Alcohol Inspector (part-time)
RESEARCH, DEVELOPMENT AND THEMATICS	Samantha Booth	Acting Head of Research, Development and Thematics
	Laura Nettleingham	Senior Researcher
	Laura Paton	Senior Policy Officer and National Preventive Mechanism Coordinator
	Hayley Cripps	Researcher
	Rachel Murray	Researcher
	Alice Reid	Researcher
	Olayinka Macauley	Researcher (part-time)
	Nalini Sharma	Researcher (part-time)
	Jessica Broughton	Research Trainee
	Chloe Flint	Research Trainee
ADMINISTRATION	Lesley Young	Head of Finance, Human Resources and Administration
	Tamsin Williamson	Publications Manager (part-time)
	Jennifer Kim	Publications Assistant
	Stephen Seago	Administration Manager
	Sandra Charlton	Administration Officer
	Francette Montgry	Administration Officer
	Stephanie Moor	Administration Officer
	Jane Parsons	Press and Media Relations Manager (part-time)
EDITORS	Anne Fragniere	
	Brenda Kirsch	
	Adrienne Penfield	
	Yasmin Prabhudas	

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	Nicholas Biskinis	Andrea Walker
	Louise Falshaw	Helen Wark
	Michael Loughlin	Emily Wood
	Bridget McEvilly	Lucy Young
	Catherine Nichols	
	Michelle Reid	
	Joe Simmonds	

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