Report on an unannounced short follow-up inspection of

HMP Hull

14–17 February 2012

by HM Chief Inspector of Prisons

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Introduction

HMP Hull is a Victorian local prison holding adult and young adult men. At the time of the inspection it held almost 1,000 men. It has had a chequered history, but our last full inspection in 2008 was positive, and we found that the prison was achieving reasonably good outcomes for prisoners in all four of our healthy prison tests: safety, respect, purposeful activity and resettlement. During this unannounced short follow-up inspection, we found the prison had made sufficient progress in implementing our recommendations in three of those healthy prison areas, but progress under the respect heading had been insufficient. Short follow-up inspections focus on recommendations made at the last full inspection and so do not provide an assessment of the prison as a whole.

The environment was poor. Fundamentally, the prison remained overcrowded. It was certified to normally hold 723 men but at the time of this inspection held almost a third as many again. Cells were extremely small and many cells designed for one, were shared. In-cell toilets were shielded by a small screen or curtain. Prisoners had to eat their meals in their cells. Some cells did not have curtains and prisoners improvised with sheets or other material. Most we saw were clean but some contained significant amounts of graffiti. Rubbish, including food waste, had accumulated between cell windows and grilles on some wings. Exercise yards remained bleak.

Hull remained a prison where prisoners were routinely addressed by their surnames only and personal officer work was weak. We had been concerned about the quality and quantity of food provided at the last inspection but this had now improved. Some progress had been made on equality and diversity issues but support for foreign national prisoners was inadequate. Other prisoners were routinely used to interpret even for very confidential and sensitive issues – in one case, in an ACCT (suicide prevention) review. Health care had also improved, although waiting times and facilities were poor. Some prisoners were inappropriately admitted to inpatient care 'on governor's order' and this appeared to be because of the vulnerability of the prisoner concerned rather than for any medical need. Arrangements for the administration of controlled drugs were poor.

The prison had made good progress in keeping prisoners safe. We did not find the prison to be unsafe at our last inspection but a high proportion of prisoners, particularly new arrivals and vulnerable prisoners, told us they felt unsafe. First night procedures had now improved and, as a result, prisoners felt safer when they first arrived. At the last inspection we had urged that suicide prevention and violence reduction procedures should be improved, and the prison had responded positively to these recommendations. Strategies to prevent violence were now sound and well informed. Suicide prevention procedures had also improved, although the quality of case management and recording was inconsistent. There was a good Listeners scheme. Use of force and segregation appeared appropriate, although governance required improvement. Drug and alcohol treatment services were adequate.

Purposeful activity outcomes had also improved since our last inspection. Good progress had been made in developing teaching and learning and there were better assessments of individual prisoner needs. A fully engaged prisoner could be out of their cell for about 8.5 hours a day and an unemployed prisoner for about 5.5 hours.

The prison had addressed our previous concerns about inadequately resourced and coordinated offender management. We had recommended that a resettlement needs analysis be completed and that this should form the basis of a resettlement strategy. Some progress had been made on this, but insufficient use had been made of the needs analysis that had

been done. There had been progress in most reintegration pathways but weaknesses remained. Prisoners were not seen by health care staff before release, the drug strategy required updating and the needs analysis informing the children and families pathway required review. However, visits arrangements had improved and there was a good specialist debt service.

HMP Hull had, therefore, responded positively to the findings of our last inspection but some long standing concerns remain. Good work had been done to reassure prisoners about their safety and to reduce the risk they reoffend on release. Nevertheless, the physical state of the prison, overcrowding and some aspects of staff-prisoner relationships threaten to undermine the progress made in other areas. We hope that when we return next time, much greater progress will also have been made in these areas.

Nick Hardwick April 2012
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Hull is a large city local prison holding category B adult and young adult males.

Prison status
Public

Region
Yorkshire/Humberside

Number held
992

Certified normal accommodation
723

Operational capacity
1,044

Date of last full inspection
10–14 November 2008

Brief history
HMP Hull is a Victorian prison, opened in 1870 to house both men and women. In 1939, it was used as a military prison and later a civil defence depot. In 1950, it reopened as a closed male borstal. In 1969, after extensive security work, it became one of the first maximum-security dispersal prisons. In August 1976, it suffered considerable damage following a five-day disturbance. In 1986, Hull was removed from the dispersal system and assumed its current role of male local prison/remand centre. In 2002, the prison expanded and increased in size. The expansion included four new wings, a new health centre, a new sports hall, a multi-faith centre and refurbishment to other parts of the prison, including the kitchen, education department and workshops.

Short description of residential units

Wing
A: First night induction centre/PIPE unit
B: Sentenced and unsentenced adults and youth offenders
C: Sentenced and unsentenced adults
D: Sentenced and unsentenced adults
F: Health care centre
G: Integrated drug treatment system
H: Sentenced and unsentenced adults
I: Vulnerable prisoner sex offenders
J: Vulnerable prisoner sex offenders
K: Other vulnerable prisoner unit/sex offender overflow

Name of governor
Norman Griffin

Escort contractor
GeoAmey

Health service commissioner and provider
NHS Hull

Learning and skills providers
The Manchester College

IMB chair
Susan Dyas

Section 1: Summary

Introduction

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

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

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

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

1.4 Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected and giving an overall assessment against the following definitions:

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

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

Safety

1.5 At our inspection in 2008 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 55 recommendations in this area, of which 24 had been

achieved, 12 partially achieved and 17 had not been achieved. Two recommendations were no longer applicable. We have made one further recommendation.

1.6 Information about prisoners was shared between escort and prison staff, and reception staff made appropriate use of it to inform initial risk assessments. Prisoner escort records were fully completed and legible. Some of the vans we inspected were dirty, despite being new.

1.7 Most prisoners felt safe on their first night. They were not routinely offered a shower in reception and some had to wait until the following day to shower. Foreign national prisoners were given £3 free telephone credit but for some this was not enough to make a worthwhile telephone call.

1.8 Induction had been reviewed and condensed to a half-day but a few prisoners said that they had not received an induction talk or undertaken an induction programme. A talk on safer custody issues was delivered by Listeners. Some prisoners spent too long on the induction wing after completing their induction, with little to do, and no evening association was offered on the first night/induction wing.

1.9 The published violence reduction policy document was well advertised, based on a thorough analysis of the pattern of violence in the prison and further informed by regular consultation with prisoners. The collection of data relating to the number and nature of violent incidents was good and there were effective, well-resourced structures to monitor the progress of violence reduction measures. A casework approach to managing a range of antisocial behaviour through structured interventions was developing but victim support remained underdeveloped.

1.10 The suicide prevention policy had been reviewed and was properly focused on the specific risks and needs of a local prison with a diverse population. Protocols were appropriately promoted and generally understood by staff and prisoners. Most staff had received up-to-date assessment, care in custody and teamwork (ACCT) training. There had been improvements in the analysis of data to provide information about patterns and trends of self-harming behaviour.

1.11 The quality of individual plans and care mapping within ACCT documents had improved but there remained gaps in the case management arrangements of some prisoners at risk and some documents did not evidence consistently good standards of day-to-day care.

1.12 The Listener's scheme was well supported, their role well advertised and prisoner access to them was good. Samaritans telephones were available on all wings but not always fully charged.

1.13 Arrangements surrounding strip/squat-searching and visits restrictions had improved, although movement arrangements resulted in some prisoners waiting for long periods to return to wings outside of main movement times.

1.14 The incentives and earned privileges policy was not available in languages other than English. Case recording was inconsistent and those on the basic level were not set individualised or meaningful targets for change. The removal of privileges without a formal review was inappropriate.

1.15 The adjudication tariff was still not available to prisoners outside of adjudications. Unofficial gym sanctions continued.

1.16 Quality control of use of force incidents was appropriate but there was no review of planned removal videos. There was no use of force committee.

1.17 Both segregation units were clean and in good order and staffing procedures were appropriate. Records of daily contact with prisoners were good but reviews of segregation boards lacked a sufficiently multidisciplinary attendance.

1.18 There was an integrated drug and alcohol service, which was linked to local community services. Arrangements for wing administration of opiate substitution did not provide privacy on all wings.

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

Respect

1.20 At our inspection in 2008 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 79 recommendations in this area, of which 33 had been achieved, 12 partially achieved and 34 had not been achieved. We have made one further recommendation.

1.21 Cells originally designed for one person were used for two and were extremely small and cramped. The cleanliness of cells had improved but they were not always adequately prepared for new arrivals. Conditions on the wings were generally good.

1.22 Communal showers were still in place, providing inadequate privacy. Toilets in cells were screened but too many cells lacked curtains.

1.23 External communal areas, including exercise yards, were generally clean and tidy. There was no system to monitor the timeliness of responses to cell call bell activation on the older wings.

1.24 The application system mirrored the complaints system and as a result more issues were being dealt with informally but appropriately through this process.

1.25 The culture of using surnames when directly addressing prisoners persisted. Recording by personal officers was inconsistent and lacked detail about behaviour and progress. Management checks did not record feedback and more work was required to develop the role of personal officers.

1.26 The diversity action plan had been updated to include prisoner issues but was still predominantly staff focused and information for new staff did not address prisoner equality issues.

1.27 Analysis of race complaints had been carried out and actions taken to address the issues raised, with the establishment of prisoner diversity representatives, who had all been trained and supplied with a job description. There were no support groups for black and minority ethnic prisoners and no interventions for prisoners identified on the racist offenders log.

1.28 Services for foreign national prisoners had not been developed. The prison was still using other prisoners to interpret during confidential matters such as ACCT reviews and used formal interpreting services only if a prisoner interpreter was not available. There was no independent

immigration advice available and there were no formal support groups for foreign national prisoners.

1.29 There were formal care plans for older prisoners and those with disabilities and they operated well. Six cells had been adapted for prisoners with physical difficulties.

1.30 The chaplaincy team was up to full strength and provided for all prisoners' needs but links with the community and other chaplaincy activities were underdeveloped.

1.31 Information about the available legal services was available on each residential unit but most prisoners did not know how to access this service or their own external legal services. Replies to complaints were mixed, with some curt and perfunctory replies evident.

1.32 Wing health care rooms were generally clean but untidy. There was effective health promotion, with a dedicated lead, but little evidence of literature across the prison.

1.33 The care of older prisoners and those with disabilities was led by a senior nurse and delivered through care plans. A comprehensive secondary health assessment was completed within 48 hours of arrival. Prisoners attending the health care department often waited too long to return to their wings, in stark waiting rooms with uncomfortable fixed metal benches.

1.34 The proportion of prisoners allowed medication in possession had increased and risk assessment was safe and robust. Nurses were able to administer a range of medications using patient group directions. There were pharmacy-led clinics but no medication reviews.

1.35 The waiting time to see the dentist had improved with an increase in the number of sessions provided.

1.36 Prisoners were admitted to the inpatient unit without clinical need on 'governor's orders' and the validity of the decisions was not clear from records. There was no gated cell on the inpatients wing. There had been no formal review of prisoners' perceptions of primary mental health services and the service capacity was insufficient.

1.37 The kitchen continued to be staffed only by vulnerable prisoners. The overall quality and quantity of food had improved and all food areas and processes were clean and well managed. Prisoners continued to eat exclusively in their cells and breakfast packs were served on the day before consumption.

1.38 Prisoners remained unable to buy fresh fruit. They were able to order items from catalogues without being charged for administration. New prisoners could wait up to 10 days before receiving their first full shop order

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

Purposeful activity

1.40 At our inspection in 2008 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 12 recommendations in this area, of which eight had been achieved, three partially achieved and one had not been achieved. We have made no further recommendations.

1.41 Prisoners could access one hour of exercise daily but, with the exception of benches, the exercise yards were stark. A fully engaged prisoner could access over eight hours and an unemployed prisoner just over five hours out of cell per day.

1.42 The prison had made good progress in developing teaching and learning activities in education sessions. Tutors planned short breaks in learning sessions and provided refreshments to help maintain prisoners' concentration levels. Classrooms were equipped with high-quality furniture.

1.43 The results of learners' initial assessments were noted on session plans and tutors set precise and challenging targets on individual learning plans. However, literacy and numeracy targets were not always set. Learners with identified learning difficulties received sufficient support.

1.44 The pay policy ensured that rates of pay were equitable for work, vocational training and education.

1.45 Library services were adequately promoted. However, while attendance at the library had improved, timetabled visits often conflicted with other prison activities. There was inequity of access on some accommodation wings.

1.46 The range of vocational training programmes in PE had been extended, with short-term courses and qualifications for gym orderly prisoners now available.

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

Resettlement

1.48 At our inspection in 2008 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 33 recommendations in this area, of which 16 had been achieved, seven partially achieved and eight had not been achieved. Two recommendations were no longer applicable. We have made two further recommendations.

1.49 The resettlement needs analysis had been only partially completed and, although some results had been appended, the resettlement strategy had not been informed by them. Although the resettlement and offender management policy referred to a policy group meeting, this did not take place.

1.50 The offender management unit was adequately staffed and well organised, with strong links to the resettlement unit. Offender assessment system (OASys) assessments were completed on time, although some prisoners arrived with them overdue. Sentence planning was informed by staff contributions and guided the provision of interventions but there were still instances where issues identified in assessments were not included in targets. The management of indeterminate-sentenced prisoners was effectively integrated into offender management.

1.51 Public protection procedures were robust and now covered those who presented a risk to adults. Those convicted of racially motivated offences were also screened.

1.52 The basic custody screening tool was used effectively with short-term prisoners but planning for remand prisoners was not structured.

1.53 Prisoners were not seen routinely by health services staff before release but were given a summary letter to take to their GP.

1.54 The drug strategy was out of date and a new one was in development. Monthly data reports were submitted to the commissioners and to the new offender health and well-being meeting. It was not clear how actions were followed through. A needs assessment of the local community included the prison population.

1.55 A specialist debt service was provided by a community agency.

1.56 The needs analysis informing the children and families pathway was not up to date and links to the wider resettlement strategy and sentence planning were limited. Provision to address domestic violence was developing but the ending of the parenting courses left a gap.

1.57 The means of booking visits had been improved and the furniture in the visits hall was of adequate quality, as was the closed visit provision. The wearing of bibs by prisoners on visits was unnecessary, given the other security procedures in place.

1.58 Information from the partially completed resettlement needs analysis had driven the development of offender behaviour programmes to address alcohol-related offending and domestic violence.

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

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 All staff should receive assessment, care in custody and teamwork (ACCT) foundation training and refresher training, and further training should be provided to staff regarding the expected standards of ACCT documents. (HP45)

Achieved. It was mandatory for all prison staff to receive ACCT foundation and refresher training. At the time of inspection, all frontline staff had received foundation training and more than 80% of the total staff group had received up-to-date refresher training. It was clear that ACCT training had been given a high priority and was scheduled as part of the prison's overall training plan.

2.2 There should be a greater focus on and adequate resources for violence reduction. (HP46)

Achieved. Resources to support the violence reduction strategy were adequate. A violence reduction coordinator had been appointed and worked as part of the full-time safer custody team. The team also included a full-time suicide prevention coordinator, a safer custody officer and an administration support worker. An overarching violence reduction committee met monthly to monitor the implementation of the violence reduction policy and update the overall strategy as required. Attendance at meetings was good and representation from senior managers and the security department was consistent.

2.3 Two prisoners should not share cells designed for one. (HP47)

Not achieved. Cells designed for one had been re-designated by the National Offender Management Service (NOMS) as two-person cells. In one cell on D wing, it was difficult to get into the toilet area because the screening had been installed too near the rear wall due to the lack of space.
We repeat the recommendation.

2.4 The catering provision should be overhauled to ensure that food is palatable, sufficient and healthy. (HP48)

Achieved. We observed reasonable-sized portions being served. The menu choices provided a range of options, which regularly included a healthy option. Complaints about food were rare and prisoners we spoke to were mainly positive about the standard and quantity of food.

2.5 There should be an up-to-date resettlement needs analysis, covering all resettlement needs and the various prisoner populations, and this should be the basis for a coordinated strategy. (HP49)

Partially achieved. A needs analysis had been started and offender assessment system (OASys) data had been used, along with a prisoner survey, to identify some needs, notably for programmes. Data from the partially completed needs analysis were appended to the current

resettlement strategy but did not underpin the direction and priorities of the document. We repeat the recommendation.

2.6 There should be sufficient dedicated offender supervisors, and better links between offender management and the resettlement unit. (HP50)

Achieved. There were three teams of offender supervisors and a review had resulted in important changes to the organisation of their work and their other duties. Teams were at full strength and prison officer offender supervisors worked to a core day, with their commitment to other duties being limited to tasks that did not interfere with their offender management work. Links with the resettlement team were good, with an effective referral system (see recommendation 2.158) and information sharing through the P-Nomis electronic recording system.

Recommendations

Courts, escorts and transfers

2.7 Prisoner escort records should be fully completed by escort contractors and should clearly record all the movements of prisoners in their charge. (1.8)

Achieved. The prisoner escort records we examined were fully completed, legible and showed that relevant information about prisoners, including their movements, was shared systematically. Reception staff used them to inform initial risk assessments and passed on relevant information to induction staff.

2.8 Escort vans should be cleaned, graffiti removed and seats replaced where necessary. (1.9)

Partially achieved. Most vans we inspected were reasonably clean, free from graffiti and in good condition. However, some were dirty, despite being new.

2.9 Prisoners attending court should be offered a further breakfast pack in reception if they have not eaten beforehand. (1.10)

Not achieved. Breakfast packs were offered to prisoners on the day before they were to be consumed (see also section on catering). Prisoners attending court were not offered a further pack in reception, regardless of whether or not they had eaten.
We repeat the recommendation.

Early days in custody

2.10 Prisoners should be permitted to have a shower in reception on request. (1.27)

Not achieved. None of the prisoners we spoke to who had arrived at the prison in the previous few weeks had been offered a shower in reception. One prisoner said that he had arrived on a Monday afternoon and had not had the chance to have a shower until 3pm the following day.
We repeat the recommendation.

2.11 Foreign national prisoners should receive enough PIN telephone credit on the first night centre to make a call to family and friends overseas. (1.28)

Partially achieved. All foreign national prisoners were allowed free telephone credit to the value of £3, as opposed to the £1 received by British nationals. The price of international calls varied depending on the country to be called, which meant that some foreign national prisoners received a call of shorter duration than others.
We repeat the recommendation.

2.12 Prisoners' feelings of being unsafe on their first night should be explored and improvements implemented where necessary. (1.29)

Achieved. All the prisoners we spoke to said that they had felt safe on their first night. Listeners had been introduced in reception and on the first night wing, and time was allocated during the first night process for them to speak to all new arrivals. The first night interview always took place, which allowed prisoners to express any concerns.

2.13 The induction policy should be re-distributed to reception and induction staff, and made available to prisoners on the first night centre. (1.30)

Achieved. The induction policy had been reviewed in October 2010 and was available in reception and on the first night wing for staff and prisoners.

2.14 Induction staff should take responsibility for delivering elements of the induction programme, supported by prisoner representatives. (1.31)

Partially achieved. Induction staff were detailed to give an induction talk to all new arrivals within the first 24 hours. This was followed by individual departments seeing prisoners on the day after they arrived. Some prisoners we spoke to said that they had not been seen by induction staff but instead had been given an induction information booklet to read. Some prisoners we spoke to said that they had not undertaken an induction programme, especially those who had been located on the treatment or vulnerable wings on their first night.
We repeat the recommendation.

2.15 The induction programme should include the delivery of information about safer custody issues. (1.32)

Partially achieved. The induction programme included a slot for Listeners to see inductees in a group and talk about safer custody issues. However, not all prisoners undertook the induction programme (see recommendation 2.14), so some would have missed out on this opportunity.
We repeat the recommendation.

2.16 Prisoners should receive association on their first night and subsequently on the unit. (1.33)

Not achieved. Newly arrived prisoners did not receive a period of association on their first night in custody or on any subsequent evening on the first night unit. Most prisoners we spoke to said that their first period of association had taken place in the afternoon on the day after their arrival.
We repeat the recommendation.

2.17 Induction should be structured so that it fills the timetable. Prisoners should be occupied rather than locked in their cells during its delivery. (1.34)

Partially achieved. Induction had been condensed and was now completed by lunchtime on day 1. The programme was structured and prisoners were unlocked during the morning. After completion of the programme, association was scheduled to take place each morning and afternoon until prisoners were located on their permanent wings. Many prisoners told us that the morning association often did not take place. Some prisoners spent too long on the induction wing waiting for relocation, with little to occupy them.
We repeat the recommendation.

Bullying and violence reduction

2.18 The recently updated violence reduction strategy should be distributed to all staff. (3.10)

Achieved. The violence reduction policy had not been issued to all staff but was available on the shared drive of the prison's computer system. Copies of the document were found on all residential units and other communal areas, such as reception and the education department. Staff we spoke to, particularly residential officers, were aware of its content.

2.19 Safety questionnaires should be re-introduced. (3.11)

Achieved. An annual safety survey was issued to prisoners on all wings. The results were analysed and there was evidence that the prison used this to help to identify trends. However, completion results were low, at about 20%. To supplement this, prisoners completed an exit survey and received a structured interview by resettlement staff before their discharge. These explored with the prisoner the extent and nature of bullying in the prison, how threats of violence were confronted and how their lives in the prison could have been made safer.

2.20 Data pertaining to acts of violence and bullying incidents should be recorded and monitored, and trends should be discussed at the safer custody meetings and action taken. (3.12)

Achieved. Information provided by the safer custody team about the number, type and location of violent incidents each month had improved and analysis of information to identify trends, patterns and problem areas was carried out each month at well-attended safer custody meetings. There was evidence that this was being used to inform necessary changes to strategy and that action was being taken as required.

2.21 The use of violence reduction support plans for victims of bullying should be clarified and staff given guidance on when a victim booklet should be opened. (3.13)

Not achieved. There was little evidence that formal plans had been used to support victims, even though they were described in the prison's violence reduction policy. Victims of violence were usually offered relocation to another wing or subjected to informal observation.
We repeat the recommendation.

2.22 The low use of violence reduction support plans on C and D wings should be investigated and the use of the support plans on wings where assaults occur should be monitored. (3.14)

Achieved. The quality of investigations into alleged incidents and the use of support plans was generally good on all wings. Outcomes were recorded and consistently acted on by residential officers, supported by the violence reduction coordinator. Residential officers appeared to be confident in implementing formal procedures.

2.23 Safety questionnaires should be distributed more regularly in areas where problems are identified. (3.15)

Achieved. Questionnaires were issued to prisoners from all residential areas (see also recommendation 2.19).

2.24 The content and quality of open and closed violence reduction support plans should be monitored by the safer custody coordinator and discussed at the safer custody meeting. (3.16)

Achieved. A casework approach to managing antisocial behaviour through structured support from staff was developing. The three-stage violence support plan for perpetrators had been replaced by a simpler method based on using the incentives and privileges (IEP) scheme and was organised by a nominated case manager. The quality of entries in associated documentation had improved and was generally good. Complicated cases were discussed in detail at the monthly safer custody meeting.

2.25 All staff should receive anti-bullying training. (3.17)

Not achieved. Formal training in anti-bullying measures was not offered to staff.
We repeat the recommendation.

Self-harm and suicide prevention

2.26 The safer custody strategy should clearly outline how high-risk prisoners will be supported and managed. (3.28)

Achieved. The suicide prevention policy had been reviewed in 2011 and was properly focused on the specific risks and needs of a local prison with a diverse population. Protocols were appropriately promoted and, on the whole, understood by staff and prisoners. Detailed instructions about how high-risk prisoners were to be supported through multidisciplinary case management were explicit, as were the individual responsibilities of staff and managers.

2.27 Terms of reference for the safer custody practice meeting should be devised, with clear objectives, and include how prisoners most at risk will be strategically managed. (3.29)

Achieved. The safer custody practice meeting was attended by members of the safer custody team, senior managers and mental health professionals and included discussion of the case management of more complicated cases. The terms of reference for the meeting had been agreed and published.

2.28 Information concerning acts of self-harm should be collated and analysed, and trends discussed at the safer custody meetings. (3.30)

Achieved. Minutes of the safer custody meeting showed that individual cases were discussed appropriately and that the specific needs of prisoners were addressed. It used a wide range of information, provided by the administration support worker, to help to identify trends and patterns of self-harming behaviour in terms of location, type, timing and peripheral circumstances of individual incidents. This was being used to develop the strategy and update the continuous improvement action plan.

2.29 The definition of a near-death incident should be distributed to all relevant staff, and roles and responsibilities for producing reports and implementing action plans

following such an incident should be established. (3.31)

Achieved. A clear definition of a near death in custody had been published and distributed to all members of staff. It was also added to the overarching suicide prevention policy and was discussed at all ACCT training sessions.

2.30 A review of the number of assessment, care in custody and teamwork (ACCT) assessors should be undertaken and further ACCT assessors trained if appropriate. (3.32)

Achieved. Most senior officers had been trained as ACCT assessors. Overall, the quality of initial interviews and assessments was reasonable but there were examples of poor initial care planning (see also recommendation 2.31).

2.31 The content and quality of open and closed ACCT documents should be monitored by the safer custody coordinator and discussed at the safer custody meeting. (3.33)

Partially achieved. Regular management checks by safer custody staff had driven up the quality of entries in ACCT documents but there remained gaps in case management arrangements in too many cases. There were some good examples that demonstrated positive interaction between staff and prisoners and an awareness of ongoing issues but too often this was not the case and they did not show consistently good standards of day-to-day care. Support plans were not always prepared through consultation with the prisoner and did not always specify needs or apportion responsibility to a nominated key worker. Progress was reviewed at predetermined times, in agreement with their prisoner, but many reviews were poorly attended.

Further recommendation

2.32 The content and quality of ACCT supervision and documentation should be improved.

2.33 Staff should be briefed about all the forms provided in ACCT documents to assist in the management of prisoners at risk of self-harm. (3.34)

Achieved. Scheduled training in using ACCT documents included full briefings about the purpose of each form, plan and review sheet. Staff appeared to be aware of how to use these documents, despite the poor quality of some we examined (see also recommendation 2.31).

2.34 Samaritans telephones should be regularly checked and should all be in working order. (3.35)

Not achieved. Samaritans telephones were located on all residential units but not all of them were charged and working properly.
We repeat the recommendation.

2.35 Listeners should be invited to attend the safer custody meetings on a rota basis. (3.36)

Achieved. Listeners routinely attended safer custody meetings.

2.36 The location of Listener call-outs should be monitored by the safer custody coordinator and discussed at safer custody meetings. (3.37)

Not achieved. There was no recording of the number of times that Listeners were called out, the time they were called or the location of the call.
We repeat the recommendation.

2.37 Listeners should be available on all wings. (3.38)

Achieved. The Listener scheme was well established and all prisoners had access to them. This was explained to prisoners in reception and during induction. Their role and how to gain access to them was also publicised around the prison on noticeboards. At the time of the inspection there were 10 trained Listeners, providing 24-hour cover through a published roster. A further nine prisoners were being trained.

Security

2.38 The movement system should be changed so that prisoners are able to return to their wing or activity outside main movement times. (6.13)

Not achieved. Most activities and health care appointments were accessed via a mass movement process. Prisoners still waited for long periods to be taken back to the wings outside of these events.
We repeat the recommendation.

2.39 The searching strategy should be amended and explicitly state that squat searches should only be conducted in exceptional circumstances. All squat searches should be appropriately authorised and recorded. Strip-searching should only be carried out on the basis of a risk assessment or specific intelligence. (6.14)

Partially achieved. The searching policy provided clear guidance on the use of squat searching. Authorisation was granted depending on the intelligence received; staff could also ask prisoners to squat if they became suspicious during a search. No records were maintained of who had been required to squat during a search. All prisoners coming into the establishment or being located onto the segregation units were routinely strip-searched.
We repeat the recommendation.

2.40 Closed visits should not be imposed as a result of a single positive drug dog indication. (6.15)

Achieved. Only the initial visit following the dog indication was conducted under closed conditions. Visitors also had the opportunity to rebook the visit at a later date. The prisoner concerned was not then placed on ongoing closed visits.

Incentives and earned privileges

2.41 The incentives and earned privileges (IEP) policy should be available in a range of languages. (6.60)

Not achieved. Policies were not routinely available in languages other than English but we were told that they would be translated if the need arose.

2.42 Prisoners on the basic level of the IEP scheme should be set behaviour improvement targets, and staff should demonstrate that they are actively monitoring behaviour through daily wing file entries. (6.61)

Not achieved. We inspected the case recording for eight prisoners on the basic level of the IEP scheme but did not find any individualised targets for improvement. Daily entries were not always made on P-Nomis; when they were, they tended to be limited and lacked relevant information about behaviour.
We repeat the recommendation.

2.43 IEP review boards and applications for enhanced status for all prisoners should consistently be linked to a prisoner's engagement with his sentence plan and participation in offending behaviour work. (6.62)

Not achieved. IEP reviews for the general prison population continued to lack a focus on sentence plan objectives. Those completed on vulnerable prisoners made good use of the prisoner's progress in offending behaviour programmes and his willingness to comply with his sentence plan as two of the criteria in deciding to award or decline the application for enhanced status.
We repeat the recommendation.

2.44 A prisoner's privileges should not be removed unless a formal IEP review board has been held. The interim removal of a prisoner's television following receipt of two warnings in a 21-day period should cease. (6.63)

Not achieved. The IEP policy continued inappropriately to allow the removal of a prisoner's television without a formal review board on receipt of two behaviour warnings. Staff and prisoners we spoke to confirmed that this was the case and were confused about when it would happen and for how long. For example, some staff said that this sanction would apply only if two warnings were given in one day, while others thought it was two warnings in two weeks.
We repeat the recommendation.

Disciplinary procedures

2.45 The local tariff should be published to prisoners. (6.38)

Not achieved. A copy of the tariff was available during adjudications but not in the library or anywhere else in the prison.
We repeat the recommendation.

2.46 The practice of issuing prisoners with unofficial cooling-off periods from gym sessions should cease. (6.39)

Not achieved. Although there were no current instances of prisoners being banned from the gym outside of formal disciplinary procedures, we were told by staff, prisoners and managers that this occasionally happened.
We repeat the recommendation.

The use of force

2.47 Planned removals should be recorded and used for staff development purposes. (6.47)

Partially achieved. Planned use of force was recorded but the incidents were not reviewed to

identify any procedural or training issues.
We repeat the recommendation.

2.48 Governance arrangements for the use of force should be improved. (6.48)

Not achieved. Use of force data were reported at the security committee but there was no specific meeting of key personnel to assess individual uses, demographics or trends.
We repeat the recommendation.

2.49 Quality assurance arrangements should be introduced for the use of force. (6.49)

Achieved. The head of residence quality checked all use of force paperwork and compiled a report for the security committee. All paperwork we observed had been fully completed to an acceptable standard.

2.50 Officers certifying the use of force should be independent of the incident. (6.50)

Not achieved. All use of force paperwork that we reviewed had been authorised by one of the officers involved in the incident.
We repeat the recommendation.

Segregation

2.51 All separation and care unit (SACU) cells should be thoroughly cleaned and toilets de-scaled. (6.40)

Achieved. All cells in both units were clean and in good order. There was minimal graffiti and prisoner cleaners/painters prepared each cell as soon as it was vacated.

2.52 Showers on K wing should be fitted with privacy screens and should be adequately ventilated. (6.41)

No longer relevant. Prisoners showered individually and the door provided adequate screening. The ventilation operated well when tested.

2.53 Wing history sheets should detail the frequency and content of contact with prisoners by staff and visitors to the unit. (6.42)

Achieved. All prisoners on both segregation units had a paper-based file. Official visits (by such individuals as the duty governor, chaplain and health services staff) were recorded, as were interactions with other visitors to the unit.

2.54 Wing personal officers should make regular visits to prisoners on the SACU or K wing and record this contact in wing files. (6.43)

No longer relevant. Due to the uncertainty of where prisoners would be located after periods of segregation, unit staff were allocated as personal officers as soon as a prisoner was located onto the units, and carried out the role until prisoners returned to normal location.

2.55 Reviews of segregation should be conducted by a multidisciplinary team and targets set at reviews should be geared towards effective reintegration planning. (6.44)

Not achieved. The records of Rule 45 (segregation for own protection) reviews that we

observed showed that they had been conducted mainly by discipline staff. Targets were simplistic and did not relate to any effective reintegration planning.
We repeat the recommendation.

2.56 The role of K wing should be reviewed and should not provide an unofficial means of segregating prisoners. (6.45)

Achieved. K wing had been designated as a segregation unit, including the allocation of two cells for young adults. All prisoners held on the unit were appropriately held under the correct prison rule. Governance of the unit was in line with expected segregation policies.

2.57 The use of additional staff to unlock prisoners should be as a result of a risk assessment which is reviewed daily. (6.46)

Achieved. Unlocking procedures on both units were proportionate and the norm was for only two officers to be present at each unlock. When there was a greater perceived risk, the number of staff deployed could be increased following a risk assessment.

Substance misuse

2.58 The new medication administration facility should be made operational as soon as possible. (3.114)

Achieved. A new substance use treatment room had been commissioned on G wing (the substance use wing) and we saw prisoners receiving their substitution medications safely and with appropriate privacy. A discipline officer was sited adjacent to the treatment room and ensured that prisoners' privacy was not compromised.

2.59 The establishment should take steps to improve the privacy of prisoners receiving opiate substitution. (3.115)

Not achieved. The substance use treatment room in the 'under centre' between A, B, C and D wings was sited where the wings converged and was extremely noisy. Prisoners attended the hatch individually but it was difficult for them to hear what the nurse was saying or for them to make themselves heard if they had questions. Additionally, the practice of discipline staff shouting onto the wings for prisoners to attend for methadone administration was inappropriate.
We repeat the recommendation.

2.60 Clinical services should be extended to offer adequate alcohol detoxification. (3.116)

Achieved. Prisoners arriving with alcohol withdrawal needs were seen by a substance use officer in reception, then health screened by a nurse and transferred to G wing. They were seen by a substance use doctor in the evening and prescribed supportive medication. Men waited a maximum of six hours between arriving and being seen by the doctor for medication. Those with acute alcohol withdrawal needs had 24-hour access to a substance use nurse.

Residential units

2.61 The cells on A and C wings should be deep cleaned and redecorated. (2.26)

Achieved. There was a cleaning and redecorating programme and the cells we saw were, on the whole, clean and well decorated.

2.62 Graffiti should be removed and its recurrence prevented. (2.27)

Not achieved. Despite attempts to remove it, some cells, particularly those holding young adult prisoners, contained graffiti. Vacated cells were not always redecorated or cleaned before the next prisoner moved in.
We repeat the recommendation.

Housekeeping point

2.63 Vacated cells should be cleaned before the next prisoner moves in.

2.64 The temperature problems on D wing should be rectified. (2.28)

Achieved. The heating problems on D wing had been resolved and most of the wings were adequately heated. However, we were told about some difficulties in maintaining an adequate temperature on parts of H and K wings.

2.65 The in-built system for testing cell call bell responses in the newer accommodation should be activated and checked regularly by managers. A system for assessing the promptness of responses on the older accommodation should be introduced. (2.29)

Not achieved. There was no system to assess the promptness of cell call bell responses on the older wings. The electronic system on the newer accommodation had been activated and the timeliness of responses was recorded centrally but managers did not use this information to assure themselves that response times were appropriate or to identify any recurring delays.
We repeat the recommendation.

2.66 A wider range of leisure activities should be made available and any disincentives for their use removed. (2.30)

Achieved. A wide range of leisure equipment, such as table tennis and pool tables, had been installed. The availability of board games remained limited but we did not receive any complaints from prisoners about this.

2.67 The external communal areas should be cleaned. (2.31)

Achieved. The external communal areas, including exercise yards, were generally clean and tidy. However, some window grilles on the induction wing contained rubbish, including food waste.

Housekeeping point

2.68 Rubbish should be removed from inside window grilles.

2.69 Exercise areas should be made more appealing and outdoor seating provided. (2.32)

Partially achieved. Benches had been added to exercise yards but they remained unappealing (see recommendation 2.143).

2.70 A mending service for torn clothing should be available locally. (2.33)

Not achieved. There was no mending service but we did not see many torn clothes and prisoners did not complain about this.

2.71 All cells should be properly cleaned before prisoners are allocated to them. (2.34)

Partially achieved. There were procedures to inspect cells as they were vacated and undertake cleaning or repairs but they were not always carried out. Some prisoners we spoke to complained about moving into a dirty or damaged cell.
We repeat the recommendation.

2.72 Restitution for property and cash losses should be more expeditious. (2.35)

Achieved. A new complaints monitoring system had improved the timeliness of responses, with almost all being responded to within the required timescales, and prisoners we spoke to did not express concerns about delays in being reimbursed for lost property or cash.

2.73 The ventilation in the shower areas should be improved. (2.36)

Partially achieved. Ventilation in the shower areas had been improved on some wings but on other wings remained inadequate. However, they were cleaned daily and redecorated when necessary.
We repeat the recommendation.

2.74 Dividing screens should be provided in the large shower areas to improve privacy. (2.37)

Not achieved. The larger shower areas on some wings were communal, with no screening, and therefore provided no privacy. Privacy in the communal showers on the PIPE unit was further hindered by clear glass in the top half of the window onto the landing. Some prisoners avoided using the communal showers for this reason.
We repeat the recommendation.

2.75 Shower repairs should be made promptly. (2.38)

Achieved. We did not find any showers that were out of order and did not receive any complaints from prisoners about delays in repairs being undertaken.

2.76 All toilets should be screened from the main cell area. (2.39)

Achieved. Most cells we inspected had a curtain or some other form of screening around the toilet area.

2.77 Arrangements for regularly replacing mattresses should be improved. (2.40)

Achieved. Replacement mattresses were available and some wings held a store of them to enable easy access on request.

2.78 Curtains should be provided in all cells. (2.41)

Partially achieved. Despite the prison buying a large number of curtains in the previous year, some cells did not have any and the prisoners in them had improvised by using other materials

such as bed sheets as screens.
We repeat the recommendation.

2.79 More effort should be made to deal with minor issues raised by prisoners informally. (3.97)

Achieved. In 2011, the prison had started to run the applications system alongside the complaints system. Prisoners made informal applications which were logged centrally and disseminated to the relevant departments. Replies were then collated centrally and forwarded to the prisoner, and a log of the dates was kept. Most prisoners we spoke to had confidence in the applications system and over 1,000 applications were made monthly.

Staff–prisoner relationships

2.80 Prisoners should be addressed by title or their preferred name. (2.52)

Not achieved. The culture of addressing prisoners using surnames continued.
We repeat the recommendation.

2.81 Relevant information from the initial personal officer interview should be logged in the history sheet. (2.60)

Not achieved. Personal officers conducted an initial interview with the prisoner to introduce themselves and gather some information. However, case notes on P-Nomis were basic and did not include all relevant information – for example, individual vulnerabilities or relevant safeguarding issues.
We repeat the recommendation.

2.82 The scheme on I and J wings to improve personal officer contributions regarding vulnerability and sentence planning should incorporate the current good standard of entries in history sheets, rather than producing standard replies to set questions. (2.61)

Partially achieved. It was clear from P-Nomis records and speaking to staff that, when requested, personal officers provided written communication to others, such as offender supervisors, about an individual's progress. However, these reports did not always use the full amount of information gathered by wing staff and tended to focus on compliance with the rules.
We repeat the recommendation.

2.83 All management checks should comment on quality and list areas of good practice or where improvement is required. (2.62)

Not achieved. There was a schedule for management checks of case recording and we saw entries in P-Nomis to show that they had been done. However, few managers recorded comments about quality, good practice or areas for improvement.
We repeat the recommendation.

2.84 Personal officers should offer at least written contributions to all events significant in the lives of the prisoners in their care. (2.63)

Achieved. Personal officers submitted written reports when requested – for example, to sentence planning boards. Good weekly information exchange on I and J wings between wing staff and the programmes team also helped personal officers to keep up to date with the progress made by prisoners they were overseeing.

Equality and diversity

2.85 The diversity action plan should include actions relating to prisoners as well as staff. (3.52)

Partially achieved. The diversity action plan was a live and ongoing document. Actions for prisoners were mainly focused on prisoners with a disability, ethnic monitoring and victims of a diversity incident. The document made reference to minority prisoner group engagement but this was not taking place. The document was, on the whole, too staff orientated.
We repeat the recommendation.

2.86 The diversity handout for staff should be expanded to include policies and support available to prisoners. (3.53)

Not achieved. The handout for staff, 'Ensuring equality', was focused on staff diversity issues and had no sections on the policies and support available to prisoners.
We repeat the recommendation.

Protected characteristics

2.87 All prisoner diversity representatives should be given a job description and their role should be made clear. (3.72)

Achieved. At the time of the inspection, there were 13 prisoners who were diversity representatives, all of whom had undertaken a one-hour training course which included an explanation of discrimination, the law, protected characteristics, roles and responsibility, reporting procedures, working together, good relations and cultural awareness. Literature was given to all prisoners who had undertaken the training, for future reference. These prisoners had a job description and those we spoke to had a good understanding of their role and were content with the one-to-one support they received from the diversity team.

2.88 The black and minority ethnic prisoner support groups should be reinstated. (3.73)

Not achieved. Although the prison had plans to introduce a black and minority ethnic support group, there had been no such group in place in the previous eight months.
We repeat the recommendation.

2.89 Formal analysis should be carried out to identify the reason for the reduction in the number of racist incident report forms (RIRFs) submitted. (3.74)

Achieved. The prison had carried out research into the reasons for the reduction in the number of RIRFs submitted. The comprehensive report had concluded that there was a correlation with the reduction in the number of complaint forms submitted over the same period. It also concluded that prisoners were reluctant to submit RIRFs as they had little confidence that racist complaints would be taken seriously. The prison had responded to this by improving the training and support for prisoner diversity representatives. Thirty-six forms had been submitted in 2011.

2.90 Analysis of the high number of RIRFs for inappropriate language should be carried out and appropriate action taken to address the issue. (3.75)

Achieved. The prison had carried out research into the reasons for the high number of RIRFs for inappropriate language. The conclusion was that there were prisoners routinely using offensive language that they did not intend to be racist and this was not corrected or challenged by staff. The prison had responded to this by ensuring that staff were aware of their responsibilities via the staff induction and by training prisoner diversity representatives to a good level of understanding.

2.91 Prisoners monitored through the racist offenders log should have their racist offending, attitudes and behaviour challenged through sentence planning, offender management and public protection systems. (3.76)

Not achieved. The prison collated a racist offenders log but it highlighted only prisoners convicted of a racist offence; any prisoner not convicted of such an offence but who displayed racist behaviour while in custody was not put onto this log. Racist offenders were logged onto the OASys system but no formal targets were set to address racist behaviour.
We repeat the recommendation.

2.92 Foreign national prisoner representatives should be identified, trained and utilised in representing foreign national prisoners in the prison. (3.86)

Not achieved. At the time of the inspection there were no prisoner foreign national representatives and there had been none during the previous six months. There was an expectation by the prison that prisoner diversity representatives would undertake this role; however, it was not included in their job description and the prisoner representatives we spoke to were unaware of this function.
We repeat the recommendation.

2.93 All staff should utilise external interpreting services and not prisoners when confidential issues are discussed. (3.87)

Not achieved. A foreign national prisoner had recently been subject to ACCT procedures and the prison had used another prisoner of the same nationality to undertake interpreting services during case reviews and other subsequent confidential interviews. Staff told us that they always looked to use another prisoner before using formal confidential interpreting services, although there was evidence that such services had been used during the previous year.
We repeat the recommendation.

2.94 Independent immigration advice should be routinely offered to foreign national prisoners. (3.88)

Not achieved. The prison had previously made links with the local Asylum Refugee Centre but the links had not been developed and there had been no independent immigration advice during the previous six months.
We repeat the recommendation.

2.95 Foreign national prisoners should meet as a group with the foreign nationals coordinator and this should be fed back into the race equality action team meeting. (3.89)

Not achieved. There had been no foreign national support group meetings. The prison's expectation was that prisoner diversity representatives would speak individually to foreign national prisoners and report back to the equalities action team (EAT); however, the minutes of

the EAT did not show that this was occurring.
We repeat the recommendation.

2.96 Formal care plans should be provided for older prisoners and those with disabilities. (3.54)

Achieved. Formal care plans were prepared by the health services team for older prisoners and those with disabilities. These were used on the wings alongside personal emergency evacuation plans and prisoners with mobility difficulties were identified on cell doors.

2.97 Prisoners with physical disabilities and those using wheelchairs should be located in specifically adapted accommodation. (3.55)

Achieved. Six cells had been adapted for use by prisoners with physical disabilities and funding was being sought to increase this number.

Faith and religious activity

2.98 The size of the full-time chaplaincy team should be reviewed in light of the size of the establishment. (5.38)

Achieved. The chaplaincy team was at full strength, with three full-time chaplains and sessional faith leaders to cover the needs of all prisoners except one who had requested Jewish instruction. The coordinating chaplain was confident that the resources of his team were adequate.

2.99 Regime activities should not clash with corporate worship. (5.39)

Achieved. The clash between exercise for vulnerable prisoners and Roman Catholic services noted at the previous inspection had been resolved by holding services and Mass on Saturday. There was a clash on Sundays between the gym session and the Anglican service but prisoners could attend sufficient gym sessions on other days of the week.

2.100 Additional facilities should be provided to enable activities other than corporate worship to take place. (5.40)

Partially achieved. There were limited activities, such as religious instruction in different faiths and a Christian faith development course, as well as a full range of corporate worship. There were no activities to meet wider needs, such as emotional support or victim awareness.
We repeat the recommendation.

2.101 Links with locally based faith groups should be developed to enhance religious and faith provision. (5.41)

Not achieved. Chaplains had developed links with local Christian groups and introduced some prisoners to local churches on release. A limited number of volunteers assisted the chaplaincy but difficulties in renewing security clearances had led to some of them resigning their role. There were no links with local faith groups to enhance provision in the establishment.
We repeat the recommendation.

Complaints

2.102 The complaints boxes should be emptied by nominated staff who do not work on residential units. (3.96)

Not achieved. The complaints boxes were still emptied by the night orderly officer.
We repeat the recommendation.

2.103 Replies to complaints should always be detailed, respectful and constructive. (3.98)

Partially achieved. We reviewed around 10% of complaint forms and found that although many were completed to a satisfactory conclusion, with a detailed, respectful response, there were still too many that gave curt replies. The use of preferred names in responses was limited.
We repeat the recommendation.

Legal rights

2.104 The role and contact arrangements of the legal service office should be widely advertised. (3.104)

Achieved. The role and contact arrangements of the legal service office were widely advertised on all wing noticeboards and mentioned during induction but information was not immediately apparent

Housekeeping point

2.105 Information about legal services should be made more noticeable.

2.106 There should be systems to ensure that prisoners are aware of how to contact their legal representatives and how to access legal visits. (3.105)

Not achieved. The induction programme did not specifically cover legal services and legal visits, and a member of the legal services team only attended induction at the request of a prisoner. Many prisoners we spoke to were unaware of how to contact their legal representative, access legal visits or see someone from the internal prison legal services team. Residential staff were poorly informed and could not advise prisoners. There was a section on the general application for accessing the prison's legal services team but only one prisoner we spoke to was aware of this.
We repeat the recommendation.

Health services

Governance arrangements

2.107 The physical condition and facilities in health care areas on residential units should be fully assessed and remedial action taken to ensure that they provide a safe, clean and appropriate environment. There should be a regular cleaning schedule and staff using these facilities should take responsibility for maintaining cleanliness and tidiness in the

rooms. (4.57)

Partially achieved. There were treatment rooms on A wing, the 'under centre' (A, B, C and D wings), G and H wings, and I and J wings. The rooms were all reasonably clean but untidy. The floors were cleaned regularly but there were inadequate cleaning staff in relation to the activity in these areas to maintain an appropriate standard of cleanliness and order.
We repeat the recommendation.

2.108 Additional domestic staff should be employed to raise cleanliness levels on wing treatment areas. (4.58)

Not achieved. There was a housekeeper and a cleaner responsible for ensuring that wing treatment rooms were cleaned regularly but clinical staff we spoke to and observed did not consider the levels of cleanliness to be appropriate (see recommendation 2.107). There were no formal cleaning schedules.
We repeat the recommendation.

Delivery of care (physical health)

2.109 There should be increased generic health promotion, including oral health, across the prison. (4.62)

Achieved. There was a health promotion plan, with clear time-bound objectives. A dedicated health services support worker post provided the lead on national and local campaigns. In the previous year, the support worker had coordinated work on bowel and vascular screening. There were weekly smoking cessation clinics. Blood-borne virus screening and immunisation clinics were run by health services and Compass Offender Recovery Service (CORS) staff.

2.110 A health services professional should be identified to oversee the management of older prisoners and those with disabilities. (4.63)

Achieved. The 'modern matron' led on the care of older prisoners and those with disabilities. We saw good care plans to address the needs of such men.

2.111 A secondary health screen should be implemented within 72 hours of admission. (4.64)

Achieved. A secondary health screen was completed within 48 hours of the reception screen. It included identification of and referral for long-term conditions and mental health and drug and alcohol issues.

2.112 The reason for the poor health care and dentistry attendance rates should be investigated and action taken to reduce the significant numbers of prisoners failing to attend appointments. Officers should sign for appointment slips. (4.65)

Not achieved. No specific work had been done recently on non-attendance rates but we were told that data were reported monthly to the provider and commissioner, and that wastage of appointments had reduced since the introduction of nurse triage and dental triage clinics. There was no evidence to show staff signed for appointment slips.
We repeat the recommendation.

2.113 Prisoners should not be left for hours in the health care waiting room before and after their appointment. (4.66)

Not achieved. Prisoners waited up to two hours between arriving for their appointment and returning to the wings. One prisoner who attended the health care department regularly told us that, although officers tried to take batches of prisoners back to their wings, if there were a lot of men attending, this did not happen due to strict staffing criteria for escorting prisoners around the prison and low staffing levels in the health care department during clinics.
We repeat the recommendation.

2.114 The health care waiting room should provide comfortable fixed seating for waiting prisoners. (4.70)

Not achieved. The two waiting rooms were bleak and empty, apart from fixed metal benches. The benches were not suitable for those waiting for long periods, especially older prisoners and those with disabilities.
We repeat the recommendation.

2.115 The inpatient beds should be removed from the prison's certified normal accommodation. (4.59)

Not achieved. Inpatients beds remained on the certified normal accommodation.
We repeat the recommendation.

2.116 Prisoners should only be admitted to inpatient beds if they have a diagnosable physical or mental health need. (4.60)

Not achieved. There were 11 men in the unit during the inspection; seven had diagnosed mental health conditions (with two waiting for transfer to mental health hospitals), three men had physical health problems and were fit to go to the wings but were waiting for vacant cells and one man was there on a 'governor's order' due to physical vulnerability. We were told that the prison made approximately two admissions per month under governor's orders, with no clinical reason for admission. There had been one such man with mental health problems for whom mental health staff had drawn up a plan to support his management on the wings; however, the prison had decided to admit him to the inpatient unit on the basis of 'staffing and that he might be unfairly managed on the wings'. One man who had been transferred there from the segregation unit in the previous two months had displayed challenging behaviour but had had a personality disorder and no diagnosed clinical mental or physical health needs. Staff told us that men with alcohol detoxification needs were occasionally transferred to the unit if they were being noisy or disruptive on the detoxification wing; their medication then had to be administered by the CORS nurses.
We repeat the recommendation.

2.117 A gated cell should be installed in the inpatient area to facilitate better observation and support to inpatients in distress. (4.61)

Not achieved. Nurses told us that it was difficult to interact properly with patients on close observation. There were four camera cells, which enabled nurses to view prisoners who were deemed at risk because of their acute clinical needs or previous self-harm attempts. Nurses told us that, as it was more difficult to see prisoners at night, they switched on the light to ensure that they could view them properly.
We repeat the recommendation.

Pharmacy

2.118 The keys to the controlled drugs (CDs) cupboard in the pharmacy should be locked away every night and a log instigated to record all access to CDs out of hours. (4.71)

Partially achieved. There was no access to the CD cupboard during the night; the keys were 'hidden' in various places within the pharmacy. The key to the pharmacy was returned to the gate at the end of the working day and a log maintained of access to the CD cupboard and pharmacy keys.

Further recommendation

2.119 The arrangement for the control of controlled drugs cabinet keys should be reviewed in conjunction with the security department as a matter of urgency.

2.120 The timing of medication rounds should be reviewed so that patients receive medications at the correct time. (4.74)

Achieved. There were two medication rounds each day. For the few prisoners needing more frequent doses, either the dose was split between the morning and evening rounds or a nurse delivered the medication to the prisoner on the wing. Following a review of medications and therapeutic intervals, more men received their medications in the evening.

2.121 The pharmacist should review the levels of in-possession medication, including pain relief, with a view to increasing the number of prisoners having medication in-possession. (4.75)

Achieved. There had been a review of in-possession medication and approximately 70% of prisoners were now able to have medication in possession. There was a robust in-possession risk algorithm, which clearly identified patient risk, and an agreed red/amber/green list between the prescriber and pharmacist.

2.122 Patient group directions (PGDs) should be introduced to avoid unnecessary consultations with the doctor. A copy of the original signed PGDs should be present in the pharmacy, and be read and signed by all relevant staff. (4.76)

Achieved. There was a range of PGDs, which included ibuprofen and paracetamol.

2.123 The pharmacist should develop pharmacy-led clinics and medication reviews. (4.77)

Partially achieved. There were pharmacy-led clinics and the pharmacist carried out some opportunistic reviewing of medication and prescribing; in some cases this had reduced the need for prisoners to see a nurse or GP. There were no formal medication/prescribing reviews. We repeat the recommendation.

Dentistry

2.124 The number of clinical dental sessions should be increased to at least five a week. (4.72)

Achieved. The waiting time to see the dentist had improved, with most prisoners waiting only two weeks for a routine initial assessment. Remand prisoners with an urgent dental need were also seen quickly where feasible. There were six dental sessions a week, over three days; this was temporarily reduced to four sessions during the inspection because of work to modify the dental suite.

Delivery of care (mental health)

2.125 Day care facilities should be provided for prisoners less able to cope with life on the wings. (4.67)

Not achieved. There was no day care provision for prisoners who found it difficult to cope on the wings.
We repeat the recommendation.

2.126 Regular mental health awareness training should be introduced. (4.68)

Not achieved. Only 91 prison staff out of a total of 495 (18%) had received mental health awareness training and there was no regular training programme. Listeners had received some training in the previous year.
We repeat the recommendation.

2.127 The head of health care and the primary mental health team leader should investigate prisoners' poor perceptions to ensure that effective care is being delivered, especially in light of the proposed staff reduction in the primary mental health team. (4.69)

Not achieved. There had been no formal review of prisoners' perceptions of primary mental health services. The service capacity remained insufficient to meet population needs.
We repeat the recommendation.

Catering

2.128 Prisoners from both prisoner populations should be considered for work in the kitchens. (7.10)

Not achieved. Only prisoners from the vulnerable prisoner side of the prison worked in the kitchen. There had been no attempt to integrate prisoners.

2.129 Breakfast should be served on the same day it is eaten. (7.11)

Not achieved. Breakfast packs were issued at the lunch or evening meal on the day before consumption.

2.130 Portions of food at lunchtimes should be increased. (7.12)

Achieved. The lunch sandwiches had increased in size with the opening of the prison bakery, and a hot or cold choice was available each day. Soup was also available and the food portions we observed were adequate.

2.131 The evening meal should be cooked closer to the time of serving it. (7.13)

Achieved. The regime had changed, so that the evening meal was served at 5.15pm instead

of after 6pm. The food we observed being served at the evening meal was of a good standard and there were few complaints from prisoners.

2.132 Prisoners should be able to dine in association. (7.14)

Not achieved. None of the residential units provided the opportunity to dine out of cell. The newer wings had adequate space to facilitate this but the prison chose not to do so.
We repeat the recommendation.

2.133 Prisoners should be able to have five portions of fruit and vegetables a day. (7.15)

Achieved. The menu we observed demonstrated the availability of five portions of fruit per day.

2.134 Catering staff should provide written responses to entries in food comments books. (7.16)

Achieved. Comments books included qualitative responses from catering staff. Catering staff also visited all wing serveries daily.

2.135 Wing servery areas should be improved and the flooding in the D wing servery rectified. (7.17)

Achieved. All serveries and food areas were clean and in good order. The drainage problems had been resolved in the D wing servery.

2.136 Food safety standards should be consistently applied in all servery areas. (7.18)

Achieved. Staff and prisoners were dressed appropriately and had all been trained in basic food handling and general hygiene under the Chartered Institute of Environmental Hygiene scheme.

2.137 The correct utensils should be used to serve food. (7.19)

Achieved. All serveries had appropriate tools for serving halal and non-halal food. Prisoners and staff were aware of cultural issues.

Purchases

2.138 Prisoners should be able to buy fresh fruit from the prison shop. (7.27)

Not achieved. Prisoners were not able to buy fresh fruit from the prison shop.
We repeat the recommendation.

2.139 Prisoners ordering goods from catalogues should not be charged an administration fee. (7.28)

Achieved. Prisoners were no longer required to pay an administration fee when ordering goods from catalogues.

2.140 Prisoners should be able to make a full shop order within 24 hours of arrival. (7.29)

Not achieved. Most prisoners were not able to make a full shop order within 24 hours of their

arrival. Prisoners had to hand in shop orders on Wednesdays, for delivery seven days later. Prisoners arriving at the prison after Wednesday could wait up to 10 days before receiving a full shop order.
We repeat the recommendation.

Time out of cell

2.141 Prisoners should be given the opportunity for at least one hour of exercise in the open air every day. (5.47)

Achieved. Exercise was offered daily between 8am and 9am and this was rarely cancelled. However, take-up was low and prisoners told us that this was due to the timing of the exercise.

2.142 All prisoners should have at least 10 hours out of cell each day. (5.48)

Not achieved. The prison core day did not allow for 10 hours out of cell per day. A fully engaged prisoner could access 8.5 hours and an unemployed prisoner 5.5 hours out of cell. During a random roll check, we found 40% of prisoners in off-wing activities, 13.5% working on the wings and 46.5% not fully engaged and locked in their cells.
We repeat the recommendation.

2.143 Furniture and recreational facilities should be provided in the exercise yards. (5.49)

Partially achieved. Benches had been provided on the exercise yards. However, there were no softening features such as plants and raised flower beds and no recreational facilities.
We repeat the recommendation.

Learning and skills and work activities

Provision of activities

2.144 Classroom furnishings should be improved. (5.15)

Achieved. The poor classroom furnishings identified at the previous inspection had been replaced and classrooms were now suitably furnished and provided a good learning environment.

2.145 An equitable pay scheme should be introduced for work and education. (5.20)

Achieved. The rates of pay were equitable and did not act as a disincentive to attending education.

Quality of provision

2.146 A wider range of teaching and learning activities should be developed and implemented to improve prisoners' motivation and interest. (5.16)

Achieved. Tutors used a range of teaching and learning activities to interest and motivate learners, including project work, games and computer software packages. Newly purchased interactive whiteboards were to be installed imminently which would potentially extend teaching and learning activities.

2.147 Tutors should include natural breaks during two and a half hour teaching sessions and provide at least basic refreshments, in line with learning and skills 'every adult matters' policy. (5.17)

Achieved. Tutors planned short breaks during two and a half, and three-hour learning sessions and provided learners with a cold drink to help to maintain their concentration levels.

2.148 The results of initial and diagnostic assessments should be used to inform individual learning plans and set challenging targets. (5.18)

Partially achieved. The results of learners' initial assessment were recorded on lesson plans. New individual learning plans had been introduced and most tutors set more precise and challenging academic and personal targets than had previously been the case. However, particularly in vocational training, too few tutors took sufficient account of the results of learners' initial assessments to include improvement targets in literacy and numeracy where applicable.

2.149 Support should be provided for dyslexic prisoners. (5.19)

Achieved. Practical support was provided for prisoners identified with dyslexia. Three staff had recently undertaken training to expand the support provided to include all learners with 'hidden' disabilities.

Library

2.150 Library activities should be promoted through induction and on the accommodation wings. (5.21)

Achieved. Information on library services was provided in a prison induction booklet and prisoners received a bookmark with the library timetable on it. The timetable was also displayed on the accommodation wings, and library staff visited the wings weekly to collect borrowed books. Prisoners' views on the library were sought and improvements had been made as a result of their comments.

2.151 Attendance at the library should be improved. (5.22)

Partially achieved. Attendance had marginally increased in the present year. Two officers were assigned to escort prisoners to the library at their allocated time, and this had improved access. However, for some prisoners their allocated time conflicted with education or vocational training sessions. Time slots were sometimes cut short if delays occurred in roll checks or movement to activities. Prisoners did not have access to the library during the evenings or at weekends, and while some wings had up to two library sessions a week, others had only one.

Physical education and health promotion

2.152 More accredited courses should be developed. (5.31)

Achieved. Accredited courses had extended to include level 2 awards in understanding health improvement, first aid at work and a gym instructor course for orderlies.

Strategic management of resettlement

2.153 A broader range of prison managers should attend the resettlement committee, including those from residential areas. (8.6)

Not achieved. Although the resettlement policy referred to membership of the resettlement committee, in reality the meeting did not take place and there was an absence of governance which involved all of the prison and other contributors to resettlement.

Further recommendation

2.154 There should be a meeting of a broad range of prison managers, including those from residential areas, and representatives of service providers which provides governance for resettlement and offender management.

Offender management and planning

2.155 Completion of the prisoner passport should be integrated into the assessment work being done by resettlement specialists during the induction process. This should form one document. (8.24)

Achieved. The system of assessment had changed and there was no longer a prisoner passport. Basic custody screening had been introduced for all sentenced prisoners which incorporated resettlement needs into one document (see recommendation 2.167).

2.156 The resettlement unit waiting room should be large enough to accommodate the number of prisoners routinely held there. (8.25)

Achieved. The resettlement waiting room was located in the centre of the resettlement area and had limited seating but new rooms had been made available and were used when required to ensure that the waiting room did not become overcrowded. Arrangements had been made to escort prisoners back to residential wings outside of prisoner movement times so that they did not have to spend too long in waiting areas after interviews had been completed.

2.157 Sentence planning targets should be used to sequence and guide the delivery of interventions for those subject to OASys assessment. (8.26)

Achieved. There was good communication between the programmes team and the offender management unit. Prisoners were assessed and allocated to programmes according to sentence planning targets. Sequencing was based on the logical order of interventions and took account of important events in the prisoner's sentence.

2.158 Managers should ensure that all relevant information about prisoners' resettlement is speedily passed between offender management (risk management unit) and the resettlement unit. (8.27)

Achieved. The resettlement manager had developed a system of email templates, which were used by offender supervisors to make referrals. Offender supervisors told us that this was more dependable and quicker than the old paper-based system.

2.159 Key workers involved with a particular prisoner should routinely attend sentence planning boards. (8.28)

Partially achieved. Although the attendance of key workers at sentence planning boards was not routine, personal officers and other staff involved with prisoners made written contributions to sentence planning boards.

2.160 Sentence planning targets should focus on the behaviour, attitudes and other factors identified in OASys assessments. (8.29)

Partially achieved. The sentence plans we saw mostly included issues identified in OASys assessments but we found some examples where important matters of substance misuse had not been addressed. The manager responsible had identified some of these deficits in his quality checks and had fed back his findings to offender supervisors as part of his efforts to improve performance.
We repeat the recommendation.

2.161 OASys assessments should be completed within agreed timescales. (8.30)

Achieved. The offender management unit was adequately staffed and well organised. All assessments were completed within the agreed timescales of eight weeks or 16 weeks from reception, according to sentence length. However, the prison received prisoners from other establishments for whom assessments had not been completed, so in these cases there was a considerable delay from the point of sentence which was beyond the prison's control.

Public protection

2.162 The public protection panel should discuss all prisoners who present serious risk of harm to the public (or while in custody). (8.31)

Achieved. At the time of the previous inspection, the public protection panel had only discussed prisoners who presented a risk to children. The scope of the panel had since increased and records showed that prisoners who presented a risk to adults of violence, sexual offending or harassment were discussed and appropriate restrictions put in place.

2.163 Work to identify and manage prisoners with racially motivated offending behaviour or attitudes should be fully integrated with other public protection work. (8.32)

Achieved. Racially motivated offending was included in the criteria for screening prisoners and those determined as high risk were referred to the public protection panel.

2.164 Work with prisoners serving indeterminate sentences for public protection should be fully integrated into offender management. (8.33)

Achieved. Prisoners serving indeterminate sentences for public protection (IPP) were managed by a lifer manager. They were now included in the mixed caseloads of offender supervisors, with higher-risk prisoners usually being allocated to offender supervisors with a background in the Probation Service.

Categorisation

2.165 Prisoners should be notified both verbally and in writing of the outcome of recategorisation reviews. (6.16)

Achieved. Offender supervisors notified prisoners verbally and in writing of the outcome of recategorisation reviews. Prisoners signed a copy of the notification to demonstrate that they had received it.

2.166 Prisoners should routinely be encouraged to contribute to recategorisation reviews. (6.17)

Achieved. Offender supervisors interviewed prisoners who were due to have a recategorisation review. In the interview, their views on their recategorisation were recorded and taken into account.

Reintegration planning

2.167 Passport information should be transferred into a custody plan for short-term and remand prisoners to ensure targets set are followed up in good time. (8.48)

Partially achieved. Planning for short-term sentenced prisoners was achieved through the basic custody screening process. There was no structured planning for remand prisoners (see also recommendation 2.155).

Further recommendation

2.168 There should be structured assessment and resettlement planning for remand prisoners.

Health care

2.169 A structured documented health care discharge protocol should be established so that every prisoner is offered an appointment with a health professional before release. (8.49)

Not achieved. Prisoners were not seen routinely by health services staff before release. We repeat the recommendation.

2.170 Pre-release health care clinics should be implemented. (8.50)

Partially achieved. Men with long-term conditions were identified four weeks before discharge and seen by a nurse approximately a week before release. At this time their medication regime was discussed and they were given a summary letter for their GP.

Drugs and alcohol

2.171 The drug strategy document should be updated and contain detailed action plans and performance measures. (8.62)

Not achieved. The drug and alcohol strategy was out of date. A new prison strategy was being developed but had not been finalised. There was an overall community strategy framework for Kingston upon Hull which included the prison. Monthly prison data reports were submitted to the commissioners and the new offender health and well-being meeting. We were told that there was good cross-prison working in regard to supply and reduction but it was not clear from the minutes of this new meeting how cross-prison drug and alcohol issues were identified, targets set or actions followed up.
We repeat the recommendation.

2.172 A comprehensive needs analysis of the prison's population should be carried out annually to inform the drug and alcohol strategy and future service provision. (8.63)

Partially achieved. A prison needs analysis had been started in September 2011 but was incomplete and undergoing revision. A joint needs assessment had been completed by NHS Hull in 2011 which included the prison population but referred to counselling, assessment, referral, advice and throughcare (CARAT) information from 2009/10.
We repeat the recommendation.

2.173 Specialist alcohol services should be provided to meet the need. (8.64)

Achieved. All drug and alcohol services were provided by the local community provider, the CORS team. Prisoners with alcohol-only problems were provided with alcohol withdrawal support and case managers worked with them to address their alcohol problems.

2.174 An information sharing protocol should be established between tutors running the alcohol awareness programmes and the newly appointed alcohol worker. (8.65)

No longer relevant. There was a fully integrated drug and alcohol service and all alcohol education was provided by this service.

2.175 Psychometric test results taken before and after the short duration programme should be recorded for individual prisoners as a measure of progress. (8.66)

Not achieved. This recommendation had been rejected because it did not comply with interventions group policy. The head of programmes told us that he could see the value of using individual psychometric data to gauge the progress of prisoners but he was required to submit test results to a central database rather than use it locally.

2.176 All voluntary drug testing facilities should include adequate privacy screening around urinals. (8.67)

No longer relevant. There was no voluntary or compact-based drug testing in the prison.

2.177 Information on blood-borne virus treatment availability should be displayed in key locations throughout the prison, especially in drug testing suites and group session rooms. (8.68)

Not achieved. There was no literature on display anywhere in the prison to raise awareness of blood-borne diseases or of any clinics available. There were, however, regular blood-borne virus clinics both on G wing and in the health care department. Identification of immunisation needs was done at the secondary health assessment and opportunistically. There was little evidence of related health promotion literature around the prison.
We repeat the recommendation.

Finance, benefit and debt

2.178 A specialist service for prisoners with more significant debt management needs should be introduced. (8.51)

Achieved. A representative from the Citizens Law Advice Centre (CLAC) attended the prison to provide debt advice and support. This included contact with courts to ensure that fines were appropriately remitted, contacting creditors, arranging repayment schedules and advising on insolvency.

Children, families and contact with the outside world

2.179 A needs analysis should be conducted to inform the provision of family visits and relationship building courses. (8.79)

Partially achieved. While there was still no current needs analysis informing this pathway, family days were run regularly. A prisoner survey had been completed and analysed. Further work aimed at identifying the full range of needs across the pathways was being undertaken. The prisoner survey showed that 30% of prisoners felt that they had a problem with relationships; 23% reported being a perpetrator and 25% a victim of domestic violence. However, the relationship courses delivered through the education department had ended and, although the pilot offending behaviour programme to address domestic violence was a positive step forward, the number of prisoners completing it to date was small.
We repeat the recommendation.

2.180 Links should be developed between initiatives to improve and maintain family relationships and the resettlement strategy, including sentence planning. (8.80)

Not achieved. Provision to promote family ties had deteriorated with the ending of the relationships and parenting courses. Links between work to promote family ties (for example, through family days) and offender management were not well developed, with little connection to sentence planning and no joint meetings to take forward the reducing reoffending work.
We repeat the recommendation.

2.181 Visitors should be able to book future visits while they are at the prison or by email. (8.81)

Achieved. A future visit could be booked at the visitors centre before leaving the prison or by email.

2.182 The furniture in the main visits room should be in a suitable condition. (8.82)

Achieved. The furniture in the visits hall was comfortable and in good condition.

2.183 Prisoners should not be required to wear boiler suits during visits. (8.83)

Not achieved. While the wearing of boiler suits had ended, prisoners had to wear red bibs for identification. This was disproportionate, given the range of other security measures in place, such as the use of fingerprint recognition system used for checking male visitors before leaving the prison.
We repeat the recommendation.

2.184 The closed visits area should be clean, free from graffiti and furnished with comfortable chairs for visitors. (8.84)

Achieved. The closed visits area was clean, well decorated and appropriately furnished.

Attitudes, thinking and behaviour

2.185 A detailed prisoner needs analysis should be completed to inform the provision or expansion of offending behaviour programmes. (8.91)

Achieved. The partially completed resettlement needs assessment included a survey of prisoners which identified the further interventions required. This had led to the introduction of programmes to address domestic violence and alcohol-related violence.

Section 3: Summary of recommendations

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

Recommendation — To NOMS

3.1 Two prisoners should not share cells designed for one. (2.3)

Recommendations — To the governor

Courts, escorts and transfers

3.2 Prisoners attending court should be offered a further breakfast pack in reception if they have not eaten beforehand. (2.9)

Early days in custody

3.3 Prisoners should be permitted to have a shower in reception on request. (2.10)

3.4 Foreign national prisoners should receive enough PIN telephone credit on the first night centre to make a call to family and friends overseas. (2.11)

3.5 Induction staff should take responsibility for delivering elements of the induction programme, supported by prisoner representatives. (2.14)

3.6 The induction programme should include the delivery of information about safer custody issues. (2.15)

3.7 Prisoners should receive association on their first night and subsequently on the unit. (2.16)

3.8 Induction should be structured so that it fills the timetable. Prisoners should be occupied rather than locked in their cells during its delivery. (2.17)

Bullying and violence reduction

3.9 The use of violence reduction support plans for victims of bullying should be clarified and staff given guidance on when a victim booklet should be opened. (2.21)

3.10 All staff should receive anti-bullying training. (2.25)

Self-harm and suicide prevention

3.11 The content and quality of ACCT supervision and documentation should be improved. (2.32)

3.12 Samaritans telephones should be regularly checked and should all be in working order. (2.34)

3.13 The location of Listener call-outs should be monitored by the safer custody coordinator and discussed at safer custody meetings. (2.36)

Security

3.14 The movement system should be changed so that prisoners are able to return to their wing or activity outside main movement times. (2.38)

3.15 The searching strategy should be amended and explicitly state that squat searches should only be conducted in exceptional circumstances. All squat searches should be appropriately authorised and recorded. Strip-searching should only be carried out on the basis of a risk assessment or specific intelligence. (2.39)

Incentives and earned privileges

3.16 Prisoners on the basic level of the IEP scheme should be set behaviour improvement targets, and staff should demonstrate that they are actively monitoring behaviour through daily wing file entries. (2.42)

3.17 IEP review boards and applications for enhanced status for all prisoners should consistently be linked to a prisoner's engagement with his sentence plan and participation in offending behaviour work. (2.43)

3.18 A prisoner's privileges should not be removed unless a formal IEP review board has been held. The interim removal of a prisoner's television following receipt of two warnings in a 21-day period should cease. (2.44)

Disciplinary procedures

3.19 The local tariff should be published to prisoners. (2.45)

3.20 The practice of issuing prisoners with unofficial cooling-off periods from gym sessions should cease. (2.46)

The use of force

3.21 Planned removals should be recorded and used for staff development purposes. (2.47)

3.22 Governance arrangements for the use of force should be improved. (2.48)

3.23 Officers certifying the use of force should be independent of the incident. (2.50)

Segregation

3.24 Reviews of segregation should be conducted by a multidisciplinary team and targets set at reviews should be geared towards effective reintegration planning. (2.55)

Substance misuse

3.25 The establishment should take steps to improve the privacy of prisoners receiving opiate substitution. (2.59)

Residential units

3.26 Graffiti should be removed and its recurrence prevented. (2.62)

3.27 The in-built system for testing cell call bell responses in the newer accommodation should be activated and checked regularly by managers. A system for assessing the promptness of responses on the older accommodation should be introduced. (2.65)

3.28 All cells should be properly cleaned before prisoners are allocated to them. (2.71)

3.29 The ventilation in the shower areas should be improved. (2.73)

3.30 Dividing screens should be provided in the large shower areas to improve privacy. (2.74)

3.31 Curtains should be provided in all cells. (2.78)

Staff–prisoner relationships

3.32 Prisoners should be addressed by title or their preferred name. (2.80)

3.33 Relevant information from the initial personal officer interview should be logged in the history sheet. (2.81)

3.34 The scheme on I and J wings to improve personal officer contributions regarding vulnerability and sentence planning should incorporate the current good standard of entries in history sheets, rather than producing standard replies to set questions. (2.82)

3.35 All management checks should comment on quality and list areas of good practice or where improvement is required. (2.83)

Equality and diversity

3.36 The diversity action plan should include actions relating to prisoners as well as staff. (2.85)

3.37 The diversity handout for staff should be expanded to include policies and support available to prisoners. (2.86)

Protected characteristics

3.38 The black and minority ethnic prisoner support groups should be reinstated. (2.88)

3.39 Prisoners monitored through the racist offenders log should have their racist offending, attitudes and behaviour challenged through sentence planning, offender management and public protection systems. (2.91)

3.40 Foreign national prisoner representatives should be identified, trained and utilised in representing foreign national prisoners in the prison. (2.92)

3.41 All staff should utilise external interpreting services and not prisoners when confidential issues are discussed. (2.93)

3.42 Independent immigration advice should be routinely offered to foreign national prisoners. (2.94)

3.43 Foreign national prisoners should meet as a group with the foreign nationals coordinator and this should be fed back into the race equality action team meeting. (2.95)

Faith and religious activity

3.44 Additional facilities should be provided to enable activities other than corporate worship to take place. (2.100)

3.45 Links with locally based faith groups should be developed to enhance religious and faith provision. (2.101)

Complaints

3.46 The complaints boxes should be emptied by nominated staff who do not work on residential units. (2.102)

3.47 Replies to complaints should always be detailed, respectful and constructive. (2.103)

Legal rights

3.48 There should be systems to ensure that prisoners are aware of how to contact their legal representatives and how to access legal visits. (2.106)

Health services

3.49 The physical condition and facilities in health care areas on residential units should be fully assessed and remedial action taken to ensure that they provide a safe, clean and appropriate environment. There should be a regular cleaning schedule and staff using these facilities should take responsibility for maintaining cleanliness and tidiness in the rooms. (2.107)

3.50 Additional domestic staff should be employed to raise cleanliness levels on wing treatment areas. (2.108)

3.51 The reason for the poor health care and dentistry attendance rates should be investigated and action taken to reduce the significant numbers of prisoners failing to attend appointments. Officers should sign for appointment slips. (2.112)

3.52 Prisoners should not be left for hours in the health care waiting room before and after their appointment. (2.113)

3.53 The health care waiting room should provide comfortable fixed seating for waiting prisoners. (2.114)

3.54 The inpatient beds should be removed from the prison's certified normal accommodation. (2.115)

3.55 Prisoners should only be admitted to inpatient beds if they have a diagnosable physical or mental health need. (2.116)

3.56 A gated cell should be installed in the inpatient area to facilitate better observation and support to inpatients in distress. (2.117)

3.57 The arrangement for the control of controlled drugs cabinet keys should be reviewed in conjunction with the security department as a matter of urgency. (2.119)

3.58 The pharmacist should develop pharmacy-led clinics and medication reviews. (2.123)

3.59 Day care facilities should be provided for prisoners less able to cope with life on the wings. (2.125)

3.60 Regular mental health awareness training should be introduced. (2.126)

3.61 The head of health care and the primary mental health team leader should investigate prisoners' poor perceptions to ensure that effective care is being delivered, especially in light of the proposed staff reduction in the primary mental health team. (2.127)

Catering

3.62 Prisoners should be able to dine in association. (2.132)

Purchases

3.63 Prisoners should be able to buy fresh fruit from the prison shop. (2.138)

3.64 Prisoners should be able to make a full shop order within 24 hours of arrival. (2.140)

Time out of cell

3.65 All prisoners should have at least 10 hours out of cell each day. (2.142)

3.66 Furniture and recreational facilities should be provided in the exercise yards. (2.143)

Strategic management of resettlement

3.67 There should be an up-to-date resettlement needs analysis, covering all resettlement needs and the various prisoner populations, and this should be the basis for a coordinated strategy. (2.5)

3.68 There should be a meeting of a broad range of prison managers, including those from residential areas, and representatives of service providers which provides governance for resettlement and offender management. (2.154)

3.69 Sentence planning targets should focus on the behaviour, attitudes and other factors identified in OASys assessments. (2.160)

Reintegration planning

3.70 There should be structured assessment and resettlement planning for remand prisoners. (2.168)

3.71 A structured documented health care discharge protocol should be established so that every prisoner is offered an appointment with a health professional before release. (2.169)

3.72 The drug strategy document should be updated and contain detailed action plans and performance measures. (2.171)

3.73 A comprehensive needs analysis of the prison's population should be carried out annually to inform the drug and alcohol strategy and future service provision. (2.172)

3.74 Information on blood-borne virus treatment availability should be displayed in key locations throughout the prison, especially in drug testing suites and group session rooms. (2.177)

3.75 A needs analysis should be conducted to inform the provision of family visits and relationship building courses. (2.179)

3.76 Links should be developed between initiatives to improve and maintain family relationships and the resettlement strategy, including sentence planning. (2.180)

3.77 Prisoners should not be required to wear boiler suits during visits. (2.183)

Housekeeping points

Residential units

3.78 Vacated cells should be cleaned before the next prisoner moves in. (2.63)

3.79 Rubbish should be removed from inside window grilles. (2.68)

Legal rights

3.80 Information about legal services should be made more noticeable. (2.105)

Appendix I: Inspection team

Andrew Rooke	Team leader
Paul Rowlands	Inspector
Gordon Riach	Inspector
Kevin Parkinson	Inspector
Sandra Fieldhouse	Inspector
Nicola Rabjohns	Health care/substance use inspector
Sheila Willis	Ofsted inspector

Appendix II: Prison population profile

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

Status	18–20-year-olds	21 and over	%
Sentenced	62	588	65.79
Recall	10	63	7.39
Convicted unsentenced	28	85	11.44
Remand	21	122	14.47
Civil prisoners	0	1	0.1
Detainees	0	5	0.51
Other	1	2	0.3
Total	122	186	100

Sentence	18–20-year-olds	21 and over	%
Unsentenced	49	220	27.23
Less than 6 months	16	83	10.02
6 months to less than 12 months	9	55	6.48
12 months to less than 2 years	20	110	13.16
2 years to less than 3 years	11	70	8.2
3 years to less than 4 years	8	47	5.57
4 years to less than 10 years	8	144	15.38
10 years and over (not life)	0	56	5.67
Life/IPP	1	81	8.3
Total	122	866	100

Age	Number of prisoners	%
Minimum age;	18	
21 years to 29 years	348	35.22
30 years to 39 years	257	26.01
40 years to 49 years	150	15.18
50 years to 59 years	54	5.47
60 years to 69 years	40	4.05
70 plus years	17	1.72
Under 21	122	12.35
maximum age; 86	86	
Total	988	100

Nationality	18–20-year-olds	21 and over	%
British	117	801	92.91
Foreign nationals	5	57	6.28
Not stated	0	8	0.81
Total	122	866	100

Security category	18–20-year olds	21 and over	%
Category A exceptional			
Category A high risk			
Category A provisional			
Category A standard			
Category B	0	71	7.19
Category C	1	535	54.25

Category D	0	16	1.62
Female closed			
Female open			
Female semi			
Other			
Uncategorised sentenced			
Uncategorised sentenced male			
Uncategorised unsentenced			
Unclassified	55	236	29.45
Unsentenced	5	4	
YOI closed	60	3	
YOI open	1	1	0.2
Total	122	866	100

Religion	18–20-year-olds	21 and over	%
Baptist	0	0	
Buddhist	1	14	
Church of England	13	260	1.61
Hindu	0	0	29.29
Jewish	0	1	
Muslim	0	28	0.11
No religion	85	383	3
Not Stated	0	2	50.21
Other	1	5	0.21
Roman Catholic	13	125	0.64
Sikh	0	1	14.81
Total	122	866	100

Ethnicity	18–20-year-olds	21 and over	%
Asian or Asian British	4	11	1.52
Bangladeshi	0	1	0.1
Indian	0	3	0.3
Pakistani	0	5	0.51
Total	4	20	2.43
Black or black British			
African	1	9	1.01
Caribbean	0	2	0.2
Other black	2	4	0.61
Total	3	15	1.82
Chinese or other ethnic group	0	1	0.1
Chinese	0	0	0
Total	0	1	0.1
Mixed			
African	0	2	0.2
Asian	0	0	0
Caribbean	0	5	0.51
Other mixed	0	4	0.4
Total	0	11	1.11
White			
British	113	774	89.79
Irish	0	2	0.2
Other White	2	40	4.25

Total	115	816	94.24
Not stated, code missing	0	3	0.3
Total	0	3	0.3
Total	122	866	100

Sentenced prisoners only

Length of stay	18–20-year-olds		21 and over	
	Number	%	Number	%
1 month to 3 months	23	2.3	177	17.9
1 year to 2 years	4	0.4	69	7
2 years to 4 years	0		41	4.1
3 months to 6 months	15	1.5	104	10.5
4 years or more	0		16	1.6
6 months to 1 year	6	0.6	81	8.2
Less than 1 month	25	2.5	158	16
Total	73	7.3	646	65.3

Unsentenced prisoners only

Length of stay	18–20-year-olds		21 and over	
	Number	%	Number	%
1 month to 3 months	15	1.5	72	7.3
1 year to 2 years	0		1	0.1
2 years to 4 years	0		0	
3 months to 6 months	12	1.2	50	5.1
4 years or more	0		1	0.1
6 months to 1 year	1	0.1	11	1.1
Less than 1 month	21	2.1	85	8.6
Total	49	4.9	220	22.3