Report on an unannounced short follow-up inspection of

HMP Everthorpe

19–21 March 2012

by HM Chief Inspector of Prisons

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Introduction

HMP Everthorpe is a category C training prison, based in the Yorkshire and Humberside area, holding 666 male prisoners at the time of this short follow-up inspection.

We judged that HMP Everthorpe was generally a safe and decent establishment. Sufficient progress in relation to safety and respect had been made since our last full inspection in 2009 but some aspects required ongoing attention. For example, a new violence reduction policy had been developed but needed better integration in practice. Consultation with prisoners about suicide and self-harm arrangements had improved but the lack of a definition of what constituted a serious incident of self-harm meant that we were not fully assured that all such incidents were investigated. Improvements to the IEP scheme were being undermined by the continued differences in pay for prisoners doing the same job. Management oversight of substance misuse had improved.

Cells designed for one person were still being used for two and were far too small. Toilet screening remained poor but some shower areas had been adequately refurbished. Personal officer case recording was good but they did not directly contribute to sentence planning. Diversity and chaplaincy arrangements had improved. Major improvements to health services had been made, including a new centre, but some aspects of governance needed improving.

We previously said that work to promote diversity was under developed. Significant progress had been made with a clear and well developed strategy underpinning the various elements of support.

Insufficient progress had been made in purposeful activity. This was mainly due to a reduction in time out of cell with no analysis of why this had happened. In addition, there were too few work, training and activity places, compounded by poor utilisation of those available. For those in education or employment, literacy and numeracy support in workshops was good, but individual learning plans were not consistently used.

We found insufficient progress in resettlement. This was largely due to weak governance during a long period of major change, with some lead responsibilities remaining unclear and, until recently, a lack of formal sentence planning boards. Prisoners were still arriving at HMP Everthorpe without a completed OASys assessment. The needs analysis was adequate, as were the range of programmes provided and the management of waiting lists. Offender management arrangements were, on the whole, adequate but little additional support for ISPs was available. Too many prisoners were waiting for specialist housing advice and too many were released without suitable accommodation. Some improvements in the provision of advice about finance, benefit and debt, and to tackle drugs and alcohol use had been made. Visits facilities remained limited in a couple of key respects.

Overall, sufficient progress against the recommendations we made in 2009 had been made in relation to safety and respect. However, more needed to be done to make some important improvements to purposeful activity and resettlement, which given HMP Everthorpe's role as a training prison, are clear priorities.

Nick Hardwick — June 2012
HM Chief Inspector of Prisons

Fact page

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

Prison status
Public

Region
Yorkshire and Humberside

Number held
666

Certified normal accommodation
603

Operational capacity
689

Date of last full inspection
12–16 January 2009

Brief history
HMP Everthorpe opened in 1958 as a borstal. It was converted to its present role in 1991 and now holds convicted male prisoners. In 2005 it underwent a significant expansion programme that provided two new wings and 220 places. The expansion also included a new workshop complex, gym and visitors centre.

Short description of residential units
HMP Everthorpe has seven residential units plus a separation and care unit.

A wing – holds 86 prisoners plus a Listener suite (RAPt staff are based on A wing)
B wing – holds 87 prisoners
C wing – holds 87 prisoners (induction unit)
D wing – holds 87 prisoners (pre-release unit)
E wing – holds 120 prisoners, all in single cells (enhanced wing)
F wing – holds 95 prisoners (IDTS detoxification treatment unit; five double cells)
G wing – holds 127 prisoners plus a Listener suite (37 double cells)
SACU – holds 14 prisoners, including two special accommodation cells

Name of governor
Ed Cornmell

Escort contractor
GeoAmey

Health service commissioner and provider
Commissioner: East Riding of Yorkshire PCT
Provider: Humber Foundation Trust

Learning and skills providers
Manchester College

IMB chair
Tim Haley

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 2009 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 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 48 recommendations in this area, of which 21 had been

achieved, nine partially achieved and 15 had not been achieved. Three recommendations were no longer applicable. We have made three further recommendations.

1.6 The creation of a fenced area at the entrance to reception allowed prisoners to disembark from escort vans without being handcuffed. The reception area had been slightly improved and processes were mostly appropriate, including an individual interview with first night staff. Early structured access to Listeners/Insiders was limited during the first day at the establishment but better on the induction wing, where comprehensive information was provided (but only in English).

1.7 Violence reduction work had improved through the introduction of a new policy which included support for victims, improved target setting, better analysis of information gathered and an appeals process. However, the policy was not fully embedded and there were no structured interventions to challenge attitudes and behaviour.

1.8 Consultation with prisoners about self-harm had improved, with prisoners attending the suicide and self-harm reduction meetings, and information about self-harm incidents was analysed. There was good consultation with Listeners. There was no guidance on what constituted a serious act of self-harm which required investigation, so we could not be confident that all such incidents had been investigated. Staff carried anti-ligature knives but assessment, care in custody and teamwork (ACCT) refresher training was not up to date.

1.9 There was a proactive approach to the analysis of security information, and objectives were reviewed monthly to ensure that they remained appropriate. Strip-searching was not always based on intelligence. Monthly reviews resulted in the use of closed visits being removed at the earliest opportunity.

1.10 There had been some improvement in the management of the incentives and earned privileges system, with good documentation and regular and timely reviews. However, there was no formal monitoring of prisoners on the basic regime, beyond the establishment policy requirements. There were large variations in pay for prisoners on different levels of the scheme doing the same job.

1.11 Analysis of the use of force was adequate. Recording and reviewing of planned interventions had been introduced but not always undertaken. Special cells remained bleak, despite some basic remedial work, and were used inappropriately to hold prisoners pending adjudication.

1.12 The separation and care unit (SACU) policy had been reviewed but did not fully set out a differential regime, the use of individualised targets or care planning. In-cell electricity in the SACU went some way to improve conditions for prisoners but other aspects had not been addressed. For example, daily showers were not provided and toilets remained unscreened. Recording of daily events for individuals was limited.

1.13 Management oversight of substance use had improved and integration with other services in the prison was good.

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

Respect

1.15 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 58 recommendations in this area, of which 31 had been achieved, two partially achieved and 18 had not been achieved. Seven recommendations were no longer applicable. We have made one further recommendation.

1.16 Some cells designed for one prisoner were being shared, with insufficient space for two men. There was inadequate toilet screening in double cells and a lack of screening in single cells. Showers on A and B wings had been refurbished to a good standard.

1.17 Access to general application forms was poor and limited to set times of the day. Delays in outgoing mail had been investigated and improvements made but despite this prisoners still complained about the issue. There were insufficient telephones on some wings but privacy when using the telephone had improved. Prisoners could exchange visiting orders for telephone calls but this facility was not widely understood or incorporated into a policy.

1.18 Personal officers made regular, high-quality entries in wing files, indicating an adequate knowledge of prisoners, but limited contributions to sentence planning boards.

1.19 Diversity arrangements had improved and were well managed. The weekly staff and prisoner diversity meeting was a useful forum for early identification of issues and the exploration of prisoners' perceptions.

1.20 The diversity manager was proactive and ensured that the lack of dedicated foreign nationals officers and disability/older prisoner liaison officers was mitigated by ensuring that prisoners were seen individually and care plans developed. The small foreign national population was well catered for and links had been maintained with the UK Border Agency despite the minimal need. Access to free international telephone calls was over-restrictive. Legal services had ceased to exist and provision was limited to a list of solicitors.

1.21 Chaplaincy arrangements were good, with cover for staff when on leave and effective links with community faith organisations.

1.22 Arrangements for quality assuring complaints had improved as had the analysis of data to identify trends and themes.

1.23 Some important improvements in health care had been made. The new health care department provided a clean and appropriate environment. The health care applications process had improved. There was better use of the dental service but gaps in cover remained. Prisoners could access pharmacy advice. Some aspects of governance, including staff training, required attention. Access to out-of-hours pain relief had not been established.

1.24 Formal qualifications in catering were not available in the kitchen or staff mess, breakfast packs were inappropriately issued on the night before consumption and few prisoners could dine in association. While consultation about the shop list had improved, access to the prison shop within 24 hours of arrival was still not possible and the administration charge for catalogue orders remained.

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

Purposeful activity

1.26 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 18 recommendations in this area, of which 11 had been achieved and six had not been achieved. One recommendation was no longer applicable. We have made no further recommendations.

1.27 Time out of cell had reduced since the previous inspection and, when we checked, an average of just over a quarter of prisoners were locked up during the core day. There had been no analysis of why so many prisoners were unoccupied during activity times.

1.28 The skills for life strategy promoted a whole-prison approach to the development of purposeful activity. However, there was insufficient work or training to occupy the whole prison population purposefully. Activity places were also poorly utilised due to prisoners leaving to attend recreational PE. One consequence was that courses took an excessive amount of time to complete.

1.29 In workshops, education tutors provided good literacy and numeracy support. Level 2 qualifications in construction were available. Vocational workshops used entry-level training to provide initial skills and knowledge before progressing the learner onto the full level 2 award. Individual learning plans were not used consistently to set short- and long-term targets and regularly review progress.

1.30 Library provision remained good. The availability of books and bilingual dictionaries for speakers of languages other than English was adequate and there were arrangements with a nearby prison to share resources. Prisoners could access DVDs through formalised arrangements and well-managed lending processes.

1.31 PE staffing levels were adequate to enable the good provision to continue, and more short courses had been introduced. Showers, toilet and changing facilities were of a high standard and suitable for the number using the facility. However, safety issues with the football pitch had not been resolved.

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

Resettlement

1.33 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 26 recommendations in this area, of which six had been achieved, four partially achieved and 13 had not been achieved. Three recommendations were no longer applicable. We have made two further recommendations.

1.34 Strategic management and governance of reducing reoffending was weak. The function was in a state of flux. There had been no reducing reoffending meetings for almost a year and responsibilities for some of the pathways were still unclear. A comprehensive needs analysis had been completed and there was a good selection of accredited and substance misuse programmes, with reasonable waiting times.

1.35 Prisoners were still being received at the prison without an offender assessment system (OASys) assessment. Offender management arrangements were adequate. A small number of

prisoners in the SACU had received some motivational work to promote engagement with sentence plan objectives.

1.36 Sentence planning boards had only recently recommenced. There were no specific forums or family days for prisoners with an indeterminate sentence for public protection.

1.37 There had been some improvements in pathway provision. There had been some improvements in the number of prisoners receiving specialist accommodation advice, but the waiting list was too long and too many prisoners were being discharged with no fixed abode.

1.38 Alcohol services had developed, with screening on arrival and the provision of an alcohol programme. Access to advice on finance, benefit and debt had improved.

1.39 There was no properly equipped visitors centre and the seating arrangements in the visits hall remained unsatisfactory.

1.40 There was no strategy to address issues of denial of offending but the prison had introduced the 'A to Z' motivational programme which went some way to meeting this need.

1.41 On the basis of this short follow-up inspection, we considered that the establishment was making insufficient 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 Anti-bullying and violence reduction procedures should be strengthened and adhered to. (HP55)

Partially achieved. The violence reduction policy had been reviewed and rewritten. The most recent policy, dated November 2011, was a comprehensive and practical guide for staff on reducing, identifying and responding to bullying behaviour. The procedures had been improved to include target setting for perpetrators and victims alike. The levels of reported bullying were low, with just 10 monitoring booklets having been opened in the six months before the inspection, and there were none open at the time of the inspection. The procedures were new and most staff had not yet implemented them. Staff we spoke to were not familiar with some aspects of the procedures and we were not confident that they would adhere to the procedures without further training and management supervision.

2.2 The role of the segregation unit should be clearly defined, with supporting policies and procedures developed and implemented to include: an improved regime; individual assessments for access to regimes; individually assessed targets for each prisoner; and care plans for those remaining in the unit beyond their second review. (HP56)

Partially achieved. The separation and care unit (SACU) policy had been recently reviewed but remained limited. For example, it did not specify the role of objective setting and care planning for individual prisoners. Reintegration planning was not adequately formalised. The regime remained limited for most prisoners, although two segregated prisoners were accessing activities in the main prison at the time of the inspection. In-cell education was rarely provided and in-cell work was not available. Prisoners did not receive association and those we spoke to reported being locked up for all but just over one hour a day. No differential regime had been developed for individual prisoners who were in the SACU for their own protection or for long periods of time compared with those placed there for indiscipline. One prisoner had been in the SACU for over two months for his own protection, with little activity or constructive regime provided.
We repeat the recommendation.

2.3 The health care building should be replaced. (HP57)

Achieved. The health care department was sited in a purpose-built building. It was clean and provided adequate consulting rooms and specialist surgery facilities.

2.4 The poor perceptions of black and minority ethnic and Muslim prisoners should be explored and any necessary action taken to improve current negative perceptions. (HP58)

Achieved. The diversity manager ran a weekly staff and prisoner representatives meeting to discuss any emerging issues, and had conducted a review of racist incident report forms (RIRFs) to identify common themes to discuss with this group. When there were concerns,

members of staff were invited to attend to talk through the issues, and a number of resolutions had been reached that had made a clear impact on reducing the number of RIRFs submitted.

2.5 All prisoners should be unlocked during the core day and engaged in employment, education or training. (HP59)

Not achieved. There was insufficient work or training to occupy the whole prison population purposefully. The full utilisation of many purposeful activities was inconsistent throughout the core day due to prisoners leaving at different times of the day to attend recreational PE. This resulted in courses taking an excessive amount of time to complete.
We repeat the recommendation.

2.6 Arrangements for supporting prisoners into accommodation on release should be improved as a matter of priority. (HP60)

Partially achieved. The prison had a Service Level Agreement with Shelter to provide 16 prisoners per month with independent housing advice. One full-time equivalent qualified housing adviser was contracted to deliver this service. Prisoners could either self-refer to this service or be signposted to it by two prisoner peer support workers, based in the library. At the end of February 2012, 107 prisoners were waiting to be seen, which was an improvement on the number at the time of the previous inspection but was still insufficient to meet demand. Priority was given to those with no fixed abode and those with tenancy preservation cases. However, from the 468 prisoners discharged between June and November 2011, 47 (10%) had no fixed abode.
We repeat the recommendation.

Recommendations

Courts, escorts and transfers

2.7 Prisoners should only be handcuffed when being escorted between reception and the escort vehicle on the basis of an individual risk assessment. (1.6)

Achieved. The creation of a fenced area at the entrance to reception had made the disembarkation area into a sterile area, so prisoners were no longer handcuffed between reception and the escort vehicle, except when indicated by a risk assessment.

Early days in custody

2.8 The reception area should be improved to provide more space, light and greater privacy for new arrivals, and afford the reception area autonomy from the healthcare centre. (1.27)

Partially achieved. The health care department had been relocated and the space in the reception area used to provide holding rooms. Private interviews were held with the first night officer in a separate area but this still did not provide sufficient privacy because it was at a table in a corridor, albeit away from the main reception area.
We repeat the following part of the recommendation: The reception area should be improved to provide greater privacy for new arrivals.

2.9 Non-smokers should be offered a suitable alternative to the smokers' pack. (1.28)

Achieved. Three types of canteen packs were available for new receptions. One contained tobacco and a lighter, another had biscuits, chocolate and a drink, and the third was a dairy-free non-smokers' alternative.

2.10 All prisoners should be able to order from the prison shop within 24 hours of arrival. (1.29)

Not achieved. Shop orders could only be submitted on a Tuesday, for Friday delivery. To reduce the possibility of newly arriving prisoners incurring debt, they were given credit to purchase additional canteen packs on the induction wing pending delivery of their first shop order (see also recommendation 2.105).

2.11 All new arrivals should have access to a Listener and an Insider in reception. (1.30)

Partially achieved. A Listener was employed as the reception orderly. He was identifiable by his Listener shirt but had no formal role in the reception process. Insider prisoners told us that they had formerly been taken to meet prisoners in reception but this had been stopped and they now met them on the induction wing with their Listener colleagues. Although this was satisfactory for most prisoners, it was not reliable in the case of those who arrived late. We repeat the recommendation.

2.12 The mandatory drug testing suite should be relocated out of the reception area. (1.31)

Achieved. The mandatory drug testing suite was located in the same building as reception but was at the far end, beyond a closed door. Newly arrived prisoners and those attending for drug testing were kept separate.

2.13 Every prisoner should be privately interviewed by a member of staff before lock-up on his first night and this should be recorded in his wing file. (1.32)

Partially achieved. A first night officer went to reception and interviewed newly arrived prisoners but the interview area lacked full privacy. There were entries in wing files which recorded the interview, including the advice given to the prisoner and any concerns about him.

2.14 The induction booklet should be available in a wider range of languages. (1.33)

Not achieved. Newly arrived prisoners were provided with a comprehensive information pack which covered all they needed to know but this was not available in any language other than English. The number of prisoners who did not speak English had fallen dramatically since the previous inspection, so the need had reduced. Insiders told us that when a new prisoner did not understand English, other prisoners or staff had been asked to interpret. Staff told us that they rarely used the formal interpreting services that were available, even for confidential matters.

Bullying and violence reduction

2.15 Formal interventions should be introduced for perpetrators of bullying, including racist bullying. (3.12)

Not achieved. There were no structured programmes or formal interventions for perpetrators of bullying. The procedures relied on individualised behavioural targets rather than generic

interventions. The manager responsible had considered formal interventions but believed that effective target setting and monitoring would reduce bullying.

2.16 Support should be introduced for victims of bullying, including racist bullying. (3.13)

Achieved. The violence reduction policy included a strategy for supporting vulnerable prisoners and victims. The strategy was linked to the personal officer scheme and emphasised keeping the prisoner safe on normal location by developing a closely monitored support plan. The plan required actions by staff and targets for the prisoner to reduce his vulnerability. At the time of the inspection there were no victim support plans in place.

2.17 Authority to downgrade a prisoner's incentives and earned privileges (IEP) level under the anti-bullying strategy should be consistent with that stipulated in the IEP policy. (3.14)

Achieved. Prisoners made subject to stage 3 of the anti-bullying procedures were no longer automatically reduced to the basic level of the IEP scheme but were formally reviewed under IEP procedures.

2.18 Investigations into alleged bullying behaviour should be formally recorded and the alleged perpetrator informed in writing of the outcome(s). (3.15)

Not achieved. The anti-bullying strategy did not include instructions for formally recording an investigation into bullying behaviour. There was an official notification form for prisoners placed on anti-bullying monitoring but this did not include details of the outcome of an investigation.
We repeat the recommendation.

2.19 All prisoners placed on the anti-bullying scheme should be given the reasons for such a decision in writing, and the reasons for any subsequent move to a different level on the scheme should be provided in writing. (3.16)

Not achieved. As described in recommendation 2.21, prisoners were officially notified that they were being placed on anti-bullying procedures but the form did not record any specific details. Staff we spoke to told us that they would interview alleged perpetrators to explain why they were suspected of bullying and the changes they expected in their behaviour but this was not formally recorded and given to them.
We repeat the recommendation.

2.20 Only when there is evidence of bullying should prisoners be subject to anti-bullying measures. Any other forms of violent or anti-social behaviour should be managed through separate measures. (3.17)

Achieved. The record of bullying monitoring procedures for the nine months before the inspection showed that the reasons for prisoners being made subject to them had all been for violent, threatening or intimidatory behaviour towards other prisoners.

2.21 There should be a formal appeal process for any prisoner placed on the anti-bullying strategy. (3.18)

Achieved. The strategy included a formal appeal process to the wing manager which required a response within three days. The prisoner was told that if he was not satisfied with the response he could use the formal complaints procedure.

2.22 Violence reduction meetings should analyse data to look at trends and themes and decide on action accordingly. (3.19)

Achieved. A violence reduction report was provided to the monthly violence reduction meeting. This gave prison-wide information about violent behaviour and the details of individual incidents. The meeting minutes showed that this information was linked to security information and that action was identified to reduce the likelihood of further incidents.

Self-harm and suicide prevention

2.23 Suicide and self-harm prevention meetings should analyse data to look at trends and themes and decide action accordingly. (3.34)

Achieved. A safer custody report was provided to the monthly meeting which gave prison-wide information about self-harm incidents, assessment, care in custody and teamwork (ACCT) documents and the details of individual incidents. The meeting minutes showed that this information was considered to identify trends. This practice had been introduced only recently, so no historical information was available to give a longer-term view of trends.

2.24 The Listeners should play a larger part in informing self-harm and suicide prevention strategies in the prison, both through the formal monthly meetings and through other consultative processes. (3.35)

Achieved. The Listeners met the Samaritans coordinator and the safer custody governor every month for consultation about safety in the prison. The prisoner Listener coordinator and Samaritans representatives attended the monthly suicide and self-harm prevention meetings.

2.25 All staff trained in suicide prevention should receive regular refresher training. (3.36)

Not achieved. Training records showed that a large number of staff trained in ACCT procedures had not received refresher training in the previous three years.
We repeat the recommendation.

2.26 The safer custody policy should provide guidance to staff as to what constitutes a near-death, and ensure that such incidents are investigated and an action plan put in place as a result. (3.37)

Not achieved. The suicide prevention and self-harm management policy described the practical procedures for responding to an incident of attempted suicide by hanging but did not specify how such incidents should be investigated. A recent act of serious self-harm had been investigated by the health care department, and safer custody staff had contributed, but there were no criteria for initiating investigations and we were not confident this would happen in every case.
We repeat the recommendation.

2.27 There should be regular monitoring of the action plan raised following the Prisons and Probation Ombudsman's recommendations after a self-inflicted death in 2006. (3.38)

No longer relevant. At the time of the inspection it had been six years since the self-inflicted death and recommendations had been incorporated into prison policy. There had been no deaths in custody at the prison since then.

2.28 Anti-ligature knives should be issued to and carried by all frontline staff. (3.39)

Achieved. All staff that we met who had contact with prisoners carried anti-ligature knives in pouches attached to their belts. We were told that two members of staff did not have pouches but they had been ordered.

Security

2.29 Security measures implemented to address identified security risks should be reviewed monthly to ensure that they remain appropriate. (6.12)

Achieved. Physical security remained appropriate and a recent review had led to the identification of further improvements, including the installation of more fencing around specific areas of the prison. The number of items thrown over the prison walls had reduced as a result of improved security. Intelligence was gathered, analysed thoroughly and presented to the monthly security tasking group in an intelligence assessment report. This was clear and well presented, making excellent use of the information gathered to identify trends, themes and issues. Actions were identified and reviewed each month to ensure that they remained appropriate. Security objectives were clear and amended to reflect new intelligence.

2.30 Strip-searching should be carried out only after a risk assessment indicates that it is necessary. (6.13)

Partially achieved. Strip-searching practice was inconsistent. While it was not always undertaken on those transferring in from another prison, it was routinely carried out, without a risk assessment, on those returning to the SACU after a visit and on 10% of prisoners leaving the visits hall.
We repeat the recommendation.

2.31 Prisoners should not routinely be kept on closed visits for three months unless additional information has been received that warrants the continued use of this measure. (6.14)

Achieved. There was only one prisoner on closed visits at the time of the inspection and he had been on these restrictions for less than a month. Such prisoners were reviewed each month and we saw examples of prisoners being removed from closed visits before the end of three months if there was no further intelligence to support their use.

Incentives and earned privileges

2.32 The pay policy should be reviewed to remove inconsistencies in pay between those on different regime levels doing the same work. (6.53)

Not achieved. The pay policy had been reviewed in November 2011 but it remained linked to the IEP policy, which meant that prisoners working in the same job were paid different rates depending on their IEP status. For example, a prisoner in a bricklaying job would receive a weekly salary of £14 if he was on the enhanced level, £8 on the standard level and only £4 on basic.

2.33 The policy and practice of allowing adjudication punishments and automatic downgrade to basic for some serious disciplinary offences should cease. (6.54)

No longer relevant. In January 2012 our expectations changed, and we now considered it acceptable, when appropriate, for the prison to change a prisoner's IEP status as a result of a serious individual act. We noted several cases where this had occurred and downgrade was consistent with the establishment's policy. However, we also noted one case where a prisoner with no previous warnings had been downgraded before an adjudication hearing for climbing onto the safety netting.

2.34 Monitoring systems should be developed and implemented for those on the basic regime. (6.55)

Not achieved. There were no formal monitoring arrangements for those on the basic regime to evidence changes in behaviour or compliance with the regime. We were satisfied that prisoners on basic were routinely offered exercise, a shower and telephone call daily.
We repeat the recommendation.

2.35 Routine reviews and those triggered by warnings should take place without undue delay. (6.56)

Achieved. In all of the documentation we saw, routine IEP review boards or those triggered by warnings had usually been conducted promptly.

2.36 Regular management checks of reviews should take place consistently. (6.57)

Achieved. Examination of IEP documentation showed that management checks took place monthly.

Disciplinary procedures

2.37 Records of adjudication hearings should be comprehensive and reflect all the evidence that has been considered and a full investigation of the charges heard. (6.32)

Partially achieved. The quality of the adjudication paperwork we inspected was mixed. Some completed paperwork included a detailed record of the hearing, the evidence considered and the investigation of the charges. However, some was too brief and did not provide enough information about the investigations undertaken.
We repeat the recommendation.

2.38 Appropriate holding facilities for prisoners awaiting adjudication should be provided. (6.33)

Not achieved. There were no holding rooms for prisoners waiting for adjudication, and they were inappropriately held in the special cells.
We repeat the recommendation.

2.39 Punishments should be given in line with the published tariff. When the punishment is unusually high, the reasons for it should be recorded clearly. (6.34)

Achieved. Most of the punishments we reviewed were in line with the local tariff. However, the tariff booklet had not been updated to reflect recent changes. Adjudication records were clear about the punishment that had been made. We did not see any punishments in excess of tariff guidelines.

Housekeeping point

2.40 The disciplinary tariff should be updated and published.

The use of force

2.41 On the wholly exceptional occasions when a body belt is deployed, governance, procedures and paperwork must be rigorously adhered to. (6.35)

No longer relevant. The body belt was not used and had not been deployed since 2009.

2.42 The senior management team should monitor and analyse the use of force and the reasons for the high number of incidents. (6.36)

Achieved. Use of force data were collated and explored the location, time of day and staff involved in order to identify any themes. Additionally, the reports were regularly discussed at the safer custody meeting. The number of incidents in which force had been used had declined since 2008.

2.43 Remedial work to the special accommodation should be carried out as a priority. (6.37)

Partially achieved. Some recommended remedial work to ventilation had been completed since the previous inspection. However, the added ventilation grilles were not effective and the special cells remained poorly ventilated and lacking in adequate lighting. The cells were still bleak and poorly decorated.
We repeat the recommendation.

2.44 Planned removals should be video-recorded and reviewed. (6.38)

Partially achieved. The recording and reviewing of planned removals had been introduced a couple of months before the inspection but only one out of the two incidents that had taken place since then had been recorded and reviewed.
We repeat the recommendation.

Segregation

2.45 Individual prisoner records should be fully completed to give an accurate record of daily events. (6.39)

Not achieved. The records we looked at were often incomplete or lacked sufficient detail to evidence daily events. P-Nomis was used for recording, with weekly updates, but these were limited to comments on prisoners' compliance with the regime, omitting any other evidence of behaviour, progress or issues. Reviews did not result in individual objective setting.
We repeat the recommendation.

2.46 In-cell electricity should be provided on the unit. (6.40)

Achieved. In-cell electricity had been installed.

2.47 Toilets should be cleaned and screened. (6.41)

Not achieved. None of the toilets in the SACU had screens and many were dirty.
We repeat the recommendation.

2.48 The number of showers on the unit should be increased as a matter of urgency. (6.42)

Not achieved. The unit still had only one shower. When the unit was full, it was difficult to enable each prisoner to shower (see also recommendation 2.49).

2.49 Prisoners should be given access to showers daily. (6.43)

Not achieved. Showers were offered only on alternate days, even when there was enough time to provide them daily.
We repeat the recommendation.

2.50 The secreted items policy should be reviewed as to its effectiveness. (6.44)

Achieved. The secreted items policy was part of the wider SACU policy and clearly set out the procedures to follow. We reviewed the records and found that all uses of the closed-circuit television cell had been reasonable and some of them had resulted in items being recovered.

Substance misuse

2.51 The post of specialist substance misuse lead nurse should be filled as soon as possible to ensure the smooth running of the integrated drug treatment system and an increase in the number of prisoners treated. (3.117)

Achieved. There was a dedicated substance use lead nurse. In the previous year, the number of men able to access the integrated drug treatment system (IDTS) had increased from 30 to a cap of 105; there were 95 men on the programme at the time of the inspection. There was good joint working between IDTS and counselling, assessment, referral, advice and throughcare (CARAT) staff and effective links with the GPs, to ensure safe, appropriate prescribing for men with substance use problems.

2.52 The mandatory drug testing holding cell should be deep cleaned and redecorated to remove all graffiti from the cell. (3.118)

Achieved. The holding cell was clean and graffiti free.

Residential units

2.53 Prisoners should not share cells designed for single occupancy. (2.24)

Not achieved. Cells designed for one prisoner were being shared on F and G wings. There was not sufficient space for both prisoners in these shared cells to sit and eat meals and some complained that ventilation was inadequate for two men.
We repeat the recommendation.

2.54 Screening should be provided for in-cell toilets and toilet seats should be fitted. (2.25)

Not achieved. Toilets in single-occupancy cells did not have screening and in shared cells there was an inadequate curtain for privacy. Toilets on A, B, C, D and E wings had seats but

those on F and G wings were made of moulded plastic, without a seat.
We repeat the recommendation.

2.55 The refurbishment of the showers on A and B wings should be completed and remedial work undertaken in the E wing showers. (2.26)

Achieved. Showers on A, B and E wings were of a good standard. Walls and fittings were clad in stainless steel and there were partitions between showers stalls.

2.56 Information explaining the applications and complaints process should be made available in a wider range of languages. (3.98)

Partially achieved. A multi-language notice explaining the applications and complaints process was located next to most but not all complaint boxes.

2.57 Application forms should be made freely available on the wings, so that prisoners are not required to ask staff for them. (3.99)

Not achieved. The process of prisoners having to ask for general applications at a set time of day remained. Wing cleaners told us that they could get application forms at any time but that this was not the case for other prisoners.
We repeat the recommendation.

2.58 Managers should investigate why outgoing mail is being delayed and take steps to keep delays to a minimum. (2.27)

Achieved. An investigation had found that mail was not being brought to the mail censors promptly from residential units, which led to delays. This had been resolved but some prisoners still complained to us about delays to outgoing mail. There was no collection by Royal Mail at weekends, delaying letters posted by prisoners on Fridays, as they would not be delivered before the following Tuesday. The issue continued to be raised by managers in consultative groups with prisoners but had not been identified as a problem.

2.59 Additional telephones should be installed, to allow one for every 20 prisoners. (2.28)

Not achieved. Although additional telephones had been installed on A, B, C and D wings, prisoners told us that it was difficult to access the telephones each day. Although prisoners in our groups complained that telephones were often out of order, we found them all to be in working order and that any necessary repairs were carried out promptly.
We repeat the recommendation.

2.60 All prisoners should be permitted to exchange visiting orders for telephone credit. (2.29)

Achieved. Prisoners who did not receive visits told us that they could apply to exchange visiting orders for telephone credit. We found one example of a prisoner who had been allowed a five-minute telephone call from the wing office. He had not been granted ongoing credit but the wing manager said that this could be provided. However, this facility was not well publicised or understood by all those advising prisoners, including staff and Insiders and was not included in a formal policy.

Housekeeping point

2.61 Information about the facility to exchange visiting orders for telephone credit should be incorporated into prison policy and advised to prisoners during induction.

2.62 Adequate privacy hoods should be fitted to telephones to enable prisoners to make calls in private. (2.30)

Achieved. All telephones had privacy hoods or were enclosed in booths which afforded adequate privacy.

Staff–prisoner relationships

2.63 Wing history file entries should be made at least weekly. Entries should reflect the individual prisoner's circumstances and contain sufficient information for an uninformed reader to understand the context. (2.43)

Achieved. Files we looked at contained regular personal officer entries, generally every two weeks, and they were mostly of high quality. They gave a clear account of the prisoner's circumstances and detailed information about any problems and the action being taken, indicating commitment and a good knowledge by personal officers of the prisoners in their care.

2.64 The involvement of personal officers in sentence planning should be developed and further integrated into individual prisoners' sentence planning. (2.44)

Partially achieved. Although personal officers demonstrated knowledge of sentence planning targets for many of their prisoners, they were not involved in the development of the plan. We were told that although they were invited, they did not attend sentence planning boards because of wing commitments, and only occasionally made written contributions. Sentence planning boards had fallen into disuse for some time but had been reinstated, and the two most recent sentence planning boards had been attended by personal officers (see section on offender management and planning).
We repeat the recommendation.

Equality and diversity

Strategic management

2.65 A diversity policy should be produced which encompasses all types of diversity and outlines how the establishment aims to meet the diverse needs of the population. (3.49)

Achieved. The prison had developed a well-constructed and succinct policy document that covered all of the protected characteristics and outlined key actions to be taken in each.

2.66 The work of the race equality action team should be better publicised, both to prisoners and to staff. (3.71)

Achieved. The weekly representatives meeting (see recommendation 2.4) was used as a vehicle to promote diversity work across the prison which was further supported by regular cultural and religious events throughout the year. Well-presented noticeboards in all

accommodation areas and on the main prisoner thoroughfares further disseminated the work of the team.

2.67 Actions identified in the race equality action plan to increase black and minority ethnic recruitment should be implemented. (3.72)

Achieved. Before the recruitment freeze, the prison had been represented at regional employment fairs across Yorkshire.

2.68 The focus group for prisoner race relations representatives and staff should be publicised to staff and prisoners and its effectiveness reviewed after six months. (3.73)

Achieved. The representatives meeting had developed into a weekly forum that was valued by prisoners we spoke to. The diversity manager had monitored the number of racist incident report forms (RIRFs) submitted and found there to be a steady decline, indicating that the meeting was effective (see also recommendation 2.4).

2.69 The low use of racist incident report forms (RIRFs) by prisoners should be investigated and the use of RIRFs should be promoted, particularly their confidentiality and how they are investigated and scrutinised. (3.74)

Achieved. The diversity manager had reviewed the low number of RIRFs (see recommendation 2.68) and had ensured that the process was fully explained during the induction process. The scrutiny panel met regularly and diversity representatives took a full and active role in assessing the quality of responses to them.

Protected characteristics

2.70 Staff should be trained to deal with allegations of racism made by prisoners and encourage them to use the systems available to make a complaint. (3.75)

Achieved. A series of staff briefings had been held throughout the year following the previous inspection and at intervals since then, to communicate to staff how to deal with allegations of racism. Additionally, on the rare occasions that a RIRF was submitted by a member of staff who had been called racist, the diversity manager met the member of staff and discussed the correct procedures to be adopted.

2.71 The foreign nationals strategy document should be made available to prisoners. (3.84)

Not achieved. The strategy document was not available when requested and although an electronic copy was eventually found, it was out of date.
We repeat the recommendation.

2.72 The foreign nationals coordinator should receive more allocated time to work with foreign national prisoners, and prisoners should be kept informed of when he is available. (3.85)

No longer relevant. The role of foreign nationals coordinator no longer existed. HMP Hull managed the allocations for the region and did not send any prisoners to Everthorpe who did not have leave to remain in the UK or were of interest to the UK Border Agency, with which contact was maintained. Consequently, there were only six such prisoners at the time of the inspection. One of the wing senior officers had taken on the work as part of his remit and met each prisoner individually to ensure that his needs were being met.

2.73 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. (3.86)

No longer relevant. See recommendation 2.72.

2.74 Foreign national liaison officers should be advertised across the residential wings and prisoners should be informed of what they can expect from them in the absence of the foreign nationals coordinator. (3.87)

No longer relevant. See recommendation 2.72.

2.75 An accredited, independent immigration advice agency should be sourced to attend the establishment and meet foreign national prisoners at least quarterly. (3.88)

No longer relevant. The previous provider of immigration advice had ceased to operate and the only support available was referral to a list of solicitors who 'specialised' in immigration matters. This service was rarely requested due to the status of foreign nationals at the establishment (see recommendation 2.72).

2.76 The establishment should facilitate meetings between foreign national prisoners and UK Border Agency representatives or the foreign nationals coordinator to improve their understanding of the facilitated returns scheme. (3.89)

No longer relevant. See recommendation 2.72.

2.77 Prisoners should be permitted a free international telephone call if they have family members abroad, regardless of whether they receive a visit, and the process for accessing international telephone calls should be simplified and communicated to staff and prisoners. (3.90)

Not achieved. The policy of not allowing international calls if prisoners received visits remained. Information on how to access the facility was included in the induction leaflet given to all prisoners on arrival. This leaflet confirmed the disqualification of access to the free call if a visit was received, although, confusingly, stated that a five-minute call would be allowed, while going on to say that the allowance would be a standard £5 PIN credit.
We repeat the recommendation.

2.78 The disability liaison officer (DLO) should receive profiled time to develop services for older prisoners and those with a disability. (3.50)

Achieved. The role of disability liaison officer was encompassed by the full-time diversity manager. He apportioned some of his working week to the issues surrounding older prisoners and those with disabilities and was confident that he had enough time to fulfil these duties. We saw evidence of where services had been improved/introduced and were satisfied with the level of identification and subsequent care planning for these prisoners.

2.79 Named liaison officers should be available on all the residential wings and appropriately trained to support the DLO. (3.51)

Not achieved. There were no support liaison officers on any of the residential wings.
We repeat the recommendation.

2.80 A DLO support worker should undertake the assessment and subsequent coordination of reasonable adjustments and care planning, where appropriate, for all prisoners with a disability. (3.52)

No longer relevant. The diversity manager met all prisoners identified as requiring further support. He had adequate time to facilitate care planning (including personal emergency evacuation plans) when required.

2.81 Regular diversity forums for prisoners with a disability should be held and inform policy and service delivery. (3.53)

Achieved. The weekly representatives meeting (see recommendation 2.4) included drop-in provision for any prisoner who wished to attend and the diversity manager ensured, through individual interviews, that all prisoners with disabilities were aware of the meetings.

2.82 Links should be made with community organisations to assist with the reintegration of older prisoners and those with a disability. (3.54)

Achieved. The diversity manager had established links with Age UK, which attended the prison when requested. He was also a panel member of the Humberside Diversity Panel, which was a multi-agency panel at which he promoted the needs of older prisoners and those with disabilities; this had led to a number of positive outcomes for prisoners resettling in the area.

Faith and religious activity

2.83 Arrangements should be made for cover when the coordinating chaplain is unavailable. (5.46)

Achieved. A part-time session chaplain had been appointed to cover the times when the coordinating chaplain was not available. He also provided assistance in running religious study groups during the week.

2.84 Links with faith communities outside the prison should be established to meet prisoners' individual needs. (5.47)

Achieved. The chaplaincy team had access to a directory of faith organisations and support services to which they could refer prisoners before and after release. Some successful referrals had been made and the prison had bid for resources to develop these services further and to offer post-release support.

Complaints

2.85 The quality assurance system should effectively address and improve the quality of responses and ensure that complaints requiring formal investigation receive it. (3.100)

Achieved. A 10% sample of all complaints was reviewed for quality assurance. When shortfalls were identified, the respondent to the complaint was contacted, with advice and guidance offered to rectify any issues.

2.86 A detailed analysis of complaints should be carried out by ethnicity, disability, location and prisoner type to inform local policy. (3.101)

Achieved. A detailed analysis of all complaints was maintained which included ethnicity, disability and location. The analysis also identified common themes and prison demographic data, which were discussed at the senior management team meeting.

Legal rights

2.87 Legal services officers should keep a log of all applications received and legal services provided to prisoners. (3.107)

Not achieved. The prison told us that they were no longer required to provide legal services. A list of solicitors was available from whom prisoners could seek advice. There was no log of any such requests or of any outcomes.
We repeat the recommendation.

Health services

2.88 All staff should have at least annual resuscitation and defibrillation training. (4.40)

Not achieved. Some staff had been trained in the previous few months. Formal records were incomplete and there was no flagging system to ensure that training was completed within required timescales.
We repeat the recommendation.

2.89 A protocol for reception procedures, including where the reception health care screen should take place and the process for those arriving after 5.30pm, should be developed. (4.41)

No longer relevant. Health screening was conducted in the designated health care room in reception or occasionally in the main health care suite, when this was more appropriate. There were no reception arrivals after 5pm or at weekends.

2.90 Triage algorithms should be developed to ensure consistency of advice and treatment to all prisoners. (4.42)

Not achieved. There were no triage algorithms. Nurses worked to recognised nursing models and most had received clinical skills training in the previous year.
We repeat the recommendation.

2.91 Health care applications should be collected and screened daily, including weekends. (4.43)

Achieved. Applications were collected from the wings every day, including weekends, by health services administrative or nursing staff. Applications for the nurse and the doctor were then triaged by nursing staff before men were given a GP or nurse clinic appointment. Administrative staff put all other applications onto the relevant waiting list on SystmOne, the electronic recording system.

2.92 The health care application system should be reviewed, with applications being screened by a clinician and prisoners notified of their internal health care appointments in advance. (4.44)

Achieved. Prisoners were informed about their appointments via reply slips and movement slips sent by the health care department to the wings daily. Most men knew about their internal appointments at least a day in advance (see also recommendation 2.91).

2.93 Prisoners should be able to obtain simple pain relief at night. (4.45)

Not achieved. Prisoners were only able to access pain relief at night when it was prescribed by a doctor in medical emergencies. They could obtain paracetamol and ibuprofen in advance from nurses using patient group directions (see also recommendation 2.94).
We repeat the recommendation.

2.94 The special sick arrangements should be reviewed by the medicines and therapeutics committee, with the aim of increasing the range of treatments available without reference to the general practitioner. (4.46)

Not achieved. There was no special sick policy. There were patient group directions for paracetamol and ibuprofen but they were out of date.
We repeat the recommendation.

2.95 The pharmacy controlled drugs register should be maintained in accordance with current legal requirements, and a separate controlled drugs register should be maintained for each room in which controlled drugs are stored. (4.47)

Achieved. The controlled drugs register in the pharmacy and for stock received were compliant with current regulations, with fields for checking proof of identity. There were also National Pharmacy Association registers in the treatment rooms.

2.96 The pharmacist should be added to the list of health services professionals available for consultation detailed on the health care request forms. (4.48)

Achieved. Application forms now included the pharmacist. Prisoners could either make an application or ask at medication times for advice and information from a pharmacist.

2.97 Facilities should be made available to allow patients to receive confidential counselling from the pharmacist. (4.49)

Achieved. The pharmacist held consultations in a room adjacent to the pharmacy room, which ensured privacy.

2.98 The failure to attend rates for dental services, and the reasons why appointments are missed, should be assessed. (4.50)

Achieved. Total 'did not attend' rates for dental services were 7% across the previous three months compared with 15% at the time of the previous inspection. Prisoners waited up to 12 weeks for a first routine appointment and to complete treatments, reflecting a doubling of waiting time in the previous year. At the time of the inspection, all clinics were fully booked up for the next eight weeks. Patients were no longer triaged by the dental nurse, which had impacted on waiting times. Wherever possible, if men did not attend, efforts were made to refill appointment slots on the day.

2.99 Dental cover should be available when the regular dentist is unable to attend the prison. (4.51)

Not achieved. There was no dental cover available. In February 2012, four clinical sessions had been lost due to dental leave.

Catering

2.100 Prisoners should be able to gain formal catering qualifications. (7.9)

Not achieved. There were no opportunities for prisoners working in the kitchen or staff mess to obtain formal qualifications.
We repeat the recommendation.

2.101 Breakfast should be served on the morning it is to be eaten. (7.10)

Not achieved. The practice of giving out breakfast packs with the evening meal continued.
We repeat the recommendation.

2.102 A system for ensuring that serveries have been cleaned after service should be introduced. (7.11)

Achieved. The serveries we inspected at varying times of the day were all clean and all waste food had been removed.

2.103 Prisoners should not be required to eat meals in their cells. (7.12)

Not achieved. With the exception of E wing, prisoners had to eat meals in their cell. This was particularly inadequate for those sharing a cell, for whom there was a lack of toilet screening. Tables and chairs had been installed on some of the other wings but these had been damaged beyond repair and not replaced.
We repeat the recommendation.

Purchases

2.104 Prisoners should be regularly consulted, in addition to the ongoing meetings with the canteen provider, so that their views can be discussed. (7.22)

Achieved. Consultation with prisoners was adequate and amendments to the shop list had been made as a result.

2.105 Prisoners should be able to buy items from the shop within 24 hours of arrival. (7.23)

Not achieved. Prisoners received the shop order form on a Tuesday. Those arriving after this had to wait a week to get a form and a total of 10 days to receive their first order (see also recommendation 2.10).
We repeat the recommendation.

2.106 Non-smokers' packs should be available on reception (7.24)

Achieved. See recommendation 2.9.

2.107 Prisoners should not be charged an administrative fee for purchasing goods from a catalogue. (7.25)

Not achieved. A 50 pence charge was still being made for each catalogue order placed.
We repeat the recommendation.

2.108 The range of catalogues currently available should be extended. (7.26)

Achieved. The range of catalogues had been extended to include access to Very and Play.com. Prisoners could also have property sent in.

2.109 The range of black and minority ethnic products should be expanded in consultation with race representatives and black and minority ethnic prisoners. Race representatives and the race equality action team should be consulted regarding any amendments to the shop list. (7.27)

Achieved. The number of foreign national prisoners had reduced considerably (see recommendation 2.72). Black and minority ethnic prisoners were appropriately consulted about amendments to the shop list and those in our focus groups did not express any major concerns about lack of access to products. The weekly diversity committee and the chaplaincy were also consulted regularly.

Time out of cell

2.110 Time out of cell should be increased. (5.53)

Not achieved. There was no target for time out of cell but the establishment was reporting 7.3 hours a day, which was low for a category C prison but appeared accurate. The prison had the capacity to provide 8.5 hours out of cell from Monday to Thursday, seven hours on a Friday and approximately 6.75 hours on a weekend. These figures were lower than those at the time of the previous inspection, where they were nine, eight and seven hours, respectively.
We repeat the recommendation.

2.111 Prison managers should investigate why so many prisoners are locked up during activity times and action taken to improve the numbers attending purposeful activity. (5.54)

Not achieved. There had been no investigation to determine why so many prisoners were locked up during activity times. On one morning and one afternoon during the inspection, 202 (31%) and 155 (24%) prisoners, respectively, were locked up. A few of these were engaged in in-cell activities but most were either unemployed, not required or on induction.
We repeat the recommendation.

2.112 Alternative activities should be provided for those whose regular activities are cancelled. (5.55)

Not achieved. There were no arrangements to provide alternative activities for those whose regular activities were cancelled.
We repeat the recommendation.

2.113 Exercise should be arranged and announced as published. (5.56)

Achieved. Exercise times were published in the core day and wing exercise logs evidenced that exercise corresponded with the times advertised.

2.114 Prisoners should be provided with appropriate clothing for inclement weather. (5.57)

Not achieved. Outdoor clothing was not provided for exercise and was not available on the facilities list.
We repeat the recommendation.

Learning and skills and work activities

2.115 The skills for life strategy should be completed and established to promote a whole prison approach. (5.19)

Achieved. Managers had developed a policy and strategy to provide good basic skills support for learners in education, on the wings, in production areas and in the training workshops. A rota had been implemented to ensure that skills for life provision was targeted to the areas in most need of the support.

2.116 The provision of embedded literacy and numeracy support in workshops should be increased. (5.20)

Achieved. Additional tutors had been recruited, increasing the number by 17% and resulting in an increase in the provision of embedded literacy and numeracy support in the workshops. Most of the workshops had literacy and numeracy support two days a week, and tutors provided good support, mainly linked to the requirements of vocational training areas.

2.117 The availability of level 2 qualifications in offender learning and skills service (OLASS) construction should be improved. (5.21)

Achieved. The availability of level 2 qualifications in OLASS construction had improved. Level 2 qualifications were offered across most vocational areas, including construction.

2.118 Vocationally related opportunities for learners at entry level should be developed. (5.22)

Achieved. Entry-level vocationally-related opportunities had been developed for learners who did not have any previous experience. Vocational workshops offering a level 2 qualification used entry-level training to provide initial skills and knowledge before progressing the learner onto the full level 2 award.

2.119 The effective use of individual learning plans for all aspects of learning and skills should be established. (5.23)

Achieved. The use of individual learning plans for all aspects of learning and skills had been established. They were used to set short- and long-term targets for all courses and to review progress regularly. However, they were not all used consistently. A new form was being introduced and training given to improve the consistency of completion.

Library

2.120 The capacity for Storybook Dads should be extended (5.24)

Achieved. The capacity for Storybook Dads had been extended to allow more prisoners to record stories for their children. Improvements had been made in the time required to

administer and edit the process, and access for prisoners was adequate to meet the needs of the prison population.

2.121 The availability of books and bilingual dictionaries for speakers of languages other than English should be increased. (5.25)

Achieved. Although there was limited need for these publications, dictionaries were now available in most of the languages spoken by the prison population and additional foreign language books had been purchased. There were arrangements with a nearby prison to share books and other foreign language publications.

2.122 The DVD club arrangements should be formalised (5.26)

Achieved. The DVD club arrangements had been formalised. Enhanced prisoners could join the club and borrow DVDs to watch in the evenings. A stock of DVDs had been purchased and the borrowing process was well managed and administered.

Physical education and health promotion

2.123 Current staffing levels should be maintained so the good recreational and accredited provision can continue and develop further (5.33)

Achieved. PE staffing levels had been maintained, enabling the good recreational and accredited provision to continue and be developed further. An additional classroom had been acquired since the previous inspection, allowing additional short courses to be provided.

2.124 The scheduled work on the showers and changing area should be completed. (5.34)

Achieved. The work scheduled for the showers and changing area had been completed. The walls and floors were of a good standard and showers and changing facilities were suitable and properly maintained.

2.125 The safety issues with the football pitch should be resolved. (5.35)

Not achieved. The safety issues with the football pitch had not been resolved. The grass surface was unsuitable for contact sports such as football and rugby because of sharp flints in the topsoil surface. The surface was also uneven due to mole activity in the area. Some contact sports such as circuit training and coaching were being carried out on the football pitch but these were limited.
We repeat the recommendation.

2.126 Sufficient toilet facilities should be provided to meet need. (5.36)

Achieved. Staff and prisoners were satisfied that there were sufficient toilet facilities available to meet the needs of those using the gym. A separate toilet for gym users with disabilities was also available.

Strategic management of resettlement

2.127 Sufficient places on appropriate offending behaviour courses should be available to meet the needs of prisoners. (8.8)

Achieved. The number of offending behaviour courses offered at the establishment was commensurate with the need identified in a comprehensive needs analysis, completed in November 2011. The establishment offered a good selection of accredited courses, including the thinking skills programme (TSP), controlling anger and learning to manage it (CALM) and drug and alcohol programmes. At the time of the inspection, the establishment was conducting a needs analysis for the control of violence for angry impulsive drinkers (COVAID) programme. Waiting lists for TSP and CALM were not excessive.

2.128 Prison managers should act promptly on the results of the review of resettlement pathway provision. (8.9)

Achieved. There was evidence to show that, as a result of the review of resettlement pathway provision, Shelter contract options had been chosen to support those issues seen as a priority, Alcoholics Anonymous and Narcotics Anonymous sessions had been reinstated, money management sessions had been introduced, and a team of volunteers had been recruited and trained to support the demand for opening savings accounts.

2.129 Current provision in the resettlement pathways should be better publicised to prisoners, so they are aware of whom to contact about the range of pre-release support available. (8.10)

Partially achieved. We evidenced publication of some aspects of the pathway provision in some communal areas. There was a useful resettlement directory but this was not widely distributed and was aimed more at staff than prisoners, giving contact details and telephone extension numbers.
We repeat the recommendation.

2.130 Responsibility for each of the nine reducing reoffending pathways should be clarified. (8.11)

Not achieved. Responsibility for each of the pathways had only recently been discussed but this information had not been publicised to staff or prisoners and it was still unclear who would take the lead for the finance, benefit and debt and children and families pathways.
We repeat the recommendation.

2.131 The purpose and aims of the two resettlement committee meetings should be clarified, and in particular which is responsible for discussing strategy and policy. (8.12)

No longer relevant. The prison had a single up-to-date reducing reoffending policy document, which described how the establishment would develop a coordinated approach to resettlement and reducing reoffending. It was supported by an up-to-date needs analysis but the establishment requirement to hold bimonthly meetings was not being achieved, with the most recent meeting taking place in May 2011.

Offender management and planning

2.132 Offender assessment system (OASys) assessments and sentence plans should be up to date when transferring prisoners between different prisons. (8.27)

Not achieved. Records had only recently begun to be maintained of prisoners arriving at the establishment with an OASys assessment outstanding. In the week before the inspection, four prisoners had been received from a local prison without the documentation completed; they

had been identified and seen by an offender supervisor.
We repeat the recommendation.

2.133 Additional administrative support should be offered to offender supervisors. (8.28)

Achieved. There were 11 offender supervisors, seven of whom were uniform staff and four probation officers. Offender supervisors and case administrators were split equally into two teams and, although caseloads remained relatively high (70–80), effective use was made of the administrative resources available.

2.134 Sentence planning targets should address the behaviour and attitudes needing to be changed, rather than the interventions available at the prison. (8.29)

Achieved. There was evidence to show that sentence planning targets addressed behaviour and attitudes that needed to be changed. We saw examples of prisoners being required to complete the healthy relationships, self-change, victim awareness counselling and domestic abuse programmes, none of which were available at the establishment.

2.135 Residential managers should ensure that personal officers attend all sentence planning boards. (8.30)

Partially achieved. Sentence boards had only recently been reintroduced but there was little evidence of personal officer involvement at those. We were told by some residential managers that personal officers were rarely released to attend boards because of wing or other commitments.

2.136 There should be improved cooperation and communication between areas to ensure better management of prisoners identified as high risk in terms of drug activity or indiscipline. (6.11)

Not achieved. It was still the case that many prisoners (120) at the establishment lived over 100 miles away. Due to population pressures nationally, 10% of these were from the north-west of England and security intelligence evidenced that they contributed to a considerable number of security information reports through gang-related behaviour or other breaches of discipline. There was no evidence to suggest that any of the out-of-area transfers were for any reason other than overcrowding. The prison had entered into negotiations with the National Offender Management Service, but to little effect.
We repeat the recommendation.

2.137 Forums and days for prisoners with an indeterminate sentence for public protection should be run monthly. (8.31)

Not achieved. There were no forums or family days for prisoners with an indeterminate sentence for public protection. There were plans to train a number of peer mentors to broker communication with this group but there was nothing in place at the time of the inspection.
We repeat the recommendation.

Reintegration planning

Accommodation

2.138 A prison manager should be given the clear lead for the accommodation pathway. (8.43)

Not achieved. Discussion about the identity of the pathway leads had taken place only recently and, although a lead manager for accommodation had been identified, this information was not known to staff or prisoners and had not been formally included in the manager's role.

2.139 Adequate specialist accommodation provision should be made available. (8.44)

Not achieved. Although a Service Level Agreement existed between the prison and Shelter to provide specialist accommodation, only 16 prisoners per month were contracted to receive it and, with a waiting list of 107 prisoners requiring advice, existing provision was inadequate.

2.140 The number of prisoners benefiting from the One Step Closer event should be increased. (8.45)

No longer relevant. The initiative had been stopped towards the end of 2011. Alternative support services were in place.

2.141 Prisoners should have a discharge address in advance of their release from the prison. (8.46)

Not achieved. Forty-seven prisoners had been discharged between June and November 2011 with no fixed abode.
We repeat the recommendation.

Drugs and alcohol

2.142 The post of full-time alcohol worker should be funded and filled as soon as possible. (8.57)

No longer relevant. The post of alcohol worker had not been filled but an IDTS nurse was taking the lead on alcohol-related addiction, working closely with the Rehabilitation of Addicted Prisoners trust (RAPt) programme and CARAT team to provide counselling and group interventions for men with alcohol problems. All men were screened on arrival for alcohol problems using the Alcohol Use Disorders Identification Test (AUDIT), which informed referrals to the lead nurse and CARAT team.

Finance, benefit and debt

2.143 Specialist debt advice and support should be available to prisoners on arrival at the prison, pre-release and by application at any other time. (8.47)

Achieved. Prisoners had their finance, benefit and debt needs assessed as part of the induction process. The voluntary sector coordinator managed a team of external volunteers who dealt with enquiries about debt and finance. Over 300 prisoners had opened credit union accounts but bank accounts had proved more problematic; at the time of the inspection, the prison was working with the Post Office and HBOS to try to resolve matters. Referrals were

made to the visiting Citizens Advice worker where appropriate. During the previous 12 months, over 50 prisoners had been given support to deal with their debt issues, and debt relief orders had been sought for three prisoners. Two prisoners had been supported in their application for bankruptcy. The chaplaincy department ran a bimonthly money matters course, delivered by volunteers over two afternoons for up to 15 prisoners.

Children, families and contact with the outside world

2.144 A comprehensive visitors centre facility and service should be provided. (8.74)

Not achieved. There was no formal visitors centre. The prison had a visitors receiving area, which was located in the gate area. It was small, clean and had toilets, including access for those with disabilities, and baby changing facilities. Refreshment facilities were not available. A wide range of information was available to visitors, although nothing in languages other than English.
We repeat the recommendation.

2.145 The furniture and carpets in the visits hall should be replaced. (8.75)

Not achieved. The carpets had been replaced by lino to facilitate cleaning and improve hygiene. Some floor mats had been laid and soundproofing added to walls and pillars, to dampen the excessive noise mentioned in our previous report. Our major concern remained in that there had been no changes to the furniture, which comprised plastic seats mounted on a metal frame structure incorporating a table. Three fixed seats were provided for visitors, who sat opposite the prisoner. There were spaces for 42 visits but visitor seats were too close together and uncomfortable, and the whole seating arrangement gave an austere impression of the visits hall.

2.146 Additional space should be provided for the dog handlers and police to carry out searches and drug detection procedures. (8.76)

Not achieved. We observed drug dog searches being carried out in a room adjoining the visits hall. There was space to search only two visitors at a time, while the others had to wait outside until the process had been completed, with no protection against the elements. Searches following drug dog indications were conducted in a small room in the gate complex which offered privacy.
We repeat the recommendation.

2.147 Prisoners using the toilet during visits should not routinely be strip-searched. (8.77)

Not achieved. Prisoners told us that they were subject to a strip-search if they used the toilet during visits.
We repeat the recommendation.

2.148 Risk assessments should be used to determine which prisoners, if any, should be strip-searched following visits. (8.78)

Not achieved. Ninety per cent of prisoners leaving visits received a level A rubdown search and 10% received a strip-search. The visits manager received a briefing from security staff on which prisoners posed a threat to security but if there was no intelligence, the visits manager still selected 10% of prisoners.
We repeat the recommendation.

2.149 Where appropriate, families should be invited to participate in other aspects of prisoners lives, such as assessment, care in custody and teamwork (ACCT) reviews and sentence planning boards. (8.79)

Not achieved. Other than the mandatory invitation to families to attend post-programme reviews, prisoners' families were not routinely invited to participate in other aspects of their lives.

2.150 All prisoners should be able to access family visits. (8.80)

Achieved. Family days were a feature of the regime for prisoners who had completed the 'keeping up with children' course, although this had recently been suspended for staffing reasons. Prisoners did not report difficulties in accessing visits.

2.151 Provision should be made to encourage family ties for prisoners whose families are not local to the establishment. (8.81)

Not achieved. We identified 120 prisoners from outside Yorkshire and 61 (9%) from the north-west of England. There were no separate arrangements to encourage family ties for prisoners not local to the establishment, and few transfers or accumulated visits of prisoners to prisons nearer their home. The establishment accepted prisoners from outside the area to complete offending behaviour courses but the number involved was small.

Attitudes, thinking and behaviour

2.152 A strategy should be put in place to address issues of denial, and identify and implement work to motivate prisoners not engaging with sentence planning targets. (8.86)

Partially achieved. There was no strategy to address these issues but the prison had introduced the 'A to Z' motivational programme and four staff had been trained as facilitators. Some one-to-one work had been conducted with a small number of prisoners located in the SACU, with some success. Several offender supervisors and probation staff had recently completed a 'motivational interviewing' workshop.

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 the DDC

3.1 There should be improved cooperation and communication between areas to ensure better management of prisoners identified as high risk in terms of drug activity or indiscipline. (2.136)

3.2 Offender assessment system (OASys) assessments and sentence plans should be up to date when transferring prisoners between different prisons. (2.132)

Recommendations — To the governor

Early days in custody

3.3 The reception area should be improved to provide greater privacy for new arrivals. (2.8)

3.4 All new arrivals should have access to a Listener and an Insider in reception. (2.11)

Bullying and violence reduction

3.5 Investigations into alleged bullying behaviour should be formally recorded and the alleged perpetrator informed in writing of the outcome(s). (2.18)

3.6 All prisoners placed on the anti-bullying scheme should be given the reasons for such a decision in writing, and the reasons for any subsequent move to a different level on the scheme should be provided in writing. (2.19)

Self-harm and suicide prevention

3.7 All staff trained in suicide prevention should receive regular refresher training. (2.25)

3.8 The safer custody policy should provide guidance to staff as to what constitutes a near-death, and ensure that such incidents are investigated and an action plan put in place as a result. (2.26)

Security

3.9 Strip-searching should be carried out only after a risk assessment indicates that it is necessary. (2.30)

Incentives and earned privileges

3.10 Monitoring systems should be developed and implemented for those on the basic regime. (2.34)

Disciplinary procedures

3.11 Records of adjudication hearings should be comprehensive and reflect all the evidence that has been considered and a full investigation of the charges heard. (2.37)

3.12 Appropriate holding facilities for prisoners awaiting adjudication should be provided. (2.38)

The use of force

3.13 Remedial work to the special accommodation should be carried out as a priority. (2.43)

3.14 Planned removals should be video-recorded and reviewed. (2.44)

Segregation

3.15 The role of the segregation unit should be clearly defined, with supporting policies and procedures developed and implemented to include: an improved regime; individual assessments for access to regimes; individually assessed targets for each prisoner; and care plans for those remaining in the unit beyond their second review. (2.2)

3.16 Individual prisoner records should be fully completed to give an accurate record of daily events. (2.45)

3.17 Toilets should be cleaned and screened. (2.47)

3.18 Prisoners should be given access to showers daily. (2.49)

Residential units

3.19 Prisoners should not share cells designed for single occupancy. (2.53)

3.20 Screening should be provided for in-cell toilets and toilet seats should be fitted. (2.54)

3.21 Application forms should be made freely available on the wings, so that prisoners are not required to ask staff for them. (2.57)

3.22 Additional telephones should be installed, to allow one for every 20 prisoners. (2.59)

Staff–prisoner relationships

3.23 The involvement of personal officers in sentence planning should be developed and further integrated into individual prisoners' sentence planning. (2.64)

Equality and diversity

3.24 The foreign nationals strategy document should be made available to prisoners. (2.71)

3.25 Prisoners should be permitted a free international telephone call if they have family members abroad, regardless of whether they receive a visit, and the process for accessing international telephone calls should be simplified and communicated to staff and prisoners. (2.77)

3.26 Named liaison officers should be available on all the residential wings and appropriately trained to support the DLO. (2.79)

Legal rights

3.27 Legal services officers should keep a log of all applications received and legal services provided to prisoners. (2.87)

Health services

3.28 All staff should have at least annual resuscitation and defibrillation training. (2.88)

3.29 Triage algorithms should be developed to ensure consistency of advice and treatment to all prisoners. (2.90)

3.30 Prisoners should be able to obtain simple pain relief at night. (2.93)

3.31 The special sick arrangements should be reviewed by the medicines and therapeutics committee, with the aim of increasing the range of treatments available without reference to the general practitioner. (2.94)

Catering

3.32 Prisoners should be able to gain formal catering qualifications. (2.100)

3.33 Breakfast should be served on the morning it is to be eaten. (2.101)

3.34 Prisoners should not be required to eat meals in their cells. (2.103)

Purchases

3.35 Prisoners should be able to buy items from the shop within 24 hours of arrival. (2.105)

3.36 Prisoners should not be charged an administrative fee for purchasing goods from a catalogue. (2.107)

Time out of cell

3.37 Time out of cell should be increased. (2.110)

3.38 Prison managers should investigate why so many prisoners are locked up during activity times and action taken to improve the numbers attending purposeful activity. (2.111)

3.39 Alternative activities should be provided for those whose regular activities are cancelled. (2.112)

3.40 Prisoners should be provided with appropriate clothing for inclement weather. (2.114)

Learning and skills and work activities

3.41 All prisoners should be unlocked during the core day and engaged in employment, education or training. (2.5)

Physical education and health promotion

3.42 The safety issues with the football pitch should be resolved. (2.125)

Strategic management of resettlement

3.43 Current provision in the resettlement pathways should be better publicised to prisoners, so they are aware of whom to contact about the range of pre-release support available. (2.129)

3.44 Responsibility for each of the nine reducing reoffending pathways should be clarified. (2.130)

Offender management and planning

3.45 Forums and days for prisoners with an indeterminate sentence for public protection should be run monthly. (2.139)

Reintegration planning

Accommodation

3.46 Arrangements for supporting prisoners into accommodation on release should be improved as a matter of priority. (2.6)

3.47 A prison manager should be given the clear lead for the accommodation pathway. (2.138)

3.48 Prisoners should have a discharge address in advance of their release from the prison. (2.141)

Children, families and contact with the outside world

3.49 A comprehensive visitors centre facility and service should be provided. (2.144)

3.50 Additional space should be provided for the dog handlers and police to carry out searches and drug detection procedures. (2.146)

3.51 Prisoners using the toilet during visits should not routinely be strip-searched. (2.147)

3.52 Risk assessments should be used to determine which prisoners, if any, should be strip-searched following visits. (2.148)

Housekeeping points

Disciplinary procedures

3.53 The disciplinary tariff should be updated and published. (2.40)

Residential units

3.54 Information about the facility to exchange visiting orders for telephone credit should be incorporated into prison policy and advised to prisoners during induction. (2.61)

Appendix I: Inspection team

Sandra Fieldhouse	Team leader
Paul Rowlands	Inspector
Michael Calvert	Inspector
Andrew Rooke	Inspector
Nicola Rabjohns	Health inspector
John Grimmer	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 yr olds	21 and over	%
Sentenced		598	89.8
Recall		68	10.2
Convicted unsentenced		0	0
Remand		0	0
Civil prisoners		0	0
Detainees		0	0
Other		0	0
Total		666	100

Status	18–20 yr olds	21 and over	%
Unsentenced		0	0
Less than 6 months		5	0.8
6 months to less than 12 months		34	5.1
12 months to less than 2 years		85	12.8
2 years to less than 3 years		99	14.9
3 years to less than 4 years		123	18.5
4 years to less than 10 years		248	37.2
10 years and over (not life)		16	2.4
ISPP		0	0
Life		56	8.4
Total		666	100

Age	Number of prisoners	%
Minimum age;		
21 years to 29 years	348	52.3
30 years to 39 years	194	29.1
40 years to 49 years	99	14.9
50 years to 59 years	19	2.9
60 years to 69 years	5	0.8
70 plus years	1	0.2
Under 21	0	0
Maximum age;		
Total	666	100

Nationality	18–20 yr olds	21 and over	%
British		657	98.6
Foreign nationals		6	0.9
Not stated		3	0.5
Total		666	100

Security category	18–20 yr olds	21 and over	%
Category A exceptional		0	0
Category A high risk		0	0
Category A provisional		0	0
Category A standard		0	0
Category B		0	0
Category C		638	96.3

Category D		20	3
Female closed		0	0
Female open		0	0
Female semi		0	0
Other		0	0
Uncategorised sentenced		0	0
Uncategorised sentenced male		0	0
Uncategorised unsentenced		0	0
Unclassified		2	0.3
Unsentenced		2	0.3
YOI closed		1	0.2
YOI open		0	0
Total		666	100

Religion	18–20 yr olds	21 and over	%
Baptist		0	0
Buddhist		9	1.4
Church of England		181	27.2
Hindu		0	0
Jewish		1	0.2
Muslim		45	6.8
No religion		276	41.4
Not Stated		5	0.8
Other		25	3.8
Roman Catholic		122	18.3
Sikh		2	0.3
Total		666	100

Ethnicity	18–20 yr olds	21 and over	%
Asian or Asian British			
Bangladeshi		3	0.5
Indian		6	0.9
Other		0	0
Pakistani		19	2.9
Total		31	4.7
Black or black British			
African		2	0.3
Caribbean		11	1.7
Other black		4	0.6
Total		17	2.6
Chinese or other ethnic group			
Chinese		0	0
Total		0	0
Mixed			
African		3	0.5
Asian		1	0.2
Caribbean		10	1.5
Other mixed		4	0.6
Total		18	2.7
Not stated, code missing		38	5.7
Total		38	5.7
White			
British		554	83.2

Irish		1	0.2
Other white		7	1.1
Total		562	84.4
Total		666	100

Sentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
1 month to 3 months			165	24.8
1 year to 2 years			92	13.8
2 years to 4 years			24	3.6
3 months to 6 months			150	22.5
4 years or more			2	0.3
6 months to 1 year			147	22.1
Less than 1 month			86	12.9
Total			666	100