Report on an unannounced short follow-up inspection of

# HMYOI Glen Parva

31 July–2 August 2012

by HM Chief Inspector of Prisons

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1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

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# Introduction

Glen Parva is a young offender institution in Leicester with a capacity of approximately 800 sentenced, unsentenced and remanded young male prisoners aged 18 to 21. At the time of this inspection the prison was operating well below its capacity with approximately 120 available spaces.

On our last visit to Glen Parva in 2009 we reported on a generally safe and respectful establishment that focused appropriately on the role of resettlement and offender management but we raised concerns about the lack of purposeful activity. This unannounced short follow-up inspection reviewed progress in implementing the recommendations we made at our last inspection. A short follow-up inspection such as this focuses only on the progress the prison has made in implementing the recommendations made at the last inspection and so does not provide a complete picture of the establishment as a whole. In total, 73% of all our recommendations had been achieved or partially achieved. We concluded that the prison was making sufficient progress against all four healthy prison tests.

Most prisoners felt safe on their first night although too many were still transferred on overcrowding drafts from HMYOI Feltham. The management of vulnerable prisoners had improved and the prison took a zero-tolerance approach to bullying and violence. The violence reduction programme was a good initiative but had yet to be fully evaluated. Suicide and self-harm reduction was now generally well managed, as was the incentives and earned privileges scheme, although management checks were limited. Disciplinary arrangements were generally fair, although the accommodation in the segregation unit had insufficient furniture. Substance misuse was low, and the introduction of the integrated drug treatment system since the last inspection had been a positive initiative.

Despite attempts by the prison to secure capital funds to replace or fully refurbish the older units, it had been unsuccessful and these units remained in a poor state of repair. Elsewhere accommodation varied and many cells remained dirty and lacked furniture. Relationships between staff and prisoners were generally reasonable and the work of personal officers was better than we often see. Diversity and equality work was generally appropriate, although foreign national prisoners required further support from the UK Border Agency. Care plans for prisoners with disabilities who required them were good. The reorganisation of health services had been positive and the refurbished environment was good. Prisoner access to services was reasonably quick, and the pharmacy and mental health services provision were also good.

Time out of cell was limited and a disappointing number of prisoners were still locked in their cells during our roll checks. Purposeful activity, however, had greatly improved and there were now considerably more activity places. Attendance in activities had improved and quality improvement arrangements had been introduced. Library use had increased, and there was an extensive range of formal and informal PE activities.

Resettlement arrangements were generally good. All sentenced prisoners were now allocated to an offender supervisor, and the focus and level of contact were generally appropriate. However, there was still little custody planning for prisoners on remand. Resettlement pathway work was broadly appropriate, although the children and families pathway required more focus. The range of accredited programmes broadly reflected the needs of the prisoner population and some one-to-one support was also available.

Overall this was a good inspection and we are pleased to report the prison's progress. We have identified some key areas that require further work, in particular, the residential

accommodation and the amount of time prisoners spend out of their cell. Nevertheless, the governor and staff at HMYOI Glen Parva can be proud of the progress achieved since the last inspection.

Nick Hardwick October 2012
HM Chief Inspector of Prisons

# Fact page

Task of the establishment
Young offender institution holding sentenced, unsentenced and remanded young male prisoners aged 18-21.

Prison status
Public sector

Region
East Midlands

Number held
1.8.12: 686

Certified normal accommodation (CNA)
649

Operational capacity
808

Date of last full inspection
2-6 November 2009

Brief history
Constructed in the early 1970s as a borstal, Glen Parva has always held young offenders. Additional buildings, including a health care centre, have been added over the years.

Short description of residential units

| | | Operational capacity | CNA |
|---|---|---|---|
| North: | | | |
| Unit 1 | Sentenced | 80 | 54 |
| Unit 2 | Sentenced | 80 | 54 |
| Unit 5 | Sentenced | 80 | 48 |
| South: | | | |
| Unit 8 | Sentenced | 80 | 60 |
| Unit 9 | Sentenced | 80 | 60 |
| Unit 10 | Sentenced | 80 | 60 |
| Unit 11 | Short-term sentenced/ convicted but not sentenced | 80 | 58 |
| Unit 12 | Trials and remands | 80 | 58 |
| Unit 14 | Remands | 80 | 100 |
| Unit 15 | Induction | 88 | 100 |
| Unit 7 | Segregation | | |

Name of governor
Michael Wood

Escort contractor
GeoAmey

Health service commissioner and provider
Leicestershire County and Rutland Primary Care Trust
Leicestershire Partnership NHS Trust

Learning and skills provider
Milton Keynes College

Independent Monitoring Board chair
John Schatz

# 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 33 recommendations in this area, of which 21 had been

achieved, five partially achieved and seven had not been achieved. We have made one further recommendation.

1.6 Most prisoners now arrived in the prison before 7pm, were offered a shower and felt safe on their first night in custody. However, there had been no progress on prisoners spending too long in court before transfer to the prison. Overcrowding drafts from HMYOI Feltham continued, and not every prisoner had received a full induction.

1.7 There was evidence of progress against our previous recommendations on violence reduction and bullying. There was awareness of prisoner vulnerability and some good support for prisoners, but this was not always well documented. Staff were knowledgeable about systems for tackling violence and bullying, and the prison did not tolerate any antisocial behaviour. Levels of violence and bullying were slightly lower than comparator prisons, and we were assured that incidents were properly logged, investigated and appropriate action taken, but processes were often poorly recorded. Although the violence reduction programme had not yet been formally evaluated, it appeared to be a positive initiative to challenge inappropriate behaviour.

1.8 There had been very good progress in suicide and self-harm prevention work. The strategy was clear and there were action plans following the five self-inflicted deaths since our last inspection, but ongoing review and regular reinforcement of some Prisons and Probation Ombudsman recommendations were needed. Self-harm monitoring documents were of a reasonable quality, generally included multidisciplinary input and showed good links with the mental health team. Although staff told us that preservation of life took precedence over security, some were still reluctant to make an informed risk assessment to enter a cell. A range of volunteer counsellor services was available through the chaplaincy, and prisoner access to Listeners was good.

1.9 Prisoners on enhanced status could take advantage of a wider range of incentives, such as access to better work opportunities in more trusted positions, additional time unlocked, association and gym, and could also have additional items in their cells. The visits entitlement for unconvicted prisoners on the basic regime reflected the minimum requirement of the Prison Service Instruction.

1.10 There was little evidence that managers ensured that staff were encouraging prisoners to engage with the incentives and earned privileges (IEP) scheme and sentence planning targets.

1.11 The levels of punishment were routinely discussed at monthly adjudications meetings and tariffs were adjusted to reflect current disciplinary issues. The awards given were reasonable for the offences committed and mitigation offered.

1.12 Not all segregation unit cells were adequately furnished and many had graffiti etched into windows which, combined with the lack of adequate furniture, created a poor environment. Prisoners going into the segregation unit were only strip searched when a risk assessment indicated this was necessary.

1.13 Integrated drug treatment system (IDTS) services were now well established and provided by Leicestershire Partnership NHS Trust. The department was well resourced to provide care for the small number of prisoners accessing support. Dual diagnosis nurses were also available. Facilities for new arrivals requiring stabilisation were much better than at the last inspection.

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 67 recommendations in this area, of which 40 had been achieved, nine partially achieved and 17 had not been achieved. One recommendation was no longer applicable.

1.16 Despite attempts by the prison to secure capital bids to refurbish the oldest accommodation, units 1, 2 and 5 were still in a very poor condition. Across the prison many cells designed for one continued to be occupied by two prisoners. Shower and telephone facilities were inadequate and lacked privacy. Many cells lacked cell furniture and conditions were poor. There had been some progress in installing CCTV on most units. Cell bells were now answered promptly, and the offensive displays policy was enforced.

1.17 Relationships between staff and prisoners were reasonable, although staff use of prisoners' preferred names was not yet fully embedded. Prisoners were mostly complimentary about staff and said there was someone they could ask for help if needed. Personal officers were knowledgeable about their role and the prisoners they worked with, and their involvement with resettlement and offender management was better than we usually see. Managers checked personal officer entries in prisoners' files, but their quality and effectiveness were variable and generally perfunctory. Consultation arrangements were effective and led to action.

1.18 There had been sufficient progress on diversity, but work with foreign national prisoners was embryonic. There were no specific forums, ongoing support or independent legal advice for foreign national prisoners and many felt isolated. The use of professional interpreting services had improved but was not yet fully embedded. Priority to see the UK Border Agency (UKBA) was given to foreign nationals subject to detention notices, which frustrated the rest, who had limited access. Some detainees remained at the prison for long periods after the end of their sentence.

1.19 The prison did not monitor the equality of prisoner treatment beyond that for race and religion, although SMART monitoring had been extended to include local indicators. Discrimination incident report forms were dealt with promptly, and an adequate number of prisoner representatives had been trained in diversity. There were good care plans for prisoners with disabilities who required ongoing support.

1.20 There was no longer a nominated legal services officer, and the prisoners we spoke to were not clear about what support was available.

1.21 The health care centre had been reorganised, with an improved waiting room, and the department was now almost fully staffed. Prisoner access to clinics had been improved, and there were only three prisoners waiting for a dental appointment. The pharmacy service was still very good. Prisoner involvement had been enhanced through a new health care forum, and a regular programme of mental health awareness for staff had begun.

1.22 The establishment had worked with prisoners to understand their views about the food and had held regular surveys and consultations. Most prisoners said that the quality of the food was good but that portions were small. Supervision of serveries had improved.

1.23 Problems with prisoners' shop orders had decreased and errors were now corrected promptly. There was now a sufficient number of external catalogues from which prisoners could order.

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

## Purposeful activity

1.25 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were not sufficiently good. We made 19 recommendations in this area, of which seven had been achieved, eight partially achieved and four had not been achieved.

1.26 Prisoners could not achieve 10 hours a day out of their cells. Although the prison recorded about seven hours a day, many prisoners got far less than this, particularly if they were unemployed. There was considerable regime slippage and during our two roll checks we found too many prisoners locked in their cells at times when they should have been unlocked. Implementation of the core day lacked consistency, and access to daily exercise in the open air was subject to some staff discretion and often cancelled because of the weather. There was not enough outdoor clothing for prisoners.

1.27 Since the last inspection the provision of learning and skills had improved. Staff from the new provider (Milton Keynes College) generally worked well together and there were good arrangements between the service and prison. There were more activity places, with an increase of 16% in vocational training, education and work places since 2009. The number of accredited courses had increased by 139% over the same period. Attendance had also improved and was up to 87%.

1.28 There was good management focus on improving teaching, training and learning, although there was a lack of data to evaluate the impact. Formal quality improvement arrangements across education were very well structured and increasingly effective. There was also a range of data to plan and develop provision. Allocation to activities was smoother and waiting lists shorter than at the last inspection. There had been a range of activities to promote use of the library, which had risen by 31% in the last two years.

1.29 Physical education provided an extensive programme of informal and formal accreditation courses, and use of the facilities had increased from 40% of the population in 2009 to 64% currently. Higher level courses for more able prisoners had still not been introduced.

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

## Resettlement

1.31 At our inspection in 2009 we found that outcomes for prisoners against this healthy prison test were reasonably good. We made 35 recommendations in this area, of which 13 had been achieved, nine partially achieved and 12 had not been achieved. One recommendation was no longer applicable.

1.32 The strategic management and governance of resettlement were generally good with a comprehensive reducing reoffending action plan. Although a needs analysis had been completed it was out of date and had yet to incorporate recent findings from the psychology department's analysis of offender assessment system (OASys) data. There were reasonable links with widely used community services.

1.33 The offender management strategy was clear, the model was appropriate and implementation was good. The offender management team had been reorganised and now integrated probation staff and those who were formerly part of the resettlement team. Sentence planning arrangements were reasonably good, and while personal officers did not always attend, their attendance had improved recently. However, custody planning for prisoners on remand required further development. The wider role of offender supervisors was clearly defined and contact with prisoners was consistent and oriented appropriately to sentence plans, risk management and related activity.

1.34 Prisoners were identified in advance of release and there were good arrangement to ensure pre-release sentence plans. Links with community-based services and multi-agency public protection arrangements (MAPPA) boards, where appropriate, were also good.

1.35 The virtual campus (allowing prisoners access to community education, training and employment opportunities via the internet) had recently been introduced and there were plans to extend this provision further. The use of release on temporary licence was limited, although a reasonable range of placements was available. Provision for the management of finance, benefits and debt had improved and some debt management was now available. Prisoners could also open bank accounts before release.

1.36 Not all prisoners could receive at least one visit a week. The visitors' centre could not easily accommodate the number of visitors attending and opened only 15 minutes before visits, leaving many visitors waiting outside. This delay meant there was not enough time to process visitors before the session, and some got in well after the start. Visitors complained about problems in booking visits, and it took us 12 attempts to get through to the booking line, but managers were taking steps to improve the service. Children over 10 were still inappropriately counted as adults for visits. The visits hall looked institutionalised and prisoners still had to wear bibs during visits. Play facilities for children in visits were reasonable, but family visits were only available for enhanced prisoners.

1.37 The recently completed programmes needs analysis by the psychology department was comprehensive and based on OASys data and wider consultation with offender supervisors. The range of programmes, along with one-to-one interventions, was broadly appropriate for the population.

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

# Section 2: Progress since the last report

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

## Main recommendations (from the previous report)

2.1 A comprehensive first night policy should be introduced with clear procedures to ensure that young people are, and feel, safe on their first night in custody. (HP39)

Achieved. A comprehensive first night policy was in place and described the procedures for ensuring prisoners felt safe on their first night in custody. Along with self-harm monitoring and cell sharing risk assessment documentation it covered first night checks by night staff, which were evidenced in prisoner case notes. Prisoners told us that they felt safe on their first night and knew who to turn to if they had concerns, and we found that the Listener on the induction unit was available when required. However, we were concerned about the condition of some cells on the induction unit. Many were dirty, had no toilet seat or cupboards, contained broken flooring and required painting.

Further recommendation

2.2 First night accommodation should be clean and fit for purpose.

2.3 There should be a clear strategy for managing vulnerable prisoners within an integrated regime to ensure their safety and this should be included in the safe and fear free environment policy document. (HP40)

Achieved. The safe and fear-free environment (SAFE) policy included clear guidance on the management of vulnerable prisoners within the prison's integrated regime.

2.4 The prison should fully implement the integrated drug treatment system without further delay. (HP41)

Achieved. The integrated drug treatment system (IDTS) had been fully implemented and was well established. It was delivered to a small group of patients who were supported by general and mental health nurses, as well as the psychosocial element of the programme.

2.5 Units 1, 2 and 5 should be replaced or fully refurbished. (HP42)

Not achieved. Units 1, 2 and 5 (the 'north side') were the oldest part of the prison and continued to be in a very poor condition. Despite some remedial work, there was still significant damage to the fabric of the buildings. We found water damage in some communal areas, broken concrete windowsills and many cells with damaged flooring. The senior management team had recognised the poor state of this accommodation, but bids for capital to demolish and/or completely refurbish it had been declined so far, and this part of the prison was not a decent environment for prisoners to live in.
We repeat the recommendation.

2.6 The level of young prisoners' satisfaction with the food should be increased. (HP43)

Achieved. The prison had carried out twice yearly food surveys, with the last in May 2012. There had been a 17% response to the last survey, which had led to changes to the menu. Food was discussed at the monthly prisoner consultative meeting. Most prisoners we spoke to said that the food was generally tasty, but some complained that portions were too small.

2.7 An appropriately trained foreign nationals coordinator should be responsible for overseeing all issues relating to foreign national prisoners and ensuring that their specific needs are met and fully taken into account at the diversity and race equality meeting. (HP44)

Partially achieved. The foreign national coordinator had only been in post a few months and, although not formally trained, she had visited other establishments for shadow training; the previous coordinator had been trained. The coordinator supported foreign national prisoners but prioritised those subject to an IS91 (detention notice) order. Prisoners could make applications to see her, but she was also the disability liaison officer, which affected her time for foreign nationals. The coordinator saw every foreign national prisoner initially and made a support assessment, but the high number of foreign nationals made it difficult for her to give continuing individual support. The equality risk management meeting, held every two months, did not discuss foreign national prisoners or ensure their ongoing needs were met.
We repeat the recommendation.

2.8 The number of purposeful work places should be increased to meet the needs of young prisoners. (HP45)

Achieved. The number of purposeful work places had increased, and met the needs of prisoners. The total places available in education, vocational training and work had risen by 16% since the previous inspection, and were only one less than the current prisoner population. The attendance rate had improved and was now 87%. The range of education and vocational training courses had been reviewed and now offered clear and structured progression routes from pre-entry through to intermediate levels.

2.9 The reducing reoffending policy should be based on an up-to-date analysis of the needs of all categories of prisoners and should include a strategy for action for each of the reducing reoffending pathways, including a named lead for each one. (HP46)

Partially achieved. The prison had recently updated its reducing reoffending strategy – the 'managing the custodial sentence strategy' – to reflect national developments in offender management. The strategy was comprehensive and outlined detailed plans and objectives for each resettlement pathway, as well as offender management. Lead managers were identified for each pathway. However, the most recent needs analysis was over a year old. It had been based on questionnaires about pathway needs but the prisoner response had been low and no information had been obtained from offender assessment system (OASys) assessments, even though three-quarters of the population were sentenced and most were subject to an OASys. A comprehensive needs analysis by the psychology department in early 2012 had been based on OASys data and, while specifically oriented to the provision of psychological services, much of this was relevant to offender management more widely, but had yet to be incorporated into the reducing reoffending strategy.

## Recommendations – safety

### Courts, escorts and transfers

2.10 All prisoners should arrive before 7pm. (1.5)

Partially achieved. We looked at the last three months of person escort records (PERs) and found only two cases where prisoners had arrived after 7pm. Staff in reception and prisoners in our focus groups confirmed that late arrivals were now infrequent.

2.11 Prisoners should spend as short a time as possible in court cells once their hearing is finished. (1.6)

Not achieved. Prisoners still regularly spent long periods in court cells once their court appearance had concluded. A log maintained by reception staff showed many occasions when escort staff had booked in prisoner accommodation during the morning, even though prisoners often returned in the late afternoon, including from courts relatively near by.
We repeat the recommendation.

2.12 Young prisoners should not transfer from HMYOI Feltham to Glen Parva unless it meets their individual needs and they should receive appropriate notice of their transfer. (1.7)

Not achieved. Documentation confirmed that prisoners were still transferred in from Feltham fortnightly to alleviate overcrowding rather than to meet individual needs. Prisoners transferred from Feltham told us they were unhappy at being far from home and its effect on maintaining family ties.
We repeat the recommendation.

### Early days in custody

2.13 Young prisoners should be offered a shower before being locked up on their first night. (1.21)

Achieved. New arrivals, and prisoners in our focus groups, confirmed that they had all been offered a shower in reception on their first nigh, and this was evidenced in reception and induction documentation.

2.14 First night officers should have the contact details of the local social services teams and know under what circumstances they should be called. (1.22)

Achieved. During the first night interview, new arrivals were asked if they had carer responsibilities and any immediate issues. There was a list of social services contact numbers in the induction unit office, and contacts made were recorded.

2.15 Listeners in reception and the induction unit should have clear guidance about their peer support role and all new arrivals should be introduced to them and have an opportunity to talk to them in private. (1.23)

Partially achieved. There were several trained Listeners in reception and on the induction unit, clearly identified by their T-shirts. Listeners told us that they were available to speak to

new arrivals in private, but only when staff highlighted concerns rather than routinely. We were not assured that all new arrivals saw a peer mentor in reception or on the induction unit.
We repeat the recommendation.

2.16 Professional telephone interpreting services should be used to communicate with non-English speaking prisoners throughout the induction programme. (1.24)

Achieved. Professional telephone Interpreting services were generally used during induction for non-English speaking prisoners, and this was recorded in induction documentation and evidenced in telephone records. Staff on the induction unit were aware of how and when to use interpreting services to assist prisoner induction.

2.17 All young prisoners should attend the full induction programme. (1.25)

Not achieved. The three-day induction programme consisted of two parts – 'coping in prison', focusing on prison life generally, and information on rules and regulations specific to Glen Parva. The first part included some information unique to Glen Parva, but prisoners transferring in or only recently released from Glen Parva did not have this session and so would have missed some information specific to the prison.
We repeat the recommendation.

## Bullying and violence reduction

2.18 Monitoring of prisoners suspected of violence or antisocial behaviour should be improved and include contributions from activity areas. (3.22)

Not achieved. Where necessary, prisoners were monitored under the tackling antisocial behaviour (TAB) system but electronic monitoring records were poor. In a sample of 35 cases, targets were not routinely documented, and observations were not always recorded daily and were mostly inadequate. Reviews and contributions from work places were not consistent.
We repeat the recommendation.

2.19 All violent incidents should be investigated and their outcome recorded. (3.23)

Achieved. Comprehensive logs assured us that all incidents were investigated and appropriate action taken.

2.20 Staff should adhere to the policy when moving prisoners to the second stage of the tackling antisocial behaviour strategy. (3.24)

Achieved. The SAFE policy provided clear guidance for the different stages of the TAB system, and we found no evidence of inconsistent or inappropriate application of stage two.

2.21 The effectiveness of the violence reduction programme on unit 10 should be evaluated. (3.25)

Not achieved. The violence reduction programme had changed, and now formed the third stage of the TAB system, which resulted in location to the segregation unit. Although the programme appeared to be a positive initiative it had still not been properly evaluated. However, the prison had recently commissioned a psychological evaluation of the programme.
We repeat the recommendation as follows: The effectiveness of the violence reduction programme should be evaluated.

2.22 The ethnicity of prisoners involved in violent incidents and placed on the violence reduction programme should be monitored. (3.26)

Achieved. Data were collated on the ethnicity of prisoners involved in violent incidents and those who took part in the violence reduction programme.

2.23 All staff should be trained in the procedures for tacking antisocial behaviour. (3.27)

Achieved. There was no training for TAB procedures but many staff had received a formal briefing and those we spoke with were knowledgeable about the system and their role in it.

## Self-harm and suicide prevention

2.24 The suicide and self-harm prevention policy should be revised to cover all appropriate practice and procedures, including the role of Listeners. (3.45)

Achieved. The suicide and self-harm prevention policy was comprehensive and included the role of Listeners.

2.25 Action plans developed following death in custody investigations should be periodically reviewed by the suicide prevention team to ensure continuing compliance. (3.46)

Partially achieved. There had been five self-inflicted deaths since our last inspection, and the prison had developed action plans from recommendations in Prisons and Probation Ombudsman (PPO) reports. All actions were completed but were not routinely reviewed, and some recommendations needed to be reinforced regularly and communicated more effectively to staff.
We repeat the recommendation.

2.26 More qualitative data from the perspective of prisoners who self-harm should be considered at the suicide prevention meeting. (3.47)

Achieved. The suicide prevention coordinator regularly interviewed prisoners who had been on assessment, care in custody and teamwork (ACCT) self-harm monitoring, and the results were considered at the safer custody meeting.

2.27 ACCT procedures, including reviews, should be multidisciplinary. (3.48)

Achieved. The ACCT documents we examined showed appropriate multidisciplinary involvement, particularly from the mental health team.

2.28 All permanent night staff should be trained in safer custody, with an emphasis on the need for a swift response to self-harm incidents. (3.49)

Partially achieved. There were no permanent night staff. Many staff were trained in safer custody issues. Those we spoke to were aware of the need to respond quickly to self-harm incidents but not all said they would enter a cell on their own, even to preserve life, and would wait until further staff assistance arrived.
We repeat the recommendation as follows: Staff should be trained in safer custody, with an emphasis on the need for a swift response to self-harm incidents.

2.29 The circumstances and use of protective clothing and safer cells should be monitored by the suicide prevention coordinator. (3.50)

Achieved. Data on the use of protective clothing and safer cells were collated. Protective clothing was used infrequently but always with proper authority and subject to appropriate governance.

2.30 A counselling service should be offered. (3.51)

Achieved. The chaplaincy offered a range of counselling services from volunteers, including bereavement counselling.

2.31 Prisoners should have access to Listeners over 24 hours and should not be restricted in their use of the direct telephone line to the Samaritans. (3.52)

Achieved. Listeners had good access to prisoners in crisis, and there were no unreasonable restrictions on use of the direct telephone line to the Samaritans

## Security

2.32 Closed visits should be authorised only when there is a significant risk justified to security intelligence and not just a drug dog indication. (9.91)

Not achieved. Visitors indicated by the drugs dog were still authorised to have only a closed visit with no reference to any further security information.
We repeat the recommendation.

## Incentives and earned privileges

2.33 Senior managers should ensure that the incentives and earned privileges scheme is operating fairly across all units and that demotion to basic is warranted and in accordance with local policy. (7.37)

Achieved. All reviews were checked and signed by residential managers to ensure fairness and that demotion to basic was warranted and according to the policy. The review documentation that we examined showed that reviews were carried out fairly and in line with the policy.

2.34 Managers should ensure that personal officers acknowledge positive behaviour in personal records and encourage prisoners to engage with the scheme and with sentence planning targets. (7.38)

Not achieved. Management checks of personal officer entries were inconsistent and generally brief – some said nothing more than 'good entries' or 'more entries required'. There was little evidence that managers checked to ensure that staff were encouraging prisoners to engage with the IEP scheme and sentence planning targets, and there was evidence in only some case notes from personal officers that they were doing this.
We repeat the recommendation.

2.35 The visits entitlement for unconvicted prisoners placed on the basic regime should be changed to reflect the minimum required under the relevant Prison Service Order. (7.39)

Achieved. The visits entitlement for unconvicted prisoners on the basic regime now reflected the minimum requirement of the relevant Prison Service Instruction.

2.36 A wider range of incentives should be introduced for enhanced prisoners so that all prisoners can benefit, including those without visitors or a source of private cash. (7.40)

Achieved. Prisoners on enhanced status had better work opportunities in more trusted positions and could take advantage of additional time unlocked, association and gym. They could also have additional electrical goods and other items in their cells, as well as the additional privileges for visits and private cash.

## Discipline

2.37 Starting levels of punishments at adjudications should be reduced. (7.21)

Achieved. The levels of punishment were routinely discussed at the monthly adjudications meetings and adjustments made to the tariff to reflect current disciplinary issues. In the completed documentation we examined, awards given were not excessive for the offences committed and mitigation offered.

2.38 All segregation unit cells should be adequately furnished. (7.22)

Not achieved. Although all unit cells had beds, tables and chairs, not all had cupboards and many had graffiti etched into windows which, with the lack of adequate furniture, created a poor environment for prisoners.
We repeat the recommendation.

2.39 Strip searching of prisoners relocating to the segregation unit should take place only when a risk assessment indicates a need. (7.23)

Achieved. Prisoners located on the segregation unit were strip searched only when a risk assessment indicated that this was necessary.

## Substance misuse

2.40 The prison should work with the primary care trust to develop appropriate protocols, systems and staff expertise for the clinical management of substance-dependent prisoners. Prescribing regimes should be flexible, based on individual need and adhere to national guidance. (3.86)

Achieved. The PCT had overseen the work of the new provider in the development of protocols, systems and staff expertise. GPs and some nurses had received training in the Royal College of General Practitioners (RCGP) course on management of drug misuse, and dual diagnosis nurses were available. Prescribing was based on individual need and adhered to national guidelines.

2.41 A dedicated stabilisation/detoxification unit with 24-hour nurse cover and a supportive regime should be established. (3.87)

Achieved. All new arrivals who required stabilisation/detoxification were held in appropriate cells on the first night/induction unit where they could be managed and observed effectively. The unit was supported by nursing staff who provided 24-hour cover.

2.42 Clinical substance misuse and CARAT teams should improve joint work and provide fully integrated care. (3.88)

Partially achieved. The clinical and counselling, assessment, referral, advice and throughcare (CARAT) team had improved its joint working arrangements, and its relocation to the health care centre was under consideration. Care was well integrated but the CARAT team had many vacancies and was awaiting transfer to a new provider before it could start further recruitment.

2.43 The mental health team's skill mix should include dual diagnosis expertise. (3.89)

Achieved. All of the primary care mental health team who contributed to the care of IDTS patients had received additional training in dual diagnosis.

2.44 The prison should ensure that the drug strategy budget is spent on the delivery of drug services as intended, make efforts to fill existing vacancies and avoid diverting drug support officers to other duties. (9.66)

Achieved. The drug strategy budget was used appropriately for drug services for prisoners. Drug support officers were rarely diverted to other duties.

2.45 The drug and alcohol strategy document should contain targets, performance measures and a detailed annual action plan. (9.67)

Partially achieved. The drug and alcohol strategy contained targets and performance measures but not a detailed action plan. The strategy and some actions were discussed at the monthly meeting.
We repeat the recommendation as follows: The drug and alcohol strategy should contain a detailed action plan.

2.46 CARAT services should be accessible and provision should be extended to reflect demand. (9.68)

Partially achieved. CARAT services were more widely advertised in the prison, including information given during induction. CARAT workers could see prisoners on their units, and all workshops and education areas had interview rooms. The service was not fully staffed and had to prioritise the use of one-to-one work and contribution to the 'building skills for recovery' programme.
We repeat the recommendation.

2.47 Establishment support and officer cover for drug and alcohol programmes teams should be improved. (9.69)

Partially achieved. The short duration drug programme (SDP) and P-ASRO (prison addressing substance related offending) had been discontinued and replaced with the building skills for recovery (BSR) programme. The profile of the alcohol and violence reduction programme had been raised. The reduction of the CARAT team had affected the capacity to deliver programmes.

2.48 A peer support scheme should be developed to offer ongoing support to prisoners who complete the P-ASRO programme. (9.70)

No longer relevant. The P-ASRO programme had been discontinued. A peer support scheme for the BSR programme had not yet been implemented.

## Recommendations – respect

### Residential units

2.49 Closed-circuit television should be installed on stairwells and landings on residential units. (2.21)

Partially achieved. Closed circuit television (CCTV) had been fitted on stairwells and in association areas, except on units 1, 2 and 5. The CCTV (where fitted) was monitored from unit offices. No CCTV had yet been installed on any landings on the residential units, although funding for this had been secured.
We repeat the recommendation.

2.50 Cells designed for one prisoner should not be used for two. (2.23)

Not achieved. Some cells designed for one prisoner still accommodated two, and many of those we inspected had damaged flooring, no toilet seat and required painting.
We repeat the recommendation.

Housekeeping point

2.51 All cells should be kept in a good state of repair.

2.52 Sufficient cell furniture should be provided for each prisoner in a cell and each should have a lockable cupboard. (2.24)

Not achieved. Many cells had little or sometimes no cell furniture. Although there was a rolling programme to install lockable metal cabinets in each cell, the majority were still without one.
We repeat the recommendation.

2.53 Televisions should be situated to allow both occupants of double cells to watch without difficulty. (2.25)

Not achieved. Televisions continued to be located above bunk beds, which made it difficult for the prisoner on the bottom bunk to watch. Prisoners told us that they had made a hammock-style bed up against the window to overcome viewing problems, which was clearly not appropriate.
We repeat the recommendation.

2.54 Cell bells should be responded to promptly and managers should evidence checks they have completed on all units. (2.26)

Achieved. Although prisoners in our focus groups said that staff were slow to respond to cell bells, evidence from our own tests of the system, electronic records and a staff information notice from the governor on the importance of answering cell bells promptly assured us that cell bells were responded to swiftly.

2.55 Unconvicted prisoners should not be required to wear prison clothing during visits. (2.27)

Not achieved. All prisoners were still required to wear prison clothing during visits on the grounds of security.
We repeat the recommendation.

2.56 All showers should be clean and screened to allow privacy. (2.28)

Not achieved. Except for units 1,2 and 5 there was insufficient privacy screening of showers. Most showers had three-quarters height partitions but no door, which left prisoners visible to anyone passing the shower area. The showers on units 1, 2 and 5 had been refurbished and had full privacy screening. Most of the showers we inspected required cleaning and maintenance.
We repeat the recommendation.

2.57 A clear offensive displays policy should be published and enforced. (2.29)

Achieved. A clear offensive display policy stated that pictures of nudity could not be displayed and that publications containing nudity had to be stored in a cupboard. We saw no displays of nudity, racist or sexist language in the cells we inspected. The prison had reinforced this message through daily staff cell fabric checks and subsequently through IEP warnings if displays were discovered.

2.58 Prisoners should receive incoming mail within 24 hours of arrival. (2.30)

Not achieved. Prisoners in our focus group said that incoming mail continued to be delivered more than 24 hours after its arrival in the prison, and there had been 17 formal complaints in the previous six months about this issue. Staff told us that staff shortages at weekends had delayed the delivery of prisoners' mail, but the prison had recently employed more staff to address the late arrival of mail.
We repeat the recommendation.

2.59 Operational support grades dealing with mail should receive specific public protection awareness training. (2.31)

Not achieved. Although there was public protection awareness training for operational support grades, only one had completed this to date.
We repeat the recommendation.

2.60 There should be at least one telephone to every 20 prisoners, located in quiet areas, which prisoners can use in private. (2.32)

Not achieved. The ratio of telephones to prisoners was one to 26 in most units. The telephones had hoods but many were in busy association areas, which affected privacy. Staff and prisoners said that access to telephones was a problem.
We repeat the recommendation.

2.61 Prisoners going to court who do not have adequate personal clothing should be provided with suitable non-prison clothing. (2.33)

Achieved. We saw a list for the previous 12 months of prisoners who had accessed the large stock of personal clothing held in reception, and prisoners knew about this facility and how to access it.

## Staff-prisoner relationships

2.62 Managers should consult with young prisoners to examine the varying perceptions of their treatment among different groups and take action to address these perceptions. (2.40)

Achieved. Consultation arrangements were good and there was evidence of action taken as a result of issues raised.

2.63 All staff should set a good personal example to young prisoners and treat and address them courteously using their preferred name. (2.41)

Partially achieved. We saw reasonable engagement between staff and prisoners but efforts to encourage use of preferred names were not yet fully in effect.

2.64 All personal officers should receive specific guidance and training about the scheme and what is required of them, including examples of effective interviews and wing file entries. (2.51)

Partially achieved. Clear guidance was available and understood by staff. Personal officers were knowledgeable about their prisoners, although their entries in electronic records did not always reflect this.

2.65 Managers should ensure that all personal officers make good quality entries in wing files, which, in addition to behaviour, should cover resettlement issues, any relevant family matters and progress with identified resettlement targets. (2.52)

Partially achieved. Quality assurance too often focused on quantity rather than quality of entries. Personal officers we spoke to were mostly aware of their prisoners' resettlement needs and family circumstances, and had good links with offender management, although the records did not always reflect this.

## Equality and diversity

2.66 Equality of treatment in a range of diversity areas should be routinely monitored to identify any concerns. (4.8)

Not achieved. Only equality of treatment by race and religion were monitored. The prison was working towards monitoring prisoners with disabilities but this was yet to be fully implemented. There had been some initial work for gay, bisexual and transsexual prisoners but this had not been taken forward.
We repeat the recommendation.

2.67 Racist incident report forms and investigations should be completed within the correct timeframe and the reasons for any delay communicated to the complainant. (4.20)

Achieved. The prison had set a target of 19 days to complete investigations into discrimination incident report forms (DIRFs). We examined all the DIRFs for 2012 and found that the target had been achieved in all cases, with 50% completed in seven days or under.

2.68 Sufficient diversity representatives should be appointed to provide informal advice and guidance to prisoners on all wings. (4.21)

Achieved. The prison had previously employed prisoner diversity representatives as well as representatives for other specific areas. It now employed 12 dedicated safer custody prisoner representatives to act as a conduit for prisoners across a wide range of areas, including diversity. They had been trained in diversity awareness, and met every two months to discuss and take forward diversity issues to the equality risk management (ERM) meeting.

2.69 SMART monitoring should be extended to cover areas of concern to prisoners, such as access to orderly jobs. (4.22)

Achieved. SMART (systematic monitoring and analysing of race equality treatment) monitoring had been extended to cover the induction unit, gym access, orderlies and employment status, alongside the mandatory monitoring data. Data for the previous 12 months indicated that there were no ongoing problems.

2.70 Support for foreign national prisoners should be provided through specific peer supporters and dedicated foreign national forums. (4.37)

Not achieved. There were no specific foreign national peer supporters and the prison did not hold dedicated foreign national forums. There were 94 foreign national prisoners during the inspection, and all those we spoke with said that they felt isolated and unsupported by the prison. The prison prioritised prisoners in danger of deportation for access to the UK Border Agency but, given UKBA's limited availability (see below) many other prisoners expressed frustration about gaining any information about their cases.
We repeat the recommendation.

2.71 The establishment should liaise with UKBA to ensure that foreign national detainees are moved to an immigration detention centre as soon as possible after their criminal sentence has expired. (4.38)

Partially achieved. There were nine foreign national prisoners still held at the prison beyond the end of their sentence, of whom one had been awaiting transfer for four months. In most cases, foreign national detainees were moved swiftly, although we were told that there were sometimes waits of four months or more. The UK Border Agency visited twice a month but saw only eight foreign national prisoners on each occasion.
We repeat the recommendation.

2.72 The establishment should liaise with UKBA to ensure that IS91 documentation is issued at an earlier stage and not when a foreign national prisoner is about to be released. (4.39)

Partially achieved. At the time of the inspection, 16 prisoners had been issued with IS91 (detention notice) documentation. Of these, six had only received their notice in the last 72 hours of their sentence.
We repeat the recommendation.

2.73 All foreign national prisoners should have access to appropriate independent legal advice. (4.40)

Not achieved. There was no independent legal advice services for foreign national prisoners and those that we spoke to said that they felt frustrated at the lack of available independent

help for their individual circumstances.
We repeat the recommendation.

2.74 Professional interpreting services should be used by residential staff for prisoners who do not understand English. (4.41)

Partially achieved. Although professional interpreting services were generally used for foreign national prisoners on their arrival at the prison (see 2.16), elsewhere such services had been used only occasionally in the previous six months, although more so during the previous two months. Staff and prisoners told us that other prisoners were often used to interpret for non-English speaking prisoners, and we observed this with two Vietnamese prisoners. Some key areas, such as the segregation unit, used professional interpreters for confidential matters.
We repeat the recommendation.

2.75 All foreign national prisoners should be made aware in a language they understand of the possibility of free telephone calls home. (4.42)

Achieved. All the foreign national prisoners we spoke to said that they were aware of the availability of a free telephone call to their home country, and many had received this. Information was available in a range of languages.

2.76 The disability liaison officer should receive training in the legal obligations set out by the Disability Discrimination Act. (4.52)

Partially achieved; The disability liaison officer (DLO) had only been in post a few months and was awaiting training in the Disability Discrimination Act (DDA). The previous DLO had received formal training in the Act.

2.77 The disability liaison officer should be supported by named staff on each unit with responsibility for identifying any disability issues in the residential areas and ensuring cases are appropriately managed. (4.53)

Not achieved. There was no named support staff on each wing. It was understood that wing managers acted as a support for the disability liaison officer, but their role was information gathering rather than further support.
We repeat the recommendation.

2.78 All prisoners with a disability should have a multidisciplinary care plan that includes involvement from residential staff about how their needs will be met. (4.54)

Achieved. There were multidisciplinary care support plans for prisoners with disabilities who required such support. The plans were very good and included residential and other staff input, depending on the individual's needs.

2.79 Adapted cells should be provided for prisoners with mobility difficulties. (2.22)

Not achieved. Plans to convert a dormitory into a disability living suite with a shower area had not been realised.
We repeat the recommendation.

## Faith and religious activity

2.80 The chaplaincy team should liaise with induction staff to ensure that all new arrivals are made aware of chaplaincy services. (3.76)

Achieved. The chaplaincy had a dedicated slot on the induction programme and saw all new arrivals during their induction. The presentation covered all aspects of chaplaincy services. All the prisoners we spoke to had been seen by a member of the chaplaincy.

## Legal rights

2.81 Suitable training and refresher training should be provided for legal services officers. (3.65)

Not achieved. There was no identified legal services officer in post.
We repeat the recommendation.

2.82 Designated legal services to prisoners should not be lost through redeployment of legal services officers or appropriate cover should be provided in their absence. (3.64)

Not achieved. There was no identified legal services officer.
We repeat the recommendation.

## Health services

### Governance arrangements

2.83 An up-to-date health needs analysis should be produced to identify and inform health services. (5.39)

Achieved. The health needs assessment had been completed in September 2011 and was used to inform the planning and delivery of services.

2.84 The waiting areas for prisoners in health care should be refurbished. (5.40)

Achieved. The waiting area had been refurbished and extended as part of the reorganisation of the health care centre, and it now provided a comfortable area for patients waiting for appointments.

2.85 A system to monitor equity of access for different groups of prisoners should be developed and implemented. (5.42)

Achieved. Access to health services was monitored through the electronic record SystmOne. There was a process to ensure equity of access for all prisoners across all units, and this had had a beneficial effect on attendance.

2.86 All nursing vacancies should be filled to ensure that services for patients are sustained and developed. (5.43)

Achieved. The health services were almost fully staffed with only one part-time vacancy. Services for patients had been enhanced and the new provider had invested in the development of staff.

2.87 A training needs analysis should be conducted to ensure staff training matches service needs. (5.45)

Achieved. A training needs analysis had been completed by the provider trust in 2011 and had been used to ensure that the professional development of staff reflected the needs of the prison population.

2.88 Complaints about health care should be confidential to ensure medical details are only seen by health professionals. (5.47)

Achieved. Health care complaints were placed in sealed envelopes in the health care boxes on the units, ensuring medical confidentiality. The boxes were emptied each day by health care staff.

2.89 There should be a health care forum for prisoners. (5.48)

Achieved. A health care forum for prisoners had been established following our last inspection. The forum met monthly and each unit had a prisoner representative who also gave feedback from the meetings to their units.

2.90 Checks on resuscitation equipment should be regular and records of those checks complete. (5.50)

Achieved. Resuscitation equipment, including automated external defibrillators, was located in the health care centre and the first night/induction unit. All equipment was checked and recorded appropriately.

2.91 The lead for infection control should receive specific training for the role. (5.51)

Achieved. One of the nurses had been trained in the leading role for the management of infection control. There were also good links with the infection control lead in the provider trust.

2.92 A health promotion strategy should be developed. (5.54)

Achieved. A senior nurse was responsible for the health promotion strategy, which had been widely developed and included prison-wide events.

## Delivery of care (physical health)

2.93 All nurses undertaking triage should be appropriately qualified and skilled and protocols should be developed, including for dental treatment, to ensure consistency and appropriate clinical decision-making. (5.44)

Achieved. Triage protocols had been developed and implemented for all patients. Nursing staff had received additional training in minor injuries and illnesses, enabling consistent care and treatment for patients.

2.94 A review and risk assessment of the needs of patients with acute mental health and/or detoxification needs should be undertaken and the capacity to provide inpatient care for such cases should be maintained. (5.41)

Achieved. A review had been carried out by the Centre for Mental Health (formerly the Sainsbury's Foundation for Mental Health) and several cells were allocated on units 14 and 15 with 24-hour nursing cover. Care was based on a community model with prisoners integrated on the residential units.

2.95 All prisoners with acute mental health needs and/or detoxification needs cared for on the wings should have a care plan in place that specifies the monitoring routine by health care staff and the role and responsibilities of residential staff. (5.49)

Achieved. All prisoners with acute mental health problems and/or detoxification needs had care planning through SystmOne. Relevant aspects of care were shared with residential staff and outlined their specific responsibilities.

2.96 A structured approach should be developed to manage young prisoners with chronic disease such as diabetes, asthma and epilepsy with regular follow-ups. (5.53)

Achieved. There was a structured approach to the management of patients with chronic disease through SystmOne and the chronic disease register. Some nurses had a lead role in specific diseases and were trained to deliver those services in conjunction with lead health care professionals from the trust.

2.97 All rearrangements of external secondary care appointments should be routinely reviewed by nursing staff. (5.59)

Achieved. A member of the clinical team was consulted when a clinical decision was required for the rearrangement of external hospital appointments. The health care team routinely reviewed appointments

## Pharmacy

2.98 Patient group directions should be developed to enable such things as simple pain relief and vaccinations to be administered by nurses. (5.46)

Achieved. Patient group directions (PGDs) had been developed and implemented with the provider trust. All nurses who completed the PGD training had signed up to the relevant procedure and records were maintained by the pharmacy. Prisoners could now receive appropriate medicines from nurses when required.

2.99 Prisoners should be able to access simple pain relief and nursing advice in the evenings and at night. (5.52)

Achieved. Nursing staff were available 24 hours a day and could access and provide simple pain relief.

2.100 Medication stored in the nurses' medication trolley in inpatients should be checked, with old patient medication returned to pharmacy for destruction. Special sick medication in the trolley should be date checked and its suitability for use reviewed. (5.58)

No longer relevant. The inpatient unit had been closed and medication trolleys were no longer used.

## Dentistry

2.101 The number of dental sessions should be increased to reduce the waiting list. (5.55)

Achieved. There were four dental sessions a week. We were told that the number of sessions was flexible and based on the needs of prisoners. The waiting list was very small, at only three during our inspection, and all patients were seen within an acceptable time.

2.102 The full range of dental treatments available on the NHS should be provided, based on clinical need. (5.56)

Achieved. The dental team could provide a full range of care and treatment equivalent to that provided by the NHS in the community.

2.103 Work should be done to assess the dental failure to attend rates and the reasons why appointments are missed. (5.57)

Achieved. Attendance rates had been reviewed. The contract had been awarded to the Leicestershire Partnership NHS Trust with much improved provision and subsequent attendance.

## Delivery of care (mental health)

2.104 Primary mental health services should be increased to meet prisoner needs. (5.60)

Achieved. Prisoners had access to a dedicated team of four full-time and one part-time primary mental health nurses, which was sufficient to meet the caseload and care required.

2.105 Mental health awareness training should be provided for all staff with regular prisoner contact. (5.61)

Achieved. The mental health team provided half-day mental health awareness training sessions for approximately 15 prison staff a month. There were also occasional additional sessions related to specific mental health conditions, including personality disorders.

## Catering

2.106 Unit staff should supervise serveries to ensure that all prisoners receive fair portions. (8.6)

Achieved. Staff were visible at the serveries at all times when meals were being served. The staff we spoke to understood that their role at meal times was to ensure prisoners received fair portions. We observed all prisoners receiving similar portions and those we spoke to were content that portions were equitable although many complained that they were small.

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### Purchases

2.107 Systematic problems with the provision of shop orders should be resolved and any errors rectified expeditiously without prisoners having to wait until the following week. (8.11)

Achieved. Most prisoners told us that problems were rare, and where items were not available they were refunded promptly.

2.108 The prison should retain some surplus stock to ensure prisoners have access to products when mistakes are made. (8.12)

Achieved. The prison carried stocks of smoker's and non-smoker's packs to issue as replacements for any mistakes, and the shop provider also carried spare items of popular stock to resolve problems.

2.109 Additional catalogue suppliers should be introduced for clothes and other items not available through the shop. (8.13)

Achieved. Prisoners could order from several external catalogues, which was sufficient to meet their needs.

## Recommendations – purposeful activity

### Time out of cell

2.110 All prisoners should have 10 hours out of their cell each day. (6.55)

Not achieved. The regime did not enable any prisoner to be unlocked for 10 hours a day. The prison recorded approximately seven hours out of cell a day, but we thought it was lower than this for many. During two roll checks, we found 17% and 30% of prisoners locked up, which were too many. There was too much staff discretion on unlock times and we saw much slippage against published times, with variations across the units. Only employed and enhanced-status prisoners were unlocked in the evening, which further restricted opportunities for time out of cell for many prisoners.
We repeat the recommendation.

2.111 All prisoners should receive one full hour in the open air every day. (6.56)

Partially achieved. The core day gave prisoners a daily opportunity to receive an hour in the open air but this was subject to too much staff discretion and was often curtailed if it rained, again at the discretion of individual staff with no central decision point.

2.112 Outdoor and waterproof jackets should be provided to allow access to the open air in inclement weather. (6.57)

Partially achieved. Limited outdoor clothing was provided on each wing. Staff told us that what was available was not used and that there was no exercise outside if it rained.

## Learning and skills and work activities

2.113 Accreditation to recognise and record skills developed in prison workshops should be introduced. (6.29)

Achieved. Accredited courses to recognise and record workplace skills had been introduced in prison workshops. The number of places on accredited courses had increased progressively over the past three years, rising by 139% from 120 to 287 currently.

2.114 The very low achievement rates in Skills for Life and some other qualifications should be improved significantly. (6.30)

Partially achieved. Achievement rates in literacy and numeracy had improved, but progress had been uneven. In 2010/11, 49% of learners achieved a qualification in literacy at level 1. Although 29 percentage points higher than in 2009, this rate was still low. Achievement in numeracy at level 1 in 2010/11 remained very low, at 26%. Achievement rates in almost all other subjects had risen and were generally high or better, including 91% in IT user qualifications at level 1 and 83% in level 2. In construction skills, 73% gained a qualification. The achievement rate on employability courses was 90%. Data indicated an improving picture for the year to date, but were not conclusive.

2.115 Punctuality in education and training should be improved. (6.31)

Partially achieved. There had been a wide range of appropriate management actions and improved communications with the units to improve punctuality. Although the prison believed that punctuality had improved, there were no quantitative data available to confirm this.

2.116 The proportion of good and better teaching, training and learning should be improved. (6.32)

Not achieved. The system for observation and assessing the quality of teaching and learning was ineffective in practice, although well planned and well structured. The grade profile quoted in the current self-assessment report of over 70% for good or better teaching and learning observed was unreliable. Although managers had been keen to focus on improving teaching, training and learning, their efforts had been frustrated by a high turnover of teaching staff in early 2012.
We repeat the recommendation.

2.117 The use of individual learning plans to support learners' progress should be improved and better links established with sentence planning. (6.33)

Partially achieved. The format of individual learning plans (ILPs) had been improved and they were now better organised and more clearly laid out. Tutors and others used ILPs extensively to record individuals' learning aims, achievements and medium- and long-term targets, but much less so to plan individual learning. The targets set in ILPs were usually too generalised, and the link between ILPs and sentence planning was still weak.

2.118 Quality assurance arrangements should be improved. (6.34)

Achieved. The education provider (Milton Keynes College) had introduced much improved formal quality improvement arrangements, which had had an increasingly positive impact on the provision, although this was still developing. Quality assurance was extensive, detailed and

quickly becoming well embedded. The new arrangements promoted and underpinned joint working between the education provider and the prison. The education provider's self-assessment practice was highly evaluative and the basis of effective and active improvement action planning. The prison's self-assessment practice was comparatively less well developed, but there were plans to improve its system for observing and evaluating teaching and learning.

2.119 Effective arrangements to collect, analyse and use data to inform planning and development should be established. (6.35)

Partially achieved. There was a range of accurate data to inform planning and development. The range had increased over time and was analysed particularly well by the education provider to monitor, review and plan improvement. However, although there were accurate and detailed data, for example on learners' retention and achievement rates, there were insufficient summary data on more recent and current performance.

2.120 Communication and the sharing of good practice between all providers involved in learning and skills should be improved. (6.36)

Achieved. Communication and sharing of good practice between the education provider and the prison were now very good, with a highly collaborative and productive working relationship. Extensive formal and informal joint working supported an increasingly thorough assessment of the quality of provision and good action planning for improvement.

2.121 The allocations process should be fair and transparent and waiting lists for vocational workshops better managed. (6.37)

Achieved. The allocations process had been reviewed and refocused to better identify and meet prisoners' specific individual needs and aspirations. The allocations board, education provider and information and advice service worked more closely and effectively, and the information flow had much improved. Waiting lists were short and managed effectively.

2.122 Arrangements for pay should be revised to ensure their equity. (6.38)

Partially achieved. The prison had originally rejected this recommendation. However, there had been some changes to increase the pay rate of prisoners on enhanced status, and those working as assessors, trainers or in the kitchens.

### Library

2.123 A regular schedule of activities to promote library use and reading development should be introduced. (6.39)

Achieved. A wide range of activities and initiatives had been effective in increasing library use. Library attendance had risen by 31% in the past two years, and the number of loans increased from 10,758 to 14,436. Book loss had also fallen from 25% to 10%.

### Physical education and health promotion

2.124 The promotion of health and personal fitness should be improved. (6.45)

Achieved. The percentage of the prison population using the gym for scheduled and recreational PE had risen from 40% to 64% as a result of effective promotion and a

restructuring of resources. A sports hall had been re-equipped to become a popular weights and cardiovascular area. An extensive programme of non-accredited taster courses attracted many prisoners. There were few complaints about lack of access to the gym.

2.125 Allocation from the units to recreational PE should be fair. (6.46)

Partially achieved. The units recorded the prisoners allocated to recreational PE informally, but this was inconsistent. The gym senior officer audited the records each month to check that allocations were fair.

2.126 A purpose-built classroom linked to the physical education facility should be provided. (6.47)

Not achieved. The prison had not been able to secure funding to provide a purpose-built classroom for PE.
We repeat the recommendation.

2.127 Higher level courses for more able learners that meet employers' needs should be offered. (6.48)

Not achieved. An accredited fitness instruction course had been introduced but was only available at level 1 and did not meet the needs of more able learners. There were plans to introduce a level 2 course.
We repeat the recommendation.

## Recommendations – resettlement

### Strategic management of resettlement

2.128 The prison should periodically bring together voluntary and community sector groups providing services to prisoners to inform them of their contribution to the development of the reducing reoffending strategy. (9.7)

Partially achieved. Although there was no specific forum for voluntary and community services working with the prison, the prison's social enterprise manager coordinated such work and liaison through the monthly reducing reoffending strategy group.

### Offender management and planning

2.129 The Prison Service should resolve with the Youth Justice Board the anomaly of 18 year olds sentenced to detention and training orders being sent to young offender institutions without the structures and support to meet the standards required for this sentence. (9.37)

Partially achieved. Although the prison continued to receive prisoners subject to detention and training orders, the number was relatively low – only one at the time of the inspection. The prison had made considerable effort to develop appropriate systems to manage those received effectively. It was also part of a pilot project between the Youth Justice Board and the National Offender Management Service to improve communication and information sharing between organisations working with young adults, especially where youth offending teams (YOTs) were involved.

2.130 A strategy should be developed and published specifying how offender management will be delivered. (9.31)

Achieved. There was a clear strategy outlining the work of the offender management unit (OMU) and offender supervisors. Since the last inspection, the OMU had reorganised to incorporate the former resettlement team and there was now a dedicated multidisciplinary group of offender supervisors that included both prison and probation service staff. Work was well organised, appropriately focused on issues of risk and risk management, and clearly oriented to setting and meeting identified sentence plan targets. Links with community-based service providers, and multi-agency public protection arrangements (MAPPA) boards, where appropriate, were good. The offender supervisors we spoke to were knowledgeable about the prisoners for whom they were responsible.

2.131 Prisoner officers should not be redeployed from the offender management unit. (9.32)

Achieved. Prison officers in offender supervisor roles were no longer redeployed. They were expected to supervise prisoners during Muslim Friday prayers, but this was planned and scheduled into the working week.

2.132 An effective custody planning process for un-convicted and short-sentenced prisoners should be established. (9.33)

Partially achieved. All prisoners had an induction assessment undertaken by staff from Nacro (the crime reduction charity), which covered key information and need under the resettlement pathways. They were referred to services where necessary. The assessments were forwarded to offender supervisors who were allocated to all sentenced prisoners, including those on very short sentences or at Glen Parva for only a short time. The information was subsequently used to inform pre-release planning. However, prisoners on remand had no custody planning, and assessments were not used to inform provision of their identified need.
We repeat the recommendation.

2.133 Personal officers should attend sentence plan reviews and should encourage and support prisoners to achieve agreed objectives. (9.34)

Partially achieved. Personal officers did not always attend sentence plan meetings, but contributions and attendance had improved in recent months. Offender supervisors consistently obtained information from personal officers about prisoners subject to sentence planning to help inform decisions and target setting.

2.134 Family members should be invited to sentence plan reviews. (9.35)

Partially achieved. Family members continued to be invited to review meetings following the completion of accredited programmes (such as thinking skills and controlling anger and learning to manage it, CALM), and were invited to sentence planning meetings to contribute on specific issues, but this did not happen routinely.

2.135 Managers should ensure that all young prisoners meet their offender supervisor to monitor and review sentence plans. (9.36)

Achieved. Most prisoners who we spoke to said that they had an offender supervisor and a sentence plan. Contact between offender supervisors and prisoners tended to be needs-led, and some prisoners were seen regularly. Prisoners assessed as high or very high risk of harm were seen routinely each month, and this was monitored by offender management managers.

## Reintegration planning

### Education, training and employment

2.136 A pre-release course for all prisoners should be introduced. (9.50)

Partially achieved. A caseworker now gave individual prisoners pre-release support, and all planning and preparation work was now in place. A new course, 'ETE4Me', was due to be available from September 2012.

2.137 Prisoners' access to employment information before release should be improved. (9.51)

Not achieved. The use of the virtual campus to give prisoners up-to-date information on job opportunities, through internet access to community education, training and employment opportunities, was at a very early stage and had had little impact to date. It was not clear which department had overall responsibility for developing the virtual campus further, and there was currently no productive joint working between the education and resettlement departments to resolve this issue.
We repeat the recommendation.

2.138 More use should be made of release on temporary licence. (9.52)

Achieved. Although the number of prisoners given release on temporary licence (ROTL) was only marginally higher than in 2009 – at three to five prisoners at a time, compared with two in 2009 – the prison had established several community links that offered work opportunities. Many prisoners who met the required criteria were recategorised and moved to open conditions or released on home detention curfew (HDC) before they could take advantage of these opportunities. Nevertheless, regular ROTL boards were held and, where appropriate, prisoners were able to access ROTL.

### Finance, benefit and debt

2.139 Courses on budgeting and finance should be available. (9.53)

Achieved. Nacro staff saw all new arrivals and followed up any who needed support with financial problems. Nacro corresponded with companies about prisoner debts and arranged the freezing of accounts and/or payment plans. Money management courses were provided through the education department.

2.140 Prisoners should be helped to open a bank account before release. (9.54)

Achieved. Prisoners were now able to open bank accounts through HSBC before release.

### Children, families and contact with the outside world

2.141 The visitors' centre should be big enough to cater for the numbers of visitors. (9.84)

Not achieved. The visitors' centre was the same as at our last inspection and could not easily accommodate the number of visitors attending. On the day we inspected, although only half

the total of possible visits took place, visitors were left waiting outside.
We repeat the recommendation.

2.142 All young prisoners should be able to receive at least one visit a week. (9.85)

Not achieved. Convicted prisoners on the basic and standard levels of the IEP scheme were restricted to two and three visits respectively every four weeks.
We repeat the recommendation.

2.143 The visits booking system should be easily accessible and visitors should be able to book their next visit while at the prison. (9.86)

Not achieved. Visitors we spoke to complained about the time it took to get a response from the visits booking office. We had to make 12 calls before we were able to speak to a member of staff to book a visit. Once connected, the service was efficient and the staff polite and helpful. Prison managers had recognised this problem and were taking steps to make bookings easier, although there was still no facility to book a visit on site. The new processes had only been in place for one day and we could not, therefore, measure their effectiveness.
We repeat the recommendation.

2.144 The visitors' centre should be open at least one hour before the advertised visiting time. (9.87)

Not achieved. The visitors' centre did not open until 15 minutes before the advertised visiting time.
We repeat the recommendation.

2.145 Visits should start on time. (9.88)

Not achieved. Visits did not start on time for all visitors, due mainly to the late opening of the visitors' centre and the time taken to process visiting order and identification checks. We observed that visitors who had arrived at the prison in plenty of time for the advertised visiting time of 1.45pm did not get into the visits hall until 2.15pm.
We repeat the recommendation.

2.146 Young prisoners should not have to wear bibs in the visits room. (9.89)

Not achieved. Prisoners were still required to wear fluorescent orange bibs during visits.
We repeat the recommendation.

2.147 Children aged 10 and over should not be counted as adults for the purpose of visits. (9.90)

Not achieved. Children aged over 10 were still counted as adults for visits. Prison managers informed us this was a health and safety measure to limit the number of people in the visits room at any time.
We repeat the recommendation.

2.148 The visits room should be furnished and arranged to ensure easy contact between young prisoners and their visitors and to allow some privacy between groups. (9.92)

Not achieved. The furniture was the same as at our last inspection and made the visits room look institutionalised. Tables and chairs were fixed and close together, and there was little

privacy and ease of contact for prisoners and their visitors.
We repeat the recommendation.

2.149 The play area should be supervised and all children, irrespective of age, should be able to use it without the need to be accompanied by a carer. (9.93)

Not achieved. Qualified staff supervised the children's play area on only two days a week. There was an interactive play session once a month that could be accessed by children of all prisoners, except those on the basic level.
We repeat the recommendation.

Housekeeping point

2.150 The children of all prisoners should be able to access the interactive play sessions in the visits play area.

2.151 Unused visiting orders should be able to be exchanged for telephone credit. (9.94)

Not achieved. Prisoners were not able to exchange unused visiting orders for telephone credit.
We repeat the recommendation.

2.152 Family days should be introduced where young prisoners can properly and effectively interact and bond with children. (9.95)

Achieved. Monthly family visits had been introduced in October 2011, although one visit had been cancelled due to low demand. The visits were held in the chapel and with a different theme each month. Only enhanced prisoners on unit 5 (up to 92 prisoners) and some enhanced prisoners on other wings could apply for the visits.
We repeat the recommendation as follows: Family days should be introduced so that all prisoners can properly and effectively interact and bond with children.

2.153 Young prisoners should be able to undertake general relationship counselling with their immediate family. (9.96)

Achieved. Prisoners could undertake relationship counselling through volunteer counsellors who worked with the chaplaincy.

2.154 Young prisoners should be able to receive incoming calls from children or to deal with arrangements for them. (9.97)

Not achieved. There was no facility for prisoners to receive incoming calls from their children or to deal with arrangements for them.
We repeat the recommendation.

2.155 A qualified family support worker should be employed to work with young prisoners. (9.98)

Achieved. The prison had secured funding from Leicester County Council for a family mentoring project. The project provided pre- and post-release mentoring support for prisoners and their families, signposting to relevant support services and assistance in keeping families together. There was a course that focused on parenting and play skills and improving relationships between prisoners and their children.

## Attitudes, thinking and behaviour

2.156 An up-to date needs analysis should be used to inform the provision of courses. (9.112)

Achieved. The psychology department had carried out a comprehensive needs analysis of prisoners in early 2012, drawing on the OASys data of prisoners serving determinate sentences over 12 months. The analysis was being used to inform programme and psychological services provision. The range of programmes, along with the one-to-one work by the psychology department, were broadly appropriate for the current prisoner population.

2.157 The psychology department should be fully staffed. (9.113)

Achieved. The psychology department had been reorganised and now consisted of two trainees and one chartered psychologist. There were currently no vacant posts.

# Section 3: Summary of recommendations

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

## Recommendations — To NOMS

3.1 Prisoners should spend as short a time as possible in court cells once their hearing is finished. (2.11)

3.2 Young prisoners should not transfer from HMYOI Feltham to Glen Parva unless it meets their individual needs and they should receive appropriate notice of their transfer. (2.12)

3.3 Suitable training and refresher training should be provided for legal services officers. (2.81)

## Recommendations — To the governor

### Early days in custody

3.4 First night accommodation should be clean and fit for purpose. (2.2)

3.5 Listeners in reception and the induction unit should have clear guidance about their peer support role and all new arrivals should be introduced to them and have an opportunity to talk to them in private. (2.15)

3.6 All young prisoners should attend the full induction programme. (2.17)

### Bullying and violence reduction

3.7 Monitoring of prisoners suspected of violence or antisocial behaviour should be improved and include contributions from activity areas. (2.18)

3.8 The effectiveness of the violence reduction programme should be evaluated. (2.21)

### Self-harm and suicide prevention

3.9 Action plans developed following death in custody investigations should be periodically reviewed by the suicide prevention team to ensure continuing compliance. (2.25)

3.10 Staff should be trained in safer custody, with an emphasis on the need for a swift response to self-harm incidents. (2.28)

### Security

3.11 Closed visits should be authorised only when there is a significant risk justified to security intelligence and not just a drug dog indication. (2.32)

## Incentives and earned privileges

3.12 Managers should ensure that personal officers acknowledge positive behaviour in personal records and encourage prisoners to engage with the scheme and with sentence planning targets. (2.34)

## Discipline

3.13 All segregation unit cells should be adequately furnished. (2.38)

## Substance misuse

3.14 The drug and alcohol strategy should contain a detailed action plan. (2.45)

3.15 CARAT services should be accessible and provision should be extended to reflect demand. (2.46)

## Residential units

3.16 Units 1, 2 and 5 should be replaced or fully refurbished. (2.5)

3.17 Closed-circuit television should be installed on stairwells and landings on residential units. (2.49)

3.18 Cells designed for one prisoner should not be used for two. (2.50)

3.19 Sufficient cell furniture should be provided for each prisoner in a cell and each should have a lockable cupboard. (2.52)

3.20 Televisions should be situated to allow both occupants of double cells to watch without difficulty. (2.53)

3.21 Unconvicted prisoners should not be required to wear prison clothing during visits. (2.55)

3.22 All showers should be clean and screened to allow privacy. (2.56)

3.23 Prisoners should receive incoming mail within 24 hours of arrival. (2.58)

3.24 Operational support grades dealing with mail should receive specific public protection awareness training. (2.59)

3.25 There should be at least one telephone to every 20 prisoners, located in quiet areas, which prisoners can use in private. (2.60)

## Equality and diversity

3.26 An appropriately trained foreign nationals coordinator should be responsible for overseeing all issues relating to foreign national prisoners and ensuring that their specific needs are met and fully taken into account at the diversity and race equality meeting. (2.7)

3.27 Equality of treatment in a range of diversity areas should be routinely monitored to identify any concerns. (2.66)

3.28 Support for foreign national prisoners should be provided through specific peer supporters and dedicated foreign national forums. (2.70)

3.29 The establishment should liaise with UKBA to ensure that foreign national detainees are moved to an immigration detention centre as soon as possible after their criminal sentence has expired. (2.71)

3.30 The establishment should liaise with UKBA to ensure that IS91 documentation is issued at an earlier stage and not when a foreign national prisoner is about to be released. (2.72)

3.31 All foreign national prisoners should have access to appropriate independent legal advice. (2.73)

3.32 Professional interpreting services should be used by residential staff for prisoners who do not understand English. (2.74)

3.33 The disability liaison officer should be supported by named staff on each unit with responsibility for identifying any disability issues in the residential areas and ensuring cases are appropriately managed. (2.77)

3.34 Adapted cells should be provided for prisoners with mobility difficulties. (2.79)

## Legal rights

3.35 Designated legal services to prisoners should not be lost through redeployment of legal services officers or appropriate cover should be provided in their absence. (2.82)

## Time out of cell

3.36 All prisoners should have 10 hours out of their cell each day. (2.110)

## Learning and skills and work activities

3.37 The proportion of good and better teaching, training and learning should be improved. (2.116)

## Physical education and health promotion

3.38 A purpose-built classroom linked to the physical education facility should be provided. (2.126)

3.39 Higher level courses for more able learners that meet employers' needs should be offered. (2.127)

## Offender management and planning

3.40 An effective custody planning process for un-convicted and short-sentenced prisoners should be established. (2.132)

### Reintegration planning

### Education, training and employment

3.41 Prisoners' access to employment information before release should be improved. (2.137)

### Children, families and contact with the outside world

3.42 The visitors' centre should be big enough to cater for the numbers of visitors. (2.141)

3.43 All young prisoners should be able to receive at least one visit a week. (2.142)

3.44 The visits booking system should be easily accessible and visitors should be able to book their next visit while at the prison. (2.143)

3.45 The visitors' centre should be open at least one hour before the advertised visiting time. (2.144)

3.46 Visits should start on time. (2.145)

3.47 Young prisoners should not have to wear bibs in the visits room. (2.146)

3.48 Children aged 10 and over should not be counted as adults for the purpose of visits. (2.147)

3.49 The visits room should be furnished and arranged to ensure easy contact between young prisoners and their visitors and to allow some privacy between groups. (2.148)

3.50 The play area should be supervised and all children, irrespective of age, should be able to use it without the need to be accompanied by a carer.

3.51 Unused visiting orders should be able to be exchanged for telephone credit. (2.151)

3.52 Family days should be introduced so that all prisoners can properly and effectively interact and bond with children. (2.152)

3.53 Young prisoners should be able to receive incoming calls from children or to deal with arrangements for them. (2.154)

## Housekeeping points

3.54 All cells should be kept in a good state of repair. (2.51)

3.55 The children of all prisoners should be able to access the interactive play sessions in the visits play area. (2.150)

# Appendix I: Inspection team

| | |
|---|---|
| Keith McInnis | Team leader |
| Andy Lund | Inspector |
| Kevin Parkinson | Inspector |
| Kellie Reeve | Inspector |
| Karen Dillon | Inspector |

Specialist inspectors

| | |
|---|---|
| Mick Bowen | Health services inspector |
| Nick Crombie | 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 | 18–21 yr olds | % |
|---|---|---|
| Sentenced | 513 | *74.8* |
| Recall | 48 | *7* |
| Convicted unsentenced | 46 | *6.7* |
| Remand | 69 | *10.1* |
| Detainees | 9 | *1.3* |
| Other | 1 | *0.1* |
| Total | 686 | *100* |

| Sentence | 18–21 yr olds | % |
|---|---|---|
| Unsentenced | 124 | *18.1* |
| Less than 6 months | 381 | *55.5* |
| 6 months to less than 12 months | 131 | *19* |
| 12 months to less than 2 years | 47 | *6.9* |
| 2 years+ | 3 | *0.4* |
| ISPP | 1 | *0.1* |
| Total | 686 | *100* |

| Age | Number of prisoners | % |
|---|---|---|
| 18 years | 110 | *16* |
| Other | 576 | *84* |
| Total | 686 | *100* |

| Nationality | 18–21 yr olds | % |
|---|---|---|
| British | 596 | *86.9* |
| Foreign nationals | 90 | *13.1* |
| Total | 686 | *100* |

| Security category | 18–21 yr olds | % |
|---|---|---|
| Uncategorised unsentenced | 3 | *0.4* |
| Uncategorised sentenced | 121 | *17.6* |
| Category C | 3 | *0.4* |
| YOI Open | 5 | *0.8* |
| YOI Closed | 554 | *80.8* |
| Total | 686 | *100* |

| Ethnicity | 18–21 yr olds | % |
|---|---|---|
| *White* | | |
| British | 451 | *65.7* |
| Irish | 3 | *0.4* |
| Gypsy or Irish Traveller | 4 | *0.6* |
| Other white | 24 | *3.5* |
| *Mixed* | | |
| White and black Caribbean | | |
| White and black African | 4 | *0.6* |
| White and Asian | 3 | *0.4* |
| Mixed white and black Caribbean | 46 | *6.7* |
| Other mixed | 5 | *0.7* |
| *Asian or Asian British* | | |
| Indian | 19 | *2.8* |
| Pakistani | 18 | *2.6* |
| Bangladeshi | 7 | *1.0* |
| Other Asian | 15 | *2.2* |
| *Black or black British* | | |
| Caribbean | 29 | *4.2* |
| African | 28 | *4.1* |
| Other black | 10 | *1.5* |
| *Chinese or other ethnic group* | | |
| Chinese | 1 | *0.1* |

| | | |
|---|---|---|
| Arab | 1 | *0.1* |
| Other ethnic group | 15 | *2.2* |
| *Not stated* | 3 | *0.4* |
| Total | 686 | *100* |

| Religion | 18–21 yr olds | % |
|---|---|---|
| Church of England | 58 | *8.5* |
| Roman Catholic | 107 | *15.6* |
| Other Christian denominations | 126 | *18.4* |
| Muslim | 95 | *13.8* |
| Sikh | 5 | *0.7* |
| Hindu | 1 | *0.1* |
| Buddhist | 2 | *0.3* |
| Other | 2 | *0.3* |
| No religion | 290 | *42.3* |
| Total | 686 | *100* |

Sentenced prisoners only

| Length of stay | 18–21 yr olds | |
|---|---|---|
| | Number | % |
| Less than 1 month | 124 | *22.1* |
| 1 month to 3 months | 133 | *23.6* |
| 3 months to 6 months | 124 | *22.1* |
| 6 months to 1 year | 131 | *23.3* |
| 1 year to 2 years | 47 | *8.4* |
| 2 years + | 3 | *0.5* |
| Total | 562 | *100* |

Unsentenced prisoners only

| Length of stay | 18–21 yr olds | |
|---|---|---|
| | Number | % |
| Less than 1 month | 49 | *39.5* |
| 1 month to 3 months | 46 | *37.1* |

| | | |
|---|---|---|
| 3 months to 6 months | 20 | *16.1* |
| 6 months to 1 year | 7 | *5.7* |
| 1 year to 2 years | 2 | *1.6* |
| Total | 124 | *100* |