Report on an unannounced short follow-up inspection of

# HMP Lewes

4–6 May 2010

by HM Chief Inspector of Prisons

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# Introduction

Lewes is a small local prison mainly serving the courts of East and West Sussex, and holding both adults and young offenders. It has been undergoing badly needed modernisation and, since our last visit, two new wings had opened and a further two were closed for refurbishment. This unannounced short follow up inspection found that the prison remained commendably safe, with positive relationships and a much improved focus on resettlement, however there remained a need for more purposeful activity.

Early days in custody were generally well managed and the response to bullying and violence was robust. Vulnerable prisoners were no longer separated, but most still said they felt safe. Suicide prevention arrangements were under review and we saw examples of caring and thoughtful work with prisoners at risk. Security was generally effective and proportionate. Neither adjudications nor use of force were excessive, but the segregation unit was a temporary arrangement pending completion of the refurbishment. There had been some improvement in reducing substance misuse and clinical support was comprehensive.

The refurbishment programme was beginning to make a substantial improvement to the environment at Lewes. Relationships between staff and prisoners remained very good, although the personal officer scheme required further development. Diversity was generally well managed, but work with foreign nationals and older prisoners was underdeveloped. Faith and health care services were both generally good.

Lewes, like most local prisons, has traditionally lacked sufficient purposeful activity and, while there had been improvements since our previous visit, there were still too few activity spaces for the number of prisoners and their quality was limited. It was therefore disappointing to find that there was poor take up of the available education activity opportunities. Library and PE facilities were good. Time out of cell varied considerably.

Resettlement provision was much improved. Offender management was effective for those prisoners to whom it applied, although sentence planning for short-term and un-convicted prisoners was more limited. Work with indeterminate sentence prisoners was well managed and public protection arrangements were effective. Provision along a number of resettlement pathways had improved, although homelessness on release remained a problem and more support was needed to deal with finance, benefit and debt issues.

Lewes is a prison in transition, with considerable refurbishment underway and a number of other improvements being put in place, particularly in the resettlement arena. The prison has also sustained its strong emphasis on safety and good staff prisoner relationships and, while it needs to do more to get prisoners out of cell and into purposeful activity, this inspection has been able to confirm that Lewes is an improved and improving prison.

Nigel Newcomen — July 2010
HM Deputy Chief Inspector of Prisons

# Fact page

### Task of the establishment
HMP Lewes is a category B male local prison holding adult remand and convicted prisoners and remanded young adults, serving courts in East and West Sussex.

### Area organisation
South East

### Number held
496

### Certified normal accommodation (CNA)
623 (in-use CNA 495). B and F wings currently closed for refurbishment, and G wing acting as the temporary segregation unit.

### Operational capacity
507 (reduced from 723 due to the refurbishment project)

### Last inspection
Full inspection: 20-24 August 2007

### Brief history
HMP Lewes was used as a young offenders' prison during the 1940s and '50s. It briefly became a borstal in 1963 before developing into an adult training prison with a lifer wing. In 1990 Lewes became a local prison housing remand and convicted prisoners.

The newly opened Sussex wing will provide greater opportunities to retain sentenced Sussex prisoners with up to 12 months to serve before their release back into the local community, and enable effective links with partner agencies to be developed and expanded further.

### Description of residential units
A wing – local prison and remand centre holding 134.
C wing – local prison and remand centre holding 158.
G wing – temporary segregation unit (not on operational capacity).
K wing – first night centre holding 22.
L wing – sentenced category C adults holding 80.
M wing – local prison and remand centre holding 94.
Health care centre – inpatient facility holding 19.

# Section 1: Healthy prison assessment

## Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2007 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

| | |
|---|---|
| Safety | prisoners, even 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. |

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the National Offender Management Service.

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

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

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

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

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. 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 and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

## Safety

HP4 At our inspection in 2007, we found that Lewes was performing reasonably well (outcomes for prisoners were reasonably good) against this healthy prison test. We made 35 recommendations in this area, of which 20 had been achieved, five partially achieved and seven had not been achieved. Three recommendations were no longer applicable. We have made a further 41 recommendations.

HP5 Relationships between the prison and the main escort contractor, Serco, were good, and there were few delays for prisoners disembarking vehicles. Reception was clean and welcoming, with staff courteous and friendly. Prisoners were searched sensitively and given refreshments. The main holding rooms were spacious but needed cleaning, and televisions were not working. A Listener was available in reception. Arrivals were usually processed within an hour of arrival, and reception staff treated them well.

HP6 New arrivals went to the first night centre, K wing, for their first night assessment interview and health screening. The centre was managed by a dedicated staff group, including night cover. Newly arrived vulnerable prisoners were also held on this wing awaiting space on M wing. This caused some bed blocking, which meant some new arrivals went to C wing, although we were assured that they all received first night services. Vulnerable prisoners were unlocked during the core day but had little to occupy them. There was currently no peer support on K wing.

HP7 The first day of induction was spent mostly in cell with some limited visits from departments. Day two took place in the induction and pre-release centre, and provided information about Lewes, followed by assessments relating to resettlement needs. Induction appeared well coordinated and all prisoners received some input. There was good peer support from well-trained peer advisers, who undertake a qualification for the role.

HP8 The safer community strategy encompassed violence reduction and monitoring arrangements for bullies and victims. There was an adequately resourced and enthusiastic safer custody team, and governance was generally good. Data were used well to inform strategy, although a recent violence reduction survey had not yet been included in the broader improvement plan. The three-stage anti-bully procedure was in active use and incidents were properly investigated. Levels of violence were not excessive.

HP9 There was no longer a separate vulnerable prisoner wing. M wing was now integrated with approximately half of its 94 prisoners sex offenders, with no significant restrictions to regime. This integration was generally appropriate, and most prisoners said they felt safe. Problematic prisoners were generally allocated to M wing, but the atmosphere was positive and issues were well managed.

HP10 The suicide and self-harm policy was under active review. Assessment, care in custody and teamwork (ACCT) self-harm monitoring documents were of a reasonable standard, with some good examples of engagement, care and compassion. The quality of case reviews was generally good but many were insufficiently multidisciplinary. A significant number of staff had not received ACCT refresher training. The number of ACCTs that had been opened was not excessive. The continuous improvement plan was comprehensive and included actions from previous Prisons and Probation Ombudsman reports, but no interim actions following recent deaths in custody had been sanctioned.

HP11 Rules were explained to prisoners on their arrival and were well promoted subsequently. Security was well resourced and there was a high profile security committee, but attendance was sometimes unsatisfactory and there was little analysis. There was a significant number of security information reports (SIRs), which suggested good dynamic security, but arrangements to progress suspicion drug testing were underdeveloped.

HP12 The segregation unit was temporarily located on G wing. The unit was clean and bright with appropriate facilities, and prisoners there had access to basic amenities. Cells were generally satisfactory, but only one had electricity. The attitude of staff in the segregation unit was variable, and the quality of record-keeping, risk assessment and reintegration planning required improvement. The number of adjudications was relatively low, and procedures were fair. Relatively few were referred to the independent adjudicator.

HP13 Use of force was not excessive with about 40 recorded incidents over a six-month period. The relevant paperwork was generally good with evidence that de-escalation was used. However, there had been two incidents where batons had been drawn, but with no independent assessment or enquiry into them. Special accommodation had been used five times in 2009 and three times in 2010 to date. Several stays in special accommodation had been lengthy, and for at least one occasion records did not appear to justify its use.

HP14 There was a dedicated detoxification and stabilisation unit and a comprehensive prescribing regime. There was good care coordination between the counselling, assessment, referral, advice and throughcare service (CARATs), integrated drug treatment system (IDTS) and mental health teams, and psychosocial support was available during detoxification. The mandatory drug testing positive rate had reduced to 8% in April 2010. While supply reduction remained a challenge, drug-related finds were reducing.

HP15 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

## Respect

HP16 At our previous inspection, we found that Lewes was performing reasonably well (outcomes for prisoners were reasonably good) against this healthy prison test. We made 68 recommendations in this area, of which 41 had been achieved, six partially achieved and 18 had not been achieved. Three recommendations were no longer applicable. We have made a further 30 recommendations.

HP17 Since our last inspection, Lewes had opened L and M wings and had recently closed B and F wings pending refurbishment. The new accommodation on L and M wings was very good, but there was more traditional accommodation on A, C and K wings. Cells on the older wings designed for one held two prisoners, but toilets were separate. Cells and communal areas were generally clean and airy, and there were good facilities for prisoners with disabilities in the new accommodation. Access to amenities, cleaning materials and kit were good.

HP18 There was a standard incentives and earned privileges scheme, but with an effective warning process before a prisoner's regime level was reviewed. Staff and prisoners said that the system worked well and allowed prisoners to make mistakes without regression. The scheme was applied fairly and the number of prisoners on basic regime was low. A disparity in the number of black and minority ethnic prisoners on enhanced regime had not been investigated.

HP19 Staff-prisoner relationships were courteous and friendly, and nearly all prisoners we spoke to said staff were interested in them and helpful. Personal officers were not allocated to individuals but to landings. Relationships between prisoners and those they saw as their landing officers seemed good, and some entries in wing files suggested a degree of interaction. Management scrutiny of the scheme was not well developed.

HP20 The quality of food was good and portion sizes were reasonable, although breakfast packs were issued the night before consumption. There was a three-week menu cycle, and meals could be chosen up to 48 hours in advance. Servery and kitchen workers wore appropriate clothing and had received training. Food comments books were readily available and kitchen staff responded weekly. A twice-yearly survey had led to changes to the menu.

HP21 The shop operated a standard system. Prisoners placed their order forms on Sunday evening and received deliveries on their wing on the following Wednesday or Thursday. This once-weekly delivery meant that new arrivals could have delays in using the shop.

HP22 There were race equality, disability and foreign nationals policies, but each needed to be updated. There were action plans for some diversity strands, which also needed renewal. Quarterly diversity and race equality action team (DREAT) meetings addressed diversity generally, but focused on race. Attendance at meetings was reasonably good and included prisoner diversity representatives. Work on broader issues of diversity remained underdeveloped. In particular, there was relatively little on older prisoners, although this area was addressed by the disability liaison officer. The prison had good access for prisoners with mobility problems. There was little to address gay and bisexual prisoners, although there were supportive arrangements for one prisoner pursuing gender realignment.

HP23 There were prisoner diversity representatives on all wings, who usually met monthly with the race equality officer. Ethnic monitoring was evaluated monthly, but considered by the DREAT only quarterly. There was no consistent approach to ensure appropriate investigations when there were variations outside the expected range. The number of racist incident report forms received was relatively low, with only 77 in 2009. Investigations were reasonably managed and responses were appropriate.

HP24 Work with foreign national prisoners was underdeveloped. Their individual needs were not assessed, and there was no forum for them. Although 54 prisoners had been identified as foreign nationals, we were not assured that the information on file was accurate. There was little information on wings in languages other than English, and foreign national prisoners expressed frustration about access to advice and guidance. Interpreting services were used primarily on the first night centre. Links between the prison and UK Border Agency were reasonable, but there was no independent immigration advice.

HP25 Wing staff dealt with many minor issues without the need for applications. The formal system was very basic and there was no effective tracking system. Prisoners complained that answers took too long. In the previous six months, there had been 852 formal complaints. Replies were of good quality, although one complaint relating to a member of staff was dealt with inappropriately. Quality assurance arrangements were satisfactory. Legal services provision was facilitated by four trained staff.

HP26 Faith and religious provision was generally good. The multi-faith room and chapel were relatively new and well used, and the rooms could be used together for large events. Prisoners still had to apply the day before a service to attend.

HP27 Health services have been improved with refurbished accommodation, better management of waiting lists, and integrated working with the primary care trust. A health needs assessment was due to lead to further plans. Staffing had increased with a good mix of general and mental health staff, including the introduction of a prison psychiatrist. Primary care was well developed with nurse-led clinics for lifelong conditions. Mental health provision was good and included some primary mental health services, though day services for prisoners with mild to moderate mental illnesses were underdeveloped. Inpatients had good services with access to some meaningful activities, including education and PE.

HP28 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

## Purposeful activity

HP29 At our previous inspection, we found that Lewes was not performing sufficiently well (outcomes for prisoners were not sufficiently good) against this healthy prison test. We made 12 recommendations in this area, of which three had been achieved, four partially achieved and five had not been achieved. We have made a further seven recommendations.

HP30 Education had been provided by The Manchester College since August 2009. There were approximately 102 education places available on nine sessions a week, including literacy, numeracy, English for speakers of other languages (ESOL), computing skills, art and creative, business enterprise and customer care. Take-up of provision was low, and attendance was poor, at only 46% during inspection. The curriculum was now more suitable for short-stay prisoners and included more employment and healthy living courses. The resources in education had improved and outreach provision in literacy and numeracy was managed well with increased take-up. Achievement of qualifications was good for those who attended. Initial assessments were now available, but the prison did not monitor effectively the extent to which prisoners with poor literacy and numeracy made best use the provision. The

20 young adult prisoners were integrated into work, vocational training and education opportunities.

HP31 There was a narrow range of vocational training opportunities, although there had been some improvement to provision since the last inspection. There was insufficient promotion of vocational training and only a few prisoners were on courses. The Prisons Information Communication Technology Academy (PICTA) made a significant contribution to the opportunities on offer. A reasonable range of short courses had been added to the curriculum, which included health and safety and first aid. Other opportunities included industrial cleaning, painting and decorating, horticulture and catering although only a few prisoners accessed these.

HP32 There were still insufficient activity spaces for all prisoners, although these had increased slightly from 310 at the previous inspection to about 385. Prisoners were actively encouraged to work and there were appropriate processes for allocation to activities. However, most activity areas were underoccupied, and only around half of places were filled. The limited range of work included orderly responsibilities, work on the wings, gardens, kitchen and painting and decorating. There was good acquisition of skills in most areas, although around 5% of prisoners were engaged in low quality contract work. Pay was equitable and did not discourage prisoners from attending education.

HP33 The library had good stock rotation and the wide range of DVDs and CDs attracted more prisoners to use it, but book loss was high at 20%. There were efficient arrangements for books and newspapers in foreign languages. The library had been understaffed since January 2010. There had been little use of the survey needs analysis carried out after the previous inspection, and access was limited.

HP34 Provision for recreational PE was good, and included specific training sessions aimed at young adults and the over-45s. The facilities had improved since the last inspection and were mostly of a good standard. A new outdoor all-weather football pitch and a combined weights and cardiovascular suite had been added, and there was a good range of equipment. Attendance was generally low at 45%. Due to staff shortages, no vocational training was currently offered. Good links established with health care and CARATs since the last inspection had led to programmes of remedial sport where appropriate.

HP35 The prison reported a time out of cell figure of about 7.7 hours a day for 2009-10. A fully employed prisoner could achieve about eight hours unlocked, but for a significant number of prisoners this could be as low as three hours. A random roll check showed 43% of prisoners locked up during the working day. Exercise was rarely cancelled but was only for half an hour and early in the day for some, and take-up was low. Association was rarely cancelled, but there was some evidence of slippage in core day routines.

HP36 On the basis of this short follow-up inspection, we considered that insufficient progress had been made and that outcomes for prisoners remained not sufficiently good against this healthy prison test.

## Resettlement

HP37 At our previous inspection, we found that Lewes was performing poorly (outcomes for prisoners were poor) against this healthy prison test. We made 34 recommendations in this area, of which 17 had been achieved, eight partially achieved and eight had not been achieved. One recommendation was no longer applicable. We have made a further 26 recommendations.

HP38 The reducing reoffending strategy for 2008-11 incorporated an action plan, although the needs analysis required renewal. There was a bimonthly reducing reoffending policy meeting, but no evidence of monitoring of the action plan. Assessment of initial resettlement needs took place in the induction and pre-release centre. Referrals were made but processes were fragmented and lacked cohesion with pre-release procedures. Prisoners were invited to the pre-release centre about six weeks before release to see various departments, and new referrals were made if required. A full-time interventions manager had broader responsibility for community partnerships, and the prison was engaged with some through-the-gate resettlement partnerships.

HP39 About 100 prisoners were engaged in formal offender management. Offender supervision structures and processes were good, and relationships with offender managers appeared effective and engaged. Electronic contact logs were maintained for all prisoners but recorded levels of contact varied. Sentence planning boards were attended by staff from a range of relevant departments. There was some backlog in the completion of OASys (offender assessment system) assessments for those prisoners not in scope for offender management. With the exception of induction and pre-release assessments, sentence management for unconvicted and short-term prisoners was limited.

HP40 There were about 40 life-sentenced and indeterminate-sentenced prisoners, who were well managed through the offender management structures. Fortnightly evening surgeries were attended by supervisors, and separate lifer forums had also been held but not for some time. Onward allocation of some indeterminate-sentenced prisoners was problematic.

HP41 Two public protection administrators based in offender management unit screened all new arrivals for public protection issues. Monthly public protection meetings were held, but notes indicated limited discussion, which focused primarily on monitoring arrangements.

HP42 All new arrivals received initial housing needs assessments and onward referrals made. The preventing offender accommodation loss (POAL) and the Lewes2Brighton projects worked with short-term prisoners on housing issues, and a part-time housing worker addressed the needs of those outside the scope of these projects. In 2009-10, a high 14.2% of prisoners released had no accommodation arranged.

HP43 The provision of information, advice and guidance for employment, training and education had improved, with greater focus on careers information and advice at induction and before release. Peer advisers were trained to achieve a national vocational qualification (NVQ) at level three, and provided a good advice and guidance service to prisoners on the wings and in the induction and pre-release centre. Prisoners were offered a pre-release session and follow-up interviews with external partners, including Jobcentre Plus. Arrangements for prisoners to have a record of their training and achievements were now satisfactory. However, prisoners

did not have sufficient opportunities for interim reviews of their progress towards development targets or employment goals.

HP44 Prisoners attended pre-release health clinics to arrange continuity of care, and the mental health in-reach team provided pre-discharge care programme approach case management for prisoners with serious mental illness. Local community palliative care services were available.

HP45 There were separate drug and alcohol strategies. Services to help prisoners combat drugs were effective with good engagement from CARATs and access to the P-ASRO (prison addressing substance related offending) programme. Links to community drug intervention programme (DIP) workers were good. The short duration drugs programme (SDP) was due to be introduced. Services to help prisoners with alcohol dependence were being developed.

HP46 Work on the finance, benefit and debt pathway was underdeveloped. Prisoners were seen by Jobcentre Plus staff on induction and before release, and the Citizens Advice Bureau was available each week.

HP47 Access to visits had improved, and many were now booked via email. There were no reception visits and, while those on remand could receive visits quickly, sentenced prisoners had to send out a visiting order. There was no visitors' centre. The new visits hall was an improvement but stark and unwelcoming, and prisoners had to wear bibs during visits. Extended family visits were available and families were routinely invited to offending behaviour post-course reviews.

HP48 The range of accredited programmes had increased. In addition to the accredited drug programmes, the thinking skills programme and one controlling anger and learning to manage it (CALM) course a year were now available. The restorative justice Sycamore Tree course was provided four times a year.

HP49 On the basis of this short follow-up inspection, we considered that improvement was such that outcomes for prisoners were now reasonably good against this healthy prison test.

# 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 Accommodation on F and B wings should be refurbished. (HP42)

Achieved. Both units were closed at the time of inspection and were undergoing refurbishment.

2.2 The segregation unit should be refurbished urgently. (HP43)

Achieved. The segregation unit was closed in April 2010 to facilitate a full refurbishment, anticipated to take approximately 18 months. In the interim, the segregation unit had been moved to G wing.

2.3 More purposeful activity should be provided. (HP44)

Not achieved. Although the prison had improved the quality of some activity places, and had increased the number slightly from 310 at the previous inspection, there were still insufficient places to occupy the prison population. At the time of inspection, the prison had only 346 activity places for the current role of 470 prisoners. Even with a further 39 places planned in vocational training, such as bricklaying, this meant a considerable shortfall once the prison was at full operational capacity.
We repeat the recommendation

2.4 The provision of learning and skills and vocational training should reflect prisoners' needs and enable more prisoners to obtain accredited qualifications. (HP45)

Partially achieved. There had been a needs analysis since the previous inspection. In response to the findings, painting and decorating courses had been introduced and the Prisons Information Communication Technology Academy (PICTA) workshop had been increased. A workshop was ready to offer courses in bricklaying, although these had been delayed. Achievement of qualifications had increased in education and vocational training, but take-up of learning and skills opportunities was still low.

Further recommendation

2.5 The prison should ensure that places for learning and skills are maximised, enabling more prisoners to obtain accredited qualifications.

2.6 The reducing reoffending strategy should be revised to improve outcomes across the seven resettlement pathways. (HP46)

Achieved. The prison had a three-year strategy and action plan for 2008-11. The strategy incorporated, and was informed by, a needs analysis undertaken in 2008. Managers recognised this was out of date. A similar needs analysis based on a self-reporting survey of

prisoners' resettlement needs was under way at the time of the inspection. The 2008 needs analysis did not include information obtained from OASys (offender assessment system). The strategy included an overview of the prison's offender management arrangements and a description of each of the seven resettlement pathways.

Further recommendation

2.7 The reducing reoffending strategy should be based on a comprehensive annual needs analysis, which includes information from completed OASys (offender assessment system) assessments.

2.8 The prison should revise its offender management model to ensure that offender supervisors have the capacity to engage with prisoners and deliver sentence planning effectively. (HP47)

Achieved. The offender management unit had been restructured and additional resources had been allocated. There were two offender management pods. One pod was responsible for case managing the 63 prisoners in scope for phase two of offender management and consisted of one probation service officer, two prison officers and a case administrator. Cases were allocated to offender supervisors on a geographical basis. A second pod, which consisted of one probation officer, a prison officer and a case administrator, had case management responsibility for just over 40 prisoners serving indeterminate sentences, nine of whom were newly sentenced lifers. The three prison officers who acted as offender supervisors were rarely redeployed.

2.9 Custody planning should be provided for short-term and remand prisoners. (HP48)

Not achieved. At the time of the inspection, just over half the population were unconvicted or serving sentences of less than 12 months and therefore not subject to formal offender management processes or eligible for an OASys assessment. The prison's current arrangements did not constitute fully coordinated custody planning arrangements for these prisoners, but some elements had been established (see paragraph 2.310).

## Recommendations

### Courts, escorts and transfers

*No recommendations were made under this heading at the last inspection.*

### Additional information

2.10 Serco was the contractor for court services. Escort staff had a good relationship with reception staff, and important information was shared, including through prisoner escort records, which were completed to a good standard.

2.11 Vehicles were clean and held an adequate supply of emergency supplies and first aid equipment, but some cubicles had graffiti etched into the paintwork. Prisoners returning from court were held on the vehicle for the minimum time, and escort staff were respectful to prisoners.

2.12 Reception remained open throughout the lunch period and prisoners did not report lengthy waiting times outside the prison gate. Prisoners were generally received before 7pm, but there was facility to meet the immediate needs of those returning after this time.

2.13 The number of prisoners passing through reception had dropped since the refurbishment of B and F wing had started. An average of 22 prisoners a fortnight were discharged and 21 were received, of whom 42% were new receptions.

Housekeeping point

2.14 Vans used for transporting prisoners should be free from graffiti.

## First days in custody

2.15 Closed-circuit television cameras should be installed in the three reception holding cells used to accommodate vulnerable prisoners. (1.21)

Achieved. The three holding rooms 1, 2 and 3, had CCTV coverage, monitored appropriately by staff, which gave added protection for vulnerable prisoners.

2.16 Reception holding rooms should contain information and the means to keep prisoners occupied. (1.22)

Not achieved. None of the six holding rooms contained any reading material. The televisions in rooms 1, 2 and 3 did not work as they had no suitable aerial. Holding rooms 4, 5 and 6 had no televisions, but were rarely used.
We repeat the recommendation.

2.17 All new arrivals should spend their first night in custody in the first night centre or in designated cells. (1.23)

Partially achieved. K wing was a dedicated first night centre, which held up to 22 prisoners in double cell accommodation. In the previous two months, all new arrivals were located there after completion of the reception process. However, during the inspection some vulnerable prisoners were held on K awaiting spaces on M wing. This resulted in three new arrivals being located on C wing. They received their first night assessment on K wing before relocation.

Further recommendation

2.18 Vulnerable prisoners should not be located on the first night wing while awaiting allocation.

2.19 Staff should ensure that all prisoners attend the induction sessions. (1.24)

Achieved. The induction and pre-release centre coordinator ensured that all new arrivals attended induction. Any refusals were listed, and they were not allowed to progress through the prison and into work until they had attended induction. There had been only three refusals in the previous two months, and induction staff were actively pursuing them to attend. We saw one prisoner attending induction who had refused three weeks previously.

2.20 The induction DVD should be available in languages other than English. (1.25)

No longer applicable. The DVD was no longer part of the induction programme and had been replaced by two computers holding Lewes's induction programme in 22 languages.

2.21 Peer advisers should receive appropriate training and be given the opportunity to achieve relevant qualifications. (1.26)

Achieved. There were nine peer advisers. Each was required to undertake a national vocational qualification (NVQ) level three in information, advice and guidance (IAG) – three had achieved their NVQ and six were in training.

2.22 The role of peer advisers should be agreed and support for and management of the scheme clearly defined. (1.27)

Achieved. There was a job description for peer advisers, who were managed by a manager supported by the induction and pre-release centre coordinator.

## Additional information

2.23 The reception area was clean and welcoming, but toilets were dirty and there was some graffiti in holding rooms. A Listener was available to see new arrivals.

2.24 Reception staff treated prisoners respectfully and courteously, often using their first name. All prisoners were searched sensitively, and those waiting for transport were offered a hot drink. Prisoners who returned after the meal had been served were given something to eat, but were only kept in reception for a minimum time.

2.25 Prisoners deemed as potentially vulnerable were identified by the escort contractor before their arrival at the prison and reception staff were forewarned. The reception manager ensured they got off the bus first, asked them if they wished to be separated from the other receptions, and made a risk assessment.

2.26 Irrespective of vulnerability, all new arrivals were moved to the first night wing where they were given a risk assessment interview. They were also seen by a nurse and given the opportunity for a shower and a free two-minute telephone call. Prisoners with no money were offered a smoker's or non-smoker's pack, with the cost recovered over time, and those who arrived with money could buy three packs. The staff on K wing were from a dedicated first night centre group, and one of the team carried out the night duty to ensure continuity of care through the night.

2.27 The day after their reception, prisoners were moved to A1 landing where they saw the chaplain and a member of the legal rights team, but they spent most of this day in their cell. On day three, they attended the induction pre-release centre where they were given elements of the induction programme, an education assessment and a probation talk. The induction pre-release centre was a purpose-built building that was well laid out and free from interruption. There was no information booklet for the induction programme, and the morning session was only two and a half hours long, which was not long enough for new arrivals to gain enough information to enable them to settle at the prison.

2.28 At the end of the induction programme, prisoners were given a feedback form to comment on their experience. The feedback forms were due to be used to review the induction programme.

Further recommendations

2.29 Holding rooms should be redecorated and kept free from graffiti, and the toilets should be cleaned and maintained.

2.30 The induction programme should be restructured to ensure that prisoners are kept fully occupied and given the time to gain the required information.

Housekeeping point

2.31 An induction booklet should be produced to accompany the induction programme.

## Residential units

2.32 Cells designed for one prisoner should not accommodate two. (2.10)

Not achieved. A, C and K wings still had single cells that were being used for double occupancy.
We repeat the recommendation.

2.33 All prisoners should be allowed to wear their own clothes. (2.11.)

Not achieved. Only remanded prisoners and those on the enhanced privilege level were allowed to wear their own clothes.
We repeat the recommendation.

2.34 All in-cell toilets should be adequately screened.(2.12)

Partially achieved. A, K and C wing cells had separate en-suite facilities, while L and M wing cells had no screening around the toilet. Although the toilet could not be viewed from the observation panel, prisoners still had to eat in the same area.

Further recommendation

2.35 Toilets in cells on L and M wings should be screened.

2.36 All showers should be equipped with privacy screens. (2.13)

Not achieved. Showers on A, C and K wings were not screened and had no private cubicles. Those on L and M wings had individual cubicles.
We repeat the recommendation.

2.37 Safety testing of electrical items of prisoner property should be carried out quickly. (2.14)

Achieved. Reception staff said that this depended on the availability of a tester and/or the volume of electrical items sent in. The tester attended once a week. Catalogue purchases were not required to be tested.

2.38 Prisoners should have better access to telephones in the evening. (3.87)

Achieved. L and M wings each had eight telephones, A and C wings each had six telephones and K wing one telephone. The number was adequate for the number of prisoners. Telephones were activated during the evening association period in addition to the core day.

## Additional information

2.39 The wings were generally clean, light and airy with good lines of sight for staff. The cells were clean and free from graffiti, and prisoners were allowed curtains. However, cells on A1 were dirty and toilets were not clean.

2.40 M wing had designated disabled-access/reduced mobility cells, and the shower area had a disabled-access shower. The wing had a lift for prisoners with mobility disabilities. (See also disability and older prisoners section.)

2.41 Cell cleaning took place each day between 8am and 9am. Although this conflicted with the exercise period, cells were generally clean. Clothing exchange took place weekly, and the standard of clothes was acceptable.

Further recommendation

2.42 Cells on the A1 landing should be maintained to an acceptable standard.

## Staff-prisoner relationships

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.43 The positive staff-prisoner relationships observed when we last inspected remained. The residential units were relaxed, and the positive and respectful encounters between staff and prisoners was only limited by the amount of lock up for those not at activity during the working day (see time out of cell section). Nearly all prisoners we spoke to were positive about the staff, and saw them as helpful and respectful. However, staff use of prisoners' preferred names or titles was not well embedded.

## Personal officers

2.44 Personal officer entries in wing history files should demonstrate positive interaction with prisoners. (2.24)

Achieved. Lewes had moved on to the P-Nomis IT system and, as a result, all entries were completed electronically. Staff added an entry every two week. In the random sample we checked, the entries showed positive interaction with the prisoner.

2.45 Management checks of wing history files should include an analysis of the quality of entries. (2.25)

Not achieved. Managers' routine management checks did not include an analysis of the quality of entries and were mechanistic. Managers we spoke to did not know about the monthly

management quality check form referred to in the personal officer policy document, and the document was inconsistent about whether this check was monthly or weekly.
We repeat the recommendation.

Housekeeping point

2.46 The personal officer policy document should be reviewed and clarified.

2.47 Links between personal officers and offender supervisors should be improved. (2.26)

Partially achieved. There was evidence that some personal officers attended sentence planning boards and understood their role as a link to the offender management unit (OMU). However, other staff had no concept of the link and were unaware of their role in offender management.
We repeat the recommendation.

## Additional information

2.48 Personal officers made routine case notes for each prisoner on P-Nomis once a fortnight, but we saw limited entries in between these.

2.49 Prison officers were allocated a landing where they were personal officer to all prisoners. Most prisoners we spoke to said that they did not know the name of their personal officer, but that they could go to the landing officer for help. Cell cards displayed the names of all staff responsible for each individual landing.

2.50 Staff we spoke to understood their role to be one of assisting prisoners on their landings to deal with issues that did not require referral to other agencies, and signposting prisoners who did require a referral. Staff had a mixed understanding of their prisoners' circumstances, with some knowing their prisoners better than others, and this was reflected in some P-Nomis case note entries.

Further recommendation

2.51 The personal officer scheme should be developed in line with offender management, and staff trained accordingly.

Housekeeping point

2.52 Personal officers should make entries in prisoners' case notes in between the two-week routine entry.

## Bullying and violence reduction

2.53 All violence reduction activities should be amalgamated under the umbrella of the safer custody committee. The committee should meet monthly and focus on developing and improving local procedures. (3.11)

Achieved. The safer custody committee met monthly to discuss all aspects of safer custody,

including violence reduction. The minutes from these meetings showed an appropriate focus on developing and improving local procedures.

2.54 All alleged incidents of bullying should be reported and investigated, and entries in wing observation books regularly checked. (3.12)

Achieved. The safer custody team maintained a comprehensive violence reduction database. In 2010 to date, over 200 safer community monitoring report forms had been submitted and appropriately investigated as a result of violent or antisocial behaviour. The majority of these related to minor incidents, and only 20 were for more serious events. In the previous six months, 38 prisoners had been placed on stage one of the safer community monitoring system as alleged bullies, seven of whom had been escalated to stage two and two to stage three. At the time of inspection, only one prisoner was being monitored under the system, on stage three, who was located in the segregation unit. The safer custody team regularly checked observation books to ensure that all incidents were reported and recorded, and liaised with the security team weekly to ensure that all sources of data were corroborated.

2.55 Bullying incidents reported through the racist incident report system should be referred to the anti-bullying coordinator. (3.13)

Not achieved. There was evidence that some racist incident report forms made allegations of bullying, but these were not routinely referred to the safer custody manager/team for investigation

Further recommendation

2.56 Bullying incidents reported through the racist incident report system should be referred to the safer custody manager/team for investigation.

2.57 Following staff training, the revised anti-bullying strategy should be fully implemented. (3.14)

Partially achieved. Staff training and awareness sessions on the safer community monitoring system had been delivered to the majority of staff and the system had been fully implemented. However, as a result of the recent implementation of P-Nomis, it had been decided to maintain the safer community monitoring system electronically. Despite additional guidance, some staff were not fully familiar with the new requirements, and observations were not always maintained within case notes as required.

Further recommendation

2.58 All staff should be made aware of the requirements for maintaining the safer community monitoring system on P-Nomis.

2.59 Information on bullies and victims should be cross-referenced into wing history files. (3.15)

Achieved. Information was entered onto P-Nomis in all cases, identifying prisoners as either alleged bullies or victims.

2.60 Support plans for victims of bullying should be provided. (3.16)

Not achieved. Although the safer custody team and residential staff were aware of who the victims of bullying were and could cite some informal measures taken to support them, there were no formal support plans in place.
We repeat the recommendation.

## Additional information

2.61 There was a coherent violence reduction and safer community strategy for 2010-11. Its day-to-day operation was managed by the safer custody team, which included a developing prison service manager (DPSM), a senior officer and an administrative officer and was overseen by the head of residence, all of whom were also responsible for the ongoing management of suicide prevention and self-harm protocols. Although the violence reduction coordinator post had recently been lost through efficiency savings, the team felt sufficiently resourced to undertake effective violence reduction duties.

2.62 The head of residence chaired the monthly safer custody committee. A brief violence reduction report was recorded, along with feedback from prisoner representatives, and some statistics on type and location of incidents were presented. However, analysis of data from different sources about violence, bullying and intimidation (including adjudications, incident report system, IRS, and accident report forms) was not sufficiently discussed or recorded.

2.63 Although the violence reduction database gave assurance that all incidents were recorded, it also showed that many incidents were low level. Of the 268 incidents recorded on IRS from October 2009 to March 2010, only 50 related to assaults and fights, and significantly fewer went on to be proved at adjudication. While not insignificant, these numbers were not high for the type of establishment.

2.64 There had been a safer community survey in January 2010, with 391 responses from the almost 700 forms issued. Some useful conclusions had been drawn but had not yet at been incorporated into the otherwise comprehensive violence reduction continuous improvement plan.

2.65 Safer custody was given a high priority throughout the establishment, and noticeboards clearly identified inappropriate behaviour and a zero tolerance approach to bullying. Leaflets about bullying and the consequences of such behaviour were given to all prisoners during induction. Staff and prisoner violence reduction representatives had been appointed on all units. They understood their role and were active in trying to maintain a safe community at Lewes.

Further recommendations

2.66 Analysis of all data sources on violence, bullying and intimidation should be submitted to the safer custody committee for scrutiny.

2.67 Results from the annual safer community survey should be used to inform appropriate actions in the continuous improvement plan.

## Young adults

2.68 The prison should carry out a full analysis of the needs of young adults and act on any findings. (3.43)

Not achieved. The number of young adults held at Lewes had declined since the last inspection and was currently only 20 (compared with 30 in 2007). Young adults were more widely spread across the establishment than at the previous inspection. Following the previous inspection, the learning and skills department had completed a strategy document for safeguarding young and vulnerable adults but this was primarily orientated to the range of provision available via the learning and skills department and was not based on a specific needs analysis. The document was not dated and there was no indication as to how progress was measured or that it was updated on a regular basis.
We repeat the recommendation.

## Vulnerable prisoners

2.69 Reintegration planning for prisoners on the care and separation unit should be further developed, with targets that aim to improve prisoners' behaviour and increase their coping skills. (3.44)

No longer applicable. The CAS unit had been closed since the previous inspection.

## Additional information

2.70 There was no longer a dedicated vulnerable prisoner wing. M wing had been identified as an integrated unit, and approximately half of its population were convicted of sex offences. All prisoners were allocated a single cell. The other residents were poor copers and those who had got into debt, but some prisoners had opted to be allocated there because it tended to be quieter and, as a relatively new wing, offered a good standard of accommodation. Generally this integrated model worked well. Although some prisoners perceived the wing as the place where problematic prisoners were located, most we spoke to said that they felt safe. There were no significant restrictions on the regime for prisoners on M wing.

2.71 At the time of the inspection, nine prisoners on K wing, the first night centre, were waiting to move to M. This had caused some difficulties in blocking beds for new arrivals (see paragraph 2.17), but delays were relatively short and rarely more than two weeks. K wing was also integrated, and prisoners there could associate relatively freely.

## Self-harm and suicide

2.72 Meetings of the safer custody team should be attended consistently by all key departments. Where a member of the committee is unable to attend, a fully briefed deputy should do so. (3.27)

Partially achieved. Although there had been significant improvements in the attendance at the safer custody committee meetings, on a few occasions in the previous six months key members from the security and drug strategy teams had not been represented.
We repeat the recommendation.

2.73 Adequate cover should be provided for the safer custody coordinator. (3.28)

Achieved. Although there was no designated relief officer, there was always someone available in the adequately resourced safer custody team to deal with issues as they arose.

2.74 All permanent members of night staff should receive assessment, care in custody and teamwork (ACCT) training. (3.29)

Achieved. Staff trained to deliver ACCT foundation and refresher training had attended the prison recently during the night state to deliver appropriate training to all night staff.

2.75 The quality of initial assessment, care in custody and teamwork (ACCT) assessor reports should be significantly improved, case reviews should not be conducted by a single member of staff and monitoring entries in documents should demonstrate a high level of engagement by staff with the prisoner concerned. (3.30)

Partially achieved. The quality of initial assessments had significantly improved and most documents demonstrated care and compassion, along with good levels of engagement. Quality assurance measures were good, and senior managers shared responsibility for the quality of ACCT documents. However, there was no multidisciplinary approach and inconsistent case management. There were still examples of case reviews being conducted by a single member of staff, and care maps were sometimes limited. Managers attributed these problems in part to the cancellation of scheduled case manager training for relevant staff. Most prisoners on ACCTs appeared to be involved in some activity, but the ACCT did not always accompany them to their place of activity.

Further recommendations

2.76 Case reviews should not be conducted by a single member of staff.

2.77 Case management for prisoners on assessment, care in custody and teamwork (ACCT) monitoring should be consistent and involve staff from different departments.

2.78 Only staff who have completed case manager training should develop care maps and chair ACCT case reviews.

2.79 ACCT documents should accompany prisoners to their places of activity.

2.80 Prisoners should have 24-hour access to Listeners. (3.31)

Achieved. Managers said that prisoners had unhindered access to Listeners, but acknowledged that at certain times, particularly at night when there was reduced staffing, there could be short delays in delivering Listeners to the required location.

Further recommendation

2.81 Any delays in accessing Listener services should be kept to a minimum and should be monitored.

2.82 Prisoners should only be placed in strip clothing to prevent acts of self-harm in exceptional circumstances and after other methods of support and constant

engagement have been tried. (3.32)

Achieved. Prisoners were only placed under constant watch in the health care centre as a clinical intervention, and there were no records of prisoners being placed in strip clothing as a result. Records of use of the two constant watch suites in health care were not routinely maintained, and the safer custody team did not monitor this. There were no records in the segregation unit to suggest that strip clothing had been used to prevent self-harming activity.

Further recommendation

2.83 Any use of constant supervision facilities in the health care centre should be reported to the safer custody team, and a log should be maintained.

## Additional information

2.84 The safer custody strategy document covering suicide and self-harm was unwieldy and considerably out of date, but was being reviewed. The safer custody committee covered statistics about the number and types of self-harm, feedback from Samaritans, monitoring of the quality of ACCT documents, and learning points following deaths in custody, but did not analyse data for trends and patterns. As with violence reduction, there was some useful discussion during the meeting, but the minutes did not always indicate actions needed to address issues or inform strategy.

2.85 Tragically, since the previous inspection there had been two apparent self-inflicted deaths, one illicit drug overdose shortly after release, and three deaths from natural causes, all of which had been discussed by the safer custody committee. A comprehensive suicide prevention and self-harm reduction continuous improvement plan included appropriate action points from previous Prisons and Probation Ombudsman (PPO) reports following deaths, but it was difficult to establish the source of specific action points on the plan. The establishment had not drawn up interim action plans to address issues from recent self-inflicted deaths, and was still awaiting advice from the PPO. Although we were told that there had been local investigations into serious attempts at suicide or self-harm, we were not given any evidence during the inspection, and there was insufficient discussion on these recorded at the safer custody committee. Despite these recent deaths and improvements in training for night staff, over 130 staff were out of date with ACCT refresher training.

2.86 At the time of the inspection, 19 prisoners were on ACCT documents. In the previous six months, there had been 106 ACCTs opened and 59 acts of self-harm. Although significant, these figures were not particularly high for the type of establishment. Suicide and self-harm prevention were given high priority throughout the establishment, and there was clear commitment from staff and managers to caring for those at risk.

2.87 The prison found it difficult to retain Listeners after they had been trained, and only 10 were currently in place. However, there was an appropriate and supportive relationship with the Samaritans. There were no care or crisis suites, but there were community areas on most wings where Listeners could see other prisoners during the core day. These rooms were not ideal for managing someone in crisis, and at night Listeners were required to see prisoners in their cells.

2.88 The contact number for the Samaritans was available by all telephones, and a safer custody hotline was well publicised and had been used seven times in the previous six months.

2.89 The prison had developed some standardised forms for managing and engaging prisoners on ACCTs, including a form for disclosing next of kin details, a personalised letter explaining the ACCT process to the prisoner, and a form describing post-closure sources of support.

Further recommendations

2.90 The suicide and self-harm prevention strategy should be revised and updated, and should be amalgamated with the violence reduction strategy into an overarching safer community strategy.

2.91 The safer custody committee should analyse data on suicide and self-harm to identify trends and patterns, and to inform strategy.

2.92 Interim action plans should be developed following a death in custody to identify immediate improvements.

2.93 Serious attempts at self-harm or suicide should be thoroughly investigated and discussed at safer custody committee meetings.

2.94 ACCT refresher training should be prioritised for all staff.

2.95 A crisis suite should be available at all times.

## Applications and complaints

2.96 Applications should be logged and tracked and the results recorded. (3.101)

Not achieved. Prisoners made wing applications in the morning, which were logged in the applications book and distributed for a reply. Replies went directly to the prisoner. Prisoners told us that they often did not get an answer or that replies took a long time to reach them. There was no evidence of tracking or recording of the results.
We repeat the recommendation.

2.97 Prisoners should be encouraged and enabled to solve areas of dispute and make simple applications before making official complaints. (3.102)

Achieved. Prisoners said that staff assisted them in dealing with simple applications, and the log of applications held on each wing supported this.

## Additional information

2.98 In the previous six months, there had been 852 recorded complaints. The major areas of complaint were finance, property, activities, and offender management. Responses were good, with supporting evidence attached. Prisoners were often referred to by their first name or 'Mr'. A quality assurance system supported the process and complaints were answered promptly. However, one complaint we sampled had been answered by the member of staff that the prisoner was complaining about. Information on the residential units was sparse.

Further recommendations

2.99 Complaints against named members of staff should not be answered by that individual.

2.100 Information on the application and complaints processes should be advertised on the residential units.

## Legal rights

2.101 Suitable facilities for legal visits should be provided. (3.106)

Achieved. The legal visits facility provided eight tables and nine individual rooms. The facility was bright and fit for purpose.

2.102 Official visitors should not have to wait for long periods before the visit begins. (3.107)

Achieved. The log of legal visits for the previous six months indicated that visits started on time and there were no lengthy periods of waiting for legal visitors.

## Additional information

2.103 A bail information officer saw all new arrivals, as well as any prisoner who made a request. The officer made referrals to ClearSprings, who was the main accommodation partner, although it only had accommodation in the Portsmouth, Southampton and London areas. Local landlords were used for prisoners who needed to be located in Sussex. The bail information officer also gave out information on request.

2.104 There were four trained legal rights officers, two of whom worked on K wing. Legal aid was profiled for four hours each weekday. Legal rights officers saw all new arrivals during induction and other prisoners through a wing application. They dealt with change of status, sentence, appeal, arranging solicitors and assisting with paperwork. There was no information on the residential units to inform prisoners of the service.

Housekeeping point

2.105 Legal rights and bail information should be displayed on noticeboards in the residential units.

## Faith and religious activity

2.106 Prisoners should not be required to sign up in advance to attend religious services. (5.40)

Not achieved. The prison had rejected this recommendation on the grounds that it needed to know how many prisoners wanted to attend and who, for security and management reasons. There was no indication from the complaints system or from chaplaincy staff that prisoners were not able to access services when they wanted to attend.

2.107 Arrangements should be made to ensure that prisoners with mobility problems who wish to attend services are able to do so. (5.41)

Achieved. The new chapel and multi-faith rooms had disability access via a ramp.

2.108 Prisoners of all faiths should be able to worship in decent and respectful surroundings. (5.42)

Achieved. The building and opening of the new chapel and multi-faith rooms ensured that all prisoners could use appropriate places of worship.

2.109 The new multi-faith building should be designed to cater for the needs of the anticipated prison population. (5.43)

Achieved. The new multi-faith room was large, light and airy. It was sufficient to accommodate comfortably the number of prisoners attending services. The chapel and multi-faith rooms were connected by a dividing panel, and either room could be extended to accommodate larger numbers.

## Additional information

2.110 The coordinating chaplain was from the Church of England and was supported by a team of part-time and sessional chaplains. There were currently 24 Muslim prisoners, of whom approximately 20 attended weekly Friday prayers. There were weekly Islamic classes.

2.111 A chaplaincy representative saw all new arrivals the day after their reception. There was a reasonable range of services and provision, and all services were integrated to include vulnerable prisoners. Alpha courses were provided twice a year, and the Sycamore Tree (victim awareness course) was delivered four times a year.

## Substance use

2.112 Opiate-dependent prisoners should be provided with appropriate first night clinical support. (3.121)

Achieved. Prisoners with opiate-substitute prescribing needs were seen on the first night by appropriately trained GPs who were contracted to prescribe first night clinical management, including opiate substitutes and symptomatic relief if required. The counselling, assessment, referral, advice and throughcare service (CARATs) followed up new arrivals within 24 hours, and integrated drug treatment system (IDTS) staff saw those with clinical needs.

2.113 The detoxification unit should be staffed by a team of dedicated officers who have received drug awareness training. (3.122)

Achieved. Staff working on the detoxification unit, including uniformed officers, received a multidisciplinary international treatment effectiveness programme, and further drug awareness training was planned.

2.114 Prisoners on the detoxification unit should be provided with structured psychosocial support. (3.123)

Achieved. The IDTS team provided individual psychosocial support for prisoners on the detoxification unit, and CARATs workers provided structured inputs on the unit.

2.115 Health and CARAT services should formalise joint working arrangements to coordinate prisoners' care. (3.124)

Achieved. An IDTS project board met bimonthly with good representation from the prison. There had been formalised joint working arrangements between health and CARAT services, with minuted meetings since the introduction of IDTS in 2009, and there were frequent informal meetings.

2.116 Healthcare providers' skills mix should include dual diagnosis expertise. (3.125)

Achieved. The IDTS team had recruited registered mental health nurses with experience of working with substance misusers with mental health needs.

2.117 The prison should ensure that sufficient resources are available to increase the level of target testing. (3.126)

Achieved. There were dedicated facilities and staffing for target drug testing. In the previous six months, 166 tests had been completed. In the last full month, there had been seven suspicion tests of which 28.6% were positive (compared to an expected rate of 60%). The drop in test rate was partly due to the reduction in prisoners following F wing closure. The low positive rate was attributed to insufficient analysis of security information reports, and there had been action to address this issue. In the previous month, there had been 30 risk assessment drug tests and three frequent testing programme tests, of which none were positive.

## Additional information

2.118 There had been an overall improvement in the clinical management of substance-dependent prisoners with the introduction of IDTS, the dedicated detoxification unit, the availability of 24-hour registered nursing staff and dedicated medical staffing, and the introduction of iris recognition methadone dispensing equipment. There were plans to introduce a drug-free unit when F wing refurbishment was completed. Prescribing regimes conformed to national guidance and implementation was flexible. Information about blood-borne viruses was displayed in the prison, and prisoners were offered opportunities for testing. In the previous six months, 88 new arrivals had been screened for drugs, with an average positive rate of 55.5% (range 40-78.6%) for cannabis or opiates. The random 2009-10 mandatory drug testing (MDT) rate was 10.5% against a target of 8%.

2.119 There were active supply reduction measures, including the installation of new fencing and netting and the employment of two dog handlers and dogs. In the previous three months, there had been 79 drugs and alcohol related security incidents; the trend was downward. Drugs finds accounted for the majority of incidents, followed by active or passive dog drug finds and drugs-over-the-wall finds (the latter had fallen to one incident in the last month).

## Diversity

2.120 All aspects of diversity should be subject to the same rigorous strategic planning and routine monitoring as exists for race equality. (3.53)

Not achieved. A diversity and race equality action team (DREAT) met quarterly, was appropriately constituted and well attended, including prisoner representatives. The meeting was chaired by the governor. Lead officers for race, foreign nationals and disability strands attended the meeting and usually produced reports on their areas. There was, however, no overarching diversity policy and, while race, disability and foreign national work was covered by separate policy documents, there was little on other areas – age, sexual orientation or faith. The race equality and foreign nationals policies were also out of date. The diversity and race equality action plan (DREAP) was out of date and exclusively oriented to race. There were no objectives for sexual orientation, foreign nationals or faith. The disability policy was up to date and included identified objectives and an action plan, but the latter was also out of date and was not reviewed regularly. There was monthly ethnic monitoring, but no comparable monitoring for other aspects of diversity.

Further recommendations

2.121 All aspects of diversity should be covered by appropriate policies, development objectives and action plans.

2.122 The diversity and race equality action team (DREAT) should regularly and consistently review strategic developments for all aspects of diversity.

2.123 All areas of diversity should be subject to routine monitoring to assess the impact of the prison's regime on minority prisoner groups.

2.124 The time allocated to specialist diversity posts should be reviewed to ensure that adequate resources (including contingency support and cover for absences) are provided to meet the needs of minority prisoner groups. (3.54)

Partially achieved. Since the previous inspection, the prison had introduced the post of a full-time diversity manager along with the race equality officer. A part-time disability officer was also in post, working 3.5 days a week and also covered issues relating to older prisoners and, nominally, sexual orientation. This system allowed for appropriate cover in the event of absences and there was, appropriately, some overlap in the work that each member of the team undertook. The foreign nationals function sat outside the diversity team and the role of foreign nationals coordinator was undertaken by a senior officer who was also responsible for visits. Foreign nationals work was underdeveloped (see section on foreign nationals), and the coordinator's post had been undertaken by three different officers in the previous 12 months. We were told that there had been regular problems with the allocation of facility time to manage and develop the role. Although some aspects of foreign nationals work were supported by the wider diversity team, we were not assured that there were sufficient resources to ensure necessary support for this group of prisoners.
We repeat the recommendation.

2.125 All staff, particularly those in direct contact with prisoners, should receive training and guidance to help them understand and respond appropriately to the specific needs of minority prisoner groups. (3.56)

Partially achieved. The 'challenge it, change it' staff training programme had been introduced at Lewes, although none has been run since before Christmas 2009. At the time of the inspection, 174 staff had completed the course and a further 45 newly appointed staff had completed a diversity programme as part of their induction – a total of 61%. A new schedule had been agreed with a rolling programme to ensure a course was run every four weeks,

starting the week after our inspection. There was no specific priority given to staff in direct contact with prisoners or those undertaking the role of diversity officers on wings. We were concerned that one officer had, in November 2009, been recommended to undertake the 'challenge it, change it' course following a racist incident form investigation but, at the time of the inspection, had yet to complete it.
We repeat the recommendation.

Further recommendation

2.126 Where there are specific recommendations that members of staff should undertake training as part of their personal development, this should be prioritised.

## Race equality

2.127 The system for dealing with racist incidents should be reviewed to ensure that timely and thorough enquiries are made and recorded, and the complainant should be given a detailed explanation of the enquiries conducted and the reasons for any decision, and all available appeal procedures should be explained. (3.65)

Achieved. There had been 77 racist incident forms (RIFs) submitted in 2009 and 97 in 2008. In 2010 to date, only 12 had been submitted, with none recorded in March 2010. It was not clear why the number of RIFs in the first three months of the year was so low. Concerns about this had been raised at the DREAT meeting in April 2010, but an analysis had yet to be undertaken. RIFs were managed and cases investigated by either the race equality officer or the diversity manager. The quality of RIFs was generally of a good standard. Responses to prisoners or staff were appropriately detailed and respectful. Prisoners were also informed about how to make an appeal. All RIFs were also reviewed and signed off by the governing governor, and it was apparent from attached comments that cases were considered in some detail. A quality assurance scheme included a review of a proportion of all cases by the Lewes group in support of immigration and asylum seekers.

2.128 Attempts should be made to conclude enquiries even after a witness or complainant has been discharged. (3.66)

Achieved. All investigations were concluded, regardless of whether a prisoner had been transferred or released. We saw one case where four prisoners had raised a complaint regarding a particular incident. Although one prisoner was released from court and another transferred, the investigation was concluded and the information forwarded to the prisoner still in custody.

2.129 There should be a programme of regular events to celebrate racial, ethnic and cultural diversity. (3.67)

Achieved. There had been a reasonable range of events to celebrate racial, ethnic and cultural diversity. Along with the recent celebration of the Chinese New Year, the prison had also celebrated black history month and produced staff/prisoner meals with specific ethnic themes, drawing on community input. In support of this work, a monthly leaflet for both staff and prisoners outlined festivals and anniversaries in the forthcoming month, and included brief articles giving information about particular events or occasions.

## Additional information

2.130 The black and minority ethnic population at Lewes was 10.3% (49 prisoners), although a further 38 (8%) were included in prison figures even though they were actually white non-British. Each wing had both prisoner and officer representatives. Each wing office also contained a resource/information pack that included a range of advice and information. Staff on the wings were aware of this pack and what it included. Monthly representative meetings were chaired by the race equality officer and were well attended, although officers were less likely to be able to attend. A range of issues was covered, and some training was included. Although in theory the full range of diversity issues were covered by the meetings, in practice the primary focus was on race. Prisoner representatives were also encouraged to attend the DREAT meetings.

2.131 Monthly SMART (systematic monitoring and analysing of race equality treatment) ethnic monitoring was undertaken and information shared with prisoner representatives and discussed at the DREAT. Although the 10 mandatory areas were covered, no locally agreed areas were included. Returns most months fell within the anticipated range, but this was not always the case and there was no formal system to trigger an investigation in such cases or where there was a pattern of poor returns over a period.

Further recommendation

2.132 Where SMART ethnic monitoring identifies over- or under-representation, an appropriate analysis should be undertaken, reported to the DREAT and remedial action taken.

## Religion

2.133 Although a representative from the chaplaincy attended the DREAT, there was no specific involvement in the wider diversity provision. There was no monitoring of the impact the prison's regime had on different faith groups (see further recommendation 2.123).

## Foreign nationals

2.134 Foreign national prisoners should be offered regular contact with accredited independent immigration advice and support agencies. (3.74)

Not achieved. Although there were some links with the Lewes group in support of immigration and asylum seekers, there was no mechanism to allow prisoners to access this service, though the prison was negotiating a link and forum.
We repeat the recommendation.

2.135 Foreign national support and information groups should be held at least monthly. (3.75)

Not achieved. There were no forums specifically for foreign national prisoners. Some of the prisoner diversity representatives who met monthly were also undertaking the dual role of foreign nationals representatives (see below). Foreign national issues could potentially be raised at the diversity representatives meeting, but this was rare. There was no wider forum for other foreign national prisoners.
We repeat the recommendation.

2.136 The foreign national officer's expertise should be spread more widely and additional support provided. (3.76)

Not achieved. Although the prison had a nominated foreign national coordinator, he had been in post for only a few weeks. There were indications that the needs of foreign nationals had been neglected before he took up the post. Each wing had indentified foreign national officer and prisoner representatives, but their roles were yet to be clearly defined and the representatives were awaiting guidance and information about the role. Although each wing had a copy of the foreign nationals policy, which also offered some general guidance to staff, this was now out of date (see paragraph 2.120).

Further recommendation

2.137 The roles of prisoner and officer foreign national representatives should be clearly defined, and well publicised.

## Additional information

2.138 At the time of the inspection, there were 54 foreign national prisoners at Lewes. A further 59 had been identified who were thought might be foreign nationals, but information on file was unclear. The prison depended on information about new arrivals' nationality being logged by staff on K wing (first night centre), but this was not consistent. There had been some recent attempts to rectify this shortfall, and UK Border Agency (UKBA) was informed of these potential foreign nationals.

2.139 There was no system to assess the specific needs of foreign nationals. No evaluation was made of their family needs, language limitations or need to contact outside organisations. As a consequence, there was no needs analysis of these prisoners and, consequently, few support mechanisms. There was very little information in the establishment in languages other than English. Basic generic information about prison life in general was available in 22 languages, but this was not specific to Lewes. Some information about Lewes was available on K wing, but staff there were unclear about the languages that the leaflets were in. However, telephone interpreting services had been used on 63 occasions in the six months to April 2010, mostly on K wing for first night assessments. Although the prison used prisoners as interpreters where possible, this was not appropriate in sensitive circumstances, such as in health care or adjudications.

2.140 Foreign national prisoners we spoke to expressed considerable frustration about their circumstances and many felt isolated. Information about access to free telephone calls each month, in lieu of visits, or the exchange of ordinary letters for airmail was not widely known. Only 90 telephone cards had been issued in the previous six months.

2.141 There were reasonable links with UKBA, who usually visited the prison twice a month. Prisoners could make appointments to see the representative during these surgeries, although some foreign national prisoners said that they were unaware of this. At the time of the inspection, six prisoners were held solely on detention notices, the longest of whom had passed his release date in August 2009.

Further recommendations

2.142 All foreign national prisoners should be assessed for their specific needs, information from this should be used to formulate a needs analysis, and the prison should work to meet these needs.

2.143 A wider range of information, including details of the prison's regime and policies, should be available in different languages.

2.144 Professional interpreting services should be used for prisoners with poor English during health care consultations and adjudications.

2.145 Information about access to free telephone calls in lieu of visits and airmail letters in exchange for ordinary letters should be made available to all foreign national new arrivals in a language they can understand.

2.146 Information about access to the UK Border Agency should be available to all foreign national new arrivals in a language they can understand.

## Disability and older prisoners

2.147 All prisoners over retirement age and all prisoners with disabilities should have individual care plans based on their needs. (3.55)

Partially achieved. Prisoners with a declared disability (23 at the time of the inspection) were reviewed by the disability liaison officer (DLO) but were not, as a matter of course, subject to a care plan. Where specific intervention and/or support was required, a care plan and/or personal emergency evacuation plan (PEEP) was completed, copied to the prisoner and available to staff on his wing. Where prisoners required medical interventions and support, separate health care plans were completed. This model was, broadly, appropriate, and links between the disability liaison officer and identified health care lead for disability were reasonable. All prisoners over retirement age (six at the time of the inspection) were also reviewed by the disability liaison officer and a log maintained of them. There was no formal mechanism of review, although the DLO undertook this informally. Care plans were in place if there were specific needs, due primarily to infirmity, but these were logged under disability.

## Additional information

2.148 All new arrivals were assessed for disability during induction. First night and/or induction staff completed specific assessment forms, and there was a reasonable amount of information for prisoners on facilities at the prison. Health care staff also undertook assessment and, while there was no central database, information was generally shared. Links with education regarding learning disabilities were less good, and there was no formal forum for information to be shared or collated.

2.149 Of the 23 prisoners identified with a disability, four were in wheelchairs and a further two had poor mobility; all six prisoners had PEEPs. There was one adapted cell in health care and four further cells on M wing, along with an appropriately adapted shower. A disability access review had been undertaken since the last inspection, and there had been considerable effort to ensure that prisoners with disabilities had appropriate access to all parts of the prison. Several wheelchair lifts and ramps had been constructed. The prisoner diversity representatives'

meetings and the broader prisoners' council regularly included issues raised by prisoners with disabilities, although there was no specific forum for them.

2.150 The disability liaison officer also managed work on prisoners over the age of 50. At the time of the inspection, there were 36 prisoners over 50, of whom 17 were over 60. The oldest prisoner was 72. Ten prisoners over 60 were located on M wing. There was no specific prison regime for older and/or retired prisoners. As with prisoners with disabilities, some were able to work off the wing, and a few wing-based jobs were also available. Older prisoners remaining on wings during the core day were not always unlocked, and there was little to occupy those who did not work. Retirement pay was only £4 a week, and prisoners who were retired still had to pay for their televisions.

Further recommendations

2.151 There should be formal links between education, health care and the disability liaison officer to ensure appropriate support for all prisoners with a disability.

2.152 Retirement pay for prisoners should be the same as the average wage for other working prisoners.

2.153 Prisoners over 60 should not have to pay for their television.

2.154 Older and disabled prisoners remaining on wings during the core day and not working should be offered a regime to fully occupy them.

## Sexual orientation and gender

2.155 Relatively little had been done to develop this strand of diversity. Some links had recently been made with a lesbian, gay, bisexual and transgender group in Hastings, as well as a support conference in Brighton, but these had yet to be translated into services and support for prisoners across the establishment. There was little information about the promotion of anti-homophobic views and attitudes, and no specific forum for prisoners. Issues regarding gay and bisexual prisoners were rarely discussed in DREAT meetings.

2.156 At the time of the inspection the prison was holding one transgender prisoner. There was evidence of considerable support being offered and a general sensitivity to the issues.

## Health services

2.157 There should be a dedicated primary care mental health team to ensure that prisoners on the wings receive equity of care. (4.51)

Not achieved. There was no primary mental health care team. Although the mental health nurse consultant and mental health in-reach team (MHIRT) offered some primary care – for example, counselling or one-to-one therapies – this was inadequate to meet demand. There had been discussions about the introduction of improving access to psychological therapy (IAPT) services, though no plans had been developed. A prison psychiatrist had recently been appointed by the primary care trust (PCT), and was anticipated to review the mental health provision in the prison and advise on developments.
We repeat the recommendation.

2.158 The requirement for beds should be reviewed to ensure that only prisoners with an identifiable medical diagnosis are admitted to inpatients. (4.52)

Achieved. We were assured that admission to the unit was based on clinical need.

2.159 Inpatient beds should be removed from the certified normal accommodation. (4.53)

Not achieved. Inpatient beds continued to be included in the certified normal accommodation. We repeat this recommendation.

2.160 Prisoners admitted directly to inpatients from reception should receive the same information as those on the induction wing. (4.54)

Achieved. New arrivals admitted directly to inpatient services or the detoxification unit were invited back to the first night unit for induction, or a first night team member visited them to offer induction. A health care information pack was given to prisoners on the first night unit, and a DVD introduction to the prison contained a health care component.

2.161 Following a risk assessment, inpatients should be allowed to eat out of cell. (4.55)

Achieved. Inpatients were risk assessed and, if appropriate, had the option to eat out of their cells, though none chose to do this at the time of our visit and we were told that this was rare.

2.162 Inpatients should be given greater freedom to move around the inpatient landing and there should be more meaningful interaction between staff and patients. (4.56)

Achieved. We observed inpatients in association at various times during the day. There was some meaningful activity, including education classes and gym sessions. Interactions between staff and patients appeared to be professional and positive, with first names used. There was training for inpatient staff to introduce a productive ward project, to enable them to spend more time in direct care delivery.

2.163 Multidisciplinary clinical reviews should be introduced for all inpatients. (4.57)

Achieved. Mental health staff, visiting psychiatrists, primary care nurses and IDTS staff were involved in multidisciplinary team reviews.

2.164 The introduction of day care services should be implemented as soon as possible. (4.58)

Not achieved. Although there were occasional therapy focus groups and anger management training, there were no day care services at the time of our inspection.
We repeat the recommendation.

2.165 Controlled drugs should be stored in lockable double metal cabinets. (4.59)

Achieved. Controlled drugs were stored in lockable double metal cabinets.

2.166 The treatment room on F wing should be refurbished. (4.60)

No longer applicable. F wing was closed for refurbishment.

2.167 The treatment room on K wing should have a stable door so that prisoners do not enter the room when medicines are distributed. (4.61)

No longer applicable. K wing was now the first night unit. The treatment room had been redesignated as a consultation room for reception screening, and medications were no longer administered there.

2.168 All treatment rooms should be provided with privacy hoods to allow prisoners to speak to nursing staff in private. (4.62)

No longer applicable. Treatment rooms were no longer used for private consultation, and prisoners requiring this were seen in their own cells.

2.169 The volume of work carried out on the wings in the morning should be reviewed to reduce the number of tasks. (4.63)

Achieved. A workload analysis had been completed for wing-based staff, and there had been steps to enable primary nurses to concentrate on delivering primary care services. These steps included IDTS staff administering methadone and pharmacy technicians undertaking some of the regular medicine rounds.

2.170 The pharmacy should be kept locked at all times. (4.64)

Achieved. The pharmacy door was locked during our visit.

2.171 Alternative locations for the administration of medicines on G and K wings should be provided to ensure safety of staff and privacy for patients. (4.65)

Achieved. G wing had been redesignated as the segregation facility, as part of the decanting plan for F wing. Medication was brought from the health centre for those requiring it. A prisoner staying longer than one night on K wing had his medication administered through his cell door hatch, but this was rare.

2.172 Primary care triage algorithms should be developed to ensure consistency of advice and treatment to all prisoners. (4.66)

Not achieved. Although there was some standardised guidance information for staff, such as patient group directions and core care plans on SystmOne, triage algorithms had not been introduced.
We repeat the recommendation.

2.173 GP appointment times should be reviewed to enable prisoners to see the GP within 48 hours. (4.67)

Achieved. Prisoners who wished to see a doctor were first seen by the wing primary care nurses at daily triage clinics. The nurse referred the prisoner to the doctor as appropriate and, if necessary, the prisoner could see a doctor the same day or within 24 hours.

2.174 Additional genitourinary medicine clinics should be introduced to reduce the waiting list. (4.68)

Achieved. Extra clinics had been introduced to manage the backlog, and the waiting time for the weekly clinic was less than two weeks.

2.175 The profile of health promotion should be increased and well man reviews should be offered at least annually. (4.69)

Achieved. Contemporary health promotion materials were on display and accessible in the health centre and on the wings. Well man reviews had been offered to prisoners in the last year. At the time of our visit, annual well man reviews were targeted at older prisoners.

2.176 A named health professional should be given responsibility for the care of older prisoners. (4.70)

Achieved. The matron was the named health professional for the care of older prisoners.

2.177 Resuscitation equipment should be reviewed to ensure that only necessary equipment is taken to other prison locations. (4.71)

Achieved. Resuscitation equipment was strategically located in the health care centre, reception and on the wings. The equipment contained only necessary items, and carriage time had been calculated from each storage point to reduce unnecessary time wastage when being deployed. Equipment was regularly checked, and renewable equipment was within date.

2.178 Discipline officers should supervise all prisoners attending for medication. (4.72)

Achieved. We observed discipline officers supervising prisoners attending for medication.

2.179 A health forum should be implemented to allow prisoners to discuss general healthcare issues with senior healthcare staff. (4.73)

Achieved. Health care representatives attended the monthly prisoner consultative group where general health issues were discussed.

2.180 Regular out-of-date checks should be done on all medicines. (4.74)

Achieved. There were monthly out-of-date stock checks, and we saw no out-of-date medicines in the pharmacy, health care centre or in wing medicine storage.

2.181 The pharmacist should provide pharmacist-led clinics, clinical audit and medication review. (4.75)

Achieved. The pharmacist and matron met prisoners during a weekly health care/pharmacy forum. Actions arising from discussions with prisoners were recorded, including those concerning medicines management. A clinical audit on the use of mirtazapine (an antidepressant) had recently been completed. Medication reviews were done on an individual basis and were checked in the pharmacy.

2.182 The medicines and therapeutics committee should meet at least four times a year, and meetings should be meaningful with all stakeholders attending. (4.76)

Achieved. The medicines and therapeutics committee met bimonthly, though attendance by some stakeholders was sporadic. Relevant topics were discussed at the meeting, including prescribing trends, medication alerts and new medications.

2.183 Controlled drugs should be transported to treatment rooms in secure containers. (4.77)

Partially achieved. Secure containers for the transport of controlled drugs were stacked in the pharmacy, but were not in use as padlocks had not been supplied.

Further recommendation

2.184 Padlocks should be supplied to enable the use of the controlled drugs secure transport boxes.

2.185 Signed patient group directives should be available in all treatment areas. (4.78)

Achieved. A range of PCT patient group directions was available in the pharmacy and in treatment areas.

2.186 All controlled drugs should be recorded in the controlled drugs register. (4.79)

Achieved. All controlled drugs were recorded in the controlled drugs register.

2.187 Prescriptions for controlled drugs should comply with legislation and state the quantity in words and figures. (4.80)

Achieved. The deputy head pharmacist regularly monitored compliance with standards for controlled drugs prescribing. The prescription charts we sampled demonstrated compliance and showed quantities in words and figures.

2.188 The responsible pharmacist should have professional control of the stock supplied and introduce a dual-labelling system to ensure that stock supplied by the prescriber is audited. (4.81)

Achieved. Stock supplied was dual labelled and subject to expiry date monthly checks.

## Additional information

2.189 Health services were commissioned by the East Sussex Downs and Weald Primary Care Trust (PCT). The PCT also provided prison health services as one of five divisions within the provider arm. The head of prison health care, a registered nurse who was deputy to the governor in the prison, was on long-term secondment to the PCT. Relationships between the prison and PCT were very good. There was electronic access to PCT policies and procedures, and folders containing standing orders, patient group directions and other information were available in health care. There had been prisoner health needs assessments in 2008 and 2009, and there was a prison health improvement action plan to implement change.

2.190 The health centre was adequate to meet need, but the old building limited development. The area was clean with a regular cleaning schedule, and staff assured us that rooms were thoroughly cleaned between patients. The pharmacy had recently been refurbished to a high standard, which created more space. The dental surgery was clean and well ventilated with air conditioning.

2.191 Prisoners could access health services through the wing-based triage clinics or a written application. Waiting lists to see GPs, the dentist and other health professionals were not excessive. The waiting time for prisoners in outpatients was reasonable. The approach of staff appeared courteous, and health facilities were used in a way that preserved privacy and dignity. There was an infection control policy and regular auditing by the PCT, resulting in

compliance action plans. Prison staff attended the PCT infection control committee. There was a pandemic influenza policy and information was available for staff and prisoners.

2.192 The clinical governance group met bimonthly, and there were reviews of serious incidents, complaints, deaths in custody, the risk register and discussions about the implications of National Institute for Health and Clinical Excellence (NICE) guidance. The PCT staff bank enabled existing staff to work extra hours at the prison when required. This led to minimal use of agency staff. A small administrative team supported primary care. The SystmOne IT system had recently been introduced.

2.193 The prison complaints system had been enhanced to include specific forms for health care complaints, available from wall racks on the wings. In the previous three months, there had been 120 complaints, the majority of which related to treatment (71), followed by medication (23). Responses to complaints were courteous.

2.194 There were records of professional staff registration checks, staff training and clinical supervision sessions. Ninety-eight per cent of staff were up to date with mandatory training requirements, including resuscitation. Occupational therapy equipment was available to prisoners following assessment by the PCT occupational therapy team. Prisoners with lifelong conditions, those in contact with the MHIRT and inpatients had care plans. Clinical records were stored in accord with the Data Protection Act and Caldicott confidentiality principles. An information-sharing protocol was in place and there was good information sharing between health and other departments within the limits of medical confidentiality.

2.195 New arrivals received an appropriate reception health screen, but this was administered on the first night unit rather than in reception.

2.196 All prisoners undergoing health screening had access to a GP on the first night unit. Access to out-of-hours GP cover was available if thought necessary by a nurse. There was a range of specialist clinics, and the matron led on chronic disease management. Barrier protection was available from the wing treatment rooms.

2.197 The MHIRT was employed by the PCT and provided secondary interventions and limited primary care support. The team also supported inpatient and wing-based staff with advice on a case-by-case basis. In the previous three months, no patients had been waiting for transfer to NHS mental health care. However, at the time of our visit, four mental health patients required transfer, of whom three had been waiting longer than 28 days following assessment and agreement to transfer. Prison staff attended weekly referral meetings at the local medium secure unit.

2.198 Uniformed staff training in mental health awareness was inadequate, and only 6.9% had trained in the previous year.

### Further recommendations

2.199 New arrivals should receive a health screening while they are in the reception centre.

2.200 Prisoners should be transferred expeditiously to secondary and tertiary mental health care, as clinically indicated.

2.201 Uniformed staff should have the appropriate training to recognise and take appropriate action when a prisoner has mental health problems, and work effectively with health staff to ensure a prisoner's care.

## Learning and skills and work activities

2.202 There should be an education, training and employment needs analysis, including the specific needs of young adults, to inform provision. (5.20)

Achieved. A training needs analysis had been completed and actions had been taken to improve the learning and skills provision to reflect the needs of all prisoners

2.203 The prison should improve the use of activity and education spaces. (5.21)

Not achieved. The range of activity and education places had been improved, and the processes for the allocation of activity places were fair. However, the weekly allocation board did not fully utilise the places available. Only around half the prison population were engaged in activity.
We repeat the recommendation.

2.204 All prisoners should receive an induction to learning and skills and the library. (5.22)

Partially achieved. Tribal Group had been the provider of careers information and advice support (CIAS) and gave an individual induction for all prisoners, which included information on learning and skills. Leaflets about the library were available, but new arrivals did not receive a tour or sufficient information on how to use it.

Housekeeping point

2.205 All prisoners should have an induction to the library.

2.206 Information, advice and guidance linked to education, training and employment should be available according to the individual needs of prisoners. (5.23)

Partially achieved. All new arrivals had an individual interview that gave them information, advice and guidance on learning and skills in the prison. However, they did not receive sufficient opportunities to review their progress and have further guidance later on in their sentence or once they had completed a course or programme.

Further recommendation

2.207 Prisoners with low levels of literacy and numeracy should be encouraged to improve their skills, and their take-up of provision should be monitored.

2.208 Target-setting for prisoners in work and education should be improved. (5.24)

Partially achieved. Individual learning plans had improved and were particularly good in the PICTA (Prisons Information Communication Technology Academy) workshop. In education, short-term targets were clear and relevant and linked well to the training programme or course.

However, medium-term targets did not link sufficiently to employment or resettlement goals to help prisoners identify how their learning would help them in the future.

Further recommendation

2.209 Targets in individual learning plans should have greater emphasis on future employment and resettlement, where required.

2.210 The prison should introduce more equitable access to the library. (5.25)

Not achieved. The prison had made arrangements for wheelchair users to access the library. However, prisoners working full time did not have access to the library in the evenings or at weekends. Trial bimonthly Saturday openings had been suspended because of poor use.
We repeat the recommendation.

2.211 The library service should conduct a library needs analysis. (5.26)

Not achieved. This information was not available during our inspection as there had been no librarian since January 2010. There was no information on how the needs analysis completed shortly after the previous inspection had been used or updated.
We repeat the recommendation.

## Additional information

2.212 There were still insufficient activity spaces for all prisoners (see paragraph 2.3). Attendance remained poor throughout learning and skills provision.

2.213 Prisoners were actively encouraged to work, and there were appropriate processes for allocation to activities. Most work areas were underoccupied, and figures from the prison indicated that around half of places were filled. The range of work was narrow and included orderly responsibilities, work on the wings, gardens, kitchen and painting and decorating. There was good acquisition of skills in most areas, although around 5% of prisoners were engaged in low quality contract work. Pay was equitable across all activities and did not discourage prisoners from attending education courses

2.214 There was a narrow range of vocational training opportunities, although there had been some improvement to the provision since the last inspection. There was insufficient promotion of vocational training and only a small proportion of prisoners were undertaking courses. There were 68 prisoners working towards vocational qualifications and a further eight on distance learning courses. However, the PICTA had been significantly improved since the previous inspection, and this provided particularly good opportunities for the development of ICT skills to around 40 prisoners. A reasonable range of short courses had been added to the curriculum, which included health and safety and first aid. There was training in industrial cleaning in well-equipped provision, as were courses in painting and decorating and horticulture, although only a very few prisoners went into these. Good training in food preparation and cooking was provided for six prisoners in the kitchen. Courses in bricklaying, with good resources and facilities, were planned, although these had been slow to get started. Achievement of qualifications was high, and most learners who stayed on their courses passed.

2.215 Education had been provided by The Manchester College since August 2009. The college had revised the curriculum to be more suitable for short-stay prisoners and included more six-week

modules. It had introduced some more employment and healthy living courses. Arrangements for prisoners to take qualifications had also increased from monthly to twice a week. Education offered approximately 102 education places over nine sessions a week in literacy, numeracy, English for speakers of other languages (ESOL), computing skills, art and creative, business enterprise and customer care. Take-up of provision was low and attendance was poor, at 46%. In April 2010, average weekly enrolments were 195 learners for between one and eight sessions. Average attendance was 64%.

2.216 The 20 young adults were integrated into work, vocational training and education opportunities. Staff working with them now had appropriate guidance on safeguarding young prisoners.

2.217 The resources in education had improved with increased use of computing facilities throughout the curriculum. Outreach provision in literacy and numeracy was managed well, with increased take-up of support by prisoners in inpatients and on the wings. Achievement of qualifications or modules was good by those who attended, at 81%. Initial assessments were now available for all prisoners, and previous records were used to prevent prisoners repeating assessments unnecessarily. However, the prison did not monitor effectively the extent to which prisoners with low levels of literacy and numeracy made best use the provision to improve their skills.

2.218 The library was managed by East Sussex Library Service. Stock rotation remained good and the wide range of DVDs and CDs attracted more prisoners to use the library, but book loss was high at 20%. Arrangements for books and newspapers in foreign languages were efficient. Access to the library was through individual applications or allocated sessions for each wing. However, the library had been understaffed since January 2010, with no full-time qualified librarian.

## Physical education and health promotion

2.219 Physical education programmes for more diverse groups of users should be introduced. (5.32)

Achieved. PE staff had responded well to meet the diverse needs of the prison population, and a varied programme of recreational sport was available. There were specific sessions for young prisoners, those over 45, and prisoners referred from health care and CARATs.

## Additional information

2.220 Provision for recreational PE was good. The facilities had been improved since the last inspection and were mostly of a good standard. A new outdoor all-weather football pitch and a combined weights and cardiovascular suite had been added, and there was a good range of equipment. Access to recreational PE was satisfactory, and up to 65 prisoners could be accommodated at a time. Attendance was generally low at 45%, although figures for the previous month indicated that usage had considerably improved following revision of the recreational PE timetable.

2.221 The acting senior officer and the five full- and part-time PE staff were well qualified and enthusiastic, and the six prisoner orderlies were appropriately trained. One full-time PE officer was currently away on a course. Due to staff shortages and lack of cover, no vocational training was currently offered.

2.222 There were good links with health care and CARATs. Healthy living was well promoted, and prisoners were helped with weight management and health-related issues where necessary.

Prisoners had appropriate access to sports clothes and shoes if needed, but most used their own. Shower facilities were adequate, although the sports hall changing rooms and floor were shabby. Accidents were suitably recorded and dealt with promptly.

Further recommendation

2.223 There should be sufficient staff to provide vocational training for prisoners using the PE facilities.

## Time out of cell

2.224 Exercise periods should be increased to one hour and rescheduled to increase participation. (5.48)

Not achieved. Exercise took place between 8am and 8.30am and participation was generally low. Logs for a two-week period for the four main wings showed between 77 prisoners and none taking exercise on any day.
We repeat the recommendation.

2.225 All prisoners should have access to evening association. (5.49)

Achieved. Staff and prisoners said that evening association was rarely cancelled and that all prisoners had access to it.

## Additional information

2.226 The prison reported a time unlocked figure of 7.7 hours a day, but our roll check indicated that 43% of prisoners were locked up during the core day. The core day allowed a best-case scenario of eight hours unlocked and a worst case of three hours unlocked.

2.227 There was some slippage in the published core day, with evening association ending at 7.15pm rather than at 7.30pm as stated.

Further recommendations

2.228 There should be increased opportunities for prisoners to be unlocked.

2.229 The core day should be adhered to.

## Security and rules

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.230 The security department was well resourced with an E grade manager holding functional responsibility supported by two DPSMs, four senior officers, an executive officer analyst, two collators, two communications monitors and 5.5 administrative officers. The team worked efficiently, and good links with the police had been further developed since the previous inspection.

2.231 The security committee was chaired by the deputy governor and was given a high priority. Despite this, attendance at meetings was often poor and there was sometimes no security representative, apart from the analyst, which affected full consideration of appropriate issues. Minutes of the security committee meeting were lengthy and often included text on actions that had been outstanding for a considerable period. At times, the content lacked depth and was unclear about what action was taken to address issues raised. Security objectives were apparently discussed by the committee before they were ratified by the senior management team, but there was no record in the minutes and, although developing, they were not always SMART (specific, measurable, achievable, realistic and time bound).

2.232 There were effective systems to process and analyse intelligence, and elements of dynamic security were well established. Over 1,100 security information reports (SIRs) had been processed between October 2009 and March 2010, and the prison considered its major problem areas to be drugs and mobile telephones. In 2010 to date there had been approximately 200 target searches, which had resulted in some good finds, particularly of mobile telephones. However, of the 25 suspicion mandatory drug tests (MDTs) authorised from January to April 2010, only nine had been positive, which was relatively low for the volume of intelligence on drugs received. The primary weakness in physical security was the lack of effective barriers to the throwing in of items in one part of the prison grounds, and there had been a successful bid for strengthening the perimeter with cameras.

2.233 Routine cell searching continued to be undertaken by residential staff, and quarterly targets continued to be met.

2.234 Despite ongoing refurbishment work, movement to activities was supervised appropriately and effectively by strategically placed officers.

2.235 Closed visits were not used excessively, and at the time of the inspection only one prisoner was subject to this sanction. However, some prisoners spent long periods on closed visits, sometimes with insufficient justification. Prisoners could be placed on closed visits for refusing an MDT, which was disproportionate. Once the security committee deemed it appropriate to end the closed visit arrangements, the prisoner was generally required to provide a further negative MDT, which was unwarranted.

2.236 Rules were explained on the first night centre and again during induction and were reinforced on residential units through compacts, notices and welcome packs. Prisoners were fully appraised about what was expected of them.

### Further recommendations

2.237 The security committee should be attended consistently by all key departments (or a designated deputy).

2.238 The reasons for the low positive rate for suspicion mandatory drug tests (MDTs) should be investigated and action taken to address these.

2.239 Prisoners should only be placed on and remain on closed visits when there is sufficient evidence to support it, and not simply as a result of a refused MDT.

Housekeeping points

2.240 The minutes from the security committee should be streamlined and accurately record the content of the meeting and any arising actions.

2.241 Security objectives should be SMART (specific, measurable, achievable, realistic and time bound).

## Discipline

2.242 Accident report forms should accompany all use of force forms. (6.22)

Not achieved. The use of force committee had identified the lack of F213s (injury to inmate forms) accompanying use of force documentation as a problem on many occasions, yet a significant number of the documents we sampled still had no F213 attached.
We repeat the recommendation.

2.243 All prisoners should be debriefed following an incident where force is used. (6.23)

Not achieved. Debriefing pro forma had only recently been introduced, and many of the documents we sampled had no evidence that prisoners had been debriefed after force had been used against them. The system was developing but needed to be publicised more widely to relevant staff and managers to ensure that it happened consistently.
We repeat the recommendation.

2.244 A regime should be introduced to provide long-term prisoners in segregation with purposeful activity. (6.24)

Partially achieved. There was evidence that prisoners in the segregation unit were encouraged to take part in some purposeful activity. They had daily access to showers, telephones, cell cleaning equipment and exercise. Gym sessions were available weekly, and education staff visited the unit on four afternoons a week for one-to-one work with the prisoners. Although far from ideal, the prison was managing two prisoners who had lived in the segregation unit for a considerable length of time. Efforts had been made to reintegrate these prisoners onto normal location but to no avail. These prisoners reported feeling bored and complained that they completed work given to them by education staff very quickly and then had nothing to challenge them. Prisoners were not permitted to attend education or workshops, and were offered no opportunity to associate or exercise together. Exercise was facilitated on a closed yard some distance away from the unit, with two staff escorting and supervising each prisoner, depleting the unit of staff who could have been more purposefully engaged with prisoners remaining on the unit. The unit had a small library and other reading material could be accessed on request, and most prisoners had access to art materials in their cells. Despite these efforts, there was still insufficient activity to engage prisoners constructively for sufficient periods.

Further recommendations

2.245 If there is no option but to house prisoners for lengthy periods of time in segregation, they should be provided with access to purposeful activity

2.246 Exercise for segregated prisoners should be supervised by only one member of staff.

2.247 Planning systems to allow prisoners under good order or discipline to return to normal location should be in place. (6.25)

Not achieved. Although there was anecdotal evidence of one prisoner being reintegrated to normal location following a period on good order or discipline, there was no formal planning for this and no care plans or records to show that this had taken place.

Further recommendation

2.248 Formal reintegration planning for prisoners in the segregation unit should be developed and implemented consistently.

2.249 Prisoners should be strip-searched on admission to the segregation unit only following an assessment of risk. (6.26)

Achieved. A policy stated that prisoners should only be strip-searched on admission to the segregation unit following a risk assessment. Strip-searching did not taking place routinely.

## Additional information

2.250 The adjudication room was small and cramped since the move to G wing, but only one officer was used to escort prisoners for the proceedings, which were courteous and clear. The adjudicating governor ensured that prisoners understood the charges and checked their understanding of the process. Prisoners were given sufficient time to prepare their case and to seek legal advice. In most cases, records of adjudication demonstrated that hearings were conducted fairly and that charges were fully investigated. However, written records of some hearings indicated insufficient exploration of the situation before guilt was proved, and quality assurance had only recently been introduced by the governor. Punishments were generally fair and adjudicators had sometimes dismissed cases due to lack of evidence or technical anomalies. Although only a few prisoners appealed against their adjudication decision, there was clear evidence from the governor, regional manager for custodial services and briefing and casework unit that decisions were overturned appropriately.

2.251 There had been 415 adjudications between November 2009 and April 2010, of which only 177 had been proved, and a further 50 had been referred to the independent adjudicator, of which 27 were proved. The majority of charges had been laid for positive drug tests, unauthorised items in possession, refusing orders and for being threatening and/or abusive. The figures were proportionate for the size and nature of the population. Adjudication standardisation meetings were due to take place quarterly, but took place less frequently – twice in 2008, three times in 2009 and once so far in 2010 – and were often poorly attended. Appropriate punishment tariffs had been published and were discussed and reviewed at each meeting. However, there was no discussion around quality assurance of the process and associated documentation.

2.252 Incidents involving the use of force had remained fairly static since the last inspection. Between October 2009 and March 2010, force had been deployed by staff 41 times, nine of which were planned interventions. Although not low, this figure included cases of low-level physical coercion. Much of the recorded use of force in early 2010 was to enforce compliance

with the required transfer out of prisoners as part of the decant for the closure and refurbishment of accommodation.

2.253 Training and records on use of force were effectively managed. Records showed a concern for legitimacy in the use of force, and many examples of effective de-escalation. Control and restraint equipment was very well maintained, stored and accounted for. Planned interventions were always attended by a health care professional and filmed appropriately.

2.254 A use of force committee met monthly. Although it sampled completed use of force paperwork, there was inconsistent evidence that trends or patterns were analysed. In the previous six months, a baton had been drawn on two occasions and used once. This had provoked some discussion at the use of force committee and the documentation was reviewed. Although it appeared that the use was justified, there had been no independent investigation to scrutinise this.

2.255 Special accommodation had been used five times in 2009 and three times to date in 2010. Procedures for authorisation and monitoring were not always correctly carried out and recorded, although prisoners in special accommodation were generally permitted to wear normal clothes. A prisoner on an ACCT had been located in special accommodation in 2009, but this was not considered when justifying the initial use of the facility. Paperwork did not always indicate behaviour justifying use of the special accommodation, and on a few occasions prisoners spent excessive periods in the facility when records deemed their behaviour to be, for example, 'polite and respectful'. During our inspection, we observed the special accommodation being used inappropriately for a 'cooling off' period for a young adult prisoner who had been restrained and relocated to the segregation unit, but who was not violent or refractory. The duty governor had not been advised of the use of the special accommodation and had not authorised it, and the subsequent paperwork had not been appropriately completed. A further unauthorised and inappropriate use of the special accommodation was brought to our attention during the inspection, but we found no paperwork to justify this. We had concerns that there was a lack of understanding about appropriate use of special accommodation.

2.256 The temporary segregation unit had 13 cells and was generally clean and bright. Most cells were clean and in good decorative order, although a few had some graffiti. All cells were cold as the central heating had recently been switched off, but this was rectified during the inspection. Since relocating to G wing, and by edict of the governor, electricity was available in only one cell in the segregation unit. The rationale was to discourage prisoners from wanting to remain there for long periods. This was disproportionate, and precluded the six prisoners on standard level there during our inspection from accessing facilities, such as music centre, kettle and television, that they were permitted to have in their possession.

2.257 Segregation was properly authorised in all cases we saw, and safety algorithms were completed within two hours. All prisoners were allocated a personal officer, although officers dealt with all prisoners and some prisoners responded better to some staff than others. Despite this, limited engagement was recorded in history sheets. There was a published staff selection policy, and the governor approved all selections. All staff had received ACCT training and some had received mental health awareness training. We observed variable staff-prisoner relationships, ranging from warm, friendly and engaging to oppressive, standoffish and risk averse. Although there was a staffing level of a senior officer and five officers, the unlocking of more than one prisoner at a time was prevented. This was unnecessary, disproportionate and not based on sound risk assessment, and affected the regime that could have been delivered to prisoners.

2.258 The average roll in the segregation unit was generally around nine, and was seven at the time of our inspection. Two were held pending adjudication, four were there for reasons of good order or discipline, and one for his own interest. One prisoner had been held in the segregation unit for over 12 months and another for over nine months. Use of segregation for prisoners seeking protection was low. Staff said segregation was used as a last option, and other locations were encouraged before resorting to segregation.

2.259 Good order or discipline reviews took place appropriately with reasonable multidisciplinary attendance. A health care professional was always present, and the Independent Monitoring Board was usually in attendance. Paperwork for continued segregation often lacked detail about required behaviour targets and interventions or appropriate attention to mental health concerns, particularly for prisoners who had been segregated for considerable periods.

2.260 Segregation monitoring and review group meetings took place inconsistently, and minutes did not indicate consideration of prisoners' individual circumstances. A new governor grade had recently taken over management of the segregation unit and was aware of the shortfalls of the meeting, and provided assurances that it would have a different emphasis and format in the future.

Further recommendations

2.261 Written adjudication records should demonstrate full and thorough exploration of the circumstances around the charge before guilt is proved.

2.262 Adjudication standardisation meetings should take place more frequently and should be attended by all key stakeholders.

2.263 Adjudication standardisation meetings should include quality assurance of adjudication proceedings and associated documentation.

2.264 Use of force paperwork should be consistently scrutinised to identify any trends or patterns.

2.265 Any use of a baton should be independently investigated to give assurance that its use was appropriate and proportionate.

2.266 Special accommodation should only be used, with appropriate authority, in exceptional circumstances to house violent and/or refractory prisoners for the least time possible.

2.267 Prisoners on ACCTs should only be located in special accommodation in exceptional circumstances, which should be justified in the authorising documentation.

2.268 The duty governor should ensure that all paperwork authorising use of special accommodation is appropriately and fully completed.

2.269 Electricity should be restored immediately in all cells in the segregation unit.

2.270 History sheets should demonstrate regular positive engagement by officers with prisoners during their stay in the segregation unit.

2.271 Risk assessments for staffing levels for different activities in the segregation unit should be revised.

2.272 Paperwork used for authorising segregation should take account of prisoners' individual circumstances.

2.273 Segregation monitoring and review group meetings should have an appropriate focus and take place more consistently.

## Incentives and earned privileges

2.274 The apparent disparity in the proportion of black and minority ethnic prisoners on the enhanced level should be investigated and action taken if necessary. (6.33)

Not achieved. In the period 2009-10, black and minority ethnic prisoners were generally in range with regards to enhanced status. However, in July 2009 there had been a large peak with nearly 100 black and minority ethnic prisoners on enhanced status, against a range up to 45. This peak dropped dramatically resulting in September and October being just below target, and November, December and January on the cusp of the target range. There had been no investigation into these results.
We repeat the recommendation.

2.275 Written targets should be set and reviewed when prisoners are placed on basic. (6.34)

Achieved. No prisoners were on basic at the time of inspection, and numbers for the previous quarter were relatively low, at four in January 2010, none in February and one in March. We were only able to inspect the paperwork for one previous basic prisoner; the targets set were objective and reviewed at the seven-day stage. Staff, including managers, who we spoke to understood the need to set good quality targets for basic prisoners, and the incentives and earned privileges (IEP) policy stated that basic prisoners should be set meaningful objectives and targets to move to standard level.

## Additional information

2.276 The prison operated a three-level IEP scheme. Staff and prisoners were aware of the scheme, and residential wings held a good supply of up-to-date information on it. Transfers in kept their existing privilege level, and all new arrivals were deemed as standard. In March 2010, one prisoner was on basic, 332 on standard (73%), and 122 on enhanced (27%).

2.277 Movement down the levels was through a three-strike system – unacceptable behaviour could incur a warning from staff, a further warning within 28 days incurred a written IEP warning, and if there was a third warning within 28 days of the written warning, an IEP review board took place. Warning strikes that we saw were generally appropriate for the behaviour of the prisoner, and we found no evidence that staff gave inappropriate warnings. Prisoners and staff said that they liked the system as it allowed for restorative behaviour rather than punitive punishment.

2.278 The procedure for moving up levels was through prisoner application, which included detailed information on his attitudes and behaviour from his personal officer, work place and residential manager. A review board was convened, and there was an appeal procedure for those unsuccessful in a promotion. Prisoners on enhanced level could get extra access to private cash, visits and time out of cell, wear their own clothes and got a weekly £2 bonus.

## Catering

2.279 All wing servers should be trained in food handling. (7.7)

Achieved. There were training records for all servery and kitchen workers, and all had been trained in servery induction, manual handling, heated trolleys, cleaning schedules, hazard analysis critical control points, probing of food, servery hygiene and food safety, which included a booklet, DVD and quiz.

2.280 Halal dishes should be prepared and served with separate pans, knives and serving utensils. These items should be clearly distinguishable from those used for non-halal dishes. (7.8)

Not achieved. Separate pans were not used in the kitchen for halal food and there was no separate cleaning facility. Knives and serving utensils were separate and marked in red, but they were not marked as halal and no signs indicated that red tools were for halal food only.
We repeat the recommendation.

2.281 A food survey should be conducted to inform decisions on menu choices. (7.9)

Achieved. A food survey was carried out every six months, the last in December 2009. There had been 202 responses to the 687 surveys distributed (30%). The results had been analysed and menu changes made accordingly.

2.282 Lunch should not be served before noon and the evening meal not before 5pm. (7.10)

Achieved. Lunch was served at noon during the inspection and prisoners said that the evening meal was served at 5.30pm. Food trolleys were collected from the kitchen at 11.45am and 5.15pm.

2.283 Breakfast packs should be issued on the day they are to be eaten. (7.11)

Not achieved. Breakfast packs were still given out the day before they were due to be consumed.
We repeat the recommendation.

2.284 Food comments books should be checked weekly and complaints investigated and responded to. (7.12)

Achieved. Food comments books were available and displayed in each servery area. They were well used and checked weekly by a member of the catering team

## Additional information

2.285 All serveries were clean and well maintained, servery workers wore appropriate clothes, and staff observed the serving of meals. Food portions were adequate and well controlled by staff. The quality of the food was good and prisoners had no complaints about it. There was a three-week menu cycle, and prisoners could make their choice up to 48 hours before the meal. The prison held a series of themed days, which prisoners said were successful.

## Prison shop

2.286 Shop orders should be issued to prisoners at their cell door. (7.17)

Not achieved. The prison had rejected this recommendation and prisoners continued to collect their orders on the wing during association. This system was regarded as the most pragmatic to manage orders without unduly affecting the prison's regime and association time. There were no indications from prisoners or the violence reduction committee that this practice had raised concerns about bullying.

## Additional information

2.287 A reasonable range of 373 items was available through the prison shop, including fruit, health supplements and religious items. Some black and minority ethnic specific items could also be bought. Shop orders were submitted on Sunday evening for delivery to wings on Wednesday or Thursday, depending on wing location. Access to the shop could be delayed for new arrivals, as there was no flexibility in delivery. A prisoner arriving on Monday would not get his order until the following Wednesday or Thursday.

Further recommendation

2.288 New arrivals should be able to access the prison shop within their first 24 hours.

## Strategic management of resettlement

2.289 The resettlement policy should be reviewed to reflect the priorities within the reducing reoffending delivery plan. (8.4)

No longer applicable. The prison no longer had a separate reducing reoffending strategy. The published strategy incorporated an action plan, and some resettlement pathways had separate more detailed action plans.

2.290 The resettlement policy committee structure should be revised to include the voluntary and community sector. (8.5)

Achieved. The head of interventions was a member of the reducing reoffending policy committee and represented voluntary and community sector groups at the bimonthly meetings, and chaired separate voluntary and community sector forum meetings, which discussed an overview of relevant resettlement developments.

2.291 Staff from the voluntary and community sector working in the prison should be briefed on the offender management model and the contribution they make to its deployment as key workers. (8.6)

Achieved. The head of reducing reoffending had delivered a detailed overview of the offender management model and the work of the offender management unit (OMU) to the voluntary sector forum in 2008.

## Additional information

2.292 The head of reducing reoffending had been in post since just before the previous inspection. Following some recent functional changes, one senior manager had responsibility for learning and skills, interventions and reducing reoffending work. The prison had a full-time interventions manager, although responsibility for voluntary and community sector support and coordination and some resettlement pathways was transferring from the interventions manager to a full-time community engagement manager.

2.293 Attendance at the bimonthly reducing reoffending policy meetings was reasonable. The last two meetings had been cancelled, but this was unusual and meetings had taken place consistently throughout 2009. Some of the goals identified in the reducing reoffending action plan were described at a strategic level with only limited specific and detailed information about how they were to be achieved. It was not clear how progress against the action plan was monitored, and some action points appeared to be out of date.

2.294 The prison had established a mentoring project, Sussex pathways. There was a pool of trained mentors, who were allocated to prisoners with whom they had two meetings before release. Mentors could provide support across a range of resettlement pathways tailored to the prisoner's individual needs up to six months after release.

Further recommendations

2.295 The resettlement policy should be underpinned by a clear action plan with specific objectives and development milestones.

2.296 The reducing reoffending committee should monitor the delivery of objectives identified in the strategic action plan, and update the published plan accordingly.

## Offender management and planning

2.297 Personal officers should assist in reinforcing sentence planning processes. (8.16)

Partially achieved. There was some evidence that personal officers contributed to sentence planning. For example, residential staff attended sentence planning boards or submitted a written report. However, offender management staff said attendance at boards was inconsistent, and the staff attending or submitting reports were not always the prisoner's allocated personal officer. We were told there had been attempts to increase residential staff's knowledge and use of OASys (offender assessment system) through staff briefings, but we found that personal officers' knowledge of offender management was variable (see section on personal officers).

2.298 The backlog of OASys assessments and reviews should be tackled as a priority. (8.17)

Partially achieved. Three full-time prison officers based in the OMU were responsible for completing OASys assessments for prisoners eligible for an assessment but not formally in scope for offender management. These staff were currently line managed by a full-time interventions manager who, along with the senior probation officer, was responsible for quality assuring completed assessments. The team of OASys assessors had been reduced from eight to three to ensure a greater commitment to the work and a focus on improving the quality of

assessments. Managers had focused on attempting to eradicate the backlog of assessments, but redeployment of staff remained a problem that affected their timely completion. At the time of the inspection, the OMU database showed that 23 initial assessments had not been completed within the required timescales. Some residential staff had been trained to undertake OASys assessments, but in practice they were never allocated the time for the work. Although records were not maintained, we were also told that prisoners could be transferred before their initial assessment was completed and, therefore, without an up-to-date sentence plan.

Further recommendation

2.299 All eligible prisoners should have a current OASys assessment and an up-to-date sentence plan.

2.300 Indeterminate-sentenced prisoners should be moved speedily to first stage prisons. (8.20)

Partially achieved. The two offender supervisors were responsible for arranging transfers for life-sentenced prisoners, and the full-time observation, classification and allocation (OCA) officer based in the OMU was responsible for arranging transfers for prisoners on indeterminate sentences for public protection (IPPs). The number of IPPs in the prison had reduced significantly recently, largely as a result of the cut in the prison's operational capacity following the closure of B, F and G wings, when the prison had received central support in arranging transfers. We were told by staff in OMU that the prison could still experience difficulties in transferring indeterminate-sentenced prisoners. This was particularly the case for those who had been recalled to custody or returned from open conditions, when they could not be moved until the outcome of a parole hearing, which could be delayed. For example, a prisoner returned to closed conditions in December 2009 had yet to have a date confirmed for his parole hearing at the time of the inspection. We were also told it could be difficult to secure progressive transfers for prisoners who were wheelchair users or had other additional needs. One category D prisoner had transferred the week before the inspection, and two further category D indeterminate-sentenced prisoners were awaiting transfer.

Further recommendation

2.301 Prisoners sentenced to indeterminate sentences for public protection (IPPs) and lifers should be transferred from Lewes in a timely manner to enable them to meet their offending behaviour needs.

2.302 Regular lifer forum meetings should be established. (8.18)

Partially achieved. The most recent indeterminate-sentenced prisoner forum had been held in September 2009 and attended by the indeterminate-sentenced team and six prisoners. The notes of the meeting focused on the family visits day scheduled for October. However, only one prisoner had expressed interest in participating and the event had not gone ahead. The next forum was scheduled to take place in June 2010, with the intention to hold forums quarterly. In addition to the forums, fortnightly evening surgeries for indeterminate-sentenced prisoners were held on residential units, with written notification of dates published in advance. The surgeries allowed prisoners to make enquiries about their sentence management, and gave offender supervisors an opportunity to contact individual prisoners and check progress. Following the introduction of the surgeries, there were no longer complaints about lack of contact with offender management staff.

Further recommendation

2.303 Indeterminate-sentenced prisoner forums should be held quarterly.

2.304 Staff should access relevant lifer training as soon as this is available. (8.19)

Not achieved. No staff had undertaken lifer training. There were plans to identify lifer staff representatives on each unit and deliver some training to them, including report writing.

Further recommendation

2.305 Staff in contact with indeterminate-sentenced prisoners should attend the appropriate lifer training to enable them to support prisoners.

## Additional information

2.306 The offender management unit (OMU) covered offender management, OCA, bail information, home detention curfew (HDC), public protection, life- and indeterminate-sentenced prisoners, prisoner administration and staff undertaking resettlement work. The prison had a sizeable well-integrated seconded probation team.

2.307 Electronic contact logs were opened for all new arrivals. These were initially used to document public protection screening and then by offender supervisors to provide a chronological record of case management, including contact with prisoners and offender managers.

2.308 Records we sampled showed appropriate communication between offender supervisors, offender managers and other relevant internal departments, such as CARATs. Relationships with external offender managers appeared to be positive, particularly with colleagues from Surrey and Sussex Probation Trust, as many prisoners were discharged to the local area. Key training had been provided for offender managers and, in most cases, they chaired sentence planning boards in the prison. The prison had telephone conferencing facilities and had recently installed video-link equipment to support offender management processes, but this was not yet connected. We saw some examples of comprehensive initial interviews between offender supervisors and prisoners documented in contact logs, which included obtaining relevant information across each resettlement pathway. However, the frequency of subsequent recorded levels of contact varied, although we saw examples of frequent contact, particularly with complex cases.

2.309 The interventions manager and senior probation officer (SPO) countersigned completed OASys assessments, and the SPO also made a monthly random quality assurance check of 10% of completed assessments. There was no wider quality assurance of all aspects of offender management work. Seconded probation staff had access to formal monthly supervision to discuss individual cases. These formal arrangements were not available to prison officers who were offender supervisors, but they had ready access to probation officers based in the offender management pods and provided advice as required.

2.310 Initial sentence planning boards for prisoners in scope for offender management were usually attended by a range of relevant departments. Reviews boards tended to be less formal and were attended primarily by the offender manager, offender supervisor and prisoner. Formal sentence planning boards were not convened for out-of-scope prisoners.

2.311 Until recently, two probation service officers had undertaken initial resettlement assessments of all new arrivals using a local basic assessment tool, which identified needs across the resettlement pathways. Following changes to induction processes, this tool was no longer used and a range of staff from different departments now saw prisoners during induction to assess need and made appropriate referrals. The two probation service officers continued to have an input into induction but focused solely on accommodation issues and the completion of initial housing needs assessments. The induction and pre-release centre (IPRC) coordinator maintained an induction database, which tracked prisoners' progress through induction, but initial assessments were not combined into a cohesive document that could be used to plan a prisoner's time in custody and reviewed before release.

2.312 Approximately six weeks before release, prisoners were invited to the IPRC to attend a pre-release session. Sessions were held twice a week and were attended by staff from a range of appropriate departments who interviewed prisoners about any outstanding resettlement needs. Follow-up appointments and referrals were made where necessary.

2.313 There were two full-time public protection administrators based in the OMU. They initially screened all new arrivals, including checking previous convictions, and initiated a local risk assessment. Risk assessments were forwarded to one of two probation officers responsible for public protection procedures for a more in-depth screening, which was recorded on the prisoner's electronic contact log.

2.314 At the time of the inspection, 56 prisoners were subject to multi-agency public protection arrangements (MAPPA), two of whom were at level three. Probation officers attended external MAPPA meetings, and electronic logs showed information was exchanged with other agencies. Approximately 100 prisoners were subject to risk-to-children procedures. The public protection administrators maintained a comprehensive database of prisoners subject to public protection procedures.

2.315 The public protection policy had recently been reviewed and was supported by an operational instruction that outlined key staff responsibilities. Public protection monitoring was undertaken by two operational support grade staff based in the security department, who attended the monthly public protection meeting, and monitoring records were linked with the OMU database, ensuring they were readily accessible. Notes of the monthly public protection meeting indicated only minimal discussion of individual cases with the chief focus on monitoring arrangements, although the published terms of reference clearly stated the requirement to discuss individual relevant high-risk cases. However, individual contact logs showed that appropriate consideration was given to individual prisoners to assess and manage risk factors. The police intelligence officer had not consistently attended public protection meetings.

2.316 Potential life-sentenced prisoners were identified and there were eight such prisoners at the end of April 2010. All indeterminate-sentenced prisoners were seen during induction, and monthly indeterminate-sentenced prisoner meetings, chaired by the head of interventions, discussed individual cases. Three escorted town visits had recently taken place and a further two were planned.

### Further recommendations

2.317 Offender supervisors should engage regularly with prisoners to implement sentence plans and monitor progress against targets, and this should be recorded in contact logs.

2.318 There should be an effective quality assurance scheme for all aspects of offender management.

2.319 Formal multidisciplinary sentence planning boards should be held for all eligible prisoners following OASys assessments or reviews.

2.320 Initial induction needs assessments should be combined into a custody planning document, which is monitored during prisoners' time in custody and reviewed before release.

Housekeeping points

2.321 The offender management video-link equipment should be connected and made available for offender supervisors.

2.322 The public protection committee should fully discuss all relevant prisoners, in line with the published terms of reference, and these discussions and any agreed action points should be recorded in the minutes.

## Resettlement pathways

### Accommodation

2.323 The prison should ensure that local Supporting People commissioning bodies are regularly updated on the accommodation needs of prisoners being released from Lewes. (8.26)

Achieved. There were two projects running in the prison (see below) that endeavoured to secure accommodation for short-term and unconvicted prisoners discharged to the local area. Project workers and managers felt these projects had helped raise the awareness of relevant commissioning bodies and external organisations of the accommodation needs of discharged prisoners.

### Additional information

2.324 Accommodation project workers and prison managers said homelessness continued to be a significant issue in the local areas to which many prisoners were released. The number of prisoners released with no fixed address had significantly reduced from the previous inspection but remained too high – approximately 14% of prisoners released in the year to the end of March 2010.

2.325 A project worker from Brighton Housing Trust, funded through the Brighton2Lewes project, and two further project workers funded through the preventing offender accommodation loss (POAL) project provided an accommodation service to unconvicted prisoners and those sentenced to less than 12 months and returning to the local area. The Lewes2Brighton project, initiated by the Revolving Doors Agency, worked with prisoners returning to Brighton and Hove with complex and multiple needs, including mental health and substance use problems, and provided support across a range of resettlement needs. Monitoring records showed that 31 prisoners had been accepted on the project in a nine-month period, the majority identified by the project worker following initial needs assessments.

2.326 The POAL project had commenced in March 2009 and was initially funded until 2011. There were plans to expand the service provision to include Eastbourne. The two POAL project workers worked across the prison and with the two local authorities of Brighton and Hove, Lewes and Hastings. Their work focused on sustaining or terminating tenancies and securing accommodation on release. The project also offered a deposit certificate scheme, which provided assurance to private landlords. Project workers maintained detailed records of outcomes, which showed that Brighton and Hove received 332 referrals in the year to April 2010, of which 120 tenancies were sustained, 54 prisoners were secured settled accommodation on release, 12 to a private sector tenancy and 25 to a Supporting People hostel.

2.327 The prison had a part-time housing officer who dealt with the accommodation needs of prisoners who did not fall within the remit of the two local projects. The post of part-time housing manager had not been filled since February 2010. There was no cover for the housing officer during periods of absence. Initial housing needs assessments were completed by probation service officers during induction, supported by peer advisers. Peer advisers were trained by Shelter, and there were plans to develop and extend their role in providing a housing service. The prison did not disaggregate its accommodation monitoring data to identify the number of prisoners referred to the prison-based housing officer and the outcomes of such referrals, but resources allocated to the post appeared to be insufficient. The housing officer had a current caseload of approximately 60 prisoners. He tried to see all prisoners who submitted an application, but we were told this was sometimes not possible.

Further recommendation

2.328 The prison should increase the resources allocated to meeting the accommodation needs of prisoners.

## Education, training and employment

2.329 Peer advisers should receive appropriate training and support (5.32 and 8.27)

Achieved. Training and support for peer advisers had improved significantly. Nine peer advisers had completed an NVQ in information, advice and guidance at level three, and a further six were attending the course. Peer advisers received good support and management from the coordinator of the induction and pre-release centre.

2.330 Records should be kept of the training prisoners receive at Lewes. (8.33)

Achieved. The prison and education provider used the national system for providing prisoners with records of their training. There were also arrangements for prisoners to receive their certificates, and individual learning plans were good.

## Additional information

2.331 At the previous inspection, not all prisoners had sufficient information, advice and guidance. This had improved, with greater focus on providing careers information and advice at induction and approximately six weeks before release. The trained peer advisers provided a good advice and guidance service to prisoners on the wings and in the induction and pre-release centre. Prisoners were offered a pre-release session and follow-up interviews with external partners, including Jobcentre Plus. Arrangements for prisoners to have a record of their training and

achievements were now satisfactory. However, prisoners did not have sufficient opportunities for interim reviews of their progress towards development targets or plans for career or employment goals.

Further recommendation

2.332 All prisoners should have greater opportunities for interim careers advice and information to review their progress towards agreed development targets or plans for a career or employment.

## Finance, benefit and debt

2.333 Prisoners should be given help to open bank accounts before their release. (8.60)

Not achieved. The interventions manager had endeavoured to make arrangements with local banks to facilitate prisoners opening bank accounts before release, but had been unsuccessful in all but one case.
We repeat the recommendation.

## Additional information

2.334 Pathway work on finance, benefit and debt was underdeveloped. In the 2008 needs analysis, 29% of respondents reported being in debt and 45% said they had not received support with financial needs in Lewes.

2.335 The number of Jobcentre Plus staff based in the prison had increased from one full-time worker to two in December 2009. This enabled the staff to offer a more comprehensive induction and pre-release service, including benefits advice. The Citizens Advice Bureau (CAB) visited the prison one day a week. The prison was now aware of funding to provide a CAB service to Sussex prisons, which it had not yet accessed.

2.336 Some staff and prisoners had received Unlock training, a basic financial awareness training package, but this was not delivered on an ongoing basis. The education department's revised curriculum included a discrete money management course.

Further recommendation

2.337 Specialist provision for debt and money management advice should be extended to meet the needs of the population.

## Mental and physical health

2.338 Formal discharge clinics should be introduced so that prisoners due to be released are given a health check and appropriate advice on how to access health services in the community. (8.37)

Achieved. Pre-release clinics were held twice weekly in the dedicated pre-release centre, and prisoners attended them up to one month before their release. Discharge letters and

information for the GP was provided, and take-home medication was arranged for the day of release.

## Additional information

2.339 The prison used the PCT end-of-life and palliative care policy, which had been developed in association with local services. In the last two years, there had been two deaths from natural causes, for which the prisoners had left the prison to spend the remainder of their time in more suitable accommodation. Prisoners with enduring and serious mental health problems were subject to the care programme approach, and members of the MHIRT acted as case managers to coordinate care with receiving services in the pre-release phase.

## Drugs and alcohol

2.340 The drug and alcohol strategy should contain action plans and joint working protocols. (8.50)

Achieved. The prison had separate drug and alcohol strategies. Both contained action plans and protocols, and guidance for joint working.

2.341 The establishment should conduct a detailed population needs analysis to inform the drug and alcohol strategy. (8.51)

Achieved. A population needs analysis had been completed in 2009 and there had been a survey of substance users in 2008. Both had been used to inform drug and alcohol strategies.

2.342 Prisoners undertaking the P-ASRO programme should have access to peer support and to a voluntary drug testing unit. (8.52)

Achieved. Peer supporters were available to prisoners on the P-ASRO (prison addressing substance related offending) programme, who had access to the voluntary drug testing unit.

2.343 The short duration programme should be introduced to meet the needs of its remand population, short-term prisoners and those on methadone maintenance. (8.53)

Partially achieved. Funding had been secured to run short duration drug programmes (SDPs) in association with Sussex Probation and HMP Ford. At the time of our visit, recruitment of staff was in hand and SDP had not yet commenced.
We repeat the recommendation.

2.344 Voluntary drug testing should be undertaken with the required frequency. (8.54)

Achieved. In 2009-10, 275 compacts had been registered, meeting the target, and the required frequency for voluntary compact-based drug testing was 413 a month, which had been achieved.

2.345 A separate compliance testing compact should be developed for enhanced level prisoners and trusted workers. (8.55)

Achieved. We observed separate drug compliance testing compacts in use for a variety of prisoners.

## Additional information

2.346 The drug strategy was managed by a deputy governor, and monthly drug strategy meetings were well attended and included health representation. The CARAT team was sufficiently staffed, had appropriate management and supervision arrangements, and had met its targets in 2009-10.

2.347 Prisoners could access structured one-to-one as well as group work sessions, but not those with alcohol-only problems, for whom Alcoholics Anonymous groups were the only ongoing support, which was insufficient. The PCT had recently agreed funding for an alcohol nurse and project worker, and recruitment was under way.

2.348 While SDP had not commenced, CARATs and P-ASRO programmes were offered to prisoners. In the last year, the key performance target (KPT) for drug treatment starts (96) had been met, and the KPT for completions (62) had been exceeded (79). The good range of drug intervention programmes offered from partner community organisations that we found on our last visit had been extended to enhance the throughcare and aftercare service. Some prisoners maintained on methadone had experienced delays in moving to training prisons because they lacked clinical management services.

Further recommendations

2.349 Services should be provided to meet the needs of prisoners with alcohol problems.

2.350 The transfer of prisoners to training prisons should not be delayed because they are on substance-related clinical maintenance treatment.

## Children and families of offenders

2.351 Prisoners should be able to receive their first visit within one week of admission. (3.88)

Partially achieved. There were no reception visits at Lewes. Prisoners who were sentenced had to send out a visiting order before a visit could be booked, and this process could be considerably delayed. However, visitors to prisoners on remand could book their first visit without a visiting order and access visits relatively quickly.

Further recommendation

2.352 All prisoners should be able to receive their first visit within one week of arrival.

2.353 The visits booking system should be accessible and able to deal with the number and needs of visitors. Visitors should be able to book their next visit while at the prison. (3.89)

Achieved. The visits booking line was staffed daily during the week. Although there had been some concerns about visitors' ability to access the line, this was not widespread. Since the previous inspection, there had been a significant rise in the number of visitors booking via email, and up to 30-40 emails a day were received. Visitors could book their next visit while at

the prison by completing a request form, and usually received a telephone confirmation within 24 hours.

2.354 A well-run and properly-equipped visitors' centre should be available to provide information, support, shelter and other basic services for at least an hour before and after advertised visiting times. (3.90)

Not achieved. Since the last inspection, the visitors' centre had closed. Visitors could wait in a relatively small room in the gate area for up to an hour before a visit. The room often became crowded, and it was too small to be able to process visitors in privacy.
We repeat the recommendation.

2.355 Prisoners and visitors should have reasonable access to toilet facilities during visits. (3.91)

Not achieved. There were no toilets for either prisoners or visitors in the visits area. Visitors who needed to use the facilities had to return to the gate area, and if prisoners needed them the visit was terminated.
We repeat the recommendation.

2.356 The visits hall should be staffed, furnished and arranged to ensure easy contact between prisoners and their families. (3.92)

Achieved. The visits hall had been renovated, and a new mezzanine had created a larger space that was light and airy. Up to 27 prisoners and their visitors could be accommodated, with an overflow area with a further eight seats on the floor below. There were no longer dividing panels between prisoners and their visitors.

2.357 Child visitors should be able to enjoy visits in an environment that is sensitive to their needs. A children's activity area should be provided where children can be supervised by trained staff and prisoners can play with their children. (3.93)

Not achieved. Although the new visits hall was a significant improvement, it lacked decoration and remained austere. The small play area was very limited. Although sometimes staffed by volunteers from the Mothers' Union, this was unpredictable and staff had no prior knowledge about whether a volunteer would be available during a visit.
We repeat the recommendation.

2.358 A reasonable and predictable range of refreshments should be provided for families to buy during visits. (3.94)

Achieved. The refreshment bar in the visits area was now staffed by prisoners, and had a selection of food from the kitchen

2.359 Official and social visitors should be consulted on the proposed plans for the new visits facility. (3.95)

Not achieved. There had been no survey before the completion of the new visits facility or since to establish whether it met visitors' needs.

Further recommendation

2.360 The prison should undertake regular surveys of prisoners and visitors to ensure that visits facilities meet their needs.

2.361 Designated tables for vulnerable prisoners in visits should not be situated next to the vending machines. (3.41)

Achieved. Vulnerable prisoners were no longer located next to the vending machine during visits. The machine had been replaced by a refreshments bar next to the children's play area. Prisoner seating was based on information produced for the visits manager as to whether they could have contact with children, and those who could not were now seated furthest away from this area. Prisoners were not able to leave their seats during visits.

2.362 Vulnerable prisoners should be discreetly moved from the visits hall before mainstream prisoners at the end of visits. (3.42)

No longer applicable. The prison now operated an integrated system for vulnerable prisoners, and they were not moved separately after visits ended.

2.363 Families should be invited and encouraged to participate in key aspects of a prisoner's sentence where appropriate. (8.66)

Partially achieved. Families were not invited to attend sentence planning boards or ACCT reviews. However, prisoners were encouraged to maintain family contact and support at ACCT reviews, and were supported and enabled to do so. Families were always invited to attend offending behaviour post-programme reviews, and facilitators actively endeavoured to support their attendance, for example, through timetabling reviews around childcare arrangements.

Further recommendation

2.364 Families should be invited to participate in ACCT reviews and sentence planning boards.

2.365 Regular evening visits and children or family days should be run. (8.67)

Partially achieved. Four family visits a year were now held during school holidays. Sessions were held in the visits hall and run in conjunction with East Sussex children's centres and Brighton and Hove Young People's Trust. Two such visits had taken place in 2010, with 18 families participating in the most recent event in April 2010. All prisoners other than those on the basic level of the IEP scheme were eligible to apply. The sessions were not exclusively for prisoners who were fathers of young children and could involve a visit from other family members, such as grandchildren. The prison had received positive feedback from prisoners and families who had participated. No evening visits were available.

Further recommendations

2.366 All prisoners should be able to participate in family visits irrespective of their IEP status.

2.367 There should be regular evening visits sessions.

2.368 There should be a qualified family support worker. (8.68)

Not achieved. The prison did not have a qualified family support worker.
We repeat the recommendation.

### Additional information

2.369 A detailed visits policy covered all aspects of visits. Domestic visits were available every day except Wednesday, and on four days, including weekends, both mornings and afternoons. Prisoners said that access to visits was reasonable and there were few delays. Prisoners had to wear coloured bibs during visits, which was unnecessary.

2.370 The interventions manager was the pathway lead for children and families work. The Family Man course was no longer delivered and the prison was exploring options for structured interventions, subject to funding. Patched – a crime reduction initiative – provided a support service for families of substance users who were undertaking P-ASRO. Storybook Dads was delivered through the library.

Further recommendations

2.371 Prisoners should not have to wear bibs during visits.

2.372 Prisoners should have access to structured interventions to assist and support them in maintaining family relationships in custody.

### Attitudes, thinking and behaviour

2.373 More accredited programme interventions should be made available and this should be informed by a prisoner needs analysis. (8.72)

Achieved. In the 2008 needs analysis, over half of respondents said they had not received assistance to address their offending behaviour, and around a fifth had not completed any offending behaviour programmes at Lewes. Since the previous inspection, two additional offending behaviour programmes had been delivered – enhanced thinking skills (ETS), which was replaced by the thinking skills programme (TSP) in January 2010, and controlling anger and learning to manage it (CALM).

### Additional information

2.374 A multidisciplinary team was responsible for programme delivery. There had been 61 programme completions in 2009-10. One CALM course had been delivered to date, with a second course scheduled for June 2010. There were 35 prisoners on the CALM waiting list, although the majority had not yet been assessed for their suitability for the course. The waiting list for TSP had reduced to a current figure of 16 following the recent transfer-out of sentenced prisoners and reduction in the prison's operational capacity. A flexible delivery programme had been agreed, which would allow the prison to run an additional CALM course in the current year.

2.375 The P-ASRO programme (see drugs and alcohol section) continued to be delivered, and the Prison Fellowship Trust still ran the Sycamore Tree programme, which focused on victim

awareness and restorative justice, with four courses delivered in the previous year. The six-week programme was delivered in weekly half-day sessions. The chaplain assisted in the selection and interviewing of prisoners, and worked with OMU managers to improve referral processes and provide feedback on prisoners' progress on the course.

# 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 sentenced to indeterminate sentences for public protection (IPPs) and lifers should be transferred from Lewes in a timely manner to enable them to meet their offending behaviour needs. (2.301, see paragraph 2.300)

3.2 The transfer of prisoners to training prisons should not be delayed because they are on substance-related clinical maintenance treatment. (2.350, see paragraph 2.349)

## Recommendations — To the governor

### First days in custody

3.3 Reception holding rooms should contain information and the means to keep prisoners occupied. (2.16)

3.4 Vulnerable prisoners should not be located on the first night wing while awaiting allocation. (2.18, see paragraph 2.17)

3.5 Holding rooms should be redecorated and kept free from graffiti, and the toilets should be cleaned and maintained. (2.29, see paragraph 2.23)

3.6 The induction programme should be restructured to ensure that prisoners are kept fully occupied and given the time to gain the required information. (2.30, see paragraph 2.27)

### Residential units

3.7 Cells designed for one prisoner should not accommodate two. (2.32)

3.8 All prisoners should be allowed to wear their own clothes. (2.33)

3.9 Toilets in cells on L and M wings should be screened. (2.35, see paragraph 2.34)

3.10 All showers should be equipped with privacy screens. (2.36)

3.11 Cells on the A1 landing should be maintained to an acceptable standard. (2.42, see paragraph 2.39)

### Personal officers

3.12 Management checks of wing history files should include an analysis of the quality of entries. (2.45)

3.13 Links between personal officers and offender supervisors should be improved. (2.47)

3.14 The personal officer scheme should be developed in line with offender management, and staff trained accordingly. (2.51, see paragraph 2.50)

## Bullying and violence reduction

3.15 Bullying incidents reported through the racist incident report system should be referred to the safer custody manager/team for investigation. (2.56, see paragraph 2.55)

3.16 All staff should be made aware of the requirements for maintaining the safer community monitoring system on P-Nomis. (2.58, see paragraph 2.57)

3.17 Support plans for victims of bullying should be provided. (2.60)

3.18 Analysis of all data sources on violence, bullying and intimidation should be submitted to the safer custody committee for scrutiny. (2.66, see paragraph 2.62)

3.19 Results from the annual safer community survey should be used to inform appropriate actions in the continuous improvement plan. (2.67, see paragraph 2.64)

## Young adults

3.20 The prison should carry out a full analysis of the needs of young adults and act on any findings. (2.68)

## Self-harm and suicide

3.21 Meetings of the safer custody team should be attended consistently by all key departments. Where a member of the committee is unable to attend, a fully briefed deputy should do so. (2.72)

3.22 Case reviews should not be conducted by a single member of staff. (2.76, see paragraph 2.75)

3.23 Case management for prisoners on assessment, care in custody and teamwork (ACCT) monitoring should be consistent and involve staff from different departments. (2.77, see paragraph 2.75)

3.24 Only staff who have completed case manager training should develop care maps and chair ACCT case reviews. (2.78, see paragraph 2.75)

3.25 ACCT documents should accompany prisoners to their places of activity. (2.79, see paragraph 2.75)

3.26 Any delays in accessing Listener services should be kept to a minimum and should be monitored. (2.81, see paragraph 2.80)

3.27 Any use of constant supervision facilities in the health care centre should be reported to the safer custody team, and a log should be maintained. (2.83, see paragraph 2.82)

3.28 The suicide and self-harm prevention strategy should be revised and updated, and should be amalgamated with the violence reduction strategy into an overarching safer community strategy. (2.90, see paragraph 2.84)

3.29 The safer custody committee should analyse data on suicide and self-harm to identify trends and patterns, and to inform strategy. (2.91, see paragraph 2.84)

3.30 Interim action plans should be developed following a death in custody to identify immediate improvements. (2.92, see paragraph 2.85)

3.31 Serious attempts at self-harm or suicide should be thoroughly investigated and discussed at safer custody committee meetings. (2.93, see paragraph 2.85)

3.32 ACCT refresher training should be prioritised for all staff. (2.94, see paragraph 2.85)

3.33 A crisis suite should be available at all times. (2.95, see paragraph 2.87)

## Applications and complaints

3.34 Applications should be logged and tracked and the results recorded. (2.96)

3.35 Complaints against named members of staff should not be answered by that individual. (2.99, see paragraph 2.98)

3.36 Information on the application and complaints processes should be advertised on the residential units. (2.100, see paragraph 2.98)

## Faith and religious activity

3.37 Prisoners should not be required to sign up in advance to attend religious services. (2.106)

## Diversity

3.38 All aspects of diversity should be covered by appropriate policies, development objectives and action plans. (2.121, see paragraph 2.120)

3.39 The diversity and race equality action team (DREAT) should regularly and consistently review strategic developments for all aspects of diversity. (2.122, see paragraph 2.120)

3.40 All areas of diversity should be subject to routine monitoring to assess the impact of the prison's regime on minority prisoner groups. (2.123, see paragraph 2.120)

3.41 The time allocated to specialist diversity posts should be reviewed to ensure that adequate resources (including contingency support and cover for absences) are provided to meet the needs of minority prisoner groups. (2.124)

3.42 All staff, particularly those in direct contact with prisoners, should receive training and guidance to help them understand and respond appropriately to the specific needs of minority prisoner groups. (2.125)

3.43 Where there are specific recommendations that members of staff should undertake training as part of their personal development, this should be prioritised. (2.126)

3.44 Where SMART ethnic monitoring identifies over- or under-representation, an appropriate analysis should be undertaken, reported to the DREAT and remedial action taken. (2.132, see paragraph 2.131)

3.45 Foreign national prisoners should be offered regular contact with accredited independent immigration advice and support agencies. (2.134)

3.46 Foreign national support and information groups should be held at least monthly. (2.135)

3.47 The roles of prisoner and officer foreign national representatives should be clearly defined, and well publicised. (2.137, see paragraph 2.136)

3.48 All foreign national prisoners should be assessed for their specific needs, information from this should be used to formulate a needs analysis, and the prison should work to meet these needs. (2.142, see paragraph 2.139)

3.49 A wider range of information, including details of the prison's regime and policies, should be available in different languages. (2.143, see paragraph 2.139)

3.50 Professional interpreting services should be used for prisoners with poor English during health care consultations and adjudications. (2.144, see paragraph 2.139)

3.51 Information about access to free telephone calls in lieu of visits and airmail letters in exchange for ordinary letters should be made available to all foreign national new arrivals in a language they can understand. (2.145, see paragraph 2.140)

3.52 Information about access to the UK Border Agency should be available to all foreign national new arrivals in a language they can understand. (2.146, see paragraph 2.141)

3.53 There should be formal links between education, health care and the disability liaison officer to ensure appropriate support for all prisoners with a disability. (2.151, see paragraph 2.149)

3.54 Retirement pay for prisoners should be the same as the average wage for other working prisoners. (2.152, see paragraph 2.150)

3.55 Prisoners over 60 should not have to pay for their television. (2.153, see paragraph 2.150)

3.56 Older and disabled prisoners remaining on wings during the core day and not working should be offered a regime to fully occupy them. (2.154, see paragraph 2.150)

## Health services

3.57 There should be a dedicated primary care mental health team to ensure that prisoners on the wings receive equity of care. (2.157)

3.58 Inpatient beds should be removed from the certified normal accommodation. (2.159)

3.59 The introduction of day care services should be implemented as soon as possible. (2.164)

3.60 Primary care triage algorithms should be developed to ensure consistency of advice and treatment to all prisoners. (2.172)

3.61 Padlocks should be supplied to enable the use of the controlled drugs secure transport boxes. (2.184, see paragraph 2.183)

3.62 New arrivals should receive a health screening while they are in the reception centre. (2.199, see paragraph 2.195)

3.63 Prisoners should be transferred expeditiously to secondary and tertiary mental health care, as clinically indicated. (2.200, see paragraph 2.197)

3.64 Uniformed staff should have the appropriate training to recognise and take appropriate action when a prisoner has mental health problems, and work effectively with health staff to ensure a prisoner's care. (2.201, see paragraph 2.198)

## Learning and skills and work activities

3.65 More purposeful activity should be provided. (2.3)

3.66 The prison should ensure that places for learning and skills are maximised, enabling more prisoners to obtain accredited qualifications. (2.5, see paragraph 2.4)

3.67 The prison should improve the use of activity and education spaces. (2.203)

3.68 Prisoners with low levels of literacy and numeracy should be encouraged to improve their skills, and their take-up of provision should be monitored. (2.207)

3.69 Targets in individual learning plans should have greater emphasis on future employment and resettlement, where required. (2.209)

3.70 The prison should introduce more equitable access to the library. (2.210)

3.71 The library service should conduct a library needs analysis. (2.211)

3.72 Exercise periods should be increased to one hour and rescheduled to increase participation. (2.224)

## Physical education and health promotion

3.73 There should be sufficient staff to provide vocational training for prisoners using the PE facilities. (2.223, see paragraph 2.221)

## Time out of cell

3.74 There should be increased opportunities for prisoners to be unlocked. (2.228, see paragraph 2.226)

3.75 The core day should be adhered to. (2.229, see paragraph 2.227)

## Security and rules

3.76 The security committee should be attended consistently by all key departments (or a designated deputy). (2.237, see paragraph 2.231)

3.77 The reasons for the low positive rate for suspicion mandatory drug tests (MDTs) should be investigated and action taken to address these. (2.238, see paragraph 2.232)

3.78 Prisoners should only be placed on and remain on closed visits when there is sufficient evidence to support it, and not simply as a result of a refused MDT. (2.239, see paragraph 2.235)

## Discipline

3.79 Accident report forms should accompany all use of force forms. (2.242)

3.80 All prisoners should be debriefed following an incident where force is used. (2.243)

3.81 If there is no option but to house prisoners for lengthy periods of time in segregation, they should be provided with access to purposeful activity. (2.245, see paragraph 2.244)

3.82 Exercise for segregated prisoners should be supervised by only one member of staff. (2.246, see paragraph 2.243)

3.83 Formal reintegration planning for prisoners in the segregation unit should be developed and implemented consistently. (2.248, see paragraph 2.247)

3.84 Written adjudication records should demonstrate full and thorough exploration of the circumstances around the charge before guilt is proved. (2.261, see paragraph 2.250)

3.85 Adjudication standardisation meetings should take place more frequently and should be attended by all key stakeholders. (2.262, see paragraph 2.251)

3.86 Adjudication standardisation meetings should include quality assurance of adjudication proceedings and associated documentation. (2.263, see paragraph 2.251)

3.87 Use of force paperwork should be consistently scrutinised to identify any trends or patterns. (2.264, see paragraph 2.254)

3.88 Any use of a baton should be independently investigated to give assurance that its use was appropriate and proportionate.(2.265, see paragraph 2.254)

3.89 Special accommodation should only be used, with appropriate authority, in exceptional circumstances to house violent and/or refractory prisoners for the least time possible. (2.266, see paragraph 2.255)

3.90 Prisoners on ACCTs should only be located in special accommodation in exceptional circumstances, which should be justified in the authorising documentation. (2.267, see paragraph 2.255)

3.91 The duty governor should ensure that all paperwork authorising use of special accommodation is appropriately and fully completed. (2.268, see paragraph 2.255)

3.92 Electricity should be restored immediately in all cells in the segregation unit. (2.269, see paragraph 2.256)

3.93 History sheets should demonstrate regular positive engagement by officers with prisoners during their stay in the segregation unit. (2.270, see paragraph 2.257)

3.94 Risk assessments for staffing levels for different activities in the segregation unit should be revised. (2.271, see paragraph 2.257)

3.95 Paperwork used for authorising segregation should take account of prisoners' individual circumstances. (2.272, see paragraph 2.259)

3.96 Segregation monitoring and review group meetings should have an appropriate focus and take place more consistently. (2.273, see paragraph 2.260)

### Incentives and earned privileges

3.97 The apparent disparity in the proportion of black and minority ethnic prisoners on the enhanced level should be investigated and action taken if necessary. (2.274)

### Catering

3.98 Halal dishes should be prepared and served with separate pans, knives and serving utensils. These items should be clearly distinguishable from those used for non-halal dishes. (2.280)

### Prison shop

3.99 New arrivals should be able to access the prison shop within their first 24 hours. (2.288, see paragraph 2.287)

### Strategic management of resettlement

3.100 The reducing reoffending strategy should be based on a comprehensive annual needs analysis, which includes information from completed OASys (offender assessment system) assessments. (2.7, see paragraph 2.6)

3.101 The resettlement policy should be underpinned by a clear action plan with specific objectives and development milestones. (2.295, see paragraph 2.293)

3.102 The reducing reoffending committee should monitor the delivery of objectives identified in the strategic action plan, and update the published plan accordingly. (2.296, see paragraph 2.293)

### Offender management and planning

3.103 All eligible prisoners should have a current OASys assessment and an up-to-date sentence plan. (2.299, see paragraph 2.298)

3.104 Indeterminate-sentenced prisoner forums should be held quarterly. (2.303)

3.105 Staff in contact with indeterminate-sentenced prisoners should attend the appropriate lifer training to enable them to support prisoners. (2.305)

3.106 Offender supervisors should engage regularly with prisoners to implement sentence plans and monitor progress against targets, and this should be recorded in contact logs. (2.317, see paragraph 2.308)

3.107 There should be an effective quality assurance scheme for all aspects of offender management. (2.318, see paragraph 2.309)

3.108 Formal multidisciplinary sentence planning boards should be held for all eligible prisoners following OASys assessments or reviews. (2.319, see paragraph 2.310)

3.109 Initial induction needs assessments should be combined into a custody planning document, which is monitored during prisoners' time in custody and reviewed before release. (2.320 2.311)

## Resettlement pathways

3.110 The prison should increase the resources allocated to meeting the accommodation needs of prisoners. (2.328, see paragraph 2.327)

3.111 All prisoners should have greater opportunities for interim careers advice and information to review their progress towards agreed development targets or plans for a career or employment. (2.332, see paragraph 2.331)

3.112 Prisoners should be given help to open bank accounts before their release. (2.333)

3.113 Specialist provision for debt and money management advice should be extended to meet the needs of the population. (2.337, see paragraph 2.336)

3.114 The short duration programme should be introduced to meet the needs of its remand population, short-term prisoners and those on methadone maintenance. (2.343)

3.115 Services should be provided to meet the needs of prisoners with alcohol problems. (2.349, see paragraph 2.347)

3.116 All prisoners should be able to receive their first visit within one week of arrival. (2.352)

3.117 A well-run and properly-equipped visitors' centre should be available to provide information, support, shelter and other basic services for at least an hour before and after advertised visiting times. (2.354)

3.118 Prisoners and visitors should have reasonable access to toilet facilities during visits. (2.355)

3.119 Child visitors should be able to enjoy visits in an environment that is sensitive to their needs. A children's activity area should be provided where children can be supervised by trained staff and prisoners can play with their children. (2.357)

3.120 Official and social visitors should be consulted on the proposed plans for the new visits facility. (2.359)

3.121 The prison should undertake regular surveys of prisoners and visitors to ensure that visits facilities meet their needs. (2.360)

3.122 Families should be invited to participate in ACCT reviews and sentence planning boards. (2.364)

3.123 All prisoners should be able to participate in family visits irrespective of their IEP status. (2.366)

3.124 There should be regular evening visits sessions. (2.367)

3.125 There should be a qualified family support worker. (2.368)

3.126 Prisoners should not have to wear bibs during visits. (2.371, see paragraph 2.369)

3.127 Prisoners should have access to structured interventions to assist and support them in maintaining family relationships in custody. (2.372, see paragraph 2.370)

## Housekeeping points

### Courts, escorts and transfers

3.128 Vans used for transporting prisoners should be free from graffiti. (2.14, see paragraph 2.11)

### First days in custody

3.129 An induction booklet should be produced to accompany the induction programme. (2.31, see paragraph 2.27)

### Personal officers

3.130 The personal officer policy document should be reviewed and clarified. (2.46, see paragraph 2.45)

3.131 Personal officers should make entries in prisoners' case notes in between the two-week routine entry. (2.52, see paragraph 2.48)

### Legal rights

3.132 Legal rights and bail information should be displayed on noticeboards in the residential units. (2.105, see paragraph 2.104)

### Learning and skills and work activities

3.133 All prisoners should have an induction to the library. (2.205, see paragraph 2.204)

### Security and rules

3.134 The minutes from the security committee should be streamlined and accurately record the content of the meeting and any arising actions. (2.240, see paragraph 2.231)

3.135 Security objectives should be SMART (specific, measurable, achievable, realistic and time bound). (2.241, see paragraph 2.231)

## Offender management and planning

3.136 The offender management video-link equipment should be connected and made available for offender supervisors. (2.321, see paragraph 2.309)

3.137 The public protection committee should fully discuss all relevant prisoners, in line with the published terms of reference, and these discussions and any agreed action points should be recorded in the minutes. (2.322, see paragraph 2.315)

# Appendix I: Inspection team

| | |
|---|---|
| Martin Lomas | Team leader |
| Keith McInnis | Inspector |
| Kevin Parkinson | Inspector |
| Kellie Reeve | Inspector |
| Andrea Walker | Inspector |
| Paul Tarbuck | Health services inspector |
| Karen Adriaanse | Ofsted inspector |
| Neil Edwards | Ofsted inspector |

# Appendix II: Prison population profile

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

| Status | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Sentenced | 1 | 267 | *56* |
| Recall | -- | 32 | *7* |
| Convicted unsentenced | 6 | 39 | *9* |
| Remand | 11 | 102 | *24* |
| Detainees | 2 | 15 | *4* |
| Total | 20 | 455 | 100 |

| Sentence | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Unsentenced | 19 | 163 | *38* |
| Less than 6 months | 1 | 43 | *9.5* |
| 6 months to less than 12 months | - | 20 | *4* |
| 12 months to less than 2 years | - | 39 | *8* |
| 2 years to less than 4 years | - | 76 | *16* |
| 4 years to less than 10 years | - | 72 | *15.5* |
| 10 years and over (not life) | - | 8 | *2* |
| ISPP | - | 15 | *3* |
| Life | - | 19 | *4* |
| Total | 20 | 455 | 100 |

| Age | Number of prisoners | % |
|---|---|---|
| Under 21 years | 20 | *5* |
| 21 years to 29 years | 145 | *30* |
| 30 years to 39 years | 166 | *35* |
| 40 years to 49 years | 97 | *20* |
| 50 years to 59 years | 35 | *7* |
| 60 years to 69 years | 10 | *3* |
| 70 plus years | 2 | *0.4* |
| Total | 475 | 100.4 |

| Nationality | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| British | 15 | 340 | *74.5* |
| Foreign nationals | 2 | 49 | *10* |
| Not stated | 3 | 66 | *15.5* |
| Total | 20 | 455 | 100 |

| Security category | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Uncategorised unsentenced | | 11 | *2.3* |
| Uncategorised sentenced | | 7 | *1.5* |
| Cat A | | - | - |
| Cat B | | 12 | *2.5* |
| Cat C | | 94 | *19.7* |
| Cat D | | 3 | *0.6* |
| Other | 20 | 328 | *73.4* |
| Total | 20 | 455 | 100 |

| Ethnicity | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| *White:* | | | |
| British | 17 | 367 | *81* |
| Irish | | 1 | *0.2* |

| | | | |
|---|---|---|---|
| Other white | 3 | 35 | *8* |
| *Mixed:* | | | |
| White and black Caribbean | | 5 | *1* |
| White and black African | | 1 | *0.2* |
| White and Asian | | 1 | *0.2* |
| Other mixed | | 3 | *0.6* |
| *Asian or Asian British:* | | | |
| Indian | | 1 | *0.2* |
| Bangladeshi | | 1 | *0.2* |
| Other Asian | | 8 | *2* |
| *Black or black British* | | | |
| Caribbean | | 7 | *1.5* |
| African | | 11 | *2* |
| Other black | | 9 | *2* |
| *Chinese or other ethnic group:* | | | |
| Chinese | | 1 | *0.2* |
| Other ethnic group | | 1 | *0.2* |
| Not stated | | 3 | *0.6* |
| Total | 20 | 455 | 100.1 |

| Religion | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Baptist | | 1 | *0.2* |
| Church of England | 3 | 107 | *23* |
| Roman Catholic | 2 | 69 | *15* |
| Other Christian denominations | 2 | 14 | *3* |
| Muslim | - | 25 | *5* |
| Hindu | - | 3 | *0.6* |
| Buddhist | - | 13 | *3* |
| Jewish | - | 2 | *0.4* |
| Other | 4 | 15 | *4* |
| No religion | 9 | 206 | *45* |
| Total | 20 | 455 | 99.2 |

Sentenced prisoners only

| Length of stay | 18–20 yr olds | | 21 and over | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | 3 | 1 | 104 | *27* |
| 1 month to 3 months | 5 | 1 | 108 | *30* |
| 3 months to 6 months | 2 | 1 | 73 | *20* |
| 6 months to 1 year | - | | 38 | *10* |
| 1 year to 2 years | - | | 16 | *5* |
| 2 years to 4 years | - | | 4 | *1* |
| Total | 10 | 3 | 353 | 96 |

Unsentenced prisoners only

| Length of stay | 18–20 yr olds | | 21 and over | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | 5 | 1 | 42 | *38* |
| 1 month to 3 months | 3 | 1 | 42 | *38* |
| 3 months to 6 months | 2 | 1 | 16 | *14* |
| 6 months to 1 year | - | | 2 | *2* |
| Total | 10 | 3 | 102 | 92 |