Report on an unannounced short follow-up inspection of

# Hydebank Wood Women's Prison

**21 - 25 March 2011**

by the Chief Inspector of Criminal Justice in Northern Ireland, Her Majesty's Chief Inspector of Prisons and the Regulation and Quality Improvement Authority

October 2011

HM Inspectorate of Prisons

The Regulation and Quality Improvement Authority

Criminal Justice Inspection Northern Ireland
*a better justice system for all*

Report on an unannounced short follow-up inspection of

# Hydebank Wood Women's Prison

**21 - 25 March 2011**
by the Chief Inspector of Criminal Justice in Northern Ireland, Her Majesty's Chief Inspector of Prisons and the Regulation and Quality Improvement Authority.

October 2011

Laid before the Northern Ireland Assembly under Section 49(2) of the Justice (Northern Ireland) Act 2002 (as amended by paragraph 7(2) of Schedule 13 to The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010) by the Department of Justice.

HM Inspectorate of Prisons

The Regulation and Quality Improvement Authority

Criminal Justice Inspection Northern Ireland
*a better justice system for all*

# Contents

# List of abbreviations

| | |
|---|---|
| **CAB** | Challenging Anti-Social Behaviour |
| **CJI** | Criminal Justice Inspection Northern Ireland |
| **EMIS** | Egton Medical Information System |
| **ETI** | Education and Training Inspectorate for Northern Ireland |
| **HBW** | Hydebank Wood |
| **HMIP** | Her Majesty's Inspectorate of Prisons |
| **NIACRO** | Northern Ireland Association for Care and Resettlement of Offenders |
| **NIPS** | Northern Ireland Prison Service |
| **NMC** | Nursing and Midwifery Council |
| **OMU** | Offender Management Unit |
| **PREP** | Progressive Regimes and Earned Privileges |
| **PRISM** | Prison Record and Information System Management |
| **RLO** | Residential Liaison Officer |
| **RQIA** | Regulation and Quality Improvement Authority |
| **SPAR** | Supporting Prisoners At Risk |
| **YOC** | Young Offenders Centre |

# Chief Inspectors' Foreword

This unannounced short follow-up inspection of Ash House Women's Prison was undertaken by HM Inspectorate of Prisons (HMIP) on behalf of Criminal Justice Inspection Northern Ireland (CJI) and was supported by CJI Inspectors, staff from the Education and Training Inspectorate for Northern Ireland (ETI) and staff from the Regulation and Quality Improvement Authority (RQIA). The inspection focused on the progress Ash House had made in implementing the recommendations contained in our last full inspection in 2007.

In 2007 we found that Ash House was providing a generally safe environment and in 2011 we found the prison was continuing to make reasonable progress in this area. It is therefore particularly sad that a woman prisoner was found dead shortly after the inspection.

It was encouraging that girls under the age of 18 were no longer being held at Ash House. Reception arrangements had been significantly improved by provision of a new reception building specifically for women and the end of routine strip-searching of all new arrivals. First night procedures and induction were generally satisfactory. The prison appeared safe and calmer than at our last inspection, and most women said they felt safe. However, there were few interventions to challenge bullies or support victims. Despite the subsequent tragic death we found there was greater recognition of the specific needs of women in relation to suicide and self-harm. At the time of the inspection, levels of self-harm were not high. There was less reliance on physical measures such as the use of observation cells and protective clothing. Managers and staff needed however, to learn more systematically from incidents and to complete care plans consistently. There was better monitoring of women at risk, both on an individual level and through a fortnightly safer custody meeting.

Women were constrained both by the restrictions arising from a shared site with young men and by the inappropriate implementation of security measures relating to the male side, which were not sufficiently intelligence-led. However punishments for disciplinary offences were not too severe, the level of force was not high and there was no segregation unit.

Relationships between staff and women continued to be reasonably good but there were too many male staff. The chaplains played a valuable role in the life of the establishment. The general environment was good though women's access to the site was still too restricted and the Ash House building was far from ideal for a women's prison – it was particularly claustrophobic for life-sentenced and long-term prisoners. There was still no guidance from the Northern Ireland Prison Service (NIPS) on how the prison should tackle diversity issues and work in this area was under-developed.

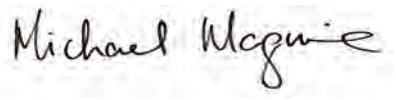
Health services had not improved sufficiently, despite transfer of responsibility to the South Eastern Health and Social Care Trust. Health services were under-resourced, poorly managed and there was sometimes unsatisfactory attention to the needs of patients. The needs of women with mental health problems were a particular concern. Mixing children, young male adults and women in the health centre made it difficult to provide an appropriate regime.

Women had too little exercise. There were too many lock-downs and association regularly started late and finished early. There was no coherent learning and skills strategy that differentiated between the needs of the various groups held on the Hydebank Wood (HBW) site or matched to the needs of

employers and provision in the community. Only 27% of previous education recommendations had been implemented in comparison to over 50% of all other recommendations. While access to the library had improved, physical education facilities were good, and we observed examples of good teaching, some was clearly inadequate and there had been no achievement of an ICT qualification for years. There was insufficient work to keep prisoners occupied. We suggest it is now necessary to establish effective collaborative partnerships with external education and training providers – such as further education and/or work-based learning suppliers – as a matter of urgency.

Resettlement provision had improved. There was a detailed resettlement strategy that specified how the needs of women would be met and the Offender Management Unit (OMU) was well established. There was generally good support to help women with practical needs when they left the prison and useful links had been established with womens' community groups. The Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO) visitor centre offered good facilities for mothers and their children and the new extended visits provision was a very welcome facility.

Ash House is now an improving establishment. Inspectors were pleased to see the progress in resettlement provision, a better environment and a greater focus on the specific needs of women. However, the progress that could be achieved within the confines of an establishment catering for young adults and children, as well as women, was significantly limited. This was particularly apparent in the poor quality of learning and training provision available and the inadequate health care arrangements. We yet again recommend that the NIPS should create a separate and dedicated women's facility, without which the needs of this vulnerable population are unlikely ever to be properly met.



**Dr Michael Maguire**
Chief Inspector of Criminal Justice
in Northern Ireland

October 2011

**Nick Hardwick**
Her Majesty's Chief Inspector
of Prisons in England and Wales

October 2011

Criminal Justice Inspection
Northern Ireland
*a better justice system for all*

# Fact page

### Task of the establishment

To accommodate all female prisoners in Northern Ireland.

### Number held

49.

### Cost per place per annum

The cost per prisoner place for the NIPS is calculated for the service as a whole. The cost per prisoner place for 2007-08 was £81,000. The forecast cost for 2010-11 is £74,746 against a target of £76,500. The forecast for Hydebank Wood alone is £66,660.

### Certified normal accommodation

74.

### Operational capacity

71.

### Last inspection

5 - 9 November 2007 (announced).

### Brief history

Ash House opened for women on 21 June 2004 following a major refurbishment programme. Further refurbishments, including the installation of in-cell sanitation, were completed in April 2007.

### Short description of residential units

Ash House is a stand-alone residential unit in Hydebank Wood, adjacent to the male accommodation. It has five self-contained landings, each with dining and association areas and four with integral sanitation in all cells. A2 is used as a first night centre and for prisoners on induction. A3 and A4 are enhanced landings and A5, which is the best accommodation, houses long-term prisoners who are given the opportunity to cook their own meals and is effectively self-contained. A1 holds women on basic level. There are two mother and baby cells on A4 and two cells adapted for women with disabilities on A2. The ground floor has two multi-functional rooms and a medical facility. There is a new purpose-built female reception to the side of Ash House.

### Escort contractor

NIPS: Prison escort and court custody service.

### Health service commissioner and provider

Health services are commissioned by the Health and Social Care Board and were provided by South Eastern Health and Social Care Trust.

### Learning and skills providers

NIPS.

Section 1

# Inspection Report

CHAPTER 1:

# Summary

## Introduction

1.1 The purpose of this inspection was to follow-up the recommendations made in our last full inspection of 2007 and the progress achieved against the recommendations. All full inspection reports include a summary of outcomes for prisoners against the model of a healthy prison. The four criteria of a healthy prison are:

- **Safety:** prisoners, 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; and
- **Resettlement:** prisoners are prepared for their release into the community and helped to reduce the likelihood of re-offending.

1.2 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.

1.3 The assessments of outcomes for prisoners and therefore of the establishment's overall performance against these tests, made in 2007, are detailed below. In some cases, this performance was affected by matters outside the establishment's direct control, which need to be addressed by the Northern Ireland Prison Service (NIPS). At this inspection we have commented where we have found significant improvements, and where we believe little or no progress has been made and work remains to be done.

## Safety

1.4 In 2007, Ash House was performing reasonably well against this healthy prison test. Out of 52 recommendations in this area, 13 had been achieved, 18 partially achieved and 21 not achieved. We have made seven further recommendations.

1.5 Some women continued to travel to Hydebank Wood in vans with young men. Some of the escort vans we examined were dirty. A new reception building specifically for women was a good improvement and women were no longer routinely strip-searched on arrival. Staff dealt well with new arrivals but the use of individual holding rooms was unnecessary and reception interviews were not held in private.

1.6 Officers ensured that all new arrivals were given a meal and the opportunity to make a telephone call. First night procedures had improved, with better interviews to assess needs and vulnerabilities and staff dealt with women compassionately. This was backed up by good peer support by Insiders. The quality of induction was generally satisfactory but the relatively small numbers meant some women could wait a while to attend formal sessions.

1.7 A new anti-social behaviour policy had just begun to be piloted but there had been no staff training for it. As previously, there were relatively few investigations into allegations of bullying but those we looked at were thorough. There were few effective interventions to support victims and challenge bullies to change their behaviour and usually either the victim or perpetrator was moved to keep them apart from each other. Other women prisoners who had difficulties with each other were kept apart on different landings, although this was difficult within the constraints of the building. Ash House appeared generally safe and calmer than previously. Most women said they felt safe and this was supported by a relatively recent survey undertaken by Opportunity Youth when 68% of women said they had never felt unsafe in Ash House.

1.8 There was better recognition of the distinct needs of women in relation to suicide and self-harm issues. Levels of self-harm were not high. Although some useful investigations into serious incidents had been carried out, learning points did not appear to be identified to inform local practice. There was still a need to continue to develop better therapeutic responses to support women at risk of self-harm but this had improved and there was less reliance than previously on physical measures such as use of observation cells and protective clothing. Supporting prisoners at risk (SPAR) procedures had also improved with well-attended multi-disciplinary reviews, although some care plans were not completed. Better entries in monitoring documents demonstrated some good engagement with prisoners at risk. SPAR procedures were supplemented by useful fortnightly safer custody meetings that discussed individual cases and helped ensure appropriate support was provided. A Listener scheme had not been sustained. Insiders provided some peer support and there was appropriate access to Samaritans telephones and other help lines.

1.9 Communication of general security information had improved with monthly security bulletins but the security meeting still had restricted attendance. More security information reports than previously were submitted but many staff were still reluctant to commit things to paper. There were still too many cell searches and insufficient analysis of finds to evaluate their effectiveness. Women were now able to move more freely to activities in their area of the prison, but inevitably movements continued to be constrained by the fact that the site was shared with young men. We welcomed the introduction of revised searching arrangements for women that recognised their particular sensibilities and risks but too many continued to be searched coming from visits.

1.10 Adjudication arrangements were reasonable and took better account than previously of the specific circumstances of women. Punishments were not too severe and, as there was no segregation unit for women, cellular confinement when imposed was usually in the woman's own cell. The level of use of force was not high and there were improved governance arrangements, but we were concerned to find an incident when male officers had been involved in the strip-search of a woman under restraint.

1.11 First night treatment and symptomatic relief for substance-dependent women were available but arrangements for those who were not on an established programme in the community were not sufficiently robust. There were recent policies for managing withdrawal from alcohol and benzodiazepines but it was not clear that these were fully embedded and followed. We were concerned, particularly given the circumstances of a recent death in the Young Offenders Centre (YOC), that protocols for those undertaking a clinical alcohol detoxification did not require admission to the health care centre. Addictions services for Hydebank Wood (HBW) as a whole were under-resourced with only one session

a week but all five patients on the caseload were from Ash House. Mandatory drug testing had been introduced but the results were not monitored to give an indication of prevalence or the efficacy of supply reduction arrangements.

1.12 Although we still considered that a more therapeutic approach to support women at risk of suicide or self-harm was needed, reasonable progress had been made in the area of safety.

## Respect

1.13 In 2007, Ash House was not performing sufficiently well against this healthy prison test. Out of 62 recommendations in this area, 20 had been achieved, 15 partially achieved, 26 not achieved and one was no longer relevant. We have made seven further recommendations.

1.14 Relationships between staff and the women prisoners in Ash House continued to be reasonably good. Although officers were usually at their desks on the landings, they were approachable and helpful. There was better managerial recognition of the specific needs of women but there were too many male staff. Staff were generally supportive and a residential liaison officer scheme had been introduced to provide a named officer to be responsible for each woman. A number of women commented that they found the scheme useful. Wing files did not contain many in-depth entries.

1.15 The general environment of Ash House was good, with some excellent artwork on display. The grounds were well kept but women still had little access to them. Living accommodation was generally good. Landing consultation meetings were held but not all actions were properly followed-up.

1.16 There was still no clear guidance from the NIPS on diversity. There had been little training in religious and cultural differences and 70% of staff including the diversity manager and diversity officer had not received any diversity training. Equality was not actively promoted and some staff had little enthusiasm for, or understanding of equality issues. The diversity committee did not always meet as scheduled and attendance was generally poor. There was insufficient routine analysis and monitoring of data to help ensure equality of treatment by religion, race, nationality or other diversity areas. Foreign national women prisoners mostly received good individual support.

1.17 The spiritual and pastoral needs of women prisoners continued to be well catered for and chaplains played an active role in the life of the prison, including in safer custody and diversity areas. Religious services for women prisoners continued to be held on Wednesdays.

1.18 Many women prisoners complained about the quality of food, which they said was bland and stodgy and lacked variety, but there was only limited consultation about food. It was good that most women were able to eat their meals together rather than in their cells and there were welcome opportunities for those on the enhanced landing to cook for themselves.

1.19 Replies to complaints were often impersonal and did not always deal fully with the issues raised. The process allowed them to be closed after discussion but some were closed when the prisoner did not believe the matter had been resolved. There was no analysis of complaints or formal quality assurance to examine the standard of replies.

1.20 Although it was nearly three years since the transfer of responsibility for the delivery of health services to the South Eastern Health and Social Care Trust, there was little evidence that services had improved and progressed. The health needs assessment was insufficiently thorough. Women had good access to a GP but primary care

services were not well structured or managed to ensure resources were well used, although the standard of service was generally better than in the YOC. We found and heard of some examples of unsatisfactory attention to the needs of patients. Mixing young men, women and children in the health care centre made it difficult to provide a satisfactory inpatient regime. Mental health services were under-resourced, primary mental health nurses did not have protected time for their role, there was no group work and very little consultant time. There was a long waiting list for mental health services even though not all women prisoners who needed help were referred.

1.21 While we still considered that a fully respectful environment for women prisoners could not be provided on a site shared with young men and we had some serious concerns about the delivery of health services, we considered on the basis of this short follow-up inspection that some reasonable progress had been made in the area of respect.

## Purposeful activity

1.22 In 2007, Ash House was performing poorly against this healthy prison test. Out of 12 recommendations in this area, one had been achieved, three partially achieved and eight not achieved. We have made two further recommendations.

1.23 Women still did not get appropriate opportunities to spend time in the open air each day and there was no regular scheduled period of exercise. Association was too often cancelled at short notice. In the 2010 Opportunity Youth survey, only 26% of women said they were able to get association time most days of the week and only 10% said they were able to go outside to exercise every day. Few women prisoners were locked in their cells during the day but women had poor access to activities, and in a group with Inspectors women identified too many lockdowns as one of the negative aspects of life at Ash House. Women prisoners were regularly unlocked late and locked up early.

1.24 There was no coherent learning and skills strategy that provided any differentiation according to sentence length or the specific needs of different groups, including for women who had fewer opportunities and a narrower range of provision than young adults and children in the Young Offender Centre. The curriculum was outdated and did not match the needs of women prisoners, employers or the local labour market. Given the inadequate progress since the last inspection, there was a need to establish effective collaboration partnerships with external education and training providers, such as further education and/or work-based learning suppliers, as a matter of urgency. There was insufficient identification of learning needs to address barriers to learning and quality assurance and review arrangements were weak. Some serious problems of teaching and under-achievement had not been identified and many women with low levels of literacy and numeracy did not have their needs met. While some of the teaching observed was good, standards in ICT and some of the essential skills were inadequate. In ICT, there had been no achievement of a qualification for some years. Links between learning and skills and resettlement had improved, but there was too much emphasis on just filling places rather than ensuring individuals were appropriately placed. Despite this approach, the education and training capacity was substantially under-used.

1.25 Access to the library had significantly improved and a pro-active librarian had made the library a vibrant centre in education, with a good range of activities to promote literacy including a book club. There was an increased range of non-fiction texts and a good stock of DVDs and CDs to borrow but no regular supply of up-to-date newspapers and magazines.

1.26 There was insufficient purposeful work to occupy women and many just had domestic tasks on the landing or were required to work in the kitchens. There were too little skills training to help employability.

1.27 Physical education facilities remained reasonably good but women had little access to outdoor facilities.

1.28 There remained too little focus on providing activities to meet the needs of women prisoners and we considered on the basis of this short follow-up inspection, that very little progress had been made in this area.

## Resettlement

1.29 In 2007, we considered that Ash House was not performing sufficiently well against this healthy prison test. Out of 21 recommendations in this area, seven had been achieved, five partially achieved, eight not achieved and one was no longer relevant. We have made one further recommendation.

1.30 There was a detailed local resettlement strategy for HBW as a whole. While the strategy for women was not separate, it represented a major improvement since the last inspection in specifying resettlement needs of women, including older women prisoners, young offenders and foreign nationals, but it did not contain anything specific about women life-sentenced prisoners. The strategy set out how services were to be delivered and needs were articulated within the context of background research, legislation, roles and responsibilities. The strategy referred to performance measurement but contained no measurable targets or arrangements for review, which awaited the overall NIPS resettlement strategy. A detailed Ash-Inspire resettlement initiative information booklet set out a range of specific provision for women, including the important contribution made by the Women's Support Network.

1.31 The Offender Management Unit (OMU) was well-established and increased resources received to implement the new Criminal Justice Order (2008) sentences had benefited resettlement work generally. All women prisoners including those on remand were involved in the development of their resettlement plans and had their needs assessed. However, there was a disjunction between the work of the OMU and residential staff in Ash House, and more effective links needed to be forged through better communication. Those covered by Criminal Justice Orders received good attention. There was still a need to improve local strategic management of resettlement and ensure that resettlement plans were more meaningful and actively informed what women prisoners did. There had been little change in the management arrangements for life-sentenced women. Women lifers had only the potential of the enhanced accommodation on Ash 5 and category D status to look forward to, although the latter did not change their residential environment. A considerate approach was taken locally to try and meet the particular needs of individual women lifers and there was good support from identified and trained lifer officers.

1.32 Sentence managers interviewed and identified resettlement needs for all new arrivals and made referrals to appropriate services as necessary. A good range of services were provided to help with accommodation, debt and other issues that would impact on effective resettlement. Useful links had been established with women's community groups and through the Inspire project with probation to help ensure that women received effective support and advice on release, including those who had been remanded and did not receive a custodial sentence. There were no scheduled pre-discharge health clinics but community GPs were informed when prisoners on medication were released and those identified as having mental health problems were referred to the South

Eastern Trust prison health discharge liaison team or their GP.

1.33 The visitors' centre continued to offer good facilities. NIACRO staff identified and talked to all first-time visitors and offered a wide range of practical support. Visits could be booked in person and on the internet, but some visitors said they found it difficult to book by telephone. Family support services continued to be very good with two-hour visits in the family room and pro-active family liaison officers who saw all new prisoners and visitors. Mothers now had excellent opportunities to enjoy extended visits with their children in a new dedicated facility.

1.34 There was no up-to-date and comprehensive drug and alcohol strategy based on an assessment of the needs of women. However, a good range of services was provided, including solution-focused therapies and individual counselling. Pre-release work was also provided and there were some effective links to community services to enable treatment to continue after release.

1.35 On the basis of this short follow-up inspection, we considered that some reasonable progress had been made in the area of resettlement.

CHAPTER 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 2007.*

## Main recommendations (from the previous report)

2.1 **A separate prison should be provided for women in Northern Ireland. (HP42)**
**Not achieved.** There was still no separate prison for women. A strategic outline case and options for the location of a separate prison for women had been developed and were being considered as part of a wider Northern Ireland prisons estate strategy. The prison did its best to meet the specific needs of women, including adopting gender-specific standards and a partnership with the probation Inspire project for women prisoners, but Ash House remained unsuitable. The restrictive and cramped accommodation on a site shared with young men still meant the needs of women prisoners could not be met appropriately. **We repeat the recommendation.**

2.2 **First night procedures should be agreed so that all new women receive consistent and supportive care on arrival, including private interviews to assess immediate needs, access to peer support and appropriate supervision. (HP43)**
**Partially achieved.** There was no published first night strategy and no job descriptions for first night staff to ensure a consistent approach. Women received good support and information from female officers in the reception centre, but interviews did not take place in private. Other staff and prisoners often moved through the area and interviews were also disrupted by telephone calls. Staff on the first night and committal landing gave verbal information and were accessible to prisoners and new arrivals were seen by an Insider on their first evening if there was no early lock-down. (See also section on first days in custody.)

## Further recommendation

2.3 A first night strategy should ensure that all newly arrived women receive consistent and appropriate support.

2.4 **A personal officer scheme should be established to support women at Hydebank Wood, liaise with families and encourage effective resettlement. (HP44)**
**Partially achieved.** A residential liaison officer (RLO) scheme had been piloted and all prisoners were allocated a RLO within 24 hours of arrival. The women we spoke to knew who their RLO was and many said it was helpful to have a named officer to go to if they had a problem. However, wing files indicated little regular contact between prisoners and their RLO, with most entries made by class officers and largely restricted to comments about behaviour and day-to-day prison issues.

**Further recommendation**

2.5 Residential liaison officers should meet with their allocated prisoners regularly, record this in wing files and help support resettlement objectives.

2.6 **There should be a separate suicide and self-harm prevention policy specifically for women at Ash House. This should comprehensively set out the gender-specific needs of women at risk of suicide and self-harm, include a more therapeutic response to support women at risk and provide guidance for staff in implementing the policy. (HP45)**
**Achieved.** The NIPS suicide and self-harm policy revised in 2011 did not fully reflect and differentiate the distinct and specific needs of women but these were contained in other documents. Gender-specific standards for, and a guide to working with women prisoners, had been published in November 2010. Both included sections on safer custody and outlined some essential and different needs of women. Appendix 1 of the suicide and self-harm prevention standard operating procedure (recognising risk) referred to the additional pressures and difficulties for women prisoners.

2.7 **The Northern Ireland Prison Service should issue clear guidance on the implementation of a diversity strategy indicating areas to be prioritised and provide relevant staff training including in religious and cultural differences. (HP46)**
**Not achieved.** Diversity was still not seen as a priority or well promoted, and the NIPS had not issued any guidance on the implementation of a diversity strategy. Only 30% of staff in the prison had received training in diversity and those we spoke to did not feel it had been relevant to the Northern Ireland setting.
**We repeat the recommendation.**

2.8 **The transfer of responsibility for health services should be completed expeditiously so that health services for women can be planned, provided and quality assured through integrated working. (HP47)**
**Partially achieved.** Responsibility for health services had finally been transferred in April 2008 but the services provided were not planned or quality assured through integrated working. A separate governance structure for the management of health care in the NIPS had been developed. Since the transfer of health care services, significant resources had been allocated to Maghaberry Prison but there was little evidence that equivalent time and commitment to improvement had been focused on in Hydebank Wood and Ash House. A service improvement board for Hydebank Wood had been established and had first met in January 2011. Its purpose was to lead and direct the development of work streams to provide a focus for continuous improvement to advance the health of prisoners.

**Further recommendation**

2.9 The service improvement board should ensure that the health needs of women prisoners are identified and met.

2.10 **An education and training policy for women should be developed that provides sufficient work and education places to keep women purposefully occupied. (HP48)**
**Not achieved.** There was no coherent learning and training strategy for women. The number of vocational training places was limited, there were too few opportunities for women to gain relevant employability skills and work activities were often restricted to domestic duties on the landings. The curriculum was outdated and not matched to the needs of the women, employers or the local labour market. The needs of many women prisoners with low literacy and numeracy levels were not

adequately met.
**We repeat the recommendation.**

### Further recommendation

2.11 Effective collaborative partnerships with external education and training providers, such as further education and/or work-based learning suppliers, should be established.

2.12 **The standard of food should be improved. (HP49)**
**Not achieved.** The quality of the food had not changed.
**We repeat the recommendation.**

2.13 **There should be a separate resettlement strategy for women prisoners at Ash House based on their identified needs. The new strategy should specify roles and responsibilities, set SMART objectives, outline provision for specific groups of women and include arrangements for regular review. (HP50)**
**Partially achieved.** There was a detailed local resettlement strategy for 2011-14. The women's strategy was not separate but there had been a major improvement in that the resettlement needs of women, including older women prisoners, young offenders and foreign nationals, were now specified. There was nothing specific about women life-sentenced prisoners. The strategy set out how services were to be delivered and needs were articulated within a context of background research, legislation, roles and responsibilities. While there were references to performance measurement, there were no SMART objectives or arrangements for review, which awaited the overall NIPS resettlement strategy. The strategy cross-referred to the offender management practice manual and a separate, detailed Ash-Inspire resettlement initiative information booklet set out a range of provisions, including the important Women's Support Network contribution.

## Recommendations

### Courts, escorts and transfers

2.14 **Women should be transported separately from male prisoners. (1.9)**
**Not achieved.** Women often travelled with male prisoners and reported verbal abuse and sexual harassment. Records kept by reception officers showed that male and female prisoners had travelled together at least 25 times since the beginning of 2011.
**We repeat the recommendation.**

2.15 **Pregnant women should not travel in cellular vehicles. (1.10)**
**Not achieved.** The gender-specific standards for working with women prisoners dated November 2010 stated that 'pregnant women should not be transported in standard cellular vehicles unless, exceptionally, the health care manager has assessed the risk to be acceptable'. Despite this, reception officers said pregnant women often arrived in cellular vans.
**We repeat the recommendation.**

2.16 **Staffing should be arranged so that women do not wait unnecessarily in vans because reception is closed and women on Ash House should not be locked down to provide staff from the landings. (1.11)**
**Not achieved.** The women's reception was closed for an hour at 12.30pm and for 30 minutes at 4.15pm. Women arriving at these times had to wait outside reception for staff to return. Officers were detailed to cover reception during evening association but this was one of the first posts to be dropped if staff were required elsewhere. When this happened, women prisoners had to wait in vans until women officers could be released to staff reception. Records showed numerous lock-downs in Ash House but no reasons were given. Minutes of prisoner consultation meetings recorded many complaints about 'having to lock-up to receive new committals'.
**We repeat the recommendation.**

2.17 **Women should arrive before 7pm. (1.12)**
**Achieved.** Women prisoners rarely arrived after 7pm.

2.18 **Women should be escorted in vehicles that are safe, clean and comfortable. (1.13)**
**Not achieved.** The vans we examined were uncomfortable, did not contain seat belts and some were dirty and covered in graffiti.
**We repeat the recommendation.**

2.19 **Women should be given the information leaflet about Hydebank Wood at court by Northern Ireland Prison Service escort staff. (1.14)**
**Not achieved.** We saw only one woman arriving at Ash House with a copy of the information leaflet. Reception officers and most women prisoners said they had not been given any published information in advance.
**We repeat the recommendation.**

2.20 **Property and private cash should accompany unsentenced prisoners to court. (1.15)**
**Not achieved.** Property and private cash did not accompany women prisoners to court.
**We repeat the recommendation.**

2.21 **Women should not be asked about their treatment by escort staff in the presence of these staff. (1.16)**
**Achieved.** Women prisoners were not asked about their treatment in front of escort staff.

## First days in custody

### Reception and first night

2.22 **The new reception should include decent waiting areas with relevant information in a variety of formats. (1.35)**
**Not achieved.** The purpose-built reception area adjacent to Ash House was bright and clean. Reception staff were polite to new arrivals and quickly put them at ease. Women could make a free call on the reception telephone and were offered refreshments and a shower. However, they were locked in small individual holding rooms and, once inside, could not see out or be seen, which was not entirely safe. The rooms contained little information and only a few magazines to pass the time. Easy chairs in the open reception area were not used and the information available there was not freely accessible to women.
**We repeat the recommendation.**

2.23 **Full information should be available to reception and first night staff to inform initial assessments. (1.36)**
**Partially achieved.** Women arrived with limited information, although escort staff usually provided some verbal information. The Causeway IT system had been introduced to facilitate the sharing of information between the NIPS, police, probation and court services. It had not operated as well as expected due to the incompatibility of different IT systems but reception officers said this was improving. Some women arrived before their warrant had been received electronically and reception officers were therefore reluctant to admit them into the prison.

2.24 **Insiders should provide peer support to women in reception and for all new committals on their first night. (1.37)**
**Achieved.** There was no peer support for women in reception but they were there only a short time. Insiders gave new arrivals a range of information on their first night if there were no lock-downs.

2.25 **Checks should be made to ensure that a free telephone call and a meal have been offered to new committals before they are locked up on their first night and this should be recorded in individual case files. (1.38)**
**Achieved.** All women were offered refreshments and could make a free

telephone call in private on the first night and committal landing (A2). Checks on telephone calls and meals were recorded.

## Induction

2.26 **Prisoner feedback should be used to improve and develop the induction programme. (1.39)**
**Not achieved.** Some staff said evaluation forms were no longer used while others said completed forms were placed in wing files. None of the files we looked at contained a completed evaluation form.
**We repeat the recommendation.**

2.27 **Induction information should be provided in a range of formats. (1.40)**
**Achieved.** Each cell on A2 contained printed information and an informative DVD that women could watch on their television. Published information was available in a range of languages and a picture dictionary in 10 languages. Landing officers were freely available to answer questions. There were plans to show the induction presentation on a recently installed large television in the communal room. In the meantime, an officer talked through each induction topic. Women did not always receive a formal induction immediately and many said they found out what they needed to know from other women. In the induction session we saw, two of the women attending had recently arrived, two had been at the prison for four or five days and one had already been there for three weeks, which was too long. Induction information was comprehensive and delivered by a knowledgeable officer. Women were encouraged to ask questions and were engaged throughout.

## Accommodation and facilities

2.28 **The role of A1 should be clarified so that it does not hold an inappropriate mix of women with different and incompatible needs. (2.12)**
**Achieved.** A1 no longer had a specialised role. The cell previously used for women serving a punishment of cellular confinement had reverted to normal use and women given cellular confinement as a punishment at an adjudication or who had been demoted to the basic regime level were managed on their own landing.

2.29 **All women should have a lockable cupboard in their room. (2.13)**
**Achieved.** Each room contained a small lockable cabinet where women could store in possession medication and small personal items.

2.30 **Mother and baby rooms should be improved and should not contain an open toilet. (2.14)**
**Not achieved.** Although the rooms designated for mothers and babies showed that efforts had been made to create a pleasant environment, there was still a toilet in the room, albeit separated by a partial wall. The toilet had no lid to minimise the risk of infection from aerosol spray from the toilet flush.
**We repeat the recommendation.**

2.31 **Dirty mattresses should be replaced. (2.15)**
**Achieved.** All the mattresses we inspected were in good condition and women said they could get a replacement quickly when necessary.

2.32 **Consultation meetings should provide the opportunity for women in Ash House as a whole to meet together as a group. (2.16)**
**Not achieved.** Women in Ash House were not able to meet together as a group. The residential principal officer held landing meetings but these did not take place every month and some meetings were cancelled because prisoners were involved in activities. The meetings did not follow a standing agenda and action points were not always followed-up.
**We repeat the recommendation.**

2.33 **All rooms should be supplied with kettles. (2.17)**
**Not achieved.** Kettles were not supplied. Managers said the location of power sockets some distance from tables meant it was difficult to use a kettle safely. However, women were now given flasks rather than having to buy them as previously.

2.34 **Women should be allowed to order catalogue products from a range of suppliers. (2.18)**
**Achieved.** Women could buy products from a range of suppliers. They could also buy toiletries and make up from the prison shop or Avon and could make a local purchase from Boots.

2.35 **There should be no unnecessary delays in prisoners receiving their mail. (3.80)**
**Partially achieved.** A standard operating procedure for mail had been introduced. Records of incoming and outgoing post were kept on all wings and prisoners signed on receipt of their mail. Some women still complained about post being delayed. The minutes of the A3 prisoner consultation meeting in February 2011 indicated that women had been asked to report any delays to landing managers and 53% of female respondents to a recent survey by Opportunity Youth said they had experienced problems with mail.

### Further recommendation

2.36 Managers should discuss prisoner dissatisfaction with the mail at prisoner consultation meetings and take action to address any identified shortfalls.

### Staff-prisoner relationships

2.37 **Staff should routinely use first names or title and surname when speaking or referring to women prisoners. (2.24)**
**Achieved.** Staff routinely used first names when speaking to and about women. In writing, they often used only their last name or sometimes the prison number.

2.38 **The governor responsible for Ash House should be based there in order to model and encourage good relationships between staff and prisoners and deal appropriately with those who do not act professionally and respectfully with the women. (2.25)**
**Not achieved.** The governor responsible for Ash House was based in an office in the main administration area, which she felt was important to ensure that she was able to advocate on their behalf with other senior managers. Prisoners said the governor visited the unit regularly and that they were able to contact her if they had an issue.

### Additional information

2.39 Relationships between staff and the women prisoners in Ash House had improved. The interactions we observed were polite and relaxed and staff were generally supportive and sensitive to the women's needs.

### Bullying and violence reduction

2.40 **There should be a dedicated safer custody manager and a safer custody committee specifically for Ash House focusing on anti-bullying, the prevention of suicide and the reduction of self-harm. (3.11)**
**Not achieved.** Two principal officers had until recently managed the areas of suicide prevention, violence reduction and child protection across Ash House and the Young Offenders Centre. This had since been reduced to one full-time principal officer who had no administrative support. A single safer custody steering group met monthly and covered women and young men and children. This was often chaired by the governor or senior manager and was reasonably well attended, although there was not always a representative from health care or security. Prisoner representatives did not attend. Basic data about bullying and anti-social behaviour, self-harm, supporting prisoners at risk (SPAR)

procedures and the use of the observation cells had only recently been presented to the meeting in a systematic way. The meeting had only recently discussed how to give appropriate consideration to the two separate populations. Without a dedicated meeting, there was insufficient focus on women in Ash House.
**We repeat the recommendation.**

2.41 **The anti-bullying policy for women should be implemented. (3.12)**
**Partially achieved.** The draft strategy for women written in 2007 had not been implemented but a new strategy on challenging anti-social behaviour (CAB) was undergoing a six-month pilot on Ash House. The policy document for Ash House described the nature of anti-social behaviour specific to women, its impact on others and the role of staff in implementing the strategy. There had been three investigations under the new procedure. Two had resulted in no further action and one woman had been placed on a monitoring booklet. Some staff were resistant to the implementation of CAB as they had not been trained in the strategy, it had not been explained to women prisoners and there were no interventions to support it. These concerns had been raised consistently at safer custody steering group meetings.

### Further recommendation

2.42 Ash House staff should be trained to implement the challenging anti-social behaviour strategy and the strategy should be explained to women prisoners.

2.43 **An in-depth survey specific to women's perceptions and experiences of bullying by prisoners and staff should be completed and considered by the women's safer custody committee to inform the development of the safer custody policy. (3.13)**
**Not achieved.** A survey of 19 women on Ash House had been undertaken in September 2010 using one-to-one interviews by staff from Opportunity Youth. It included just two questions on safety, was not sufficiently detailed or in-depth and had not been used to inform the development of the safer custody strategy. In the survey, 68% of women said they had never felt unsafe and 37% of those who had said staff did not take them seriously. There were no effective interventions to support victims or challenge bullies and the main response was to move the victim or perpetrator to another landing.
**We repeat the recommendation.**

2.44 **Regular staff-led landing meetings should be held focusing constructively on resolving tensions caused by small group living. (3.14)**
**Not achieved.** There had been some attempt to hold landing meetings two years previously and some staff had been supported by the psychology department to facilitate them. These had, however, stopped after one particularly difficult meeting had led to conflict between some women. Staff did not feel sufficiently skilled to run such meetings.
**We repeat the recommendation.**

2.45 **Bullying awareness training for staff and prisoners should be provided. (3.15)**
**Not achieved.** See paragraph 2.40.

### Self-harm and suicide

2.46 **Formal investigations should be conducted into serious or near-fatal incidents to establish what, if any, lessons could be learned. (3.32)**
**Partially achieved.** Useful investigations into serious incidents of self-harm were carried out by a member of staff from the operations branch at headquarters. However, identified learning points were not shared with relevant managers or incorporated into action plans to inform local practice and findings were not sent to the director of prison health at the South Eastern Health and Social Care Trust.

**Further recommendation**

2.47 Investigations, recommendations and learning points from serious or near-fatal incidents should be shared with relevant staff including the South Eastern Health and Social Care Trust and incorporated into action plans monitored by the safer custody committee.

2.48 **Prisoner at risk (PAR 1) reviews should be multi-disciplinary and trained senior officers should provide continuity in the management of cases, with key workers to support them. (3.33)**
**Partially achieved.** Following a revision of procedures to support prisoners at risk of self-harm, PAR 1s had been replaced by SPAR documents. Reviews were held on specific days so that representatives from various departments could plan ahead and attendance had subsequently improved. Principal officers had been trained in the case management of SPAR but senior officers had not. Reviews were chaired by whichever senior officer was on duty at the time so there was not always continuity. There was no effective key worker system to support those at risk.

**Further recommendation**

2.49 Trained senior officers should provide consistency in the management of supporting prisoners at risk case reviews.

2.50 **Support plans for those at risk should be improved by identifying clearly the main concerns, how these are being addressed and who is responsible for ensuring agreed actions are taken. (3.34)**
**Partially achieved.** SPAR care plans had improved and there was less reliance on physical measures such as observation cells and protective clothing. Some plans named individuals responsible for ensuring agreed actions were taken forward but too many still referred to 'all staff'. Plans did not always clearly identify the main concerns and there was still a need to develop a more therapeutic approach. SPAR reviews contrasted significantly with the good quality fortnightly safer custody case reviews of women about whom there were particular concerns. These were well attended by a range of staff including the art therapist, psychology, chaplaincy, probation, Opportunity Youth and Ad:ept and had developed some meaningful action plans.

**Further recommendation**

2.51 Care plans for women at risk of suicide or self-harm should identify the underlying issues associated with the woman's vulnerability and indicate what help would be provided to address these.

2.52 **Entries in the PAR 1 daily supervision records (now SPAR process) should be improved, with regular management checks on the quality of care. (3.35)**
**Partially achieved.** The quality of entries varied. Some better entries in the daily supervision records indicated good engagement with prisoners at risk and showed staff had asked how they were feeling. Other entries were too regular and made at predictable times. Each page of the SPAR document included space for a required management check. In nearly every case, the manager had simply signed to confirm they had completed the check and none included any comment on the quality of care provided.
**We repeat the recommendation.**

2.53 **Follow-up interviews should be conducted following the closure of PAR 1 documents. (3.36)**
**Achieved.** All closed SPAR documents included notes of a follow-up interview undertaken seven days later.

2.54 **The length of time women are placed in the observation rooms should be monitored by the safer custody meeting and alternative therapeutic**

**responses should be developed. (3.37)**
**Partially achieved.** The safer custody meetings had recently started monitoring how often observation rooms were used each month but not for how long. According to information available through prison record and information system management (PRISM), observation rooms had been used 20 times between September 2010 and March 2011 involving 10 different women. One woman had remained in the observation room for 19 days. Minutes of fortnightly safer custody meetings indicated that more therapeutic responses were available, including art therapy, bereavement counselling, Rape Crisis, Ad:ept and Samaritans. There was limited psychiatric input and no regular ongoing counselling service.

2.55 **Women should be able to use advertised telephone helplines free of charge. (3.38)**
**Achieved.** A good range of 16 free helplines had recently been made available and were advertised by landing telephones. Women could access these by using a published personal identification number and there was over £90 credit on this account. Women could call the Samaritans free of charge using either the landing telephone or one of the dedicated mobile telephones.

2.56 **All staff with direct contact with women prisoners should have suicide and self-harm awareness training specifically related to women. (3.39)**
**Partially achieved.** We were informed that 68% of Ash House staff had completed training in applied suicide intervention skills and 78% had completed the women's awareness staff programme (WASP) training.

2.57 **There should be improved peer support, with a training programme for Insiders and they should meet regularly with the co-ordinator. (3.40)**
**Partially achieved.** Five women had recently been recruited as Insiders and provided good peer support but had not received any training. They talked to all women prisoners on the day of their arrival using an information checklist. Managers were available informally to discuss any difficulties with the scheme.

2.58 **A Listener scheme should be developed. (3.41)**
**Not achieved.** A Listener scheme had run for around four months in late 2009 but had since stopped. Undated minutes of a meeting between prison managers and Samaritans indicated that the support of Samaritans was welcomed but the prison considered that a Listener scheme was not viable. This was despite a commitment to develop Listener schemes in all prisons in Northern Ireland at meetings of the safer custody forum in 2010 that had included ministerial support. Problems cited included maintaining confidentiality in a small community and insufficient women who met the criteria. While we understood the difficulty of operating a Listener scheme in the small environment of Ash House, we were not persuaded that there had been full management backing for the operation of such a confidential scheme.
**We repeat the recommendation.**

## Additional information

2.59 Tragically, some weeks after the inspection a young woman in Ash House apparently took her own life. This was the first such death since women had moved from Mourne House. Recorded levels of self-harm were not high. On average, two women a month were recorded as self-harming, with an average of six incidents a month. Three women were on open SPAR documents on one day of the inspection. SPAR procedures had improved and a comprehensive audit was completed of closed documents. Although strip clothing was used less often than previously, some women still believed that the threat of being placed in an observation room and strip clothing was a deterrent to disclosing vulnerability. A new

initiative to reduce the potential use of cell door handles as ligature points had been introduced.

## Applications and complaints

2.60 **Verbal requests should be logged to provide an audit trail. (3.98)**
**Achieved.** All verbal requests were recorded on computer by a class officer. Two copies of the request and the response were printed, with one given to the prisoner and the other placed on their wing file.

2.61 **Prisoners should be able to access and submit complaint forms confidentially. (3.99)**
**Achieved.** Women were told how to make a complaint during induction and information on the complaints system was displayed in association areas. Complaints forms were freely available in association areas and in a range of languages. Women posted completed forms in a locked complaints box on the unit. These were emptied daily by an operational support grade.

2.62 **Managers should speak to prisoners who withdraw complaints to ensure that they have not been coerced. Records should outline the reason given for withdrawal of the complaint. (3.100)**
**Not achieved.** A senior officer interviewed all complainants. In some cases, they simply noted that an interview had taken place and the complaint had been closed, with no details of what had been discussed and why the complaint had been withdrawn or closed. There were also examples where complaints had been closed when the prisoner clearly believed that her complaint was ongoing.
**We repeat the recommendation.**

2.63 **Requests and complaints should be routinely analysed to identify patterns or trends. (3.101)**
**Not achieved.** The prison recorded whether requests and complaints were responded to within the specified timeframes and the weekly business performance report produced for the senior management team included a breakdown of complaints by subject. However, there was no routine analysis of complaints by subject or location to identify patterns or trends and no monitoring by religion or any other diversity strand.
**We repeat the recommendation.**

## Additional information

2.64 A new complaints system had been introduced in February 2010. Although timescales for replies were generous, not all were answered within the specified period. Replies to most complaints were impersonal and written in the third person and some were abrupt and unhelpful. There was no formal quality assurance procedure.

### Further recommendation

2.65 There should be a formal system of quality assurance of complaints to ensure that they are fully investigated and that replies are courteous and directly and clearly address the nature of the complaint.

## Faith and religious activity

2.66 **Chaplains should be formally invited to all prisoner at risk (PAR 1) reviews. (5.36)**
**Partially achieved.** Chaplains were not routinely notified of, or invited to, all SPAR reviews. The chaplain attached to Ash House regularly attended the weekly safer custody meetings and played a prominent part in discussions about vulnerable women, some of whom were subject to SPAR procedures.

2.67 **Women should have the opportunity to attend religious services on Sundays. (5.37)**
**Not achieved.** Religious services for women were still held only during the week because the chaplains were part-time and attended to their congregations in the community on Sundays. Chaplains said their only alternative was to schedule a short Sunday service, which they felt was equally unsatisfactory and said their best option was to continue with the full-length mid-week services. While we understood the pragmatism of this approach, young men in the YOC had their services on Sundays so this was another area where women had inequality of provision.
**We repeat the recommendation.**

## Additional information

2.68 The female Roman Catholic chaplain visited the unit each weekday. She was highly regarded by staff and prisoners and supported prisoners from all backgrounds. She played a particularly key role in helping vulnerable women and often advocated on behalf of those from a minority background, such as foreign nationals or Irish Travellers.

## Substance use

2.69 **Substance-dependent women should be provided with adequate first night treatment/symptomatic relief following screening and testing. (3.108)**
**Partially achieved.** Drug testing was not carried out when a woman arrived at Ash House. When women had been on an established opioid substitution programmes in the community, staff contacted the community addictions team and the programme was continued at committal. If a woman was not on an established programme, the duty nurse completed an initial assessment using withdrawal assessment scales, although the evidence indicated that these assessments were used at the discretion of the nurse on duty rather than routinely. There was no evidence that they were audited to monitor compliance. When deemed appropriate by the duty nurse, the prison GP was contacted and a verbal instruction was obtained for the administration of symptomatic relief. This was recorded on Egton Medical Information System (EMIS) and a prescription generated within a maximum of 72 hours, although this was not always signed by the prescriber in line with Nursing and Midwifery Council (NMC) guidelines.
**We repeat the recommendation.**

2.70 **Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes. (3.109)**
**Partially achieved.** Women were referred to the addictions team nurse at the discretion of the duty nurse. The addictions nurse, who provided one session a week across Hydebank Wood and Ash House, had five women on her caseload. She carried out a comprehensive assessment and was able to organise stabilisation, maintenance or detoxification regimes for individual woman with the addictions consultant. However, some women indicated that not everyone with addiction problems prior to committal was referred to the addictions service for assessment and care. This affected the wellbeing of the women in terms of support and recovering as well as the need for service improvement in this area. Decisions needed to be made by specialist staff rather than primary health services staff.
**We repeat the recommendation.**

2.71 **Prescribing regimes should be flexible and meet the individual needs of women. (3.110)**
**Achieved.** The addictions nurse was able to organise stabilisation, maintenance or detoxification regimes for individual woman with the addictions consultant.

2.72 **There should be protocols and procedures for the close monitoring of women experiencing alcohol**

**withdrawal to ensure their safety. (3.111)**
**Not achieved.** Most women with addiction problems were still detoxed on the landings rather than as an inpatient in the health care unit, although there had been a recent death in custody of a young man in a cell in the YOC during an alcohol detoxification regime. Prison officers had not been trained in the care of women withdrawing from alcohol and a member of the health services team was not available on the unit 24 hours a day.
**We repeat the recommendation.**

### Further recommendation

2.73 All prisoners requiring a clinical alcohol detoxification should be admitted to the inpatient unit.

2.74 **Women should receive effective support during and post clinical intervention. (3.112)**
**Achieved.** In addition to the addictions nurse, women received support from Ad:ept. One-to-one counselling was available, as were solution-focused therapy and a pre-release course. Women were also encouraged to undertake an OCN level 1 drug and alcohol awareness course.

## Diversity

2.75 **The equality and diversity committee should meet regularly with all designated members or representatives attending, and consider and take action on any identified or potential areas of discrimination. (3.58)**
**Not achieved**. The equality and diversity committee did not meet regularly and attendance was often poor. Areas of actual or potential discrimination were sometimes identified but no action was then taken.
**We repeat the recommendation.**

2.76 **A system of monitoring that identifies and highlights areas of under and over-representation should be introduced and monitoring data should distinguish between male and female prisoners. (3.59)**
**Partially achieved**. A new system of monitoring data capable of identifying 'discrepancies' was being introduced but had not yet been implemented. The existing system was able to differentiate between male and female prisoners but the process was complicated and comparative data based on sex were not used to discern patterns and trends.
**We repeat the recommendation.**

### Additional information

2.77 A draft policy on diversity was more a statement of intent than a working tool and did not adequately reflect the distinctive features of Hydebank Wood. A separate equality and diversity action plan was not being monitored because the equality and diversity committee did not function effectively. The gender-specific standards for working with women prisoners (see paragraph 2.6) contained a chapter detailing how the needs of women prisoners from most minority backgrounds should be met. It provided useful guidance on foreign nationals, black and minority ethnic prisoners, life sentence prisoners, young prisoners, older prisoners and prisoners with disabilities but did not cover the needs of gay prisoners. It was not clear how these standards were to be applied but, unlike the overall diversity strategy, they were linked to measurable outcomes. Apart from the work carried out by a few specialist staff, particularly the last equality and diversity officer, there was little evidence that diversity was positively promoted. A specialist adviser had made some useful contributions to the equality and diversity committee in the past year but this had not been sustained.

## Race equality

2.78 **The equality and diversity officer should receive specialist training,**

**including in investigating racist incidents, and should be allocated dedicated time to carry out their additional duties. (3.60)**
**Not achieved.** There was currently no equality and diversity officer. The previous post-holder appeared to have been committed but said she had resigned due to lack of support. The post had recently been advertised but no one had applied.
**We repeat the recommendation.**

2.79 **Links with Irish Traveller support groups should be strengthened and consolidated. (3.61)**
**Partially achieved.** Attempts to strengthen links with the Irish Traveller organisation, An Munia Tober, had resulted in this group running an awareness-raising event for prison staff in November 2010. The group had since regularly been invited to visit but it was proving difficult to keep the link active.
**We repeat the recommendation.**

## Additional information

2.80 The population was predominantly white. The largest minority group was Chinese, who made up just under 9% of the population. Race relations did not appear to be an area of conflict. We spoke to Chinese prisoners and one woman from an Irish Traveller background and all said they were content with how they were treated.

## Religion

*No separate recommendations were made against this heading in the 2007 report, which were covered under diversity.*

## Additional information

2.81 Fifty-one per cent of prisoners said they were Roman Catholic, 25% had registered as from a Church of Ireland or Presbyterian tradition and the remainder followed different minority faiths or no faith. There was no obvious religious discrimination or sectarianism and we received no complaints from prisoners about this, although Roman Catholics still appeared to be over-represented in adjudications. There was, however, no reliable way of analysing data relating to religion so it was not clear whether any discrimination was actually taking place and this was a significant failure. Funding had just been obtained for a research project across all three Northern Ireland prisons to examine this more closely.

## Foreign nationals

2.82 **The Border and Immigration Agency should be asked to supply a named liaison person so that the prison can help foreign national prisoners prepare for their release. (3.62)**
**Achieved.** The UK Border Agency had nominated a named liaison person. This had improved communication between the prison and the immigration authorities and meant foreign national cases were better administered before release.

2.83 **Professional interpretation services should be used when legal matters or issues relating to vulnerability are discussed with women with little or no English. (3.63)**
**Not achieved.** Professional interpreting services were little used and staff relied instead on using other prisoners to interpret. In one well-intentioned but inappropriate case, a vulnerable Chinese woman had been used to interpret for a male Chinese prisoner. It was later discovered that she was unhappy with the situation but had felt under pressure to agree.
**We repeat the recommendation.**

2.84 **The draft interim guidance for foreign national women should be formally approved and published. (3.64)**
**Achieved.** Guidance on the needs of foreign national women prisoners was included in the overall NIPS strategy on working with women prisoners (see paragraph 2.6).

### Additional information

2.85 Work with foreign national prisoners was given more prominence than other areas of diversity. There were six women prisoners from a foreign national background and all had received some support from the equality and diversity officer. Each one we spoke to with family members abroad said they were helped to stay in contact with them. The Chinese prisoners were occasionally allowed to prepare traditional Chinese food and had been given DVDs and newspapers in their own language.

### Prisoners with disabilities, older prisoners and sexuality

*No recommendations were made against this heading in the 2007 report.*

### Additional information

2.86 No work to develop practice on diversity was being carried out in relation to disability, sexuality or age.

### Health services

### General

2.87 **The health needs assessment of women in Ash House should be reviewed and services to meet their specific needs should be commissioned and provided through the National Health Service. (4.37)**
**Partially achieved.** A baseline health needs assessment had been carried out in 2009 by combining the results of the previous needs assessments with prevalence data for the Northern Ireland population. The latter were adjusted where UK prison data showed an increased prevalence of a particular condition. An annual health needs assessment was carried out for the commissioners, the Health and Social Care Board. However, this relied on counting the number of referrals to specific services, such as mental health and addictions services, which were not always made as such services were not available in sufficient quantities. The assessment method was therefore flawed and resulted in an under-identification of needs.
**We repeat the recommendation.**

2.88 **A lead nurse with sufficient seniority and knowledge should take responsibility for the needs of older women. (4.38)**
**Not achieved.** There was no identified nurse with particular responsibility for older women prisoners as we would expect in line with the Department of Health National Service framework for older people.
**We repeat the recommendation.**

2.89 **Complaints about health services should be monitored by the health care manager. (4.48)**
**Not achieved.** Complaints were not monitored to identify emerging patterns or trends.
**We repeat the recommendation.**

2.90 **All policy documents should be up-to-date and redundant documents removed. (4.49)**
**Partially achieved.** The health care unit used the policies and procedures provided by the South Eastern Health and Social Care Trust. A great many policies were available but not all had been reviewed to ensure they were relevant to prison health care. Apart from some pharmacy policies, those we looked at were up-to-date. We were told that the policies were due to be made available to staff on the Trust intranet the following week as part of the transition to the Trust EMIS system.

### Further recommendation

2.91 There should be a system to ensure that staff have read and understood the policies and procedures relevant to the delivery of health services in the prison.

2.92 **All pharmacy policies should be formally reviewed and adopted via the medicines and therapeutic committee. (4.50)**
**Achieved.** Pharmacy policies were formally reviewed and adopted by the medicines and therapeutics committee, which met three times a year. As policies were reviewed and updated, they were rewritten in the standard operating procedure format.

2.93 **There should be an information-sharing policy with appropriate agencies to ensure efficient sharing of relevant health and social care information. It should include the need to obtain a patient's consent when appropriate. (4.51)**
**Not achieved.** There was no information-sharing policy. Patients' consent to share information was obtained but there was little evidence that information was shared with relevant staff, such as drugs and alcohol workers, to enhance prisoner care.
**We repeat the recommendation.**

## Clinical governance

**2.94 All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose; documented evidence of such checks should be kept. (4.39)**
**Not achieved.** There was a large and heavy emergency response bag, a separate bag containing oxygen and a suction machine that was not plugged in to charge. Some of the equipment was inappropriate and there were no emergency drugs. There were supposed to be weekly checks but records showed these did not always take place. Defibrillators had recently been placed at strategic locations but not all discipline staff had been trained in their use.
**We repeat the recommendation.**

2.95 **Specific and sufficient nursing staff should be allocated to Ash House to ensure continuity of care and the provision of regular necessary clinics. (4.40)**
**Partially achieved.** A nurse was allocated to Ash House as the nominated nurse for women for a six-month rotation. However, other commitments such as night duty meant she was not always on duty during the core day. On one day of the inspection, the one nurse allocated to the unit had 16 women to see while health care staff in Hydebank Wood appeared to be underutilised during the same shift.
**We repeat the recommendation.**

2.96 **All health services staff, including allied health professionals, should have annual training in resuscitation and child protection. (4.41)**
**Not achieved.** Not all health services staff had received child protection or annual resuscitation training.
**We repeat the recommendation.**

2.97 **Clinical supervision should be available to all health services staff. (4.42)**
**Partially achieved.** There were two trained clinical supervisors but staff we spoke to did not take advantage of clinical supervision and there was no protected time for it.
**We repeat the recommendation.**

2.98 **There should be formal arrangements for the loan of occupational therapy equipment and specialist advice to ensure that patients are able to access mobility and health aids if required. (4.43)**
**Achieved.** Following the transfer of health services to the South Eastern Health and Social Care Trust, health services staff could now access occupational therapy equipment. Specialist nurses, such as the continence adviser for the Trust, could also be asked to see patients when required.

2.99 **All clinical records should be contemporaneous and conform to professional guidance from regulatory bodies. (4.44)**
**Partially achieved.** Clinical records were kept on EMIS. Some entries were poor and no time was recorded, which was not in line with NMC guidance. Other entries were detailed and gave an excellent account of the care provided. The health care manager and senior officer did not know how the system was backed up or whether all information was saved at times when the system failed. Registered Mental Nurse (RMN) staff confirmed that the regional risk assessment was carried out in line with Northern Ireland policy, but there was no evidence that this information was shared with other disciplines or that an enhanced risk assessment was undertaken that necessitated multi-disciplinary meetings were initiated. A care plan was devised for all patients on whom the regional risk assessment had been carried out and a written copy of both documents was kept in a file but all other patient documentation was recorded on EMIS.
**We repeat the recommendation.**

## Additional information

2.100 RMN staff said they needed more regular updates on mental health issues, including new developments and medications. They had identified a need for additional training in carrying out risk assessments and the care of women with personality disorders. A training needs analysis was under way.

## Primary care

2.101 **Following a reception screening, a further health assessment should be carried out by trained staff no later than 72 hours after the woman's arrival in custody. (4.52)**
**Achieved.** There were templates on EMIS for both an initial reception screen and a further screen within 72 hours of a woman's arrival. We checked on women who arrived during the inspection and all who stayed longer than 72 hours had been seen by health services.

2.102 **The rapid vaccination course for Hepatitis B should be adopted. (4.53)**
**Achieved.** The rapid vaccination course had been adopted but had since stopped due to a perceived stock supply problem. We raised this with managers and the course was restarted.

2.103 **Health services staff should liaise with the physical education department to ensure that women can take full advantage of the physiotherapy services offered. (4.54)**
**Achieved.** The sports therapist confirmed that health services staff liaised and appropriately referred women to the physical education department.

## Pharmacy

2.104 **The use of prescription forms, card index and administration charts should be revised to avoid the need for duplication and transcription. One chart should be used for prescriptions and administration record. (4.46)**
**Partially achieved.** A new prescription form had been audited by the medicines management pharmacist and a revised format developed. However, more than one record was sometimes in use for one prisoner and not all prescribed medicines were always included. Medicines were not discontinued appropriately and there was no record of their disposal.
**We repeat the recommendation.**

2.105 **The special sick policy should be reviewed regularly by the medicines and therapeutic committee to ensure that all appropriate medicines can be supplied. (4.47)**
**Achieved.** The special sick policy had been reviewed and a range of medicines

made available for health services staff to administer without the need for a prescription. These were recorded on the prescription chart of each individual patient.

2.106 **All pre-packs should be dual-labelled. When the pre-pack is dispensed against a prescription, one label should be removed and attached to the prescription chart, which should then be faxed to the pharmacy provider so that the pharmacist can satisfy him/herself that the prescription was appropriate and that the correct item has been supplied. (4.55)**
**No longer relevant.** There were no pre-packs. Prisoners received their individual named supply when prescribed. Any stock medicines used were issued on a dose-by-dose basis.

2.107 **Patient information leaflets should be supplied. A notice should be prominently displayed to advise patients of the availability of leaflets on request. (4.56)**
**Achieved.** A patient information leaflet (PIL) was provided with all dispensed medicines and, when medicine was issued daily or weekly, was given with the first supply. Notices advising patients that leaflets were available on request were put up during the inspection.

2.108 **Women attending the Ash House treatment room for medications should be appropriately supervised by landing staff to reduce opportunities for bullying and the passing of medications. (4.57)**
**Partially achieved.** Women were now unlocked by landing to collect their medications so we did not see any poorly supervised queues. However, some women said there were still opportunities for bullying and passing medication.

2.109 **Decisions about daily, weekly or monthly in possession medications should be clearly documented. (4.58)**
**Not achieved.** The in possession policy published in November 2010 was not being adhered to. The up-to-date risk assessment for decision-making was not in use and the recommended number of random monitoring checks was not being achieved. An obsolete risk assessment document was used but nurses said the decision was usually subjective. Documentation was often incomplete and there was little evidence of review.
**We repeat the recommendation.**

2.110 **There should be patient group directions (PGDs) for all vaccinations. (4.59)**
**Not achieved.** There were patient group directions for some vaccinations but a complete range of vaccinations, such as Meningitis C, was not available. Not all the patient group directions were in date and appropriately signed.
**We repeat the recommendation.**

### Further recommendation

2.111 All patient group directions (PGDs) should be in date and signed in accordance with Trust policy.

2.112 **Over-the-counter medicine should be available for women to buy from the tuck-shop. (4.60)**
**Not achieved.** Over-the-counter medicines were not available. However, a number of general sales list medicines for treating minor ailments were available following a consultation with a member of the health services team.
**We repeat the recommendation.**

2.113 **Women who arrive with ongoing dependence on prescription medications should be carefully assessed and monitored before any detoxification regime is commenced. (4.61)**
**Partially achieved.** Women were not assessed by specialist staff at committal but

most with ongoing dependence were referred to the addictions team. Women we spoke to did not complain as they had done previously about severe reductions in prescribed medications on arrival.
**We repeat the recommendation.**

### Dentistry

2.114 **Dental staff should have access to women's clinical records and complete medical history sheets for each patient. (4.45)**
**Achieved.** Dental staff had access to women's clinical records on EMIS and completed the relevant medical records for each patient.

### Inpatient care

*No separate recommendations were made against this heading in the 2007 report.*

### Additional information

2.115 The reorganisation and refurbishment of the health care unit had provided four beds for males and two for females. However, the layout did not promote privacy or dignity as male and female patients were cared for in one area, creating difficulties with personal hygiene and free association. During the inspection, one young man was accommodated as an inpatient for the whole week and another stayed for one night, but the week before had seen two males and one female accommodated on what had been designed as the male side of the health care unit. Staff appeared reluctant to admit patients to health care, particularly in relation to self-harm and detoxification. One woman in Ash House who was self-harming quite severely was not admitted to the unit despite request from Ash House staff.

2.116 The health care unit had two holding areas where patients waited to be seen by the nurse or doctor. Both rooms were converted cells with only partly screened toilets and, while basins were provided, there was no soap or paper towel dispenser to allow patients to wash their hands.

### Further recommendation

2.117 All health services accommodation should be fit for purpose, with appropriate provision for male and female patients to be held separately.

### Secondary care

2.118 **Arrangements for attendance at outside hospital appointments, including waiting times and cancellations, should be subject to audit. (4.62)**
**Not achieved.** We were told that a record was kept of cancellations of outside hospital appointments but no evidence of this was provided. Minutes of the prison health care partnership board indicated ongoing problems in this area.
**We repeat the recommendation.**

### Mental health

2.119 **Psychiatric services should be reviewed to ensure that there are sufficient resources to meet the needs of women, including child and adolescent services. (4.63)**
**Not achieved.** Girls under 18 were no longer held at Ash House so there was little requirement for child and adolescent services. However, there was less psychiatric input from specialist services for women. The psychiatric consultant post was vacant. A staff grade doctor covered one session a week and there was some input from a forensic psychiatric consultant. The Trust was considering the appointment of a permanent forensic psychiatric consultant. Staffing levels meant RMNs were not always on duty when the psychiatric physicians were on site so there were few opportunities for multi-disciplinary meetings to ensure continuity

of care and develop strategies for the care of patients. Women had previously received input from three cognitive behaviour therapy (CBT) nurses but this been reduced to one CBT nurse for half a day a week. The prison regime meant the CBT nurse could not offer any enhanced services such as 'mindfulness' or dialectical behaviour therapy. Some women at risk of self-harm said they had either not received help or had had to wait five months for referral to CBT and anger management.
**We repeat the recommendation.**

### Time out of cell

2.120 **Unlock and lock-up should take place at the published times. (5.44)**
**Not achieved.** Women were still locked up about 15 minutes early in the evenings. The core day indicated that women should be locked up at 7.45pm and staff were off duty at 8pm. However, we saw staff encouraging women into their rooms from 7.20pm and most areas were secure by 7.30pm, with some staff already waiting at the gate to leave at that time. There was also some slippage in the core day at morning unlock and at lunchtimes, with unlock taking place five to 10 minutes late.
**We repeat the recommendation.**

2.121 **Inter-landing association should be introduced. (5.45)**
**Not achieved.** Women from different landings were not allowed to meet each other during association. They could still apply to visit someone on a different landing but were restricted to spending time in that woman's cell rather than being able to associate freely.
**We repeat the recommendation.**

2.122 **Staffing ratios should be reviewed to ensure they are appropriate to the risk posed by prisoners. (5.46)**
**Not achieved.** Staffing ratios were unchanged and unlock restrictions were still imposed if the house was not regarded as fully staffed.
**We repeat the recommendation.**

2.123 **Women should be consulted about ways to promote more constructive use of association time. (5.47)**
**Not achieved.** The principal officer with responsibility for Ash House held monthly landing meetings. There was no standing agenda and the minutes did not indicate any discussion on how to promote more constructive use of association time.
**We repeat the recommendation.**

### Additional information

2.124 Most women were unlocked during the core day and, if not involved in activities, could use the association area to watch television, use the pool table or board games or get a book from the book shelf. Ash House had a small enclosed exercise yard that was landscaped and contained seating. The core day did not have a scheduled period of exercise in the open air. Staff said the yard was open in the morning and afternoon but this was not always the case and exercise periods rarely lasted more than 30 minutes. Staff shortages resulted in a restricted regime during the day and the cancellation of evening association, often at short notice. The number of cancellations had reduced in recent months.

### Further recommendation

2.125 Women should have the opportunity to spend at least an hour in the open air every day.

### Learning and skills and work activities

**2.126 Essential skills provision should be improved and should meet the literacy and numeracy needs of women at Ash House. (5.16)**
**Not achieved.** There was no essential skills policy to inform strategic planning and on which monitoring and evaluation could take place. Poor levels of literacy and numeracy were a barrier to progression. The results of initial

assessments were not used effectively to inform planning and there was a mismatch between the levels women were assessed at and the qualifications achieved. Classes were clearly not sufficiently challenging. Monitoring and tracking of women's progress in the essential skills by some tutors was weak and this was not identified by the quality assurance process.
**We repeat the recommendation.**

2.127 **Robust quality assurance and self-evaluation systems should be developed. (5.17)**
**Not achieved.** The quality assurance and self-evaluation review arrangements remained weak and had not identified or addressed any of the under-achievement or aspects of teaching and learning that were inadequate. Not enough use was made of data to inform evaluations and the self-evaluation process remained at a very early stage of development. Senior managers needed to acquire and develop the necessary skills to undertake effective monitoring and evaluation. The consistently poor outcomes and quality of the women's learning experiences in some areas of the provision needed to be challenged and improved.
**We repeat the recommendation.**

2.128 **Access to the library should be improved. (5.18)**
**Partially achieved.** Access to the library had significantly improved and a pro-active librarian had made it a vibrant centre in education with a good range of activities to promote literacy. There were more non-fiction texts and a good range of DVDs and CDs. However, women did not have access to the library in the evenings or at weekends.

2.129 **Access to ICT facilities in the library should be improved. (5.19)**
**Partially achieved.** Some additional computers were available but there was no internet access. Ongoing ICT technical issues prevented the effective use of this resource.

## Physical education and health promotion

2.130 **The range of vocational courses leading to awards should be expanded to meet the needs and interests of all women. (5.26)**
**Not achieved.** There were not enough opportunities for women to participate in vocational programmes leading to awards and this was not just restricted to those offered in physical education. The range of vocational programmes was out-dated and did not meet women's needs. The ICT provision was unsatisfactory.
**We repeat the recommendation.**

2.131 **A greater range of outdoor and adventurous activities should be available for women subject to suitable risk assessments. (5.27)**
**Partially achieved.** The facilities for physical education were good and had improved with the addition of the astroturf pitch, but this and the other outdoor pitches were under-used. Some outdoor adventure activities had been run but these were limited by security restrictions.

**2.132 A wider range of activities should be developed to meet the needs and interests of all women, especially those who do not use the gym regularly. (5.28)**
**Achieved.** The recruitment of a female gym instructor since the previous inspection had provided increased opportunities for the development of activities that were better planned and suited to the needs of women prisoners, including the acquisition of spinning equipment.

## Security and rules

2.133 **Following the security categorisation review, women classified as low or medium risk should be allowed free movement within Ash House and the grounds. (6.17)**
**Partially achieved.** A small fence erected around Ash House and the education block allowed women some unescorted movement around this area. Women were still escorted around the main body of the prison, which was unfortunately necessary due to safety issues and highlighted the need for a separate establishment for women.

2.134 **The role of the security liaison officers should be reinforced by residential managers and staff should be encouraged to submit security information based on their own observations. (6.18)**
**Partially achieved.** All wings now had officers assigned to the role of security liaison officers, who maintained good links with the security department and attended all security committee meetings. More staff now submitted security information but security managers said some still preferred to pass on information by telephone rather than committing it to paper.

2.135 **Security bulletins should be posted on the prison intranet for staff information and guidance. (6.19)**
**Achieved.** A monthly security briefing provided staff with general security information specific to Ash House and Hydebank Wood. It was available in hard copy and on the prison intranet.

2.136 **The security committee should include representatives for education, workshops and other departments that have direct dealings with prisoners. (6.20)**
**Partially achieved.** Minutes from the monthly security committee meeting indicated that the education manager attended but there was no other functional attendance other than security and residential.
**We repeat the recommendation.**

2.137 **The number of routine cell searches should be reduced and the searching strategy reviewed to find a more efficient and effective way of tackling supply reduction. (6.21)**
**Not achieved.** The frequency with which every cell was searched had increased from every 14 days to every eight days but had since reverted to once a fortnight. Managers said that reducing the level to every 28 days was being considered but this was still too high given that only 4% of all searches, random and target, resulted in any find across the whole prison. Disaggregated figures for Ash House were not available. Searching data were not monitored for patterns and trends and the searching strategy had not been reviewed.
**We repeat the recommendation.**

2.138 **Escort arrangements should be established that reflect the risk posed by individuals according to the new security classification system. (6.22)**
**Partially achieved.** Women were now risk assessed before each escort. Police escorts were no longer used but we found no example where women were escorted without handcuffs, suggesting the assessments were too risk averse.

2.139 **Strip-searching should be carried out only based on a risk assessment and not because of security concerns in the Young Offenders Centre. (6.23)**
**Partially achieved.** Strip-searching for women had been reviewed and had been divided into two types based on whether or not women were required to remove their underwear. Searches where underwear had to be removed had to be authorised by a manager and be based on intelligence indicating the presence of an unauthorised article. The inappropriate practice of routinely strip-searching male

and female prisoners after visits when a drug dog was not available had recently been reviewed and one in six prisoners were now randomly selected instead. This was the same for women and the young men and it was not clear that the same security considerations had been identified.

2.140 **Wing rules should be displayed on all landings and staff should ensure that prisoners are aware of the rules applying to them. (6.24)**
**Achieved.** Wing rules were clearly displayed in the association areas on all landings.

## Discipline

2.141 **There should be a written record of adjudication hearings to ensure that managers are able to scrutinise and evaluate disciplinary procedures. (6.34)**
**Not achieved.** Adjudications were still recorded onto CD and recordings were not reviewed for quality assurance purposes.
**We repeat the recommendation.**

2.142 **The reasons for the disproportionate number of Roman Catholic prisoners placed on report should be investigated and appropriate action taken as necessary. (6.35)**
**Not achieved.** There had been no investigation into why a disproportionate number of Roman Catholic prisoners had been and continued to be placed on report.
**We repeat the recommendation.**

2.143 **Cellular confinement should not routinely be given as a punishment in cases where women have not used or threatened violence and should not routinely include the loss of all privileges unless specifically decided in exceptional circumstances by the adjudicating governor. This should be documented. (6.36)**
**Achieved.** Records showed that cellular confinement had been given only when merited in cases involving drug and violence-related incidents. Such punishments were rare and usually for no more than two or three days.

2.144 **Guidance on appropriate levels of punishments should be updated to make punishments more commensurate with offences and should be subject to regular review through standardisation meetings. (6.37)**
**Not achieved.** A national tariff for all prisoners regardless of sex or age had been produced. A wide range of punishments could be applied for offences and the maximum punishment for most offences still exceeded what we would consider proportionate. Standardisation meetings were not held. In practice, although not reflected in guidance, adjudicators tended to take account of the circumstances applying in Ash House.
**We repeat the recommendation.**

2.145 **All staff should be refreshed in control and restraint techniques every 12 months. (6.38)**
**Not achieved.** Just under half of staff had received control and restraint refresher training in the previous 12 months. Particular issues with the number of female staff trained had led to one incident currently subject to internal investigation where male staff had been involved in the strip-search of a woman under restraint.
**We repeat the recommendation.**

2.146 **The use of the cellular confinement cell on A1 should be logged. Prisoners located there should have a daily record of events, which includes use of exercise, showers, telephone calls and details of interactions with staff. (6.39)**
**Partially achieved.** Ash 1 no longer acted as a segregation landing and women serving cellular confinement could do so

in their own cell or in another one on their landing. Women who had served cellular confinement said they had been given daily access to the telephone and showers but that exercise was not routinely provided. Records were poorly kept and wing files gave incomplete accounts of whether or not women were serving cellular confinement and what parts of the regime they could access.

### Further recommendation

2.147 The wing files of women receiving cellular confinement as a punishment following adjudication should be updated daily to indicate whether or not they have received their regime entitlements, who has visited them and details of their interaction with staff.

2.148 **The Independent Monitoring Board should be informed when a prisoner is confined to a room or located under rule 32. (6.40)**
**Partially achieved.** The Independent Monitoring Board was routinely informed when a prisoner was placed on rule 32 but not when someone was confined to a room under cellular confinement.

## Progressive regimes and earned privileges

2.149 **Visits and telephone allowances should not be part of the progressive regimes and earned privileges scheme. (6.52)**
**Achieved.** Visits were a part of the progressive regimes and earned privileges (PREP) scheme but appropriately so as the minimum entitlement was available on basic level and additional visits on enhanced. Visits lasted the same amount of time regardless of the prisoner's PREP level. Child-centred visits were available at all levels. Prisoners on the basic level were limited to spending £20 a week on telephone credit, those on standard to £24 and those on enhanced to £30. These levels were reasonable.

2.150 **The progressive regimes and earned privileges scheme should be routinely monitored by religion by the equality and diversity committee. (6.53)**
**Not achieved.** The PREP scheme was not routinely monitored by religion by the equality and diversity committee.
**We repeat the recommendation.**

2.151 **The procedures for applying for special privileges status should be published, transparent and monitored. (6.54)**
**Not achieved.** Guidance on applying for special status had been produced for staff but not for prisoners and none of the women we spoke to understood what special privilege status meant, what the criteria were and how to apply for it.
**We repeat the recommendation.**

## Catering

2.152 **All personnel responsible for handling food should be subject to a health check. (7.8)**
**Partially achieved.** All prisoners working in the kitchen or on the serveries were subject to a health check but staff responsible for handling food were required only to report relevant illnesses or medical conditions.

### Further recommendation

2.153 All staff responsible for handling food should be subject to a health check.

2.154 **The consultation arrangements about food should be improved so that views expressed by prisoners are considered seriously and, when valid, acted on. (7.9)**
**Not achieved.** There was no effective regular consultation with prisoners about the food. A single meeting had been held by the catering manager with five women prisoners in February 2011. Some useful points had been made but the minutes showed that the catering manager had

taken offence to a question and his response had been dismissive and unhelpful.
**We repeat the recommendation.**

2.155 **More women should be given opportunities to prepare their own food. (7.10)**
**Not achieved.** Only women prisoners on A5 were able to prepare their own food and six women were doing so.
**We repeat the recommendation.**

2.156 **All personnel involved in handling food should wear protective clothing. (7.11)**
**Achieved.** All staff and prisoners we saw preparing and handling food wore full protective clothing in the kitchen and on the serveries. Male prisoners no longer worked in the kitchen. We were told that the women prisoners were more mature and easier to manage and the catering manager believed this had resulted in much improved hygiene standards.

2.157 **There should be clear and reliable arrangements to obtain special diets. (7.12)**
**Achieved.** Prisoners needing a medical diet made a formal request to a nurse or the medical officer and a record was kept of all those deemed suitable. Four women had been added to the record in the previous six months, including a diabetic and those needing extra milk for health reasons. Prisoners who required special diets for religious or cultural reasons had to use the general application system.

## Additional information

2.158 We received numerous complaints about the quality of the food. Many women said it was bland, stodgy and lacked variety. Food was also kept in the heated trolleys for some time before being served so was often over-cooked and unappetising. Women on A5 had some opportunities to cook food for themselves, which they prefereed. Most women chose to eat together.

## Strategic management of resettlement

2.159 **A resettlement team should be established along the lines of the teams that exist in the other two Northern Ireland prisons. (8.10)**
**Achieved.** A new Offender Management Unit (OMU) had been established in September 2009 in dedicated premises where prison officers, probation personnel, chaplains, psychologists and voluntary sector providers were co-located and worked well together. Sentence managers were mostly long-standing main grade prison officers who volunteered for these positions. Their job was essentially to ensure that all remanded and sentenced prisoners had a resettlement plan. The training provided was good. The reason for establishing the OMU was the introduction of new (Criminal Justice Order 2008) sentences requiring greater input by both prisoners and staff in advance of release. This population represented only six out of 48 women but resettlement work as a whole benefited as it was subsumed within the new arrangements. Unfortunately, some NIPS staff viewed the OMU as remote from their roles. Ash House had its own dedicated offender management personnel who appeared to be better integrated.

2.160 **The weekly operational and monthly strategic resettlement meetings should be reprioritised and should have clear terms of reference that clarify their distinct purposes. (8.11)**
**Not achieved.** Resettlement board minutes from October 2008 to January 2011 showed that meetings had lapsed in early 2009 until September 2009. Subsequent minutes were available for February, August, November and December 2010 and January 2011, by which stage the meeting had been renamed as 'resettlement/inmate activities'. Representatives from health care, custody,

the gym and kitchen were consistently absent. In November 2010, it was recorded that there were no terms of reference for the group but the situation began to clarify in December 2010, when it was minuted that the purpose of the meeting was 'to inform everyone of what programmes and interventions were taking place in the centre and to discuss new initiatives'. However, the non-attendance of key members precluded any further discussion. More recently, the managers' weekly performance meetings and the introduction of an intervention panel to oversee programme delivery had improved accountability.
**We repeat the recommendation.**

## Offender management and planning

2.161 **Women prisoners should be invited to attend their resettlement meetings and meaningfully engaged in preparing for these meetings. (8.25)**
**Partially achieved.** All new committals, including those on remand, were expected to attend a resettlement board within four weeks and most did so. Some women were confused about the purpose of the meeting and some said the activities and programmes suggested to them had not materialised several months later. An Ash House manager said it was difficult for some cross-site functions, including resettlement and home leave boards, to apply a female focus when most cases were young males.

2.162 **Resettlement plans should actively inform allocation to activities and programmes and decisions about regime status. (8.26)**
**Not achieved.** Sentence plans had improved, particularly for prisoners on Criminal Justice Order 2008 sentences. However, neither prisoners nor staff believed the plans influenced allocation to activities or regime status, which depended more on security decisions, prisoner conduct and motivation. Everything also had to fit in with the increasingly limited regime. There were some examples where mis-communication had led to prisoners being withdrawn from activities without reference to themselves or key workers and others where prisoners were allocated to inappropriate programmes. The new resettlement strategy detailed the role of residential liaison officers (see section on main recommendations) who would 'provide an important link with sentence managers, case managers and other key support services'. The pilot was only two months old but most women prisoners knew their sentence manager and understood their role.
**We repeat the recommendation.**

2.163 **Home leave and resettlement leave statistics should be disaggregated and separately reported. (8.27)**
**Achieved.** Separate data were now available. In the year to March 2011, 111 of 118 home leave applications had been approved and all 12 resettlement leave applications had been successful. Staff understood the different purposes of resettlement and home leave.

## Indeterminate-sentenced prisoners

2.164 **Lifer liaison officers should fulfil the role of personal officers for lifers and keep in regular touch with them about their progress. (8.36)**
**Achieved.** Each of the eight women lifers had a trained lifer officer and a relief backup, and women were able to discuss their progress. The Ash House governor was their lifer governor to oversee their sentence management.

2.165 **A lifer regime should be established in Ash House similar to that proposed for Cedar House in the Young Offenders Centre. (8.37)**
**No longer relevant.** Cedar 5 landing had not become a lifer/long-term unit as proposed. In the meantime, women lifers in

Ash House had benefited from the range of other initiatives introduced there for all prisoners.

2.166 **A formal process should be agreed to identify and support potential lifers. (8.38)**
**Achieved.** Each new remand woman prisoner charged with murder was allocated a lifer officer and relevant lifer documentation was opened.

2.167 **The Northern Ireland Prison Service should develop progression opportunities for life-sentenced women beyond Ash House. (8.39)**
**Not achieved.** There had been no developments in this respect as all Northern Ireland's women prisoners were still held at Ash House. Ash 5 landing remained the optimal level for all female prisoners irrespective of sentence length. The best they could hope for was reduction to category D but this did not change their residential environment.
**We repeat the recommendation.**

## Resettlement pathways

### Finance, benefit and debt

2.168 **Advice on finances should be provided to all women who need it. (8.53)**
**Achieved.** A NIACRO benefits advice worker based in the OMU was available to see Ash House women each week.

### Drugs and alcohol

2.169 **The drug and alcohol strategy should be informed by a comprehensive needs assessment and any identified gaps in service for women provided. (8.57)**
**Not achieved.** There was no up-to-date drug and alcohol strategy. Drug strategy meetings were poorly attended and had only recently started again after several months.
**We repeat the recommendation.**

### Children and families of offenders

2.170 **There should be clear signposts to the prison, particularly at the entrance to the prison. (3.81)**
**Partially achieved.** There was a sign at the entrance but still no signposting to the prison from surrounding roads.

2.171 **All prisoners should be allowed visits of at least one hour. (3.82)**
**Achieved.** Visits lasted one hour.

2.172 **Visitors should be able to buy hot meals or snacks either in the visitors' centre or in the visits hall. (3.83)**
**Achieved.** NIACRO had introduced a trolley refreshment service in the visits room that included a selection of sandwiches.

2.173 **There should be separate visiting facilities for men and women. (3.84)**
**Not achieved.** Women still shared the visiting facilities with male prisoners.
**We repeat the recommendation.**

2.174 **Babies should be searched only when there is specific intelligence, agreed by a senior manager, that this is necessary. (3.85)**
**Not achieved.** All babies were still given a rub-down search without individual risk assessment.
**We repeat the recommendation.**

2.175 **Privacy screening should be introduced between the closed visit rooms and the general visits area. (3.86)**
**Not achieved.** The situation had not changed.
**We repeat the recommendation.**

2.176 **Guidance on closed visits should specify when decisions to impose restrictions should be reviewed. (3.87)**
**Not achieved.** An instruction to governors dated 31 March 2009 stated that the duration of a closed visit would be subject to 'periodic review' but not what this meant in practice.
**We repeat the recommendation.**

2.177 **Arrangements for consulting visitors about their experience should be improved. (3.88)**
**Partially achieved.** The visitors' comment book was no longer available. A suggestion box had been installed in the visitors' centre but no writing materials were provided. A monthly visitor forum involving visitors and prison managers had been introduced but minutes were not displayed in the visitors' centre and none were made available to us so we could not determine what had actually been discussed. There was no annual survey of visitors' experiences. NIACRO had undertaken a visitor survey in December 2010 but this had been limited to the booking provision. This showed that most visits took place on Saturday and were booked by telephone, a method that a quarter of respondents found difficult. The booking line was closed at lunchtimes and after 4pm but visits could also be booked in person and through the internet. The NIPS planned to introduce a centralised booking system for all Northern Ireland prisons.

## Additional information

2.178 The prison was reasonably well served by public transport. The visitors' centre was comfortable and well equipped and NIACRO staff ran a 'meet and greet' service for first time visitors as well as giving support and information to all visitors. A governor's order stated that individual visitor groups should comprise up to three adults and two children or two adults and three children. Women with more than three children therefore had to apply for specific permission for them to visit. Family liaison officers saw all new arrivals and their visitors to explain the support available. Family days were organised three or four times a year and women prisoners could apply for extended visits with their children lasting up to six hours, which was an excellent new development. Extended visits took place in a static mobile home and women could apply for one visit each month. Eighty-two visits had taken place since these visits had been introduced in December 2009. The facility was equipped with a range of age-appropriate books, games and toys and mothers could prepare a simple lunch. An intercom system allowed mothers to contact staff if necessary.

## Further recommendation

2.179 Women prisoners with more than three children should not have to ask permission for them to visit.

## Good practice

2.180 The extended visits facility provided a real opportunity for mothers to sustain and develop relationships with their children.

## Attitudes, thinking and behaviour

2.181 **The Northern Ireland Prison Service should provide interventions for women in denial about their current offence to address previous offending, the consequences of being imprisoned and future risks. (8.68)**
**Partially achieved.** There was still no specific provision for prisoners who denied their offending. However, the new resettlement strategy identified the seven standard pathways and the two additional pathways for women who have been abused or raped or experienced domestic violence and those who have been involved in prostitution. A range of programmes covering drug and alcohol abuse, anger

management, GOALS (a programme designed to tackle the psychology of social exclusion) and enhanced thinking skills addressed the consequences of imprisonment and future risks but were primarily for sentenced prisoners. Several new interventions had been introduced, including weekly visits by Women's Centre workers and extended visits to help women cope in prison. Other initiatives including a read aloud scheme, cookery and Indian head massage were delivered by volunteers from the community.

CHAPTER 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.*

## Main recommendations (from the previous report)

3.1 A separate prison should be provided for women in Northern Ireland. (2.1)

3.2 A first night strategy should ensure that all newly arrived women receive consistent and appropriate support. (2.3)

3.3 Residential liaison officers should meet with their allocated prisoners regularly, record this in wing files and help support resettlement objectives. (2.5)

3.4 The Northern Ireland Prison Service should issue clear guidance on the implementation of a diversity strategy indicating areas to be prioritised and provide relevant staff training including in religious and cultural differences. (2.7)

3.5 The service improvement board should ensure that the health needs of women prisoners are identified and met. (2.9)

3.6 An education and training policy for women should be developed that provides sufficient work and education places to keep women purposefully occupied. (2.10)

3.7 Effective collaborative partnerships with external education and training providers, such as further education and/or work-based learning suppliers, should be established. (2.11)

3.8 The standard of food should be improved. (2.12)

## Recommendations

### Courts, escorts and transfers

3.9 Women should be transported separately from male prisoners. (2.14)

3.10 Pregnant women should not travel in cellular vehicles. (2.15)

3.11 Staffing should be arranged so that women do not wait unnecessarily in vans because reception is closed and women on Ash House should not be locked down to provide staff from the landings. (2.16)

3.12 Women should be escorted in vehicles that are safe, clean and comfortable. (2.18)

3.13 Women should be given the information leaflet about Hydebank Wood at court by Northern Ireland Prison Service escort staff. (2.19)

3.14 Property and private cash should accompany unsentenced prisoners to court. (2.20)

## First days in custody

3.15 The new reception should include decent waiting areas with relevant information in a variety of formats. (2.22)

3.16 Prisoner feedback should be used to improve and develop the induction programme. (2.26)

## Accommodation and facilities

3.17 Mother and baby rooms should be improved and should not contain an open toilet. (2.30)

3.18 Consultation meetings should provide the opportunity for women in Ash House as a whole to meet together as a group. (2.32)

3.19 Managers should discuss prisoner dissatisfaction with the mail at prisoner consultation meetings and take action to address any identified shortfalls. (2.36)

## Bullying and violence reduction

3.20 There should be a dedicated safer custody manager and a safer custody committee specifically for Ash House focusing on anti-bullying, the prevention of suicide and the reduction of self-harm. (2.40)

3.21 Ash House staff should be trained to implement the challenging anti-social behaviour strategy and the strategy should be explained to women prisoners. (2.42)

3.22 An in-depth survey specific to women's perceptions and experiences of bullying by prisoners and staff should be completed and considered by the women's safer custody committee to inform the development of the safer custody policy. (2.43)

3.23 Regular staff-led landing meetings should be held focusing constructively on resolving tensions caused by small group living. (2.44)

## Self-harm and suicide

3.24 Investigations, recommendations and learning points from serious or near-fatal incidents should be shared with relevant staff including the South Eastern Health and Social Care Trust and incorporated into action plans monitored by the safer custody committee. (2.47)

3.25 Trained senior officers should provide consistency in the management of supporting prisoners at risk case reviews. (2.49)

3.26 Care plans for women at risk of suicide or self-harm should identify the underlying issues associated with the woman's vulnerability and indicate what help would be provided to address these. (2.51)

3.27 Entries in the PAR 1 daily supervision records (now SPAR process) should be improved, with regular management checks on the quality of care. (2.52)

3.28 All staff with direct contact with women prisoners should have suicide and self-harm awareness training specifically related to women. (2.56)

3.29 A Listener scheme should be developed. (2.58)

## Applications and complaints

3.30 Managers should speak to prisoners who withdraw complaints to ensure that they have not been coerced. Records should outline the reason given for withdrawal of the complaint. (2.62)

3.31 Requests and complaints should be routinely analysed to identify patterns or trends. (2.63)

3.32 There should be a formal system of quality assurance of complaints to ensure that they are fully investigated and that replies are

courteous and directly and clearly address the nature of the complaint. (2.65)

### Faith and religious activity

3.33 Women should have the opportunity to attend religious services on Sundays. (2.67)

### Substance use

3.34 Substance-dependent women should be provided with adequate first night treatment/symptomatic relief following screening and testing. (2.69)

3.35 Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes. (2.70)

3.36 There should be protocols and procedures for the close monitoring of women experiencing alcohol withdrawal to ensure their safety. (2.72)

3.37 All prisoners requiring a clinical alcohol detoxification should be admitted to the inpatient unit. (2.73)

### Diversity

3.38 The equality and diversity committee should meet regularly with all designated members or representatives attending and consider and take action on any identified or potential areas of discrimination. (2.75)

3.39 A system of monitoring that identifies and highlights areas of under and over-representation should be introduced and monitoring data should distinguish between male and female prisoners. (2.76)

### Race equality

3.40 The equality and diversity officer should receive specialist training, including in investigating racist incidents, and should be allocated dedicated time to carry out their additional duties. (2.78)

3.41 Links with Irish Traveller support groups should be strengthened and consolidated. (2.79)

### Foreign nationals

3.42 Professional interpretation services should be used when legal matters or issues relating to vulnerability are discussed with women with little or no English. (2.83)

### Health services

3.43 The health needs assessment of women in Ash House should be reviewed and services to meet their specific needs should be commissioned and provided through the National Health Service. (2.87)

3.44 A lead nurse with sufficient seniority and knowledge should take responsibility for the needs of older women. (2.88)

3.45 Complaints about health services should be monitored by the health care manager. (2.89)

3.46 There should be a system to ensure that staff have read and understood the policies and procedures relevant to the delivery of health services in the prison. (2.91)

3.47 There should be an information-sharing policy with appropriate agencies to ensure efficient sharing of relevant health and social care information. It should include the need to obtain a patient's consent when appropriate. (2.93)

3.48 All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose; documented evidence of such checks should be kept. (2.94)

3.49 Specific and sufficient nursing staff should be allocated to Ash House to ensure continuity of care and the provision of regular necessary clinics. (2.95)

3.50 All health services staff, including allied health professionals, should have annual training in resuscitation and child protection. (2.96)

3.51 Clinical supervision should be available to all health services staff. (2.97)

3.52 All clinical records should be contemporaneous and conform to professional guidance from regulatory bodies. (2.99)

3.53 The use of prescription forms, card index and administration charts should be revised to avoid the need for duplication and transcription. One chart should be used for prescriptions and administration record. (2.104)

3.54 Decisions about daily, weekly or monthly in possession medications should be clearly documented. (2.109)

3.55 There should be patient group directions (PGDs) for all vaccinations. (2.110)

3.56 All patient group directions (PGDs) should be in date and signed in accordance with Trust policy. (2.111)

3.57 Over-the-counter medicine should be available for women to buy from the tuck-shop. (2.112)

3.58 Women who arrive with ongoing dependence on prescription medications should be carefully assessed and monitored before any detoxification regime is commenced. (2.113)

3.59 All health services accommodation should be fit for purpose, with appropriate provision for male and female patients to be held separately. (2.117)

3.60 Arrangements for attendance at outside hospital appointments, including waiting times and cancellations, should be subject to audit. (2.118)

3.61 Psychiatric services should be reviewed to ensure that there are sufficient resources to meet the needs of women, including child and adolescent services. (2.119)

### Time out of cell

3.62 Unlock and lock-up should take place at the published times. (2.120)

3.63 Inter-landing association should be introduced. (2.121)

3.64 Staffing ratios should be reviewed to ensure they are appropriate to the risk posed by prisoners. (2.122)

3.65 Women should be consulted about ways to promote more constructive use of association time. (2.123)

3.66 Women should have the opportunity to spend at least an hour in the open air every day. (2.125)

### Learning and skills and work activities

3.67 Essential skills provision should be improved and should meet the literacy and numeracy needs of women at Ash House. (2.126)

3.68 Robust quality assurance and self-evaluation systems should be developed. (2.127)

### Physical education and health promotion

3.69 The range of vocational courses leading to awards should be expanded to meet the needs and interests of all women. (2.130)

### Security and rules

3.70 The security committee should include representatives for education, workshops and other departments that have direct dealings with prisoners. (2.136)

3.71 The number of routine cell searches should be reduced and the searching strategy reviewed to find a more efficient and

effective way of tackling supply reduction. (2.137)

### Discipline

3.72 There should be a written record of adjudication hearings to ensure that managers are able to scrutinise and evaluate disciplinary procedures. (2.141)

3.73 The reasons for the disproportionate number of Roman Catholic prisoners placed on report should be investigated and appropriate action taken as necessary. (2.142)

3.74 Guidance on appropriate levels of punishments should be updated to make punishments more commensurate with offences and should be subject to regular review through standardisation meetings. (2.144)

3.75 All staff should be refreshed in control and restraint techniques every 12 months. (2.145)

3.76 The wing files of women receiving cellular confinement as a punishment following adjudication should be updated daily to indicate whether or not they have received their regime entitlements, who has visited them and details of their interaction with staff. (2.147)

### Progressive regimes and earned privileges

3.77 The progressive regimes and earned privileges scheme should be routinely monitored by religion by the equality and diversity committee. (2.150)

3.78 The procedures for applying for special privileges status should be published, transparent and monitored. (2.151)

### Catering

3.79 All staff responsible for handling food should be subject to a health check. (2.153)

3.80 The consultation arrangements about food should be improved so that views expressed by prisoners are considered seriously and, when valid, acted on. (2.154)

3.81 More women should be given opportunities to prepare their own food. (2.155)

### Strategic management of resettlement

3.82 The weekly operational and monthly strategic resettlement meetings should be reprioritised and should have clear terms of reference that clarify their distinct purposes. (2.160)

### Offender management and planning

3.83 Resettlement plans should actively inform allocation to activities and programmes and decisions about regime status. (2.162)

### Indeterminate-sentenced prisoners

3.84 The Northern Ireland Prison Service should develop progression opportunities for life-sentenced women beyond Ash House. (2.167)

### Resettlement pathways

3.85 The drug and alcohol strategy should be informed by a comprehensive needs assessment and any identified gaps in service for women provided. (2.169)

3.86 There should be separate visiting facilities for men and women. (2.173)

3.87 Babies should be searched only when there is specific intelligence, agreed by a senior manager, that this is necessary. (2.174)

3.88 Privacy screening should be introduced between the closed visit rooms and the general visits area. (2.175)

3.89 Guidance on closed visits should specify when decisions to impose restrictions should be reviewed. (2.176)

3.90 Women prisoners with more than three children should not have to ask permission for them to visit. (2.179)

## Good practice

3.91 The extended visits facility provided a real opportunity for mothers to sustain and develop relationships with their children. (2.180)

Section 2

# Appendices

# Appendix 1: Inspection Team

| | |
|---|---|
| **Dr Michael Maguire** | Chief Inspector of Criminal Justice in Northern Ireland (CJI) |
| **Michael Loughlin** | Inspection Team Leader, Her Majesty's Inspectorate of Prisons (HMIP) |
| **Tom McGonigle** | Inspector, CJI |
| **Fay Deadman** | Inspector, HMIP |
| **Ian MacFadyen** | Inspector, HMIP |
| **Paul Fenning** | Inspector, HMIP |
| **Lucy Young** | Inspector, HMIP |
| **Ian Thomson** | Inspector, HMIP |
| **Elizabeth Tysoe** | Health care Inspector, HMIP |
| **Elizabeth Colgan** | Lead Inspector Regulation and Quality Improvement Authority (RQIA) |
| **Helen Daly** | Pharmacy Inspector, RQIA |
| **Paula Hendron** | Inspector, RQIA |
| **Gerry Colgan** | Inspector, RQIA |
| **Barry O'Rourke** | Lead Inspector, Education and Training Inspectorate (ETI) |
| **John Baird** | Inspector, ETI |
| **Deirdre Gillespie** | Inspector, ETI |
| **Jayne Walkingshaw** | Inspector, ETI |

# Appendix 2: Prison population profile

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

**Population breakdown by:**

| (i) Status | No. of women | % |
|---|---|---|
| Sentenced/fined | 28 | 57.1 |
| Remand/awaiting trial | 20 | 40 |
| Immigration detainee | 1 | 2 |
| **Total** | **49** | **100** |

| (ii) Length of sentence | No. of sentenced adult women | % |
|---|---|---|
| Less than 6 months | 3 | 11.5 |
| 6 months to less than 12 months | 2 | 7.7 |
| 12 to 18 months | – | – |
| 18 to 24 months | 1 | 3.8 |
| 24 to 36 months | 3 | 11.5 |
| 36 to 42 months | – | – |
| Over 48 months | 4 | 15.4 |
| Life | 7 | 26.9 |
| ECS | 2 | 7.7 |
| DCS | 3 | 11.5 |
| ICS | 1 | 3.8 |
| **Total** | **26** | **100** |

| (ii) Length of sentence | No. of sentenced YO women | % |
|---|---|---|
| Less than 6 months | 1 | 50 |
| 6 months to less than 12 months | – | – |
| 12 to 18 months | – | – |
| 18 to 36 months | – | – |
| 36 to 42 month | – | – |
| Over 48 months | 1 | 50 |
| Life | – | – |
| ECS | – | – |
| DCS | – | – |
| ICS | – | – |
| **Total** | **2** | **100** |

| (iii) Length of time served for unsentenced women | No. of adult women | % |
|---|---|---|
| Less than 1 month | 9 | 45 % |
| 1 month to 3 months | 7 | 35% |
| 3 months to 6 months | 2 | 10 % |
| 6 months to 1 year | 2 | 10% |
| **Total** | **20** | **100** |

| (iii) Length of time served for unsentenced women | No. of YO women | % |
|---|---|---|
| Less than 1 month | 1 | 100 |
| 1 month to 3 months | – | – |
| 3 months to 6 months | – | – |
| 6 months to 1 year | – | – |
| **Total** | **1** | **100** |

| (iv) Main offence | No. of adult women | % |
|---|---|---|
| Murder | 9 | 19.6 |
| Other offences against the person | 16 | 34.8 |
| Burglary/robbery/theft | 8 | 17.4 |
| Fraud & forgery | 1 | 2.2 |
| Drug offences | 2 | 4.3 |
| Other offences | 7 | 15.2 |
| Criminal damage | 2 | 4.3 |
| Sex offences | 1 | 2.2 |
| **Total** | **46** | **100** |

| (iv) Main offence | No. of YO women | % |
|---|---|---|
| Murder | – | – |
| Other offences against the person | – | – |
| Burglary/robbery/theft | 3 | 100 |
| Fraud & forgery | – | – |
| Drug offences | – | – |
| Other offences | – | – |
| Criminal damage | – | – |
| **Total** | **3** | **100** |

| (v) Age | No. of adult women | % |
|---|---|---|
| 18 - 21 | 3 | 6.1 |
| 21 and Over | 46 | 93.9 |
| **Total** | **49** | **100** |

| (vi) Home address | No. of adult women | % |
|---|---|---|
| Northern Ireland | 40 | 87 |
| Republic of Ireland | 1 | 2.2 |
| England | – | – |
| NFA | 4 | 8.6 |
| Unknown | 1 | 2.2 |
| **Total** | **46** | **100** |

| (vi) Home address | No. of YO women | % |
|---|---|---|
| Northern Ireland | 3 | 100 |
| Republic of Ireland | – | – |
| England | – | – |
| NFA | – | – |
| Unknown | – | – |
| **Total** | **3** | **100** |

| (vii) Location breakdown | County | No. of adult women | % |
|---|---|---|---|
| Northern Ireland | Antrim | 22 | 47.8 |
| | Down | 5 | 10.9 |
| | Londonderry | 4 | 8.7 |
| | Armagh | 4 | 8.7 |
| | Fermanagh | 1 | 2.1 |
| | Tyrone | 3 | 6.5 |
| | None | 6 | 13 |
| Republic of Ireland | Donegal | 1 | 2.1 |
| **Total** | | **46** | **100** |

| (vii) Location Breakdown | County | No. of YO women | % |
|---|---|---|---|
| Northern Ireland | Antrim | 1 | 33.33 |
| | Down | 1 | 33.33 |
| | Fermanagh | 1 | 33.33 |
| **Total** | | **3** | **100** |

| (viii) Nationality | No. of adult women | % |
|---|---|---|
| British | 2 | 4.3 |
| British – Northern Ireland | 33 | 71.7 |
| Irish | 5 | 10.9 |
| Portuguese | 1 | 2.1 |
| Polish | 2 | 4.3 |
| Chinese | 3 | 6.5 |
| **Total** | **46** | **100** |

| (viii) Nationality | No. of YO women | % |
|---|---|---|
| British – Northern Ireland | 3 | 100 |
| **Total** | **3** | **100** |

| (ix) Ethnic group | No. of adult women | % |
|---|---|---|
| Mixed ethnic | 1 | 2.2 |
| Chinese | 4 | 8.7 |
| Irish Traveller | 1 | 2.2 |
| White | 40 | 87 |
| **Total** | **46** | **100** |

| (ix) Ethnic group | No. of YO women | % |
|---|---|---|
| Black African | – | – |
| Dark European | – | – |
| Irish Traveller | – | – |
| White | 3 | 100 |
| **Total** | **3** | **100** |

| (x) Religion | No adult women | % |
|---|---|---|
| Baptist | 1 | 2.2 |
| Church of Ireland | 5 | 10. 9 |
| Methodist | 1 | 2.2 |
| Mormon | 1 | 2.2 |
| Presbyterian | 7 | 15.2 |
| Roman Catholic | 22 | 47.8 |
| Other religion | 3 | 6.5 |
| Nil | 3 | 6.5 |
| Brethren | 1 | 2.2 |
| Christian | 1 | 2.2 |
| Buddhist | 1 | 2.2 |
| **Total** | **46** | **100** |

| (x) Religion | No. YO women | % |
|---|---|---|
| Church of England | – | – |
| Church of Ireland | – | – |
| Methodist | – | – |
| Mormon | – | – |
| Presbyterian | – | – |
| Roman Catholic | 3 | 100 |
| Other religion | – | – |
| Nil | – | – |
| **Total** | **3** | **100** |

First published in Northern Ireland in October 2011 by
CRIMINAL JUSTICE INSPECTION NORTHERN IRELAND
14 Great Victoria Street
Belfast BT2 7BA
www.cjini.org

**ISBN 978-1-905283-68-2**

Typeset in Gill Sans
Printed in Northern Ireland by Commercial Graphics Limited
Designed by Page Setup