Report on an unannounced short follow-up inspection of

Guernsey Prison

17 – 19 March 2009

by HM Chief Inspector of Prisons

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Introduction

When we last inspected Guernsey prison, we felt that the extraordinary range of tasks required of this small multifunctional prison hampered its progress. It has to hold men, women, young adults and children, who may be convicted or unconvicted, and even immigration detainees. On our return for this unannounced short follow-up inspection, we were pleased to find that there had been progress in a number of areas, helped by a considerable reduction in the number of prisoners, with fewer children being detained and police detainees no longer being held in the prison.

There had been progress in ensuring safety at the prison. The reception environment and procedures had improved and, although there was no first night strategy, new arrivals said that they were treated well and felt safe. There was little evident bullying, but procedures needed tightening further. Self-harm prevention was generally well managed and the segregation unit, while still a poor and inadequately supervised facility, was no longer used routinely to hold those at risk. Security arrangements were better, use of force remained low and there was little evidence of substance misuse.

The prison was still not able to ensure appropriate care and facilities for women, separate from men. While there were many fewer children being held than at the time of our last visit, there remained limited recognition of their particular needs. We repeat our main recommendation that alternative, more appropriate accommodation should be found for both women and children.

Staff-prisoner relationships continued to be generally positive and mutually respectful, and were supported by a basic personal officer scheme and new prisoner consultative arrangements. Accommodation was adequate, and the drop in the population meant that there was now no overcrowding, but toilets remained unscreened. Arrangements to support diversity and ensure equal treatment were underdeveloped, although provision for foreign nationals had improved. The chaplaincy was under-resourced and health services remained basic.

Despite the drop in the population, the quality and quantity of purposeful activity remained insufficient. There was some good education provision, but its range was limited and quality assurance was underdeveloped. Opportunities for women, young people and those on remand were particularly poor. Most prisoners were employed, but jobs tended to be part-time and mundane. Access to the library was poor and, while access to physical education was good, the quality of provision was limited.

The prison worked well with the Guernsey probation service. Both sentence planning and preparation for release, including help with accommodation and employment, were good. However, there were few interventions to address offending behaviour and none at all for women or young people. Public protection procedures had improved. Visits arrangements and support to maintain family ties remained good and a satisfactory, but stretched, drugs service was available.

Managers and staff at Guernsey prison deserve considerable credit for the progress made since our last visit, particularly given the breadth of challenges faced by this small multi-functional facility. We were pleased to find that the population of the prison had much reduced. There were now no police detainees and fewer children being held, which had allowed a much better focus on the needs of the majority. However, we do not consider that the prison will ever

be able adequately to cater for the particular needs of women or children, and we once again call on the Home Department to consider alternative options for these groups.

Anne Owers May 2009
HM Chief Inspector of Prisons

Fact page

Task of establishment
The Guernsey Prison Service serves the public by keeping in custody those legally committed to its care. Its duty is to look after them with humanity and to help them lead law-abiding lives in custody and after release.

Brief history
The present prison was opened in 1989 to replace the original prison in St Peter Port. It is based on the hotel corridor layout with a series of two-storey small wings opening off a central corridor on each floor, prisoners' movements taking place predominantly on the ground floor. The original design was driven by the need to keep a wide diversity of prisoners separate from each other in accordance with the Prison Ordinance that governs the operation of the prison. As the only prison on the island, it is obliged to hold adults, young offenders and juvenile males and females, sentenced and unsentenced and vulnerable prisoners.

Area organisation
The Guernsey Prison Service is accountable to the Guernsey Home Department.

Number held
On 17 March 2009: 60 adult men, seven adult women, six young men, two young women and one juvenile girl.

Certified normal accommodation
122

Operational capacity
163

Last full inspection
27June – 1 July 2005

Description of residential units
Nine residential wings designated for capacities ranging from six to 12 prisoners, plus a wing with a capacity of 44.

Section 1: Healthy prison assessment

Introduction

HP1 All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

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

…performing reasonably well against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

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

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

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required

amendment of the healthy prison assessment held by the Inspectorate on all establishments in England and Wales, but only published since early 2004. In Guernsey, the assessments made in 2005 were not published.

Safety

HP4 In 2005, Guernsey was not performing sufficiently well against this healthy prison test. Of the 46 recommendations in this area, 14 were assessed as achieved, 18 partially achieved and 14 not achieved. We have made 26 further recommendations.

HP5 All prisoners were handcuffed to and from reception and remained handcuffed on the vans, which was unnecessary. The reception environment and procedures had improved and prisoners said they were well treated by reception staff. Some new arrivals spent a long time in reception as induction and a thorough healthcare assessment were completed there. There was no formal first night strategy, but new prisoners said they had received all the information they needed and felt safe.

HP6 Prisoners, including vulnerable prisoners, reported feeling safe. There was a reasonable written anti-bullying strategy but, although there was little evidence of much bullying, the formal procedures were not always followed. Wing officers were unaware of the one man subject to monitoring as a suspected bully at the time of the inspection.

HP7 The particular vulnerabilities of women and children in a multi-functional prison relied heavily on good supervision rather than clear risk assessments. The lack of complete separation of men from women was still a problem. A senior officer had been given operational responsibility for women prisoners, but there was little recognition of their specific needs in formal policies and they were still disadvantaged because of their minority status. Recent legislative changes had resulted in many fewer children being held in the prison and there was only one girl aged 17 at the time of the inspection. A new child protection policy had been drafted and links with the island child protection committee had improved. Many staff had recently had some child protection training. Although some staff worked hard to meet the individual needs of juveniles, there remained only limited recognition of the distinctive position of children.

HP8 Levels of self-harm were low, with only about two incidents a month and some were repeat incidents involving the same prisoner. Multidisciplinary assessment, care in custody and teamwork (ACCT) procedures had been introduced. Many initial assessments were of a high standard and entries in ACCT documentation demonstrated a good level of care and engagement. A useful weekly multidisciplinary risk management meeting reviewed and discussed the cases of all prisoners who were causing concern. The segregation unit was no longer used routinely for prisoners at risk of self-harm, but cells still contained many ligature points and there were no safer cells, care suites or formalised peer support arrangements.

HP9 There had been good developments in security, with a new security information system and intelligence evaluation system. As a result, the number of security information reports received had increased and these were well managed. There were no clear rules of the prison displayed and prisoners said staff applied rules inconsistently. Holding men, women and children safely together in the same prison was a difficulty, but some security procedures, particularly in relation to movements, appeared too restrictive.

HP10 The segregation unit was not over used and few prisoners spent a long time there. However, there was little effective monitoring of use by age or gender and no analysis of trends. Often, prisoners were held there due to mental health problems or because they were seeking respite at their own request. A number of cells were inappropriately furnished just with cardboard furniture and the only association facility was a small exercise area. There was still no permanent staffing at night when the unit was occupied, which was potentially unsafe.

HP11 Force was little used, with just one incident so far in 2009, and no use of special accommodation. The risks involved in holding police-untried prisoners in furnished or partially furnished cells no longer applied as such prisoners were now not held in the prison.

HP12 Positive results for mandatory drug testing were very low, but the tests were for opiates and cannabis, which were not the drugs usually used by prisoners on Guernsey. There was still no therapeutic support for those who arrived withdrawing from drugs or alcohol.

HP13 On the basis of this short follow-up inspection, we considered that the prison was now performing reasonably well against this healthy prison test.

Respect

HP14 In 2005, Guernsey was performing reasonably well against this healthy prison test. Of the 66 recommendations in this area, 28 were assessed as achieved, 10 partially achieved and 28 not achieved. We have made 29 further recommendations.

HP15 Prisoners were mostly positive about relationships with staff, although some who were not from the island complained of favouritism towards those from Guernsey. Interactions appeared relaxed and positive. Personal officer entries in records varied in quality. Some were very good and indicated detailed knowledge of the prisoner, but there were often lengthy gaps between entries and there were no regular management checks for quality or regularity.

HP16 Accommodation was generally of a decent standard, with good access to showers, but toilets in cells were unscreened. Not all cells had drinking water. The population had reduced significantly and all prisoners had single cells. There were sufficient telephones on wings. Prisoners on the standard regime level and above now had televisions. Sufficient prison clothing was usually provided, but the arrangements for those without outside support were poor and prisoners could not buy their own clothes through catalogues. Regular prisoner consultative meetings were now held. Prisoners were still very positive about the quality of the food.

HP17 The application and complaints system worked reasonably effectively, but the process was still not clearly described to prisoners. Copies of applications were kept, but they were not logged to ensure prompt and effective responses. Progress with complaints was monitored and most were answered quickly.

HP18 The resources of the chaplaincy were stretched, with a heavy reliance on the support of two volunteers and the goodwill of a local parish. Few prisoners from the main Christian traditions were able to attend services of their own denomination, but a high proportion attended a general Sunday service. Prisoners were positive about the

support they received from the chaplain, who was more integrated than previously into the work of the prison.

HP19 There remained no clear policy for pregnant women and mothers with babies. Although rarely used, the accommodation in the segregation unit where mothers and babies were held was not suitable for this purpose.

HP20 There was no monitoring by race and ethnicity, but prisoners were monitored by nationality. There was little obvious promotion of cultural diversity, no training in race awareness and staff did not always challenge the use of inappropriate language about minority groups. There was no separate confidential reporting system for race matters. The needs of foreign national prisoners were generally well met, with a weekly visit from a foreign national coordinator, good translation services and additional credit for telephone calls home.

HP21 A basic health service was provided, but lack of funding was a barrier to further development and there had been no health needs analysis for the prison population to determine exactly what services were required. There was now a clinical lead for health services, but there was still a need to develop policies and protocols. Mental health services reflected those delivered in Guernsey, which were relatively undeveloped, and some prisoners waited long periods for transfers to secure mental health hospitals. A good dental service was provided.

HP22 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Purposeful activity

HP23 In 2005, Guernsey was not performing sufficiently well against this healthy prison test. Of the 16 recommendations in this area, five were assessed as achieved, one partially achieved and nine not achieved. One recommendation was no longer applicable. We have made eight further recommendations.

HP24 Time out of cell varied from about 11 hours for employed prisoners on the enhanced regime level to as little as three or five hours for unemployed prisoners depending on regime level. Despite the drop in population, too many prisoners were engaged in little regular and meaningful activity. Over 60% of prisoners remained on their wings during activity periods with little constructive activity other than cleaning. All prisoners were offered daily exercise.

HP25 Accommodation and resources in education were generally good, with experienced, well qualified teachers, but they were unable to offer a broad range of provision in the time available. There was good support for private study, but too few larger classes were run to involve more prisoners. A high proportion of prisoners attended education, but mostly for only short periods each week. Supervision of mixed groups of prisoners was improved and classroom activities were well managed, but there were no individual risk assessments. Quality assurance arrangements were underdeveloped, with no self-assessment and insufficient use of data to inform improvement.

HP26 Procedures for allocation to activities still lacked transparency, with little to ensure equality of access to jobs. Opportunities for women, young prisoners and those on

remand were particularly poor. About 60% of prisoners were employed, but most jobs were part time and did not occupy them for long. Many were domestic tasks and there were no opportunities to gain accredited qualifications. Some of the better work opportunities, such as in horticulture, were under-utilised.

HP27 Library arrangements were poor with access only one evening a week and a range of books that did not meet prisoners' needs or interests. Library usage was not monitored, but few prisoners appeared to use it regularly.

HP28 PE facilities were reasonable and access was good, but it was mostly unsupervised recreational activity. Some supervised sessions were run, but they were poorly structured and no vocational qualifications were offered. There was no remedial PE and no links with healthcare to promote healthy living.

HP29 On the basis of this short follow-up inspection, we considered that the prison was still not performing sufficiently well against this healthy prison test.

Resettlement

HP30 In 2005, Guernsey was performing reasonably well against this healthy prison test. Of the 25 recommendations in this area, 14 were assessed as achieved, two partially achieved and nine not achieved. We have made four further recommendations.

HP31 Although there was no formal resettlement policy or in-house committee to inform strategic direction of resettlement services, there were close operational and strategic links with the local probation department. Fortnightly meetings took place to discuss the development of the offender management model. All prisoners had an allocated probation officer who maintained regular contact and the prison-based probation officer had a high profile. Probation officers carried out one-to-one offending behaviour work and helped prisoners find employment and accommodation for after release.

HP32 The supervising probation officers were active case managers, well involved with sentence planning and provided a good model of offender management. There had been some improvements in sentence planning, with custody plans for all short-sentenced and remand prisoners. Interventions available in the prison were limited to just one cognitive skills programme for all prisoners. There had been no needs analysis to ensure there were interventions to meet identified needs and there was nothing specific for women or young people.

HP33 Identification of public protection cases on admission had improved in partnership with the local police and social services. A draft public protection policy had been produced. Staff were aware of relevant cases and had received some training in working with sex offenders and in domestic violence issues. Arrangements had recently been introduced to monitor and review the restrictions on prisoners subject to public protection measures.

HP34 Prisoners were given some good individual support to maintain contact with their families. Visits were run every day except Tuesdays and extended visits were run at weekends for visitors from further away. Good family visits were run every month.

HP35 Prisoners were very positive about the help they received from the drug worker, but the substance misuse service was very stretched.

HP36 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations To the Home Minister

2.1 The Home Department should draw up a strategy to provide alternative approaches and accommodation for women and children with the aim of eventually removing them from the prison. (HP44)
Not achieved. No strategy had been drawn up and the prison remained the only custodial environment for women and children.
We repeat the recommendation.

2.2 Police-untried prisoners should not be held in the prison unless sufficient resources are provided to risk assess and safeguard them properly. (HP45)
Achieved. Police-untried prisoners were held at police stations and in customs cells if the police cells were full. No police-untried prisoners had been held at Guernsey since February 2008 (see also section on health services).

Main recommendations To the Governor

2.3 A full management review and staff re-profiling exercise should take place in order to provide sufficient staff to allow appropriate staff presence and supervision on all living units. (HP46)
Partially achieved. A full service review was under way and due to report later in the year. The aims included reviewing and developing staffing arrangements and work was going forward on proposals for a new staff detail. It was not yet possible to determine whether this would result in improved staff supervision of living units.

2.4 A strategy to address bullying behaviour should be developed and implemented as a matter or urgency and all staff should be trained in the strategy. (HP47)
Partially achieved. A formal four-stage strategy had been introduced in May 2006. It was described in an 'anti-bullying policy and practice' document, but was not used consistently as outlined in the policy. Investigations and monitoring of bullying were inadequate (see section on bullying).

Further recommendation

2.5 The anti-bullying strategy should be applied consistently as outlined in the written policy.

2.6 Procedures to care for those at risk of suicide and self-harm should be reviewed with a view to introducing a multidisciplinary care plan approach that recognises the needs of the population. (HP48)
Partially achieved. Assessment, care in custody and teamwork (ACCT) procedures had been piloted in 2006 and introduced across the prison in 2007. ACCT trainers were in post and assessors and case managers had been trained. Some ACCT assessments were good, but only one assessor was from a non-uniformed grade. All staff in contact with prisoners had

received foundation training. Open ACCTs were reviewed weekly at a multidisciplinary risk management meeting attended regularly by the same representatives. These included the substance misuse worker, a probation officer, a member of healthcare and a chaplain. Meetings were usually chaired by a principal officer and often attended by the deputy governor. Meeting minutes evidenced detailed discussion of cases and staff used the meeting to share concerns, highlight significant events and in some cases prepare for the arrival of former prisoners who were known to be appearing in court and likely to be at risk if returned to custody. The policy made no reference to the specific needs of different groups of prisoners, particularly women and young people.

Further recommendation

2.7 The assessment, care in custody and teamwork (ACCT) policy (Prison Order 28) should recognise the specific needs of different prisoner groups.

2.8 Clear criteria for the use of the observation unit should be agreed and its use for prisoners at risk of self-harm, those who are detoxifying, or new prisoners waiting to see a member or healthcare should stop. (HP49)
Achieved. The observation unit was governed by a protocol and it was no longer used as additional accommodation for healthcare. Although it was still sometimes used to hold prisoners at risk of self-harm or otherwise considered vulnerable (see section on self-harm and suicide), this was only in exceptional circumstances. Far fewer prisoners at risk than when we last inspected were held in the unit.

2.9 A healthcare needs assessment should be carried out to determine the services required to provide an acceptable level and range of healthcare services to prisoners at Guernsey Prison and appropriate therapeutic accommodation provided that is fit for purpose. (HP50)
Not achieved. No health needs assessment had been undertaken to determine the services required to provide an acceptable level and range of healthcare.
We repeat the recommendation.

2.10 The range of work and accredited vocational training opportunities should be increased to provide more meaningful and better quality work opportunities in the prison and links with external agencies developed to improve employment opportunities after release. (HP51)
Not achieved. There were no opportunities for prisoners to gain accredited vocational qualifications and the range of work remained poor. Where useful employment opportunities existed, such as in horticulture, painting and decorating and the works department, places were not maximised and were generally available only to adult male prisoners. About 60% of prisoners were employed, but most jobs were part-time domestic tasks that did not occupy prisoners for long. The woodwork shop was temporarily closed due to staff illness and no contingency plans were in place.
We repeat the recommendation.

Recommendation to the Home Minister

Discipline

2.11 The Home Minister should consult with the Guernsey judicial authorities about the desirability of cases referred to the independent adjudicator being heard within one month. (6.36)
Achieved. There were no longer delays in adjudications being heard by the independent adjudicator. Of the 13 charges heard by the independent adjudicator in 2008, nine had been heard within a month and four within six weeks.

Recommendations To the Governor

Courts, escorts and transfers

2.12 The prison should be given sufficient notice of court movements. (1.7)
Achieved. Dedicated prison court custody officers managed court escorts and staffed the courts. Court listings were sent electronically to the prison in good time.

2.13 A video link facility should be provided between the prison and both courts. (1.8)
Achieved. Video link facilities had been provided for the magistrates and Royal courts.

2.14 Information about what is going to happen to them should be given to prisoners before their arrival. (1.9)
Partially achieved. An information leaflet entitled 'from court to prison' had been produced, but was not given to all prisoners at court.

Further recommendation

2.15 All prisoners should receive the 'from court to prison' information leaflet at their sending court.

2.16 Hygiene packs should be provided for women prisoners travelling to court. (1.10)
Achieved. The journey to court was very short and sanitary items were available to women on the wing, in reception and at court. There was not always a female officer on duty in reception and some women were reluctant to ask male staff for these items (see also paragraph 2.28).

Additional information

2.17 All prisoners were handcuffed on vans between reception and court without an individual risk assessment. This was uncomfortable, potentially dangerous and, no doubt, disproportionate to risk in many cases.

Further recommendation

2.18 Prisoners should be handcuffed between the prison and court only if justified by a risk assessment.

First days in custody

2.19 Female officers should receive women prisoners in reception and carry out all the associated reception duties. Women prisoners should be held separately from men in appropriate holding areas. (1.27)
Partially achieved. Reception now contained two separate holding rooms. The reception officer team included a female officer, but she was not always present when a woman arrived. Female officers went to reception to complete the search of a female prisoner when necessary, but all other reception procedures were completed by a male officer even though this might have inhibited some women from talking openly.

Further recommendation

2.20 Female officers should receive women prisoners in reception and carry out all the associated reception duties.

2.21 The reception interview should be undertaken in private. (1.28)
Not achieved. Reception interviews continued to take place in the main reception area.
We repeat the recommendation.

2.22 The interview form should properly reflect the diverse needs of prisoners and should prompt officers to gather identified information in depth. (1.29)
Achieved. Information gathering was much improved. Reception officers completed a risk assessment for each new arrival, collating 20 possible risk factors including age, gender, physical disability and detoxification needs, and any known history of bullying, drug use, escape from custody, sex offences and self-harm and suicide. Interviews of women prisoners were usually carried out by male officers. Reception officers also completed a public protection form for each prisoner. This was forwarded to the police force intelligence bureau (FIB) and returned in one of three categories: no concern, concern (when information would be disclosed by the police to the security department for the public protection coordinator) and urgent (when the FIB would disclose information to the duty manager in the event of the security department not being staffed). All prisoners were asked if they had dependent children. This was noted on the prison information management system (PIMS) accessible to all staff, but their age, status and whereabouts were not.

Further recommendation

2.23 The age, status and whereabouts of prisoners' children should be recorded on the prison information management system.

2.24 Reception staff should have the telephone number of the social services emergency duty team and be briefed about its use. (1.30)
Partially achieved. Reception staff knew the number of the social services department, but had not received any formal briefing about the circumstances in which to use it.

Further recommendation

2.25 Reception staff should be briefed about the circumstances in which they should contact social services.

2.26 Information books for prisoners should be improved and all prisoners should receive a copy on arrival. (1.31)
Partially achieved. All new arrivals were given an information booklet, but not all the information in it was correct.

Further recommendation

2.27 Information in the prisoner information booklet should be correct.

2.28 All prisoners should be given soap, shampoo and deodorant in reception, and sanitary items should be provided for women. (1.32)
Partially achieved. All prisoners were given toiletries in reception, but sanitary items still had to be requested from reception officers. There was not always a female officer on duty and some women were reluctant to ask male staff for such items.

Further recommendation

2.29 Sanitary items should be freely available in the prisoner toilet.

2.30 All prisoners should be able to shower on the day of their arrival. (1.33)
Not achieved. Some prisoners said they had been offered a shower in reception, but others had not. Those arriving on their allocated wing just before lock-up were not offered a shower until the following morning.
We repeat the recommendation.

2.31 Newly arrived prisoners should not be held in the observation unit cells to wait to see a nurse. (1.34)
Achieved. The reception area had been remodelled and now contained two holding rooms.

2.32 A first night strategy and an induction programme should be introduced to ensure that prisoners are given essential and appropriate information about the operation of the prison. (1.35)
Partially achieved. Prisoners said they had been well treated in reception, but could spend several hours there while the necessary procedures were completed. All new arrivals were given printed information and a full induction talk by reception officers. An information DVD was shown in the holding rooms, although some prisoners said the volume had been turned off. Most prisoners said they had felt safe on their first night, even though there was still no formal first night strategy to ensure that prisoners knew what to expect, could access peer support or were able to shower before lock-up (see also paragraph 2.30). An induction talk every Tuesday evening reiterated the information given on reception and prisoners were able to ask questions. However, prisoners arriving later in the week had already been at the prison several days before attending this talk. Many said they had been given information by other prisoners as most wings were unstaffed.

Further recommendations

2.33 Reception procedures should be completed without unnecessary delays.

2.34 A first night strategy should be produced to ensure newly arrived prisoners receive all essential services and information.

Residential units

2.35 In-cell toilets should be screened. (2.28)
Not achieved. A small number of cells that had been designed and built to house two prisoners had substantial screens. Some single cells were furnished for use by two prisoners (see paragraph 2.36). While a number of in-cell toilets were curtained off, most remained unscreened even though prisoners ate in their cells.
We repeat the recommendation.

2.36 Cells designed for one prisoner should not be used for two. (2.29)
Not achieved. The prison was not full so none of the single cells was used for two prisoners. However, a large number of single cells contained bunk beds so that they could be shared if necessary.
We repeat the recommendation.

2.37 Televisions should be provided in all cells except those prisoners on the basic level of the IEP scheme. (2.30)
Achieved. All prisoners had a television in their cell apart from prisoners on the basic level of the incentives and earned privileges (IEP) scheme.

2.38 Cell call bells should be checked frequently and any cell with a broken call bell put out of use until the equipment has been repaired. (2.31)
Achieved. An up-to-date and more reliable call bell system had been installed in July 2008. Any faults were automatically flagged up in the control room and reported immediately to the works department. These arrangements appeared to work well.

2.39 Cards to identify the occupant(s) of cells should be provided for each cell. (2.32)
Achieved. Cards giving the name, cell number and IEP status of each prisoner were displayed outside each wing.

2.40 All prisoners should have privacy keys to their cells. (2.33)
Not achieved. Only prisoners on J wing had keys to their cells.
We repeat the recommendation.

2.41 Regular prisoner consultation meetings should be held. (2.34)
Achieved. Monthly prisoner consultation meetings were chaired by a senior member of staff and attended by representatives from each wing.

2.42 Telephones should not be placed in toilets on the wings. (2.35)
Achieved. All telephones were appropriately located, although not all could be used in private (see paragraph 2.107).

2.43 All adult women, young women and girls should be able to wear their own clothes, and bras should be provided. (2.36)
Not achieved. Only women on remand or on the enhanced level of the IEP scheme were allowed to wear their own clothes. Other women were given prison-issue clothing, but bras were not provided and it was not possible to buy one from a catalogue. Some women said probation staff would help them get a bra.
We repeat the recommendation.

2.44 Prisoners should have access to drinking water when locked in cells. (2.37)
Not achieved. Drinking water was available in cells only on the larger wings (G, E, D and C).

Prisoners on the other wings had to get water from communal areas and store it in their cell for use when they were locked up. Flasks were not routinely provided and had to be bought from the shop. Women on A wing said the water in their cells was fit to drink, but officers on the wing were unsure if this was the case.

Further recommendations

2.45 Prisoners without direct access to fresh drinking water in their cells should be issued with flasks free of charge.

2.46 Prisoners and staff should be clear about which wings provide in-cell drinking water.

2.47 Women should be able to use the communal baths, showers and toilets in private. (2.38)
Achieved. Prisoners could use the washing and toilet facilities in private.

Additional information

2.48 The units were generally clean and most cells were reasonably well equipped. Prisoners had good access to telephones and showers and work was under way to upgrade the showers on men's wings. Improvements made since the previous inspection meant all male prisoners lived in satisfactory conditions.

2.49 Women were accommodated on one wing and juvenile and adult women were not separated. The women's exercise area adjoining the visit room was more attractive than the area used at the previous inspection, but women had to be escorted to it and therefore did not have free access to fresh air. They no longer had a separate association room, but used the area outside cells on the ground floor. This contained a small selection of books and magazines, some cardio-vascular equipment and a large table and chairs for eating meals, hobby activities and work such as putting leaflets in envelopes. Female prisoners had a limited regime and spent most of their day locked on the wing (see also paragraphs 2.1 and 2.52).

Personal officers

2.50 Personal officers should introduce themselves to prisoners as soon as possible after the prisoner's initial reception, meet their allocated prisoners regularly and record these meetings in the individual prisoner records. (2.56)
Partially achieved. Records indicated that most personal officers introduced themselves promptly to their allocated prisoners. Regularity of contact varied after this initial introduction and in some cases there were gaps of two or three months between personal officer entries in prisoner records. There were usually entries from other staff in between, but mostly just noting events rather than interaction with the prisoner. The quality of personal officers' entries also varied, but some were very good and indicated that personal officers knew the prisoners well and helped them with their problems. Entries were made in the prisoner notes section of PIMS, to which everyone had access, but there were no regular management checks for quality and quantity. Even in cases where there had been significant gaps, no management comments had been made.

Further recommendation

2.51 Managers should check prisoner records and confirm that regular personal officer entries are made.

Women prisoners

2.52 There should be a policy that recognises and provides for the needs of women and girls and a senior manager responsible for its implementation should be identified to prisoners and staff. (3.10)
Not achieved. A policy for women prisoners was being developed, but was very much a work in progress. A designated manager for women who was temporarily promoted to senior officer was responsible for developing this (see also additional information).
We repeat the recommendation.

2.53 Vulnerable girls should be protected from inappropriate and potentially abusive relationships while in prison. (3.11)
Partially achieved. Girls under 18 still had the opportunity to mix with male prisoners in the chapel, education and at prison-wide consultation meetings, but there was no evidence of inappropriate relationships as we had found at the time of the last inspection. Staff supervision was mostly good and risk flags highlighting issues for particular prisoners were easily accessible to staff. However, the mixed areas, particularly when used by potentially vulnerable girls, were unsuitable and a full solution to the problem could be achieved only by ensuring that girls under 18 were no longer held at the prison. There were no individual vulnerability assessments for each child (see paragraph 2.89).

2.54 Women and girls should have equality of access to home visits. (3.12)
Achieved. Women had equal access to home leave, which was determined by a risk assessment and recorded through the computer system. However, women working outside the prison, of whom there were none during the inspection, were accommodated on the segregation unit because of the risk of bullying to bring in contraband. Men working out had their own separate residential area. Staff did not believe this acted as a disincentive for women, even though this effectively meant they would not have association and would be held in isolation.

Further recommendation

2.55 Women working outside the prison should not be accommodated on the segregation unit.

2.56 Inappropriate and abusive behaviour between men and women prisoners should be robustly challenged by staff and, when appropriate, referred to the anti-bullying coordinator. (3.13)
Achieved. Although the location of the women on A wing allowed some contact with male prisoners through cell windows, there was no evidence that inappropriate behaviour went unchallenged. Cell windows had been replaced and prisoners said staff challenged inappropriate behaviour.

Additional information

2.57 The prison was developing a better regime and provision for women prisoners and those we spoke to said things had improved in the previous two years. A female officer had been temporarily promoted and had visited women's prisons in England to look at best practice and how the regime could be changed. The prison had started consultations with female prisoners, but this had stalled in previous months while the policy was being developed. Prisoners were not clear who was responsible for them and the female liaison team members were not advertised on the wing. Women prisoners were consequently invited to the consultation meetings for the whole prison. There had been some internal resistance to the concept of having separate policies for women, such as own clothes, and more support at a senior level was clearly required.

2.58 A total of 10 women, including two young women, were managed in a small residential unit on A wing. One of the young women was under 18 and three were foreign nationals. Staffing was more consistent than in the male part of the prison, but women had limited access to the regime and spent most of the day locked in the unit, which was claustrophobic and had little natural light. Only three of the women were working (see section on work).

Further recommendations

2.59 Details of the female liaison staff should be publicised on the wing.

2.60 Regular consultation meetings with women prisoners should be held.

Mothers and babies

2.61 Babies should not be held in Guernsey prison unless a purpose built unit with appropriate facilities, policies, skilled staff and care plans equivalent to those in the community can be provided. (3.18)
Not achieved. Healthcare staff had undertaken a brief feasibility report on the development of a mother and baby unit at the prison, but no firm conclusions had been drawn. If the situation arose, a mother and baby would be housed in the segregation unit, which was not a suitable environment.
We repeat the recommendation.

2.62 There should be a framework to identify and support pregnant women in custody before, during and after birth. This should include appropriate support for those mothers able to remain with their babies and for those who are separated from them. (3.19)
Not achieved. There was no formal framework to identify and support pregnant women. Cases were dealt with individually as they arose. Recently, a 'professionals meeting' had been held to discuss the care of mother and child if the baby was born while the mother was in prison and resettlement issues on release. The meeting was convened by probation staff and involved staff from a range of outside agencies and prison staff.
We repeat the recommendation.

Bullying

2.63 All incidents of bullying should be reported and the extent and nature of bullying should be recorded and monitored. (3.28)
Not achieved. Not all entries on PIMS had been referred to the anti-bullying coordinator for investigation. Thirty-six bullying-related entries, including several by the anti-bullying coordinator, had been made on prisoners' history sheets in 2008. In many cases, these described the incident and the action taken by officers, but few evidenced the use of the formal anti-bullying strategy. The infrequent use of the scheme and inadequate monitoring had been raised at the safer custody meeting. In many cases, officers recommended that staff be alert to the circumstances. In other cases, they had advised prisoners to submit a victim support disclosure form and it was unclear whether the alleged incident had subsequently been acted on. There was no log of prisoners identified as perpetrators or victims of bullying to record the nature, timing and location of bullying and the outcomes of investigations.
We repeat the recommendation.

Additional information

2.64 An anti-bullying strategy had been introduced and a violence reduction strategy was being developed, but some potential indicators of violence were not routinely monitored. Despite the absence of robust procedures, prisoners in groups said they felt safe, helped in part by the lower numbers of prisoners held.

2.65 The policy document described a four-stage strategy linked to the incentives and earned privileges (IEP) scheme. In theory, prisoners could be moved through the stages, which involved increasing use of warnings, target setting and periods of segregation under good order or discipline. Anyone reaching the final stage could be considered for transfer to a prison in the UK for reasons of 'control and good order'. Few prisoners had moved beyond the first stage, but no log was kept of incidents so it was not possible to establish how many prisoners had moved through the various stages.

2.66 An effective weekly risk management meeting reviewed bullying incidents along with other prisoners subject to assessment, care in custody and teamwork (ACCT) procedures, those undergoing detoxification and those causing concern for other reasons. Action points from meetings were followed up.

2.67 A bullying survey of all prisoners and staff had been completed in January 2008. Of the 29 prisoners who responded, 83% said they felt safe from being physically hurt by other prisoners. The vast majority felt safe in all areas of the prison.

2.68 A victim support disclosure form was included as part of the reception pack. These forms were also issued to all prisoners quarterly and could be used to report any incident of bullying. In 2008, some 400 had been distributed, with 13 completed forms returned to the anti-bullying coordinator. The outcomes of investigations were briefly annotated by the anti-bullying coordinator on these forms, but there was no separate record of the investigation itself.

2.69 The strategy required officers to monitor behavioural targets. These targets were not routinely recorded on PIMS. It was not clear how well behaviour could be monitored on wings that were largely unsupervised and no record was kept of the required monitoring.

2.70 There were no interventions for bullies and, given the limited supervision on wings, perpetrators, and in some cases victims, of bullying were understandably moved to other wings. Staff on one wing were unaware of a prisoner who should have been monitored and this had not been included in the daily briefing sheet.

2.71 The few vulnerable prisoners said they felt very safe, but they had a restricted regime.

Further recommendation

2.72 The procedures for reporting, investigating and monitoring bullying incidents should be improved.

Self-harm and suicide

2.73 A multidisciplinary committee should be established to oversee the development of care for those at risk, monitor the extent and nature of self-harm and promote multidisciplinary training. This should meet at least quarterly and incorporate the views of prisoners. (3.46)
Partially achieved. A safer custody meeting had been established in November 2007. Meetings were held bi-monthly, chaired by the deputy governor and attended by relevant staff and some community representatives including youth justice, Samaritans and sometimes the police. Prisoner representatives did not attend. The meeting discussed policy developments in a range of safer custody areas in addition to suicide prevention and self-harm, including bullying, substance misuse and foreign nationals and made strong links between safety and the early days of custody. Good connections were made with the development of first night procedures, drugs issues and the needs of foreign national prisoners. The ACCT coordinator maintained a database of ACCT procedures that included an audit check of the quality of documentation, which was discussed at the meeting. Incidents of self-harm and accidental injuries were collated separately under health and safety and were not analysed in detail at the safer custody meetings to identify any particular trends between the different prisoner groups.

Further recommendations

2.74 Prisoners' views should be incorporated into the safer custody meeting.

2.75 The extent and nature of self-harm should be monitored and analysed at safer custody meetings.

2.76 The recommendations from the report of the investigation into the death in custody in 2004 should be shared with all senior managers and an action plan developed. (3.47)
Not achieved. No action plan had been developed. Although the report was now several years old, the recommendations involved some important safer custody areas such as the need to review first night risk assessment procedures and mental health screening. Some recommendations, including for a review of self-harm reduction policies, had been achieved through the introduction of the ACCT procedures, but progress on other recommendations had not been assessed. Such documents should be considered live documents and periodically reviewed to ensure that any progress has been sustained. The prison had recently received a draft report of a death from natural causes. Discussion about improving procedures had taken place at the safer custody meeting.
We repeat the recommendation.

2.77 Serious incidents of self-harm should be formally investigated to establish what, if any, lessons could be learned. (3.48)
Not achieved. Serious incidents of self-harm were not formally investigated to determine what lessons could be learned.
We repeat the recommendation.

2.78 Ligature points in the observation block cells should be eliminated. (3.49)
Not achieved. Although the number of ligature points had been reduced by replacing cell windows, there were many more. Obvious ones included the standard taps and furniture. There were no cells built to meet safer cell design specifications.
We repeat the recommendation.

2.79 The observation block cells should be used only in extreme cases for those at risk of suicide and self-harm and the emphasis should be placed on direct interaction with prisoners at risk, with less reliance on the use of cameras and observation as a method of monitoring. (3.50)
Partially achieved. The ACCT policy clearly outlined the role of staff when required to care for prisoners on 'constant observations'. Prisoners were allowed to have their normal possessions, unless these were considered to be a risk, and to participate in regime activities under supervision by an officer. In 2008, prisoners on open ACCT documents had been located in segregation only nine times. This had involved seven prisoners, three of whom had been placed in the segregation, care and progress unit (SCAPU) for observation as there were concerns about their mental health and potential to self-harm. Two had been held for five days and one for three weeks. The other four were placed there primarily for protection due to the nature of their offence, but were also on an ACCT document. The need to improve the monitoring of the use of the SCAPU had been raised at the safer custody meeting.

Further recommendation

2.80 The use of segregation for prisoners on open assessment, care in custody and teamwork (ACCT) documents should be scrutinised by the safer custody meetings to ensure that each use meets the exceptional circumstances criteria outlined in Prison Order 28 – ACCT Policy.

2.81 More resources should be developed to support prisoners at risk. These should include peer supporters (including in reception), a care suite, improved confidential access to the Samaritans, counselling and free telephone helplines. (3.51)
Partially achieved. There was still no peer support scheme or care suite. It had been decided that there were not enough prisoners serving long enough to provide a viable Listener scheme. An alternative peer support scheme was being considered. Prisoners could request to use mobile telephones directly linked to the Samaritans and could also call the Samaritans and many other helplines from landing telephones free of charge.

Further recommendation

2.82 Peer support and a care suite for prisoners to provide this should be developed.

2.83 Night procedures should be improved. Staff working at night should be trained to deal with emergencies. (3.52)
Partially achieved. All officers carried ligature cutters and all cell keys were now kept in sealed pouches. Local instructions about night procedures introduced since our last inspection described the actions required when cells needed to be unlocked at night and when staff had

to respond to self-harm incidents. Staff worked nights on a rota, but had not had specific training. We were told that efforts were made to learn through post-incident debriefs. There had been no contingency exercises during the night state. The last death in the prison from natural causes in July 2008 had re-focused attention on night procedures.

Further recommendation

2.84 There should be occasional exercises during the night state to test contingency plans for incidents that could occur.

2.85 Ligature cutters should be easily accessible. (3.53)
Achieved. All officers carried ligature cutters on their belts.

Additional information

2.86 Operationally, safer custody was led by a principal officer, and a senior officer acted as ACCT coordinator. There was still relatively little self-harm, with two or three incidents a month. There had been 18 incidents involving 10 prisoners in 2008. One prisoner had accounted for seven incidents. Forms used to record details of self-inflicted injuries did not include a diagram of a woman. Six or seven ACCT documents were opened each month. Five were opened during the inspection, three of which were for women.

2.87 Although prisoners were not invited to attend, weekly risk management meetings usefully reviewed prisoners at risk. Support plans developed from these meetings were individual to the prisoner, but were not always reflected in the ACCT care maps. There were some good quality entries evidencing an effective level of care in the ongoing records.

Further recommendation

2.88 The discussion and care plans developed at the risk management meetings should be reflected accurately in the assessment, care in custody and teamwork (ACCT) document.

Child protection

2.89 Comprehensive individual vulnerability assessments should be carried out for each child. (3.62)
Not achieved. No formal needs assessment was carried out on children. Staff often treated children more sensitively than older prisoners, but this could not always be guaranteed because it was done on an ad hoc basis.
We repeat the recommendation.

2.90 Comprehensive risk assessments should be carried out to manage activities when children, young adults and adult prisoners are mixed. Risk assessments should specify adequate levels of supervision. (3.63)
Not achieved. Risk assessments were not carried out. There was always some level of staff supervision where mixing took place, but this was not 'scaled' to meet the particular level of risk.
We repeat the recommendation.

Additional information

2.91 The profile of child protection work had risen. The prison was now regularly represented at the island child protection committee, which allowed information to be shared more effectively. A local child protection policy had been produced in draft. Most discipline staff had received child protection training delivered by colleagues in the police and probation departments.

2.92 Records indicated that fewer young people and children were admitted to the prison and only one 17 year-old girl was being held during the inspection. This may have been partly due to the introduction of community service some two years previously. Some staff worked hard to meet the needs of children, but no distinction was made between juveniles and young adults. No senior person had been allocated responsibility for children and this area of work had not yet been given sufficient priority. Prison staff had been actively involved in helping to develop the new welfare-based children's legislation, which was due to be introduced later in 2009.

Further recommendation

2.93 A senior manager should be allocated responsibility for children.

Race relations

2.94 A clear race and diversity policy should be produced and promoted, supported and implemented by all in the prison, with a designated manager responsible. (3.68)
Not achieved. An 'equal opportunity, sexual and racial discrimination' order had been issued in 2007, but mostly related to staff. There was no such policy for prisoners, although a manager was in place to monitor this area.
We repeat the recommendation.

2.95 A confidential racist incident report system should be established and all racist incidents should be challenged and investigated. (3.69)
Not achieved. There was no racist incident reporting system and any complaints had to be submitted through the standard complaint route.
We repeat the recommendation.

2.96 Staff and prisoners should receive race relations training. (3.70)
Not achieved. There had been no race relations training for staff and no specific race and diversity training package was available.
We repeat the recommendation.

Additional information

2.97 There was a race equality policy, but there was no monitoring of ethnicity in any area, such as release on temporary licence or good order.

2.98 There was no race equality staff post and no obvious promotion of racial or cultural diversity. Some prisoners said a significant amount of name calling and abuse went unchallenged by staff. Derogatory names about Portuguese nationals were said to be particularly commonplace. No prisoners were trained in race awareness or acted as diversity representatives.

2.99 The lack of a confidential reporting system for racial matters meant that prisoners did not have enough confidence to report concerns and poor behaviour by prisoners or staff could go unchallenged.

Further recommendation

2.100 Prisoners should be trained as diversity and race equality representatives and given the support of senior managers to promote race equality.

Foreign nationals

2.101 Information about the position of foreign national and UK prisoners in Guernsey including transfer arrangements to the UK should be published for prisoners, their families and staff. (3.77)
Partially achieved. A comprehensive foreign national policy had been updated in 2009 and was available to staff, but had not yet been published to prisoners.

Further recommendation

2.102 The foreign national policy should be published and promoted to all prisoners.

2.103 Foreign national prisoners should be consulted about their specific needs and involved with staff in helping to support each other. (3.78)
Not achieved. There were no formal consultation arrangements, although there were some good individual arrangements (see additional information).
We repeat the recommendation.

Additional information

2.104 Foreign national matters received better attention than race issues. The proportion of foreign national prisoners had risen from 12% to 21% in the previous 12 months. There were 14 foreign national prisoners, half of whom were Portuguese. A foreign national coordinator visited weekly and carried out some translation for Portuguese nationals. There were some good individual arrangements, including that prisoners could access translators free of charge through their telephone account and received additional credit. Prisoners complained that the telephone credit did not equate to a 20-minute telephone call as advertised, but the tariffs used were up to date. No meetings were held with foreign national prisoners to discuss concerns.

Family and friends

2.105 Prisoners who are the primary carers of children should be allowed free telephone calls to deal with issues affecting their children and should also be able to receive incoming calls to help keep them in touch. (3.96)
Partially achieved. Wing files indicated that prisoners were given telephone calls to maintain contact with their children and families, but incoming telephone calls were not possible. There was no formal policy describing support for primary carers and ensuring a consistent approach.

Further recommendation

2.106 A formal policy should be introduced to identify primary carers and ensure that they are able to maintain regular contact with their children.

2.107 Prisoners should be able to use the telephones in private. (3.97)
Not achieved. Some telephones were in booths that had originally contained a toilet, but these did not have a door and provided only minimal privacy. Other telephones offered no privacy at all.
We repeat the recommendation.

2.108 Information about visits and maintaining family contact should be published and displayed for both prisoners and visitors. (3.98)
Achieved. Prisoners were given a booklet about contact and information for visitors was displayed in the visits waiting areas.

2.109 Prisoners should be able to exchange visits for telephone cards in line with the published operational order number 8 (March 2005). (3.99)
Not achieved. Prisoners could not exchange unused visits for extra telephone credit.

Further recommendation

2.110 Prisoners should be able to exchange their unused visits entitlement for extra telephone credit.

2.111 A female officer should be available to search female visitors. (3.100)
Achieved. Female officers searched women visitors.

2.112 The opportunity to arrange an extended and alternative visiting time should be available to visitors travelling long distances. (3.101)
Achieved. Extended visits could be arranged on weekend mornings.

2.113 Staff working in the visits room should receive child protection training. (3.102)
Achieved. All staff had received child protection training.

Applications and complaints

2.114 There should be clear procedures setting out how applications and complaints are made. These should be explained to all new prisoners and displayed prominently on the residential units. (3.116)
Partially achieved. The applications procedure was included in the information booklet given to new arrivals, but the complaints procedure was not. The complaints procedure was comprehensively described in governor's operational order No.23 (February 2006), but this was not displayed to prisoners.

Further recommendation

2.115 The application and complaints procedures should be displayed prominently on wing notice boards.

2.116 Prisoners should not be required to hand complaints to staff but should be able to submit complaints confidentially. (3.117)
Partially achieved. Prisoners had to ask a wing officer for a complaint form, which did not provide anonymity should the prisoner want to make a confidential complaint. Completed forms could be posted in a locked box on the lower corridor.

Further recommendation

2.117 Complaint forms should be freely available without prisoners having to request them.

2.118 Applications and complaints should be logged and there should be a clear audit trail to allow for monitoring of the timeliness and the quality of replies. (3.118)
Partially achieved. Under a new applications system, prisoners completed a single application form for a range of requests and queries. This provided three copies, one retained by the prisoner, but applications submitted were not logged. Complaints were collected from the locked complaints box by administration staff, logged and given a number and the dates from receipt to completion were tracked. Prisoners were sent an acknowledgement of receipt of their complaint. Sixty-one complaints had been submitted in 2008 and 86% had been answered within the required timescales.

Further recommendation

2.119 The submission and receipt of completed applications forms should be logged.

Healthcare

2.120 A clinical manager with relevant skills and competencies should lead the healthcare department and be a member of the prison senior management team. (4.47)
Achieved. The healthcare manager was a registered general nurse and a specialist nurse practitioner in community nursing. She had been in post for about two years and was a member of the senior management team. She was employed by the Health and Social Services Department (HSSD), which now provided nursing services to the prison.

2.121 Emergency equipment and medications, including oxygen, should be available in the dental suite when patients are receiving treatment. (4.48)
Partially achieved. There was oxygen in the surgery at all times, but the emergency equipment was held in the centre rather than in the surgery. The only drugs held in the emergency kit were aspirin and an Epipen.
We repeat the recommendation.

2.122 The emergency equipment should include a full range of kit, including drugs and equipment for use with paediatrics. (4.49)
Achieved. A large grab bag with a range of kit and an automated external defibrillator were held in the centre office. There was a range of airway sizes for adults and children. The bag contained an Epipen.

2.123 All emergency equipment should be checked at least weekly and an auditable log kept. (4.50)
Achieved. There were documented checks of the emergency equipment. In the previous three months, it had been checked at least weekly.

2.124 A skill mix review should be undertaken and subsequent recruitment of staff to meet the needs of the population served and the work to be undertaken (including administrative tasks). (4.51)
Not achieved. There had been no skill mix review, although discussions with HSSD managers had resulted in the appointment of a part-time administration officer. She had started to set up systems and processes, such as monitoring cancelled hospital appointments. Interviews were under way for another band 6 nurse, but there had been no consideration of the employment of a healthcare assistant. However, the HSSD was limited in the number of staff it could employ and retention of staff was also an issue.
We repeat the recommendation.

2.125 Local up-to-date and relevant clinical and procedural policies should be developed to reflect best and evidence-based practice such as NICE and NIMHE guidelines. (4.52)
Not achieved. There were no clinical and procedural policies that reflected best and evidence-based practice. Nursing staff were aware of the need for such policies and there had been some recent discussions with the GPs about developing these. Policies used by other prisons or by community nurses on the island had not been adapted for use.
We repeat the recommendation.

2.126 All healthcare professionals should have at least annual resuscitation training, preferably 'first on scene' training. This should include the use of the automated external defibrillator. (4.53)
Achieved. Records showed that all the nurses had received mandatory training within the previous 12 months. This included basic life support, use of the automated external defibrillator, anaphylaxis training, lifting and handling and infection control procedures.

2.127 All staff should have clinical supervision. (4.54)
Achieved. A lecturer practitioner from the HSSD provided group supervision for the band 6 nurses and one-to-one supervision for the healthcare manager.

2.128 All arrangements and contacts with local health services (including pharmacy services) should be subject to a service level agreement and monitored for compliance. (4.55)
Not achieved. There were no formal agreements with local health services, such as the GPs and the pharmacy services. As a result, there was no audit or monitoring of services provided and no service level agreement for the provision of GP services. A draft partnership agreement dated February 2008 stated that no formal agreement had ever been put in place, although it had been agreed at a meeting in February 2007 that a revision of care was needed.
We repeat the recommendation.

2.129 The reception screening form should be customised to meet the needs of different groups of prisoners, such as children and women. (4.56)
Partially achieved. The form had been redesigned, but was long and unsuitable as a first reception screen. There was a section for the nurse to determine location and level of supervision, which included the option of locating the prisoner on a detoxification wing even though there was no such wing at the prison. The first reception screen was too detailed for new arrivals and contributed to delays in reception. There was no second screen to confirm the information given. All new arrivals were also seen by a GP, which appeared unnecessary.

Further recommendations

2.130 During reception, prisoners' immediate health and social care needs should be identified, documented and responded to promptly using a reception screening tool.

2.131 Following reception screening, prisoners should have a further health assessment carried out within 72-hours of arrival.

2.132 The status of police-untried prisoners in relation to the duty of care provided by healthcare staff should be clarified. (4.57)
Achieved. Police-untried prisoners (PUPs) were no longer routinely sent to the prison. When the police cells were full, prisoners were held in customs cells and would be brought to the prison only in extreme circumstances. Healthcare staff were confident that they would have a say in whether PUPs were fit to remain in custody at the prison, but there was no formal contingency plan.

Further recommendation

2.133 There should be healthcare contingency plans for the rare occasions when police-untried prisoners are held at the prison to ensure that their healthcare needs can be met.

2.134 A woman GP should be available for the woman prisoners, who should be informed of this. (4.58)
Not achieved. Women prisoners were aware that a female GP had until recently been available at the prison, even though there was nothing in writing to let them know they could ask to see her. However, this GP had recently stopped visiting the prison and had not been replaced.
We repeat the recommendation.

2.135 Healthcare staff should assess patients using triage algorithms to ensure consistency of assessment and care delivered. (4.59)
Not achieved. There were no triage algorithms, although the healthcare manager had developed some and these had been sent to the HSSD for approval.
We repeat the recommendation.

2.136 There should be proper arrangements for the monitoring and care of patients with long-term conditions such as diabetes and respiratory conditions. Arrangements for health screening such as mammography should be formalised, as should the arrangements for annual health assessments. (4.60)
Not achieved. Under informal arrangements, specialist nursing staff from the community came in to see patients with long-term conditions who had previously been under their care. However, it was less clear how a patient with a life-long condition either diagnosed in prison or who was not known to community services would be managed. There were no arrangements for health screening or annual health assessments. We met one woman who was eligible and overdue for both mammography and cervical screening, but neither had been organised.
We repeat the recommendation.

2.137 Hepatitis B vaccinations should be offered to all prisoners. (4.61)
Not achieved. Prisoners were asked about vaccination status during their reception health screen, but no one was routinely offered hepatitis B or any other vaccinations, although influenza vaccinations had recently been offered. Prison officers were advised by their occupational health adviser to have hepatitis B vaccinations before working in the prison. Health promotion advice was limited and prisoners did not have access to condoms or other barrier protection.
We repeat the recommendation.

Further recommendations

2.138 All prisoners should be given information about health promotion and the control of communicable diseases and should have access to disease prevention and screening programmes that mirror national and local campaigns.

2.139 Condoms and other barrier protection should be available to all prisoners.

2.140 Appropriate lockable metal cabinets should be provided to ensure that all medicines can be securely locked away when not in use. It may be necessary to assess whether the current pharmacy area is large enough to house extra cabinets. (4.62)
Achieved. The pharmacy area had been moved and medications were stored in large metal cupboards and two medication trolleys. A hatch opened on to the main corridor where prisoners collected their medications. There was a fridge to store thermolabile medications. Staff recorded the fridge temperature daily, but not minimum and maximum temperatures.

Further recommendation

2.141 Maximum/minimum temperatures of the drugs fridge should be recorded daily to ensure that thermolabile items are stored within the 2 to 8 degrees Celsius range.

2.142 The use of monitored dosage systems for repacking dispensed items intended for administration at the treatment room should be reviewed as the system is bulky, costly and may not actually be helpful to healthcare staff in carrying out the administration of medication. (4.63)
Achieved. Medications were supplied for named patients in their original packages from the community pharmacy. However, there was no stock control and we found many patient-named medications put back into stock, which was bad practice.

Further recommendations

2.143 Patient-named medications should not be used as stock.

2.144 Discontinued medicines should be clearly quarantined to avoid any possibility of re-use.

2.145 There should be formal arrangements for the return and destruction of unused medications.

2.146 A medicines and therapeutics committee should be established involving representatives of all of the healthcare team. Membership should include the Island's chief/government pharmacist. The committee should develop and formally adopt procedures relating to the medicines within the prison, such as in-possession, special sick, patient group directions and stock medications. The committee should develop or adopt an evidence-based drug formulary for the prison. Consideration should be given in the future to contracting for a full pharmaceutical service in line with the 'Department of Health Pharmacy Services for Prisons Report 2003'. This recommendation should be examined in conjunction with the local Guernsey legislation covering such practices. (4.64)
Not achieved. A therapeutics committee met quarterly attended by staff from the prison healthcare department and the HSSD, the island's prescribing adviser and the local pharmacist. However, the committee lacked focus. There were no formal agreements for stock

levels or an evidence-based drug formulary for the prison. A draft in possession policy had yet to be ratified and implemented. There were no patient group directions, although we were told that some for the administration of paracetamol, ibuprofen, Sudafed and simple laxatives were being developed, despite the fact that such medications could be bought over the counter and actually required only a 'special sick' policy for administration in a prison setting.
We repeat the recommendation.

2.147 Prisoners should have access to a pharmacist or pharmacy technician as they would in the community. This could include medicines management, compliance reviews and minor ailment clinics. (4.65)
Not achieved. The pharmacy service was a 'supply only' service. The pharmacist did not visit the prison and prisoners were unable to consult with a pharmacist as they could in the community. There were plans to tender for a full pharmacy service.
We repeat the recommendation.

2.148 The number of cancelled hospital appointments should be recorded and monitored to ensure that prisoners are not being disadvantaged. (4.66)
Partially achieved. The administration officer had begun to record cancelled appointments and the reasons. However, the system was in its infancy and did not include all altered appointments. If another patient was slotted into the appointment (for example, if the hospital had altered an appointment date), then the first patient's cancellation was not recorded. In the previous three months, 18 out of about 57 booked appointments had been cancelled, 10 by the prison (including one due to inclement weather). The reason for the cancellation of three other appointments was recorded as 'consultant chose not to treat', which was of concern to us, but had apparently not been robustly challenged at the time.
We repeat the recommendation.

2.149 There should be day care provision for prisoners less able to cope with life on the wings. (4.67)
Not achieved. There was no day care provision. Primary mental health services were limited, which we understood reflected an island-wide problem. Two registered mental health nurses (RMNs) carried out generic nursing duties, but also tried to maintain contact with specific patients identified as having mental health needs, although there were no clear guidelines for referral to the RMNs (see also additional information).
We repeat the recommendation.

Additional information

2.150 The provision of health services to prisoners was fragmented across several agencies. The HSSD had taken over the provision of nursing services about two years previously, but other services such as the GPs, pharmacy, dentist, physiotherapist and other allied health professionals were provided under arrangements made directly between the prison and the provider. This was problematic because there was no overarching clinical governance framework to ensure the delivery of a safe, quality service, nor were there systems to monitor performance.

2.151 The HSSD involvement meant the prison had good links with community services, which was of benefit to prisoners. No nurse-led clinics were run in the prison.

2.152 Clinical records were paper based and there were no firm plans to include the prison in the electronic health and social care records being developed for the island. Records were of a reasonable standard, but patients seen by the consultant psychiatrist did not have full contemporaneous records. Consultations were not documented at the time and typed notes

were sent to the prison the next day. Letters from other health professionals arranged by the mental health team were not kept in the prisoner's clinical record, but only in their mental health records at the local mental health hospital. This was poor practice.

2.153 Provision of allied health professionals (AHPs) was good. A dentist provided one session a week and the wait for a routine appointment was only a week. Prisoners with acute dental problems were taken out for treatment. Other AHPs included a physiotherapist, an osteopath and a virologist who provided a sexual health clinic.

2.154 Secondary mental health care consisted of one session of a psychiatric consultant a week, but no comprehensive records were kept of her caseload. There was no monitoring of prisoners referred to secondary and tertiary mental health services. One prisoner waiting for transfer to a secure mental health bed in the UK had recently written to his consultant commenting that he had already waited at least 15 months. This was unacceptably long. Another prisoner had been referred for assessment two months previously, but was still waiting to be seen.

Further recommendations

2.155 There should be robust clinical governance arrangements to ensure the delivery of a safe, quality service from all personnel providing health services to prisoners.

2.156 All clinical records should be complete and written contemporaneously.

2.157 Multi-professional primary, secondary and tertiary mental health services should be available from staff with appropriate skills.

2.158 Primary mental health services should include talking and other appropriate therapies for those with mild to moderate mental health problems.

2.159 Prisoners needing assessment by specialist mental health services should be seen within seven days of referral and transferred expeditiously to secondary and tertiary care as clinically indicated.

Education and library provision

2.160 An educational needs analysis should be undertaken. (5.13)
Not achieved. Prisoners' educational and vocational training requirements had not been assessed. The prison lacked a clear understanding of learning and skills needs.
We repeat the recommendation.

2.161 Prisoners should be assessed for their educational needs within a week of arrival. (5.14)
Achieved. All prisoners were given an education induction within their first week and were given clear advice and guidance following the initial assessment of their literacy and numeracy needs. Education staff discussed the options with them, although written information was not made available or advertised on the wings.

2.162 Initial assessments should be linked to sentence plans. (5.15)
Achieved. Staff from the education department ensured that all prisoners were given a basic skills test at induction. Results were given to prisoners for information and recorded on the PIMS. This information was also transferred to sentence plans and available to all staff.

2.163 Weekend and evening education provision should be introduced. (5.16)
Not achieved. The range of education courses remained inadequate. No weekend or evening education was provided and insufficient use was made of the daytime activity hours to maximise the provision. Education staff were experienced and enthusiastic, but employed only part-time and did not have enough hours to provide a full and efficient service. Young prisoners were particularly disadvantaged by the narrow breadth of education courses and the lack of vocational training opportunities.

2.164 The curriculum should be developed to offer a wider range of core subjects and enrichment activities. (5.17)
Not achieved. A high proportion of prisoners attended education, but mostly for only short periods each week. The breadth of the curriculum remained poor, with no vocational qualifications offered and a limited range of courses in education. Many Friday classes were cancelled throughout the year due to shutdowns for staff training or college staff holidays. Education courses primarily focused on GCSEs, A levels, information technology (IT), literacy and numeracy, and English for speakers of other languages (ESOL). A small number of prisoners were completing distance learning courses.
We repeat the recommendation.

2.165 The number of tutorial staff should be increased to meet the demand for private study and distance learning support. (5.18)
Achieved. The number of qualified staff available to support prisoners on distance learning programmes and private study was adequate. A part-time member of staff who worked for Guernsey College of Further Education provided good individual tutorial support for the small number of prisoners who needed it.

Work

2.166 There should be equality of access to work and training opportunities for all prisoners. (5.25)
Not achieved. Access to work and training opportunities remained poor for some groups as most employment was available only to adult men. Female, young and vulnerable prisoners had little opportunity to access purposeful employment. Jobs were advertised on the wings, but there was no indication whether these were available for specific groups.
We repeat the recommendation.

2.167 Allocation to work should be linked to sentence plans and initial assessments in accordance with the prescribed allocation procedure and monitored. (5.26)
Not achieved. There were insufficient criteria or guidelines to ensure complete transparency at the weekly board for work allocation. Prisoners who were unsuccessful in their applications for employment were not informed of the reasons why and had little opportunity to appeal.
We repeat the recommendation.

Additional information

2.168 Education staff were enthusiastic and experienced, and teaching and learning were generally good. Staff ensured that additional information was written onto sentence plans following the initial assessment of a prisoner's basic skills to give a clear interpretation of the results. However, sentence plans were not used effectively to inform decisions about employability. Supervision of mixed groups of prisoners had improved and classroom activities were well managed, but no individual risk assessment was undertaken. Education was contracted out to the local college of further education, but the prison did not monitor the quality of this provision.

2.169 Education, the library and vocational training were uncoordinated and lacked clear strategic direction, although the prison had recently employed a head of learning and skills who was due to start soon. The pay structure had not changed and remained linked to the prisoner's incentives and earned privileges (IEP) level. This did little to encourage prisoners to participate in education.

2.170 There was no pre-release course to help prepare prisoners for employment or resettlement in the community. Prisoners had insufficient support with writing CVs or guidance on interview techniques. There were too few links with employers and support agencies to help with settlement on release.

2.171 There was particularly poor access to the library, which was open only one evening a week for about 45 minutes. The range of books and other learning materials was poor and did not cater sufficiently for the wide population in the prison. Prisoners had no access to computers unless they participated in an IT course.

Further recommendations

2.172 A pre-release course should be offered to all prisoners nearing the end of their sentence to assist in resettlement.

2.173 The pay structure should be revised to ensure equal access to learning and skills provision for all.

2.174 Library opening hours should be extended to allow good and equitable access for all prisoners.

2.175 A wider range of books and other learning materials should be made available in the library to meet all prisoners' needs.

Physical education and health promotion

2.176 Prisoners should be escorted to physical education sessions on time. (5.33)
Achieved. Prisoners were escorted to supervised physical education (PE) sessions and mostly arrived on time.

2.177 There should be opportunities to gain qualifications through the core sport programme. (5.34)
Not achieved. Supervised PE sessions were poorly structured and planned and there were no opportunities for prisoners to gain vocational qualifications. There was a limited amount of supervised provision for prisoners and sessions were cancelled if the supervisor was not available. Most PE activity was unsupervised.
We repeat the recommendation.

2.178 There should be equality of access to sport facilities for all prisoners. (5.35)
Achieved. Prisoners had reasonable access to sport facilities either on their wings or in the weights and cardiovascular rooms.

2.179 Take-up of sport opportunities should be monitored. (5.36)
Not achieved. There were no attendance records for prisoners who undertook supervised sport activities and no records were kept of those who participated in unsupervised PE.
We repeat the recommendation.

Additional information

2.180 Sport facilities were satisfactory, although the cardiovascular equipment was inappropriately housed in an old shower room. Facilities were underutilised due to the lack of qualified PE staff. Supervised PE sessions were contracted to an external organisation, but the prison did not monitor the contract for quality or compliance. There was no PE programme to encourage the active participation of older prisoners and inadequate links with healthcare, with no remedial PE provision. Promotion of healthy living was poor.

2.181 PE inductions were not thorough or recorded. Prisoners and staff had little awareness of health and safety and the dangers relating to the unsupervised use of free weights and other equipment. With a significant proportion of PE activity unsupervised, prisoners were at potential risk of injury. Prisoners who took part in unsupervised PE were generally unqualified and some did not have appropriate sports wear.

Further recommendations

2.182 A wide ranging and well structured sports programme should be provided by fully qualified PE staff to meet the needs of all prisoners.

2.183 A thorough PE induction programme that is fully monitored and recorded should be put in place for all new and existing prisoners.

2.184 All prisoners should have access to, and wear, appropriate sports clothing when participating in PE activity.

Faith and religious activity

2.185 The chapel should be brought into commission. (5.45)
Achieved. A large room on the upper corridor had been dedicated as a chapel and was also used as a multi-faith room. The high numbers attending meant the main ecumenical service was held each Sunday afternoon in the visits room. The multi-faith room was used for a woman's prayer group on Tuesday evenings and for other occasional activities. Music classes facilitated through the chaplaincy were also held in this room.

2.186 Prisoners of all religions should have the opportunity to attend an act of worship or faith meeting for at least one hour a week. (5.46)
Partially achieved. Almost half of prisoners were atheist or agnostic and half were from Christian traditions. One prisoner was a humanist, one was Muslim and one said he had no religion. Prisoners of non-Christian faiths had not requested visits from specific faith leaders. There was little religious diversity on the island and some faith leaders were not available. The nearest Muslim chaplain was at HMP Winchester. The part-time chaplain was alert to the difficulties and had to make arrangements to meet the faith needs of individual prisoners as they arose. Copies of the Qu'ran were available on request. Vulnerable prisoners could not attend the main Sunday service. A service was offered approximately monthly, but numbers were low and chaplaincy volunteers responded to individual requests.

Further recommendation

2.187 Vulnerable prisoners should have the opportunity to attend a religious service weekly.

2.188 Prisoners should be stopped from attending services only on the basis of individual risk assessments rather than group assessments. (5.47)
Achieved. Prisoners were not banned from services unless this was warranted by an individual assessment. The main Sunday service was a mixed service and, while this heightened concerns, few individuals had ever been stopped from attending.

2.189 Prisoners should have access to a chaplain of their own faith when they are available in Guernsey. (5.48)
Not achieved. There was not a diverse range of faith leaders on the island and the chaplain had to meet the religious needs of prisoners from minority faiths as they arose and in whatever way he could. Prisoners had poor access to chaplains from the major Christian faiths. A quarter of prisoners were Roman Catholic and a fifth Church of England, but there were no weekly services for these denominations. The prison relied on the voluntary support of these chaplains, who attended irregularly due to parish commitments, but would visit if specifically requested. The Roman Catholic priest had not visited the prison for around five weeks.

Further recommendation

2.190 The prison should provide funding to employ sessional chaplains from appropriate denominations.

2.191 The prison chaplain should have access to the prison computer database in order to fulfil his duties. (5.49)
Achieved. The chaplain had access to the PIMS.

2.192 Chaplains should be included in the reviews and support plans for vulnerable prisoners as part of their pastoral work. (5.50)
Achieved. The chaplain attended the weekly risk management meetings when the support plans for vulnerable prisoners were discussed.

2.193 Chaplains should be facilitated to provide religious classes, prayer groups or other supervised activities. (5.51)
Achieved. The chaplaincy provided two evening prayer groups and facilitated a music group. It also periodically ran an Alpha course and offered practical support with family visits. Over the previous 18 months, the chaplaincy had hosted three missions, each lasting three days, and others were planned for 2009.

Additional information

2.194 The chaplaincy was under-resourced. The part-time chaplain, an ordained Baptist minister, received an honorarium to cover the 18 hours he worked in the prison. He was the only chaplain who received any remuneration. There was a heavy reliance on the voluntary support of visiting chaplains when they were available. There was strong support from two Pentecostal volunteers. The chaplain did not have a budget and some significant costs for chaplaincy activities had been paid for by local parishes.

2.195 A high proportion of prisoners attended the main Sunday service. On most weeks, 30 to 40 attended. This was a mixed service for all prisoners except vulnerable prisoners. Men and women sat separately, but were allowed to mix for coffee at the end, which caused some staff to question the motivation for prisoners' attendance. Three or four officers attended and the strict 'no touch' rule was enforced.

2.196 The chaplain and volunteers were more integrated into the work of the prison and some links had been developed with community groups, including proposals for the development of a local hostel for ex-offenders. There were also links with a local bereavement counselling service.

Further recommendation

2.197 The chaplaincy should be given an appropriate budget to support the development of chaplaincy activities.

Time out of cell

2.198 All prisoners should be allowed a minimum of one hour's exercise each day and this should be recorded and monitored. (5.57)
Partially achieved. All prisoners were given one hour's exercise a day. Most, apart from those on the basic regime, were also offered a period of 35 to 50 minutes of core sport that could also be in the fresh air. There was no record of how often exercise was cancelled, but prisoners did not complain about this.

Further recommendation

2.199 A record should be kept of the occasions and reasons that daily exercise in the fresh air is cancelled.

2.200 Prisoners who have unsupervised exercise in yards attached to their wing should be allowed access to the yard throughout the day. (5.58)
No longer applicable. All exercise was now supervised and was in more open areas.

2.201 The time out of cell on weekdays for unemployed prisoners should be increased. (5.59)
Not achieved. Providing prisoners were unlocked on time, the core day gave most prisoners 4.75 hours unlocked on weekdays, compared to about four at the previous inspection. This included meal times and opportunities to clean their cells. However, basic and standard level prisoners did not get association every day and on these days, their time out of cell was reduced to 2.75 hours.
We repeat the recommendation.

Additional information

2.202 Time out of cell varied widely between 11 hours a day for employed prisoners on the enhanced level to less than three hours for unemployed basic and standard prisoners. Too many prisoners were engaged in little regular and meaningful activity. On average, around 15 prisoners were locked up each morning and afternoon activity period. On one mid-morning check, we found over 60% of prisoners on the wings either locked up or with little constructive activity other than cleaning.

Security and rules

2.203 Intelligence available from staff, prisoners, adjudication evidence and bullying investigations should be collated and used to target security responses. (6.11)
Achieved. A new security information system and intelligence evaluation system had been introduced and had improved the management of information.

2.204 So long as children, young adults and adults mix in the prison, supervision should be robust and work effectively to protect all prisoners. (6.12)
Partially achieved. Young male offenders were kept separately and the female unit was almost always supervised. Risk assessment protocols were in place and directed by a prison order. However, individual risk assessments for mixing children were insufficiently developed (see paragraph 2.90).

2.205 Closed visits should be used only in response to known risk to security in visits and not as a punitive measure against prisoners. (6.13)
Achieved. No prisoners had been on closed visits for some time. The procedures had changed and prisoners were placed on closed visits only in response to specific security risks.

2.206 The prison rules should be written clearly, made available to all prisoners and published on wing notice boards. (6.14)
Not achieved. Prisoners were given some information at induction and signed compacts related to telephone and television misuse. There was no explanation on display or in the induction booklet about do's and don'ts of the prison.
We repeat the recommendation.

2.207 Collective and unofficial punishments should not be used. (6.15)
Achieved. There was nothing to suggest that unofficial punishments were used. Although there were some examples in the electronic recording system of prisoners being put in their cells to calm down, there was no evidence of collective punishments for misdemeanours.

Additional information

2.208 There had been significant development in the area of security. The prison has adapted the England and Wales security strategy and had implemented a new intelligence system, employing a trained analyst and introducing new security information reports (SIRs). As a result, the number of SIRs received had increased significantly from 173 in 2008 to 272 in the first two months of 2009. The prison had taken on the "5*5" intelligence system from England and Wales and was working closely with Guernsey police and customs to increase information sharing. Police and customs staff were regular visitors to the prison and involved in joint operations. SIRs were dealt with expediently.

2.209 There was little evidence of drugs or mobile telephones and little was found in cell searches. The main security concern was the belief that 'legal highs' such as the smoking product 'spice' and opiate pain relief patches were being brought into the prison. These were not detectable as part of the drug testing process.

2.210 There was no system to authorise any intelligence-led searches, although this was about to be introduced. Some male prisoners in groups complained that they had been asked to squat during searches and this, although not routine and based on suspicion only, was not authorised on any record by senior managers.

Further recommendation

2.211 Any squat searching should be authorised by a senior manager and recorded.

Discipline

2.212 The Home Minister should consult with the Guernsey judicial authorities about the desirability of cases referred to the independent adjudicator being heard within one month. (6.36)
Achieved. See paragraph 2.11.

2.213 Prisoners subject to adjudication should be offered an opportunity to seek assistance or legal advice before the hearing. (6.37)
Partially achieved. Prisoners on serious charges that were to be heard by the independent adjudicator were given the opportunity to seek legal advice. However, legal advisers were not provided for adjudications held as part of internal procedures.

Further recommendation

2.214 Adjudicators should determine whether or not a case merits legal advice before hearing the charge. This should be documented.

2.215 Cellular confinement and segregation for reasons of good order or discipline should not be used interchangeably and the correct criteria should be met for each of these different decisions. (6.38)
Partially achieved. The segregation guidelines clearly specified how cellular confinement and good order should be used, but we did see some cases where prisoners serving cellular confinement were placed on Prison Rule 34. This happened rarely and procedures were mostly followed properly.

Further recommendation

2.216 Staff working in the segregation unit should be given refresher training to ensure that they are familiar with the correct protocols.

2.217 All incidents when control and restraint teams are deployed and all use of force should be fully recorded centrally and authorised and monitored by senior managers for trends that emerge over time. (6.39)
Partially achieved. Use of force was rare. Incidents were documented properly and were authorised at the appropriate level. Although most incidents were planned, they were not filmed. We were told that incidents were logged on a spreadsheet and reviewed by the control and restraint instructor. However, this was not available and there was no other evidence that senior managers regularly scrutinised incidents or reviewed the documentation to ensure that incidents were managed properly. Use of force was not examined at other forums such as the security committee, where it would have been appropriate to do so as part of a standing agenda item.

Further recommendations

2.218 All planned incidents should be video recorded and attended by a senior manager and healthcare staff.

2.219 Any incidents of use of force should be examined by managers at the security committee.

Additional information

2.220 Use of force was low and proportionate and 95% of staff were in date with control and restraint training. Instructors regularly received refresher training. There had been 16 incidents of use of force in 2008. In most cases, the force used appeared proportionate to the incident and forms were well completed, with sufficient detail. There were no reports of injury forms, although healthcare logged that they had seen prisoners. One female prisoner had been strip searched under restraint after refusing a random search. This did not appear necessary as there was no suspicion that she was secreting anything and she was not behaving in a violent way.

Further recommendation

2.221 Strip searching under restraint should take place only in the most extreme situations and be authorised by the most senior manager on duty.

2.222 Protocols should be put in place to manage situations when clothes or furniture are removed from prisoners. This should include a risk assessment, time limitations and authorisation by a senior manager. Each incident should be recorded and reviewed to ensure that it is managed correctly with trends monitored over time. (6.40)
Not achieved. There were no protocols to determine these arrangements. In some of the SCAPU cells, only cardboard furniture was available and some of this had been classified as unsuitable for the purpose. Only the two cells nominally for women prisoners had permanent furniture.
We repeat the recommendation.

2.223 The observation unit should be staffed at all times. (6.41)
Not achieved. The unit was staffed during the day when prisoners were located there, but had only a roving patrol during the night. Although camera cover was used, this was unsafe, particularly as some prisoners located there were acutely vulnerable.
We repeat the recommendation.

2.224 All prisoners in segregation should have clear care plans in which they are involved and which include support from staff and clear targets. (6.42)
Partially achieved. Prisoners placed in the unit were given an individual care and progress plan. These set behavioural targets and actions for how individuals were to be managed. Prisoners were also reviewed every Friday as part of a risk management meeting chaired by the duty manager and attended by healthcare, the chaplaincy, probation and the substance misuse worker. However, individual care plans were not shared with staff and targets were not put on the main electronic computer system used by all staff.

Further recommendation

2.225 Individual care plans that include management actions about moving out of segregation should be shared with all staff and placed on the electronic prisoner information system.

2.226 The observation unit should be thoroughly deep cleaned and managers should ensure that it is kept clean and in good order. (6.43)
Achieved. Although austere the segregation unit was clean, well maintained and subject to a regular painting and cleaning schedule.

Additional information

2.227 The observation unit had been renamed and was now called the segregation, care and progress unit (SCAPU). The unit was much cleaner, but basic in design. The cells were nominally separated into male and female areas, with two designated cells for police prisoners. In reality, the accommodation was used according to risk and need and no police prisoners had been located there for over a year. The guidelines governing the use of the SCAPU had been revised in 2008. It was supposed to be used for those under disciplinary investigations, those separated under Prison Rule 34 (own protection or good order), cellular confinement and those exhibiting refractory or violent behaviour.

2.228 There was no central record or log of how often the SCAPU had been used and for what reason, although it was possible to interrogate cell usage through the prisoner information system. The unit had been used 55 times in 2008. Records indicated that the main reason was Rule 34. The unit had sometimes been used for prisoners requesting 'time out' from the residential wings.

2.229 In some cases, prisoners had an open ACCT. This was not always the main reason for their location, although some had been placed there for camera observation (see also section on suicide and self-harm). Three prisoners had been located there because they were detoxifying from drugs or alcohol. Management information about why the SCAPU was used was not routinely analysed, although the electronic data system meant this would have been straightforward.

Further recommendation

2.230 Information relating to the use of the segregation, care and progress unit should be routinely analysed for ethnicity, gender, reasons for segregation and time spent in the unit in order to evaluate any trends and to ensure the unit is used appropriately.

Incentives and earned privileges

2.231 Prisoners should be informed verbally and in writing when a warning is issued. (6.52)
Achieved. Records indicated that this now happened. When a warning was given, prisoners were called to see the senior officer as well as being given the warning in writing.

2.232 Prisoners should attend reviews when they are being demoted to basic level. (6.53)
Achieved. Prisoners could attend reviews when basic was being considered, but not all chose to do so.

2.233 The incentives and earned privileges scheme should not be linked to voluntary drug testing. (6.54)
Achieved. There was no voluntary drug testing scheme and the incentives and earned privileges (IEP) policy made no reference to any links to such a scheme.

2.234 Staff entries in wing records should be subject to regular management oversight. (6.55)
Not achieved. Although managers were able to see staff entries, there were no documented checks or comments from managers about the quality or quantity of entries (see also section on personal officers).
We repeat the recommendation.

2.235 The incentives and earned privileges scheme should be routinely monitored to ensure that it operates consistently and fairly and without disadvantage to any specific groups of prisoners. (6.56)
Not achieved. Some information about foreign nationals and their IEP status was collected, but there was no routine monitoring of whether the scheme operated fairly for all groups.

Catering

2.236 Ways of establishing prisoners' views of the catering provision should be developed through a food comments book, consultation and survey. (7.11)
Achieved. Prisoners could now raise issues about food at the monthly consultative meeting. A catering survey had also been conducted, but the results had not yet been compiled. Although there were no comments books on the wings, prisoners were satisfied that they could make comments to servery workers, which were dealt with constructively.

2.237 Food temperature checks from delivery to serving should be completed and cleaning schedules should be put in place, recorded and adhered to. (7.12)
Achieved. Records indicated that staff carried out temperature checks and implemented cleaning routines.

2.238 More opportunities for eating communally should be developed. (7.13)
Not achieved. Opportunities to eat together out of cell remained very limited and normally took place only on J wing and to a limited extent with the women on A wing. There was still considerable scope to extend this opportunity, particularly on the smaller wings.
We repeat the recommendation.

Prison shop

2.239 Opportunities for catalogue shopping should be provided for prisoners who have no one in the community able to supply additional items. (7.22)
Not achieved. There were no formal opportunities for prisoners to use catalogues to buy additional items.
We repeat the recommendation.

2.240 Prisoners should be consulted about the shop provision. (7.23)
Achieved. Shop provision was discussed as part of the prisoner consultative meetings and prisoners had been asked which items they wished to change.

2.241 The repayment arrangements for reception packs should be reviewed, particularly for those with no private cash. (7.24)
Achieved. Prisoners were given an advance smoker's pack and £3 telephone credit if they

arrived without any private cash. Repayment arrangements were made individually to ensure that prisoners could still spend money at the weekend canteen. Repayments normally took place over four instalments.

Additional information

2.242 The canteen list consisted of a pharmacy order (cosmetics, toiletries and simple medication), which was an arrangement with a local pharmacy, and a list for items such as smoking products, confectionary and snacks. The latter list was very limited and prisoners had requested more food items such as tinned products or snacks.

Further recommendation

2.243 The canteen list should be expanded to include more food items.

Resettlement strategy and reintegration planning

2.244 Pre-release courses should be offered to those needing employment on release. (8.17)
Not achieved. Prisoners still could not attend a pre-release course.
We repeat the recommendation.

2.245 Discharge arrangements should take account of the individual circumstances of each prisoner and their ability to claim benefits. (8.18)
Achieved. Each prisoner was allocated a probation officer. Local prisoners were allocated to island-based workers and those returning to the mainland or elsewhere were dealt with by the establishment-based probation officer. Each prisoner was seen individually by a probation officer before release and, where necessary, arrangements were made to make appointments with the relevant benefits agencies.

2.246 Prisoners with no accommodation should receive active help to find some before their release. (8.19)
Achieved. Every prisoner was routinely interviewed by a probation officer before release. Local prisoners seeking accommodation were put in touch with relevant services on the island and, where necessary, probation officers assisted prisoners returning elsewhere to make links with relevant agencies.

Additional information

2.247 The most significant development had been the introduction of an offender management unit consisting of a principal officer and a senior officer. Two or three officers were expected to be appointed as case supervisors. Although there was no formal resettlement policy and a needs analysis had still not been carried out, resettlement work was managed well. Regular fortnightly meetings took place between prison staff and representatives from the local probation department to discuss the implementation of offender management. The chief probation officer had close links with the deputy governor and they worked closely together on a number of joint projects. As all prisoners were allocated a named probation officer who maintained contact with them during their sentence, the spirit of the 'seamless sentence' envisaged under the offender management approach was already being followed.

Sentence and custody planning

2.248 Custody plans should be prepared for prisoners serving less than 15 months. (8.29)
Achieved. Under a recently introduced system, all prisoners had the opportunity to participate in planning arrangements.

2.249 Information about resettlement need should be taken into account in sentence planning. (8.30)
Partially achieved. The new planning arrangements placed more emphasis on the use of court reports and background information to help inform initial assessments. However, this did not happen in all cases and a number of existing files on long-term prisoners contained no reference to housing or employment needs.
We repeat the recommendation.

2.250 Sentence planning boards should receive contributions from other departments. (8.31)
Achieved. The administrative arrangements associated with the new planning system were efficient and ensured that written contributions were requested and received from relevant departments.

2.251 Sentence plan targets should be collated both to check on progress in achievement and to inform resettlement policy development. (8.32)
Not achieved. Cases were considered only on an individual basis and no attempt was made to collate or aggregate this type of material.
We repeat the recommendation.

Offending behaviour programmes

2.252 The needs of the prison population should be assessed and appropriate interventions put in place accordingly. (8.43)
Not achieved. No needs analysis had been carried out so it was not clear how closely the interventions provided matched the needs of the population.
We repeat the recommendation.

Additional information

2.253 A 'choices and challenges' generic cognitive skills course was still run. This was suitable for most prisoners as a primer course and approximately 25% of the current population had completed it. One closed group had been run specifically for women. Probation officers also carried out programme work with individual prisoners assessed as presenting a high risk of reoffending.

Public protection

2.254 The prison should develop procedures for identifying those who pose a risk of harm, managing that risk during custody and making clear the relationship with multi-agency public protection arrangements. (8.52)
Achieved. Relevant cases were identified and displayed on the prison's database. A public protection committee had recently been established. Representatives from the prison also attended a strategic meeting on the island to discuss public protection matters.

2.255 Staff should be aware of those prisoners subject to public protection measures. (8.53)
Achieved. Staff generally tended to have a good knowledge of public protection cases, which were formally identified on the prison computer system, with which most staff were familiar.

2.256 Prisoners should be given written reasons for being subject to public protection measures, the implications for them and their family and how to appeal. (8.54)
Achieved. A pro-forma had been produced that specifically covered these issues and was issued to prisoners subject to public protection measures.

2.257 There should be a system to validate the identity of any child allowed to visit those considered to pose a risk of harm to children. (8.55)
Achieved. A prison order had been produced that detailed the procedures staff were expected to follow in these circumstances. Staff we spoke to in the visits area were aware of their responsibilities in relation to this.

Additional information

2.258 A recent draft public protection policy covered child protection and harassment. Early identification of relevant cases was good. Each prisoner's background circumstances were scrutinised by probation staff on admission. As well as checking the present offence and any recorded previous convictions, contact was made with the local police who were asked to supply any relevant public protection information. A bi-monthly public protection committee had just been instituted, chaired by the deputy governor. Although appropriate restrictions on access to telephones, mail and visits were imposed in relevant cases, these were not reviewed.

2.259 We were told that prison staff attended a quarterly strategic meeting with colleagues from the probation and police departments to discuss public protection matters. Prison staff were also routinely involved in meetings held on the island to discuss prisoners subject to multi-agency public protection arrangement proceedings.

Further recommendation

2.260 The restrictions imposed on public protection cases should be regularly reviewed.

Substance use

2.261 The prison drug policy and strategy should include an alcohol strategy. It should be widely circulated within the prison and should be implemented. (8.71)
Not achieved. There was an outline prison drug and alcohol strategy document, but it was in a draft stage and there was no confirmed date for completion, publication or implementation.
We repeat the recommendation.

2.262 The role of the drug policy coordinator should be formally recognised in the prison. (8.72)
Not achieved. The role of drug policy coordinator had recently been assigned to the assistant governor, but this was not well known throughout the prison.
We repeat the recommendation.

2.263 The drug policy coordinator should head a multidisciplinary team accountable to the governor for the implementation of the prison drug and alcohol strategy. (8.73)

Not achieved. Individuals in the prison and across the island had an interest in the implementation of the prison drug and alcohol strategy, but had not met as a team since 2007.
We repeat the recommendation.

2.264 Specialist advice should be sought before considering changes to the clinical management of opiate users. Maintenance programmes should be available. (8.74)
Not achieved. All prisoners with substance use problems were subject to a detoxification regime on arrival prescribed by one of the GPs, none of whom was a specialist prescriber. No maintenance programmes were available.
We repeat the recommendation.

2.265 Healthcare staff should have training in the care of patients requiring detoxification. (8.75)
Not achieved. Healthcare staff had not received training in the care of patients requiring detoxification.
We repeat the recommendation.

2.266 Drug testing should be reviewed and its role clarified. (8.76)
Achieved. Mandatory drug testing was carried out. The key performance target of 10% of the population tested each month was not always achieved. In 2008, 115 tests had been carried out, of which 22 were suspicion tests. Five tests (two random and three suspicion) had been positive in the year, but there had also been two 'failure to provide' on suspicion testing. The mandatory drug testing (MDT) suite had been redesigned to provide a separate holding room. There were clear instructions on the management of prisoners undergoing MDT.

2.267 Voluntary drug testing should be available to all prisoners who wish to participate. (8.77)
Not achieved. No voluntary drug testing was undertaken, although we were told changes were being made to legislation to allow this using saliva swabs.
We repeat the recommendation.

2.268 Effective intelligence and security measures should be put in place to monitor and control the trafficking of drugs and alcohol. (8.78)
Achieved. A new security information system and intelligence evaluation system had been introduced and had resulted in a significant increase in intelligence (see also paragraph 2.203).

Section 3: Summary of recommendations

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

Main recommendation

To the Home Minister

3.1 The Home Department should draw up a strategy to provide alternative approaches and accommodation for women and children with the aim of eventually removing them from the prison. (2.1)

Main recommendations

To the Governor

3.2 The anti-bullying strategy should be applied consistently as outlined in the written policy. (2.5)

3.3 The assessment, care in custody and teamwork (ACCT) policy (Prison Order 28) should recognise the specific needs of different prisoner groups. (2.7)

3.4 A healthcare needs assessment should be carried out to determine the services required to provide an acceptable level and range of healthcare services to prisoners at Guernsey Prison and appropriate therapeutic accommodation provided that is fit for purpose. (2.9)

3.5 The range of work and accredited vocational training opportunities should be increased to provide more meaningful and better quality work opportunities in the prison and links with external agencies developed to improve employment opportunities after release. (2.10)

Recommendations

To the Governor

Courts, escorts and transfers

3.6 All prisoners should receive the 'from court to prison' information leaflet at their sending court. (2.15)

3.7 Prisoners should be handcuffed between the prison and court only if justified by a risk assessment. (2.18)

First days in custody

3.8 Female officers should receive women prisoners in reception and carry out all the associated reception duties. (2.20)

3.9 The reception interview should be undertaken in private. (2.21)

3.10 The age, status and whereabouts of prisoners' children should be recorded on the prison information management system. (2.23)

3.11 Reception staff should be briefed about the circumstances in which they should contact social services. (2.25)

3.12 Information in the prisoner information booklet should be correct. (2.27)

3.13 Sanitary items should be freely available in the prisoner toilet. (2.29)

3.14 All prisoners should be able to shower on the day of their arrival. (2.30)

3.15 Reception procedures should be completed without unnecessary delays. (2.33)

3.16 A first night strategy should be produced to ensure newly arrived prisoners receive all essential services and information. (2.34)

Residential units

3.17 In-cell toilets should be screened. (2.35)

3.18 Cells designed for one prisoner should not be used for two. (2.36)

3.19 All prisoners should have privacy keys to their cells. (2.40)

3.20 All adult women, young women and girls should be able to wear their own clothes, and bras should be provided. (2.43)

3.21 Prisoners without direct access to fresh drinking water in their cells should be issued with flasks free of charge. (2.45)

3.22 Prisoners and staff should be clear about which wings provide in-cell drinking water. (2.46)

Personal officers

3.23 Managers should check prisoner records and confirm that regular personal officer entries are made. (2.51)

Women prisoners

3.24 There should be a policy that recognises and provides for the needs of women and girls and a senior manager responsible for its implementation should be identified to prisoners and staff. (2.52)

3.25 Women working outside the prison should not be accommodated on the segregation unit. (2.55)

3.26 Details of the female liaison staff should be publicised on the wing. (2.59)

3.27 Regular consultation meetings with women prisoners should be held. (2.60)

Mothers and babies

3.28 Babies should not be held in Guernsey prison unless a purpose built unit with appropriate facilities, policies, skilled staff and care plans equivalent to those in the community can be provided. (2.61)

3.29 There should be a framework to identify and support pregnant women in custody before, during and after birth. This should include appropriate support for those mothers able to remain with their babies and for those who are separated from them. (2.62)

Bullying

3.30 All incidents of bullying should be reported and the extent and nature of bullying should be recorded and monitored. (2.63)

3.31 The procedures for reporting, investigating and monitoring bullying incidents should be improved. (2.72)

Self-harm and suicide

3.32 Prisoners' views should be incorporated into the safer custody meeting. (2.74)

3.33 The extent and nature of self-harm should be monitored and analysed at safer custody meetings. (2.75)

3.34 The recommendations from the report of the investigation into the death in custody in 2004 should be shared with all senior managers and an action plan developed. (2.76)

3.35 Serious incidents of self-harm should be formally investigated to establish what, if any, lessons could be learned. (2.77)

3.36 Ligature points in the observation block cells should be eliminated. (2.78)

3.37 The use of segregation for prisoners on open assessment, care in custody and teamwork (ACCT) documents should be scrutinised by the safer custody meetings to ensure that each use meets the exceptional circumstances criteria outlined in Prison Order 28 – ACCT Policy. (2.80)

3.38 Peer support and a care suite for prisoners to provide this should be developed. (2.82)

3.39 There should be occasional exercises during the night state to test contingency plans for incidents that could occur. (2.84)

3.40 The discussion and care plans developed at the risk management meetings should be reflected accurately in the assessment, care in custody and teamwork (ACCT) document. (2.88)

Child protection

3.41 Comprehensive individual vulnerability assessments should be carried out for each child. (2.89)

3.42 Comprehensive risk assessments should be carried out to manage activities when children, young adults and adult prisoners are mixed. Risk assessments should specify adequate levels of supervision. (2.90)

3.43 A senior manager should be allocated responsibility for children. (2.93)

Race relations

3.44 A clear race and diversity policy should be produced and promoted, supported and implemented by all in the prison, with a designated manager responsible. (2.94)

3.45 A confidential racist incident report system should be established and all racist incidents should be challenged and investigated. (2.95)

3.46 Staff and prisoners should receive race relations training. (2.96)

3.47 Prisoners should be trained as diversity and race equality representatives and given the support of senior managers to promote race equality. (2.100)

Foreign nationals

3.48 The foreign national policy should be published and promoted to all prisoners. (2.102)

3.49 Foreign national prisoners should be consulted about their specific needs and involved with staff in helping to support each other. (2.103)

Family and friends

3.50 A formal policy should be introduced to identify primary carers and ensure that they are able to maintain regular contact with their children. (2.106)

3.51 Prisoners should be able to use the telephones in private. (2.107)

3.52 Prisoners should be able to exchange their unused visits entitlement for extra telephone credit. (2.110)

Applications and complaints

3.53 The application and complaints procedures should be displayed prominently on wing notice boards. (2.115)

3.54 Complaint forms should be freely available without prisoners having to request them. (2.117)

3.55 The submission and receipt of completed applications forms should be logged. (2.119)

Healthcare

3.56 Emergency equipment and medications, including oxygen, should be available in the dental suite when patients are receiving treatment. (2.121)

3.57 A skill mix review should be undertaken and subsequent recruitment of staff to meet the needs of the population served and the work to be undertaken (including administrative tasks). (2.124)

3.58 Local up-to-date and relevant clinical and procedural policies should be developed to reflect best and evidence-based practice such as NICE and NIMHE guidelines. (2.125)

3.59 All arrangements and contacts with local health services (including pharmacy services) should be subject to a service level agreement and monitored for compliance. (2.128)

3.60 During reception, prisoners' immediate health and social care needs should be identified, documented and responded to promptly using a reception screening tool. (2.130)

3.61 Following reception screening, prisoners should have a further health assessment carried out within 72-hours of arrival. (2.131)

3.62 There should be healthcare contingency plans for the rare occasions when police-untried prisoners are held at the prison to ensure that their healthcare needs can be met. (2.133)

3.63 A woman GP should be available for the woman prisoners, who should be informed of this. (2.134)

3.64 Healthcare staff should assess patients using triage algorithms to ensure consistency of assessment and care delivered. (2.135)

3.65 There should be proper arrangements for the monitoring and care of patients with long-term conditions such as diabetes and respiratory conditions. Arrangements for health screening such as mammography should be formalised, as should the arrangements for annual health assessments. (2.136)

3.66 Hepatitis B vaccinations should be offered to all prisoners. (2.137)

3.67 All prisoners should be given information about health promotion and the control of communicable diseases and should have access to disease prevention and screening programmes that mirror national and local campaigns. (2.138)

3.68 Condoms and other barrier protection should be available to all prisoners. (2.139)

3.69 Maximum/minimum temperatures of the drugs fridge should be recorded daily to ensure that thermolabile items are stored within the 2 to 8 degrees Celsius range. (2.141)

3.70 Patient-named medications should not be used as stock. (2.143)

3.71 Discontinued medicines should be clearly quarantined to avoid any possibility of re-use. (2.144)

3.72 There should be formal arrangements for the return and destruction of unused medications. (2.145)

3.73 A medicines and therapeutics committee should be established involving representatives of all of the healthcare team. Membership should include the Island's chief/government pharmacist. The committee should develop and formally adopt procedures relating to the medicines within the prison, such as in-possession, special sick, patient group directions and stock medications. The committee should develop or adopt an evidence-based drug formulary for the prison. Consideration should be given in the future to contracting for a full pharmaceutical service in line with the 'Department of Health Pharmacy Services for Prisons Report 2003'. This recommendation should be examined in conjunction with the local Guernsey legislation covering such practices. (2.146)

3.74 Prisoners should have access to a pharmacist or pharmacy technician as they would in the community. This could include medicines management, compliance reviews and minor ailment clinics. (2.147)

3.75 The number of cancelled hospital appointments should be recorded and monitored to ensure that prisoners are not being disadvantaged. (2.148)

3.76 There should be day care provision for prisoners less able to cope with life on the wings. (2.149)

3.77 There should be robust clinical governance arrangements to ensure the delivery of a safe, quality service from all personnel providing health services to prisoners. (2.155)

3.78 All clinical records should be complete and written contemporaneously. (2.156)

3.79 Multi-professional primary, secondary and tertiary mental health services should be available from staff with appropriate skills. (2.157)

3.80 Primary mental health services should include talking and other appropriate therapies for those with mild to moderate mental health problems. (2.158)

3.81 Prisoners needing assessment by specialist mental health services should be seen within seven days of referral and transferred expeditiously to secondary and tertiary care as clinically indicated. (2.159)

Education and library provision

3.82 An educational needs analysis should be undertaken. (2.160)

3.83 The curriculum should be developed to offer a wider range of core subjects and enrichment activities. (2.164)

Work

3.84 There should be equality of access to work and training opportunities for all prisoners. (2.166)

3.85 Allocation to work should be linked to sentence plans and initial assessments in accordance with the prescribed allocation procedure and monitored. (2.167)

3.86 A pre-release course should be offered to all prisoners nearing the end of their sentence to assist in resettlement. (2.172)

3.87 The pay structure should be revised to ensure equal access to learning and skills provision for all. (2.173)

3.88 Library opening hours should be extended to allow good and equitable access for all prisoners. (2.174)

3.89 A wider range of books and other learning materials should be made available in the library to meet all prisoners' needs. (2.175)

Physical education and health promotion

3.90 There should be opportunities to gain qualifications through the core sport programme. (2.177)

3.91 Take-up of sport opportunities should be monitored. (2.179)

3.92 A wide ranging and well structured sports programme should be provided by fully qualified PE staff to meet the needs of all prisoners. (2.182)

3.93 A thorough PE induction programme that is fully monitored and recorded should be put in place for all new and existing prisoners. (2.183)

3.94 All prisoners should have access to, and wear, appropriate sports clothing when participating in PE activity. (2.184)

Faith and religious activity

3.95 Vulnerable prisoners should have the opportunity to attend a religious service weekly. (2.187)

2.269 The prison should provide funding to employ sessional chaplains from appropriate denominations. (2.190)

3.96 The chaplaincy should be given an appropriate budget to support the development of chaplaincy activities. (2.197)

Time out of cell

3.97 A record should be kept of the occasions and reasons that daily exercise in the fresh air is cancelled. (2.199)

3.98 The time out of cell on weekdays for unemployed prisoners should be increased. (2.201)

Security and rules

3.99 The prison rules should be written clearly, made available to all prisoners and published on wing notice boards. (2.206)

3.100 Any squat searching should be authorised by a senior manager and recorded. (2.211)

Discipline

3.101 Adjudicators should determine whether or not a case merits legal advice before hearing the charge. This should be documented. (2.214)

3.102 Staff working in the segregation unit should be given refresher training to ensure that they are familiar with the correct protocols. (2.216)

3.103 All planned incidents should be video recorded and attended by a senior manager and healthcare staff. (2.218)

3.104 Any incidents of use of force should be examined by managers at the security committee. (2.219)

3.105 Strip searching under restraint should take place only in the most extreme situations and be authorised by the most senior manager on duty. (2.221)

3.106 Protocols should be put in place to manage situations when clothes or furniture are removed from prisoners. This should include a risk assessment, time limitations and authorisation by a senior manager. Each incident should be recorded and reviewed to ensure that it is managed correctly with trends monitored over time. (2.222)

3.107 The observation unit should be staffed at all times. (2.223)

3.108 Individual care plans that include management actions about moving out of segregation should be shared with all staff and placed on the electronic prisoner information system. (2.225)

3.109 Information relating to the use of the segregation, care and progress unit should be routinely analysed for ethnicity, gender, reasons for segregation and time spent in the unit in order to evaluate any trends and to ensure the unit is used appropriately. (2.230)

Incentives and earned privileges

3.110 Staff entries in wing records should be subject to regular management oversight. (2.234)

Catering

3.111 More opportunities for eating communally should be developed. (2.238)

Prison shop

3.112 Opportunities for catalogue shopping should be provided for prisoners who have no one in the community able to supply additional items. (2.239)

3.113 The canteen list should be expanded to include more food items. (2.243)

Resettlement strategy and reintegration planning

3.114 Pre-release courses should be offered to those needing employment on release. (2.244)

Sentence and custody planning

3.115 Information about resettlement need should be taken into account in sentence planning. (2.249)

3.116 Sentence plan targets should be collated both to check on progress in achievement and to inform resettlement policy development. (2.251)

Offending behaviour programmes

3.117 The needs of the prison population should be assessed and appropriate interventions put in place accordingly. (2.252)

Public protection

3.118 The restrictions imposed on public protection cases should be regularly reviewed. (2.260)

Substance use

3.119 The prison drug policy and strategy should include an alcohol strategy. It should be widely circulated within the prison and should be implemented. (2.261)

3.120 The role of the drug policy coordinator should be formally recognised in the prison. (2.262)

3.121 The drug policy coordinator should head a multidisciplinary team accountable to the governor for the implementation of the prison drug and alcohol strategy. (2.263)

3.122 Specialist advice should be sought before considering changes to the clinical management of opiate users. Maintenance programmes should be available. (2.264)

3.123 Healthcare staff should have training in the care of patients requiring detoxification. (2.265)

3.124 Voluntary drug testing should be available to all prisoners who wish to participate. (2.267)

Appendix I - Inspection team

Michael Loughlin	Team leader
Joss Crosbie	Inspector
Paul Fenning	Inspector
Hayley Folland	Inspector
Ian MacFadyen	Inspector
Elizabeth Tysoe	Healthcare inspector
Neil Edwards	Ofsted inspector

Appendix II - Prison population profile

Population breakdown by:

Adult male 21+ years

(i) Status	Number of prisoners	%
Sentenced	51	67.1
Convicted but unsentenced		
Remand	9	11.8
Civil prisoners		
Detainees (single power status)		
Detainees (dual power status)		
Total	60	78.9

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	10	13.2
6 months to less than 12 months	3	3.9
12 months to less than 2 years	8	10.5
2 years to less than 4 years	10	13.2
4 years to less than 10 years	19	25
10 years and over (not life)	1	1.3
Life		
Total	51	67.1

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month	2	2.6		
1 month to 3 months	8	10.5		
3 months to 6 months	8	10.5	7	9.2
6 months to 1 year	12	15.8	1	1.3
1 year to 2 years	11	14.5	1	1.3
2 years to 4 years	10	13.2		
4 years or more				
Total	51	67.1	9	11.8

(iv) Main offence	Number of prisoners	%
Violence against the person	16	21
Sexual offences	5	6.6
Burglary	5	6.6
Robbery	1	1.3
Theft & handling	5	6.6
Fraud and forgery	1	1.3
Drugs offences	22	28.9
Other offences	5	6.6
Civil offences		
Offence not recorded/holding warrant		
Total	60	78.9

(v) Age	Number of prisoners	%
21 years to 29 years	29	38.2
30 years to 39 years	14	18.4
40 years to 49 years	11	14.5
50 years to 59 years	3	3.9
60 years to 69 years	2	2.6
70 plus years	1	1.3
Maximum age	80	
Total	60	78.9

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	51	67.1
Between 50 and 100 miles of the prison	6	7.9
Over 100 miles from the prison		
Overseas	3	3.9
NFA		
Total	60	78.9

(vii) Nationality	Number of prisoners	%
British	50	65.7
Foreign nationals	10	13.2
Total	60	78.9

(viii) Ethnicity	Number of prisoners	%
White		
British	49	64.4
Irish	1	1.3
Other White	10	13.2
Mixed		
White and Black Caribbean		
White and Black African		
White and Asian		
Other Mixed		
Asian or Asian British		
Indian		
Pakistani		
Bangladeshi		
Other Asian		
Black or Black British		
Caribbean		
African		
Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group		
Total	60	78.9

(ix) Religion	Number of prisoners	%
Baptist	1	1.3
Church of England	13	17.1
Roman Catholic	14	18.4
Other Christian denominations	1	1.3
Muslim	1	1.3
Sikh		
Hindu		
Buddhist		
Jewish		
Other	1	1.3
No religion	29	38.2
Total	60	78.9

Adult women 21+

(i) Status	Number of prisoners	%
Sentenced	4	5.2
Convicted but unsentenced		
Remand	3	3.9
Civil prisoners		
Detainees (single power status)		
Detainees (dual power status)		
Total	7	9.1

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months		
6 months to less than 12 months		
12 months to less than 2 years	2	2.6
2 years to less than 4 years		
4 years to less than 10 years	2	2.6
10 years and over (not life)		
Life		
Total	4	5.2

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month				
1 month to 3 months	1	1.3		
3 months to 6 months	1	1.3	3	3.9
6 months to 1 year				
1 year to 2 years	1	1.3		
2 years to 4 years	1	1.3		
4 years or more				
Total	4	5.2	3	3.9

(iv) Main offence	Number of prisoners	%
Violence against the person	1	1.3
Sexual offences		
Burglary		

Robbery		
Theft & handling	1	1.3
Fraud and forgery	1	1.3
Drugs offences	4	5.2
Other offences		
Civil offences		
Offence not recorded/holding warrant		
Total	7	9.1

(v) Age	Number of prisoners	%
21 years to 29 years	4	5.2
30 years to 39 years	2	2.6
40 years to 49 years		
50 years to 59 years	1	1.3
60 years to 69 years		
70 plus years		
Maximum age		
Total	7	9.1

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	3	3.9
Between 50 and 100 miles of the prison		
Over 100 miles from the prison	1	1.3
Overseas	3	3.9
NFA		
Total	7	9.1

(vii) Nationality	Number of prisoners	%
British	4	5.2
Foreign nationals	3	3.9
Total	7	9.1

(viii) Ethnicity	Number of prisoners	%
White		
British	4	5.2
Irish		
Other White	2	2.6
Mixed		
White and Black Caribbean		
White and Black African		
White and Asian		
Other Mixed		
Asian or Asian British		
Indian		
Pakistani		
Bangladeshi		
Other Asian		

Black or Black British		
Caribbean		
African	1	1.3
Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group		
Total	7	9.1

(ix) Religion	Number of prisoners	%
Baptist		
Church of England	1	1.3
Roman Catholic	2	2.6
Other Christian denominations		
Muslim		
Sikh		
Hindu		
Buddhist		
Jewish		
Other		
No religion	4	5.2
Total	7	9.1

Young men 18-21 years

(i) Status	Number of prisoners	%
Sentenced	5	6.5
Convicted but unsentenced		
Remand	1	1.3
Civil prisoners		
Detainees (single power status)		
Detainees (dual power status)		
Total	6	7.8

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	1	1.3
6 months to less than 12 months		
12 months to less than 2 years	3	3.9
2 years to less than 4 years	1	1.3
4 years to less than 10 years		
10 years and over (not life)		
Life		
Total	5	6.5

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month				
1 month to 3 months	1	1.3	1	1.3
3 months to 6 months	1	1.3		
6 months to 1 year	3	3.9		

1 year to 2 years				
2 years to 4 years				
4 years or more				
Total	5	6.5	1	1.3

(iv) Main offence	Number of prisoners	%
Violence against the person	5	6.5
Sexual offences		
Burglary		
Robbery		
Theft & handling		
Fraud and forgery		
Drugs offences		
Other offences	1	1.3
Civil offences		
Offence not recorded/holding warrant		
Total	6	7.8

(v) Age	Number of prisoners	%
18 years	1	1.3
19 years	1	1.3
20 years	4	5.2
21 years		
Total	6	7.8

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	5	6.5
Between 50 and 100 miles of the prison		
Over 100 miles from the prison		
Overseas	1	1.3
NFA		
Total	6	7.8

(vii) Nationality	Number of prisoners	%
British	5	6.5
Foreign nationals	1	1.3
Total	6	7.8

(viii) Ethnicity	Number of prisoners	%
White		
British	5	6.5
Irish		
Other White		
Mixed		
White and Black Caribbean		
White and Black African		
White and Asian		
Other Mixed	1	1.3

Asian or Asian British		
Indian		
Pakistani		
Bangladeshi		
Other Asian		
Black or Black British		
Caribbean		
African		
Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group		
Total	6	7.8

(ix) Religion	Number of prisoners	%
Baptist		
Church of England		
Roman Catholic	2	2.6
Other Christian denominations		
Muslim		
Sikh		
Hindu		
Buddhist		
Jewish		
Other		
No religion	4	5.2
Total	6	7.8

Young women 18-21 years

(i) Status	Number of prisoners	%
Sentenced		
Convicted but unsentenced		
Remand	2	2.6
Civil prisoners		
Detainees (single power status)		
Detainees (dual power status)		
Total	2	2.6

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months		
6 months to less than 12 months		
12 months to less than 2 years		
2 years to less than 4 years		
4 years to less than 10 years		
10 years and over (not life)		
Life		
Total		

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month			1	1.3
1 month to 3 months				
3 months to 6 months			1	1.3
6 months to 1 year				
1 year to 2 years				
2 years to 4 years				
4 years or more				
Total			2	2.6

(iv) Main Offence	Number of prisoners	%
Violence against the person	1	1.3
Sexual offences		
Burglary		
Robbery		
Theft & handling		
Fraud and forgery		
Drugs offences	1	1.3
Other offences		
Civil offences		
Offence not recorded/holding warrant		
Total	2	2.6

(v) Age	Number of prisoners	%
18 years	2	2.6
19 years		
20 years		
21 years		
Total	2	2.6

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	1	1.3
Between 50 and 100 miles of the prison		
Over 100 miles from the prison		
Overseas	1	1.3
NFA		
Total	2	2.6

(vii) Nationality	Number of prisoners	%
British	1	1.3
Foreign nationals	1	1.3
Total	2	2.6

(viii) Ethnicity	Number of prisoners	%
White		
British	1	1.3
Irish		
Other White	1	1.3

Mixed		
White and Black Caribbean		
White and Black African		
White and Asian		
Other Mixed		
Asian or Asian British		
Indian		
Pakistani		
Bangladeshi		
Other Asian		
Black or Black British		
Caribbean		
African		
Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group		
Total	2	2.6

(ix) Religion	Number of prisoners	%
Baptist		
Church of England		
Roman Catholic	1	1.3
Other Christian denominations		
Muslim		
Sikh		
Hindu		
Buddhist		
Jewish		
Other		
No religion	1	1.3
Total	2	2.6

Girls 15-18 years

(i) Status	Number of juveniles	%
Sentenced	1	1.3
Convicted but unsentenced		
Remand		
Detainees (single power status)		
Detainees (dual power status)		
Total	1	1.3

(ii) Number of DTOs by age & sentence (full sentence length inc. the time in the community)

Sentence	4 mths	6 mths	8 mths	12 mths	18 mths	24 mths	Total
Age							
15 years							
16 years							

17 years		1					1
18 years							
Total		1					1

(iii) Number of SECTION 53/91/92s by age & sentence

Sentence	2-3 yrs	3-4 yrs	4-5 yrs	5 yrs +	Life/HMP	Total
Age						
15 years						
16 years						
17 years						
Total						

(iv) LENGTH OF STAY for UNSENTENCED by age

Length of stay	<1 mth	1-3 mths	3-6 mths	6-12 mths	1-2 yrs	2 yrs +	Total
Age							
15 years							
16 years							
17 years							
18 years							
Total							

(v) Main offence	Number of juveniles	%
Violence against the person		
Sexual offences		
Burglary		
Robbery		
Theft & handling		
Fraud and forgery		
Drugs offences		
Driving offences		
Other offences	1	1.3
Breach of community part of DTO		
Civil offences		
Offence not recorded/holding warrant		
Total	1	1.3

(vi) Age	Number of juveniles	%
15 years		
16 years		
17 years	1	1.3
18 years		
Total	1	1.3

(vii) Home address	Number of juveniles	%
Within 50 miles of the prison	1	1.3
Between 50 and 100 miles of the prison		
Over 100 miles from the prison		
Overseas		
Total	1	1.3

(viii) Nationality	Number of juveniles	%
British	1	1.3
Foreign nationals		
Total	1	1.3

(ix) Ethnicity	Number of juveniles	%
White		
British	1	1.3
Irish		
Other White		
Mixed		
White and Black Caribbean		
White and Black African		
White and Asian		
Other Mixed		
Asian or Asian British		
Indian		
Pakistani		
Bangladeshi		
Other Asian		
Black or Black British		
Caribbean		
African		
Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group		
Total	1	1.3

(x) Religion	Number of juveniles	%
Baptist		
Church of England		
Roman Catholic		
Other Christian denominations		
Muslim		
Sikh		
Hindu		
Buddhist		
Jewish		
Other		
No religion	1	1.3
Total	1	1.3