HM Chief Inspector of Prisons for England and Wales

Annual Report 2015–16

HM Chief Inspector of Prisons for England and Wales

Annual Report 2015–16

Presented to Parliament pursuant to Section 5A of the Prison Act 1952 as amended by Section 57 of the Criminal Justice Act 1982.

Ordered by the House of Commons to be printed on 19 July 2016.

HC 471

This publication is available at:
www.gov.uk/government/publications and
www.justiceinspectorates.gov.uk/hmiprisons

Any enquiries regarding this publication should be sent to us at:
hmiprisons.enquiries@hmiprisons.gsi.gov.uk

Print ISBN 9781474136310
Web ISBN 9781474136327

ID 11071646 07/16

Printed on paper containing 75% recycled fibre content minimum.
Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office.

CONTENTS

WHO WE ARE AND WHAT WE DO

Our purpose

To ensure independent inspection of places of detention, report on conditions and treatment, and promote positive outcomes for those detained and the public.

Our values

- Independence, impartiality and integrity are the foundations of our work.
- The experience of the detainee is at the heart of our inspections.
- Respect for human rights underpins our expectations.
- We embrace diversity and are committed to pursuing equality of outcomes for all.
- We believe in the capacity of both individuals and organisations to change and improve, and that we have a part to play in initiating and encouraging change.

Our remit

We inspect:

- adult men's and women's prisons in England and Wales
- young offender institutions (YOIs) in England and Wales
- secure training centres (STCs) in England
- all forms of immigration detention, including escorts, throughout the UK
- police custody in England and Wales
- court custody in England and Wales
- Border Force custody in England and Scotland
- military detention facilities throughout the UK, by invitation
- prisons in Northern Ireland by invitation
- prisons and other custodial institutions in other jurisdictions with links to the UK, by invitation.

Our remit is set out in section 5A of the Prison Act 1952 as amended by section 57 of the Criminal Justice Act 1982; Section 152 (5) of the Immigration and Asylum Act 1999; Section 46 (1) of the Immigration, Asylum and Nationality Act 2006; the Police and Justice Act 2006 section 28; the Education and Inspection Act 2006 section 146; and the Criminal Justice and Courts Act 2015 section 9.

Most inspections take place in partnership with other inspectorates, including Ofsted, Estyn, HM Inspectorate of Constabulary (HMIC), Care Quality Commission (CQC), HM Inspectorate of Probation and the General Pharmaceutical Council, appropriate to the type and location of the establishment.

OPCAT and the National Preventive Mechanism

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK and coordinates its joint activities.

Our approach

All inspections of prisons, immigration detention facilities, police and court custody suites and military detention are conducted against published *Expectations*, which draw on and are referenced against international human rights standards.[1]

Expectations for inspections of prisons and immigration detention facilities are based on four tests of a healthy establishment. For prisons, the four tests are:

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

1 All the Inspectorate's *Expectations* are available at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria

The tests for immigration detention facilities are similar but also take into account the specific circumstances applying to detainees and the fact that they have not been charged with a criminal offence or detained through normal judicial processes. The other forms of detention we inspect are also usually based on variants of these tests, as we describe in the relevant section of the report.

For inspections of prisons and immigration detention facilities, we make an assessment of outcomes for prisoners or detainees against each test. These range from good to poor as follows:

*Outcomes for prisoners/detainees are **good** against this healthy prison/establishment test*
There is no evidence that outcomes for prisoners/detainees are being adversely affected in any significant areas.

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

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

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

Inspectors use five key sources of evidence in making their assessments:

- observation
- prisoner/detainee surveys
- discussions with prisoners/detainees
- discussions with staff and relevant third parties
- documentation.

Since 1 April 2013, all inspections of adult prisons and immigration detention centres have been unannounced (other than in exceptional circumstances), and have followed up recommendations made at the previous inspection. Prisons are inspected at least once every five years, although we expect to inspect most every two to three years. Some high-risk establishments may be inspected more frequently, including those holding children under 18, which are now inspected annually.

Every immigration removal centre (IRC) receives a full unannounced inspection at least once every four years, or every two years if it holds children. Non-residential short-term holding facilities are inspected at least once every six years. Residential short-term holding facilities are inspected at least once every four years. Within this framework, all immigration inspections are scheduled on a risk-assessed basis.

We inspect each police force's custody suites at least once every six years, or more often if concerns have been raised during a previous inspection or by other intelligence. Courts are visited at least once every six years for an inspection of their cells.

In addition to inspections of individual establishments, we produce thematic reports on cross-cutting issues, singly or with other inspectorates as part of the Criminal Justice Joint Inspection process. We also use our inspection findings to make observations and recommendations relating to proposed legislative and policy changes.

1

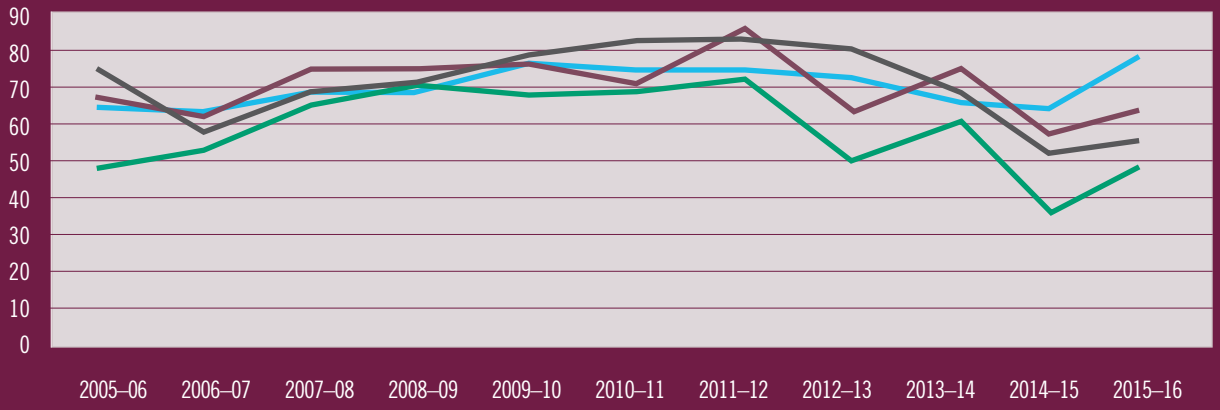
Introduction
by the Chief Inspector of Prisons

This is my first annual report since being appointed HM Chief Inspector of Prisons. I am privileged to lead a skilled and dedicated team in HM Inspectorate of Prisons who take great pride in their work, their independence, their values and their focus on the personal experiences of those held in detention. Our many and varied stakeholders hold the Inspectorate in very high regard. My predecessor, Nick Hardwick, can take pride in his achievements at the Inspectorate, and I wish him well in his future endeavours.

I took up post on 1 February 2016, and as a consequence of the inevitable delay between an inspection taking place and the publication of the report, all of the inspection activity referred to in this annual report took place under my predecessor. The reports of those inspections have all now been published and are available on our website.

In my first few months as Chief Inspector I have tried to visit and inspect as many prisons, secure training centres, young offender institutions and immigration removal centres as possible. I have found that the grim situation referred to by Nick Hardwick in his report last year has not improved, and in some key areas it has, if anything, become even worse. This is despite a slight upturn in our assessments of adult prisons and young offender institutions.

Figure 1: Percentage of 'good'/'reasonably good' outcomes in all adult prison and YOI reports published between 2005-06 and 2015–16



Published reports (%)

	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
Safety	75	57	69	72	78	84	83	80	69	52	56
Respect	65	63	69	69	76	74	74	73	67	64	78
Purposeful activity	48	53	65	71	68	69	72	50	61	36	49
Resettlement	68	62	75	75	76	71	85	64	75	57	63

Any improvement is welcome, but it is far too soon to say whether these improvements will be maintained. They are, in any event, still at historically low levels, and in all bar one area far below where they were five years ago. Year on year comparisons are also notoriously tricky as we do not inspect the same institutions each year, and we deliberately skew our inspection programme towards those places where we assess the risk to be greatest. These are usually announced rather than unannounced inspections, designed to help the establishment make improvements within a short timeframe. There is thus a risk in placing reliance in year on year comparisons.

What I have seen is that despite the sterling efforts of many who work in the Prison Service at all levels, there is a simple and unpalatable truth about far too many of our prisons. They have become unacceptably violent and dangerous places.

During 2015 there were over 20,000 assaults in our prisons, an increase of some 27% over the previous year. As if that were not bad enough, within that huge increase, serious assaults have risen by even more, by 31%, up to nearly 3,000. It is hardly surprising that in the face of this surge in violence, the number of apparent homicides between April 2015 and March 2016 rose from four to six. In the face of this upsurge in violence, we should not forget the dangers faced by staff who work in our prisons and other places of detention. The tragic death of court escort officer Lorraine Barwell, killed by a prisoner at Blackfriars Crown Court in June 2015, serves as a stark reminder of this.

The picture in respect of self-harm and suicide is equally shocking. Over 32,000 incidents of self-harm in 2015 is an increase of 25% on the previous calendar year, and the tragic total of 100 self-inflicted deaths between April 2015 and March 2016 marks a 27% increase.

It is clear that a large part of this violence is linked to the harm caused by new psychoactive substances (NPS) which are having a dramatic and destabilising effect in many of our prisons. In December 2015 we published our thematic report *Changing patterns of substance misuse in adult prisons and service responses*. The report pointed out that these synthetic substances, often known as 'Spice' or 'Mamba,' were becoming ever more prevalent in prisons and exacerbating problems of debt, bullying, self-harm and violence. The effects of these drugs can be unpredictable and extreme. Their use can be linked to attacks on other prisoners and staff, self-inflicted deaths, serious illness and life-changing self-harm. The Prisons and Probation Ombudsman has recently identified 39 deaths in prisons between June 2013 and June 2015 that can be linked to the use of NPS. The situation has shown no signs of improvement since June 2015; in fact quite the reverse, and tragically the death toll will inevitably rise.

During my visits to prisons I have met prisoners who have 'self-segregated' in order to escape the violence caused by these substances, and I have talked with members of staff who have described the terrifying effects they can have on those who take them.

Some prisons are making every effort to mitigate the impact of these drugs by trying to disrupt the supply routes and lessen demand for them through education and targeted interventions. However, in other places the response has been more patchy, with no clear strategy in place.

On a national level, while various aspects of the problem are being addressed, through, for example, criminalising possession of the products and the better use of testing and detection technologies, the simple fact remains that there is, as yet, no overall national strategy for dealing with the problem. I have been told by a member of staff in a local prison that too many prison leaders regard the problem as just another iteration of the long-standing problem of drugs in prisons. He told me in no uncertain terms that this was wrong. In many years of working in prisons he had seen nothing like it before. We have seen how NPS-fuelled instability has restricted the ability of staff to get prisoners safely to and from education, training and other activities. The implications of this for a reform programme based on enhancing the role of education in rehabilitation and resettlement should be obvious.

In my first few months I have also been struck by the sheer number of people in various forms of detention who are clearly contending with mental health issues. There can be no substitute for professional assessment, diagnosis and treatment, but if as a layman I may make an observation it is this: I have seen for myself that sometimes those with the most severe issues find themselves being subjected to the most severe treatment. All too often those who cannot be accommodated on a wing, either for their own safety or that of their fellow prisoners, find themselves housed in the segregation unit. There, the conditions are often such that by internationally recognised standards they would be classified as solitary confinement. At one prison where this was happening, I was told that it was because there were no secure beds available elsewhere. No one could sensibly argue that a segregation unit is a therapeutic environment or a suitable place to hold such people.

These three issues of violence, drugs and mental health will, on many occasions, find themselves intertwined. They are, in turn, compounded by the perennial problems of overcrowding, poor physical environments in ageing prisons, and inadequate staffing. The fact that I shall not explore these issues in depth in this introduction does not mean that I do not attach great importance to them. They are inextricably linked to, and indeed to some extent underpin what I might describe as the strategic threats posed by NPS, violence and the prevalence of mental illness in our prisons.

In contrast with much of the men's prison estate it is reassuring to be able to report that outcomes for prisoners in the two women's prisons inspected during the year were impressive. Three of the four areas of our healthy prison tests covered in those inspections were judged to be good or reasonably good in both prisons, although Holloway continued to struggle in delivering meaningful purposeful activity. Holloway has, of course, now closed, and it is to be hoped that the standards that are now widespread across the women's estate will be replicated or indeed improved on in the facilities to which the women move.

Perhaps some of the most troubling findings and incidents in the past year have been in relation to those places where children are detained. We inspected five young offender institutions and two secure training centres, with an additional unscheduled visit to a secure training centre. Section 5 should be required reading for anyone who is in any doubt as to whether the current arrangements for the detention of children are satisfactory. Four out of the five young offender institutions that we inspected were found to be not sufficiently good in the area of safety. This had a knock on effect on purposeful activity, as a result of which education and training opportunities suffered. Children are being kept locked in their cells for far

too much of the day. They are frequently getting insufficient fresh air and exercise. As with my layman's view of mental health issues in adult prisons, my first impression from an inspection of a young offender institution (not included in this report) was that many of the boys were not thriving physically. To my eyes, many of them looked unhealthy.

Early in 2016 allegations emerged in a BBC Panorama programme of mistreatment and abuse of children at Medway secure training centre. A team from HM Inspectorate of Prisons and Ofsted immediately deployed to Medway and took steps to ensure that the children in detention there were being properly safeguarded. An Improvement Board was installed by the Secretary of State and as a result of its later, highly critical report, the centre is no longer run by G4S, but has reverted to direct management by the National Offender Management Service (NOMS). At the time of writing we are awaiting a review of the youth justice system being carried out by Charlie Taylor. Clearly there is a need for fundamental change in order to create safe and purposeful detention for children. Meanwhile, HM Inspectorate of Prisons will maintain the momentum of its inspection programme of children's detention in 2016–17, with no easing back in the face of budgetary pressures, as had at one stage been envisaged.

During our inspections of immigration detention, perhaps the most shocking discovery was in Dover. While inspecting the immigration detention facilities there during summer 2015, inspectors found that another detention facility was being used for short-term detention of migrants who had sought to evade border controls. This was in a facility known as the Longport Freight Shed. We had not previously been notified of this facility, and the conditions that inspectors found when they insisted on visiting were totally unacceptable, even for fairly short periods of detention. Even after several months of use, conditions had not improved. The fact that the freight shed had been used at all to house detainees and that little, if anything, was done to improve matters over the course of the summer, betrays a shocking lack of contingency planning and agile response to a developing, although entirely predictable, situation. The facility has since been closed, and I have been assured that if such a situation arises again, we will be notified so that proper independent scrutiny can take place.

A further inspection in the immigration detention estate that gave cause for great concern was at Yarl's Wood immigration removal centre. The issues at this establishment were serious, and we have therefore included a specific case study in Section 6 of this report.

HM Inspectorate of Prisons also inspects conditions in police custody, courts, military detention and in other jurisdictions by invitation. We promote and support independent inspection of custody overseas, coordinate the UK National Preventive Mechanism and carry out a range of thematic work. An account of our activity in these areas is given in the body of this report.

We have been encouraged by Parliamentary committees and others to improve the impact of the Inspectorate, and this is an ambition to which I am fully committed. Following an inspection, an establishment is expected to complete an action plan in response to our recommendations. 'Action plan' is, in too many cases, a misnomer. I have seen poorly performing prisons where their implementation of previous inspection recommendations has been woeful. It is therefore hardly surprising that they have either failed to improve or actually deteriorated. As part of the prison reform programme, individual establishments and government departments alike should be placed under an obligation either to accept recommendations, or to set out

very clearly why a recommendation will not or cannot be implemented. These explanations should then be open to public and Parliamentary scrutiny.

However, there is more to increasing the impact of HM Inspectorate of Prisons than getting recommendations implemented. Despite the troubles that afflict prisons at the moment, there are large numbers of dedicated, courageous, skilful and experienced staff who care deeply about the safety of those in custody, who want to improve the conditions of detention, and are focused on the rehabilitation of prisoners. Thanks to their efforts there are countless examples of good practice to be found in all types of prison and places of detention. All too often this good practice fails to gain the widespread recognition that it deserves. I have asked inspectors to pay particular attention to good practice and to make specific mention of it in reports.

It would be remiss of me not to mention the role of prison leadership. Although judging the quality of leadership is sometimes a subjective art, the effect of good leadership in a prison is quickly apparent. I have seen both good and poor leadership, and in every case there is a direct correlation between the quality of leadership and the outcomes experienced by prisoners. Sadly, some of the finest examples I have seen have been where new governors have had to be brought in to rescue an establishment from poor or inconsistent leadership in the past.

HM Inspectorate of Prisons repeatedly asserts its independence from government and others, and it is right that it should do so. But true independence is about more than simply making an assertion. We must be able to report exactly what we find. My distinguished predecessor Lord Ramsbotham has written that 'My orders were to report what I saw.' In essence that is still the case. HM Inspectorate of Prisons neither validates nor criticises government policy, except insofar as it affects the conditions and treatment of prisoners.

Uniquely we focus on the prisoner experience. We make our judgements based on international human rights standards, in support of the UK's treaty obligations. The Inspectorate is not a regulator in the sense of having powers to enforce standards. Our power comes from the ability to publish our reports, persuade the unwilling, encourage the good and expose that which is unacceptable. We will continue to report what we see.

2

The year in brief

Between 1 April 2015 and 31 March 2016 we published 75 inspection reports.

Adult prisons (England and Wales):

- 34 prisons holding adult men, plus one protected witness unit
- two prisons holding adult women.

Establishments holding children and young people:

- five young offender institutions (YOIs) holding children under the age of 18
- two inspections of one secure training centre (STC) holding children aged 12 to 18, jointly with Ofsted, and one exceptional visit to a second STC.

Immigration detention:

- five immigration removal centres
- eight short-term holding facilities
- two overseas escorts.

Police custody:

- police custody suites in 10 forces and London boroughs with HM Inspectorate of Constabulary (HMIC).

Court custody:

- two court custody areas covering two counties and the whole of Wales.

Border Force:

- our second inspection of Border Force customs custody suites.

Extra-jurisdiction inspections:

- the prison and police custody and court cells in the Cayman Islands
- one prison in Northern Ireland.

Other publications:

In 2015–16, we published the following additional publications:

- *Changing patterns of substance misuse in adult prisons and service responses*
- *Behaviour management and restraint of children in custody*
- *Court custody: urgent improvement required*
- *Close supervision centre system* (thematic report and action plan)
- *Prison communications inquiry* (second stage)
- *Release on temporary licence (ROTL) failures* (unredacted)
- *People in prison: immigration detainees.*
- *Life in prison: peer support*
- *Life in prison: earning and spending money*
- *Life in prison: the first 24 hours in prison*
- *Monitoring places of detention. Sixth annual report of the United Kingdom's National Preventive Mechanism 2014–15* (on behalf of the NPM)
- *Children in custody 2014–15. An analysis of 12–18-year-olds' perceptions of their experience in secure training centres and young offender institutions* (jointly with Youth Justice Board)
- *Meeting the needs of victims in the criminal justice system* (a consolidated report by the criminal justice inspectorates).

In January 2016 we also published our first set of *Expectations: Criteria for assessing the treatment of and conditions for close supervision centre (CSC) prisoners*, and during 2015, we also consulted on a new edition of *Expectations for police custody: Criteria for assessing the treatment of and conditions for detainees in police custody*.

We made submissions to a range of consultations and inquiries, and also commented on a number of draft Prison Service Instructions and Orders and draft Detention Services Orders, including:

- Home Affairs Committee Inquiry on new psychoactive substances (2 September 2015)
- Justice Committee Inquiry on young adult offenders (30 September 2015)
- Reviewing and authorising continuing segregation and temporary confinement in special accommodation, as set out in Prison Service Order 1700 (29 October 2015)
- College of Policing consultation on Authorised Professional Practice on Mental Health (24 December 2015)
- Ministry of Justice Youth Justice Review interim report (16 March 2016).

Our reports and publications are published online at:
http://www.justiceinspectorates.gov.uk/hmiprisons

Report publication and other news is notified via our Twitter account. Go to:
https://twitter.com/HMIPrisonsnews
or @HMIPrisonsnews

3 Men in prison

All the findings from prison inspections in this section are based on the fourth edition of our *Expectations: Criteria for assessing the treatment of prisoners and conditions in prisons,* published in January 2012.

During our full inspections in 2015–16, we made 34 healthy prison assessments covering 34 prisons and young offender institutions holding adult and young adult men.

We have compared the outcomes for the prisons we reported on in 2015–16 with the outcomes we reported the last time we inspected the same establishments.[2] Overall, outcomes remained broadly the same for each healthy prison area, with improvements in some prisons balanced by deterioration in others.

Figure 2: Published outcomes for all prisons and young offender institutions (YOIs) holding adult and young adult men (34)

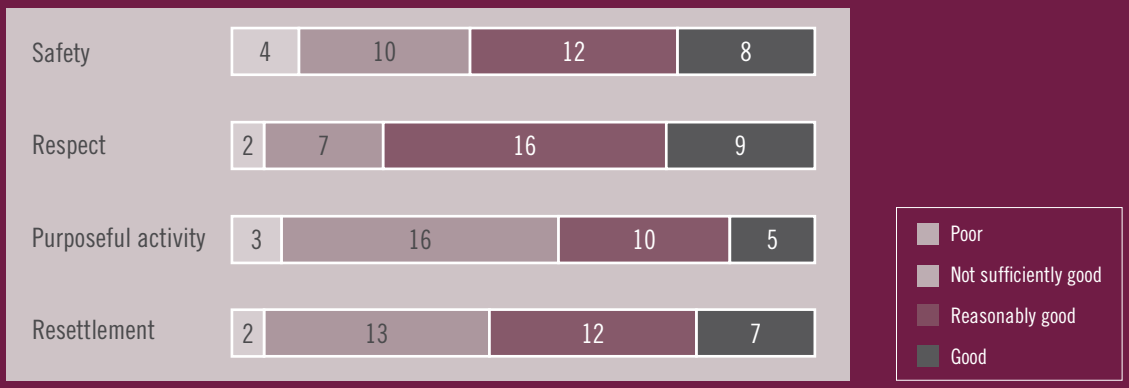
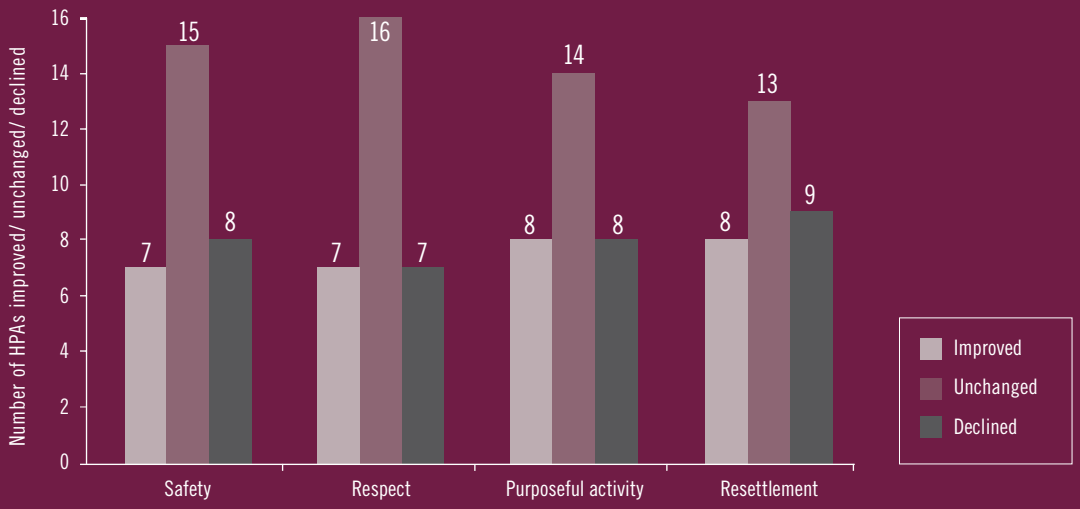


Figure 3: Outcome changes from previous inspection (prisons and YOIs holding adult and young adult men – 30)



2 These numbers total 30 as, since the previous inspection, Isle of Wight and Humber were created by merging separate prisons, and Ashfield and Warren Hill had re-roled from YOIs to become adult men's prisons. It was, therefore, not valid to compare scores for these four prisons with those from previous inspections.

Men's prisons still not safe

- There were continuing high and rising levels of self-inflicted deaths and serious self-harm among adult men in prisons.
- Violence had once again increased in almost every men's prison reported on.
- Support for the victims of bullying and violence was generally weak, and resulted in long periods of isolation for many prisoners.
- New synthetic drugs were a growing problem, which needed a nationally coordinated response.
- Although there was a slight improvement on last year in the healthy prison assessments of safety, safety outcomes were still worse than at any time between 2007–08 and 2013–14.

Figure 4: Safety outcomes in establishments holding adult and young adult men

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	1	3	4	3
Category B training prisons	1	1	2	0
Category C training prisons	3	6	3	1
Open prisons	3	0	0	0
Young adult prisons	0	2	1	0
Total	**8**	**12**	**10**	**4**

Outcome of previous recommendations

In the adult male prisons reported on in 2015–16, 46% of our previous recommendations (including main recommendations) in the area of safety had been achieved, 18% partially achieved and 37% not achieved.[3]

Suicide and self-harm

There were 290 deaths in male prisons in England and Wales in 2015–16, an increase of 51 from the previous year. These included:

- 100 self-inflicted deaths (a rise of 27% from the 79 recorded in 2014–15)
- 167 deaths from natural causes (up from 149 in 2014–15)
- six apparent homicides (up from four in 2014–15)
- 17 other deaths, nine of which were yet to be classified.

It was of particular concern that two transgender women held in men's prisons killed themselves during the year. This rightly led the Ministry of Justice to announce a review into the care and management of transgender prisoners.

Deaths in custody have a profound impact on the family and friends of prisoners and staff in establishments. We therefore continue to be extremely concerned by the high levels of self-inflicted deaths and serious self-harm among adult men in prisons. In the last year, we have been critical of one or more aspects of care for those in crisis in 26 of the prisons inspected and made nine main recommendations covering this area. These findings are shocking and clearly unacceptable.

Six prisoners had taken their own lives since the last inspection. Recorded levels of self-harm were high. Prisoners on ACCT procedures felt well cared for but this was not reflected in the documentation, which was poor. Ranby

3 Note that figures have been rounded and may not total 100. This applies throughout the report.

Despite procedures that were generally inadequate in many prisons, and frequently curtailed regimes, most prisoners were positive about the care and support from staff when they were on ACCT procedures (assessment, care in custody and teamwork case management for prisoners at risk of suicide or self-harm). We found many examples where staff dealt with prisoners in crisis compassionately and patiently, and we commend them for their efforts.

The isolation and lack of constructive activity in most segregation units were not conducive to good care for prisoners in crisis. Despite this, half of the prisons we inspected still located prisoners on ACCTs in segregation units without adequate justification.

We continued to find evidence that self-harm was linked to bullying, violence, debt and the prevalence of new psychoactive substances (NPS),[4] and yet too little was done to address the underlying issues (this was the case at Dovegate, Lowdham Grange, Pentonville, Ranby and Rochester).

> Many prisoners in crisis who we spoke to highlighted debt-related bullying as a trigger. Lowdham Grange

The Prisons and Probation Ombudsman (PPO) investigates all deaths in custody. It was unacceptable that over a third of the prisons we inspected – including Doncaster, Ranby, Wandsworth and Woodhill, which had all experienced self-inflicted deaths – had taken insufficient action to address the PPO's recommendations following deaths. It was, however, positive that appropriate attention to learning lessons had been given at prisons such as Belmarsh, High Down, Littlehey and Manchester.

> There had been five self-inflicted deaths since our last inspection and nine since 2012, five of which had occurred within two weeks of the prisoner's arrival in custody… There was a lack of a coordinated whole-prison process to safer custody and responses were too focused on process without considering the wider protective factors. Internal investigations into incidents were poor and Prisons and Probation Ombudsman recommendations in death in custody reports were still not fully implemented. Woodhill

Early days – prisoners at their most vulnerable

In 2015 there were 25 self-inflicted deaths in prisons within the first month of the prisoner's reception. These accounted for 28% of all such deaths, broadly consistent with the previous year (26%).

The first 24 hours

The first 24 hours in custody is a crucial time for prisoners… prisoners are at their most distressed and risks of self-harm and suicide are extremely high. It is therefore extremely important that individuals are made to feel safe and supported by staff and other prisoners.
Life in prison: The first 24 hours in prison: A findings paper (November 2015)[5]

4 Drugs that are developed or chosen to mimic the effects of illegal drugs such as cannabis, heroin or amphetamines and may have unpredictable and life threatening effects.
5 http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/life-in-prison-the-first-24-hours-in-prison/

Critical factors in reducing the risks for prisoners during the early days of their sentence include effective communication, opportunities to discuss issues and anxieties, and a safe and decent living environment. Access to basic requirements (such as showering in private or telephoning friends and family) and the provision of purposeful activity at the earliest opportunity affect a prisoner's ability to settle and engage with their new community. The support of staff and peer workers cannot be underestimated, particularly in the early days of a prisoner's sentence.

Initial impressions are important and reception officers often set the tone for the establishment. We described officers at Bullingdon as welcoming and treating prisoners respectfully, as was the case at Leicester and Manchester. Most prisons made use of established prisoners as peer supporters to assist new arrivals. However, first night experiences in too many prisons did little to enhance prisoners' feelings of safety or decency.

> Many cells for new prisoners were dirty, with extensive graffiti, and often lacked essential equipment, such as pillows, eating utensils and kettles. We were not assured that new prisoners were adequately monitored or supported on their first night. Pentonville

While several prisons ensured that private interviews with new arrivals took place promptly and focused on vulnerability, in many we were not assured that all new arrivals received a meaningful induction. An exception was the excellent 'well-being induction centre' at Peterborough.

> [Prisoners]… met with a range of staff, including chaplains, drugs workers, resettlement officers and prisoner peer workers. The centre was bright, welcoming, well decorated, and… prisoners were more likely to feel at ease and access the range of help that was offered. Peterborough

The notion of prisoner 'well-being' is an important one and points to a holistic approach, which is crucial to the reduction of risks and distress for prisoners in the early days of custody.

Bullying and violence

Violence had once again increased in almost every prison across the male estate. National Offender Management Service data (NOMS) up to December 2015 confirmed this concerning increase in reported assaults.

Figure 5: NOMS data on assaults in the male estate, 2015[6]

	Assault incidents	Serious assaults	Assaults on staff	Serious assaults on staff
12 months ending December 2014[7]	15,572	2,108	3,437	461
12 months ending December 2015	19,760	2,757	4,730	602
Quarter to end June 2015	4,723	679	1,130	154
Quarter to end September 2015	5,351	701	1,283	150
Quarter to end December 2015[8]	5,418	718	1,284	146

6 Assault figures are derived from the NOMS incident reporting system. They cannot be measured with accuracy and, although quoted to the last figure, should be treated as approximate.
7 Ministry of Justice (2015) Safety in Custody Statistics England and Wales. Deaths in prison custody to March 2015. Assaults and Self-harm to December 2014. London: Ministry of Justice.
8 Figures for December 2015 are provisional. Ministry of Justice (2015) Safety in Custody Statistics England and Wales. Deaths in prison custody to December 2015. Assaults and Self-harm to September 2015. London: Ministry of Justice.

With only a very few exceptions, the frequency and seriousness of acts of violence had increased in men's adult and young adult prisons. At Ranby, where both staff and prisoners reported feeling unsafe, there had been a sharp increase in serious violent incidents, one of which had resulted in the death of a prisoner. Assaults against staff had also increased significantly, and incidents included some extremely serious acts of violent mass indiscipline.

The reasons cited for the increase in violence across the estate included curtailed regimes, a lack of activity, the emergence of NPS, debt and the mixing of young adults with adult male prisoners. We found the highest incidence of violence at Doncaster, where there had been an astonishing 698 assaults in 2015 – of which 125 were against staff. There had also been 81 separate fights in the same period, and in February 2015 a prisoner died following a violent assault. Violence was also very prevalent at Brinsford and Pentonville.

Many prisons had struggled to resource safer custody teams adequately – teams of selected staff responsible for managing the systems and procedures to ensure the safety of prisoners – and violence reduction policies often failed to set out a meaningful strategy to make prisons safer. The application of policy was often inconsistent, and varied within prisons. Systems to monitor the perpetrators of violence and bullying lacked individual behavioural objectives, and recorded observations did not evidence meaningful interaction aimed at changing behaviour. Where there had been an over-reliance on formal discipline processes to respond to fights and assaults, this had not led to a reduction in violence.

However, some prisons were prioritising the need to manage violence in new ways, with examples of good practice. Liverpool, for instance, carried out early interventions with known gang members soon after their reception, which helped to manage the location of prisoners and minimise potential flashpoints. The prison had also held information/training events about gangs, guns and knives co-hosted by staff and prisoners. At a time when most prisons were experiencing a significant increase in violence, the levels at Liverpool were static.

At The Mount, perpetrators of violence and bullying were actively encouraged to take part in the thinking skills programme (TSP) – a cognitive skills programme addressing offenders' thinking and behaviour. It had also introduced a new intervention, GRASP (gangs, responsibility, antisocial behaviour, segregation, positive change), a structured programme that included one-to-one sessions with staff, which was being expanded and looked promising.

Support for victims of violence and bullying was generally poor. We found too many prisoners who spent most of their day locked up on wings too frightened to associate with others. This was particularly prevalent at Humber, Ranby, Rochester and Wealstun, and demonstrated little or no management oversight or care planning.

> Around 40 prisoners were self-isolating because they were in fear for their safety, many for debt related to the use of NPS [new psychoactive substances], and with some on open assessment, care in custody and teamwork (ACCT) documents.[9] Rochester

In Belmarsh, some prisoners had no more than 30 minutes a day out of their cell. This 'duty of care' regime was for men the prison felt it could not keep safe except by locking them up.

There were, however, some good initiatives for potential victims.

9 For the case management of prisoners at risk of suicide or self-harm.

The support mentoring unit on the A3 landing was a good initiative. Prisoners who were identified on arrival as potentially vulnerable and likely to struggle on normal location, including some who were new to custody, were located there. They were allocated a mentor, who agreed individual targets with them and maintained (with their mentee) a log of feelings, thoughts and challenges… most prisoners eventually moved on to normal location and managed to integrate into the general population successfully. Bullingdon

Close supervision centres

In August 2015, we published a report on the close supervision centre (CSC) system. The CSCs hold about 60 of the most dangerous men in the prison system. All have been imprisoned for very serious harmful offences, have committed subsequent very serious further offences in prison, and present dangerous and disruptive behaviour that is too difficult to manage in ordinary prisons. Previously, we had looked at individual CSC units during inspections of the host prison, which did not allow us to report on system-wide issues. We therefore developed a methodology for inspecting the whole CSC system, including a specific set of *Expectations*, published in January 2016.[10]

CSC prisoners were held under prison rule 46 in special units at five high security prisons, or in specially designated cells in high secure prison segregation units.

Our main finding was that there had been good progress in developing a humane and progressive system, although we made some recommendations for improvement. The system was progressive in that, subject to risk assessment, prisoners could move on to settings with fewer restrictions. We concluded that the CSC central management team in NOMS should have greater input to staff selection and the day-to-day running of units, and that better data collection and analysis were needed. For example, a disproportionate number of black and minority ethnic and Muslim men were held in CSCs, but the reasons for this were not well understood. We also concluded that decisions to hold men in such extreme conditions needed independent scrutiny and more meaningful challenge, and that prisoners should have an adequate means of challenging these decisions.

While there had been some progress in developing opportunities for prisoners to demonstrate a reduction in their risk, much more was needed to enable this. Although prisoners were generally managed safely, when this went wrong the consequences could be severe. Some prisoners still spent far too long held in the designated segregation cells, often with a very poor regime and little opportunity to progress. And while we found that prisoners were largely treated well, we asked NOMS to provide a less austere and oppressive environment in the CSC units.

10 www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

Incentives and earned privileges scheme

The incentives and earned privileges (IEP) scheme should provide prisoners with incentives and rewards for effort and behaviour. Prisoners should understand the purpose of the scheme and how to progress through it. The scheme should be applied fairly, transparently and consistently.

We found that the national IEP scheme was being implemented rigidly in some establishments, affecting prisoner perceptions of prison life and creating greater hardship for some. In some prisons, too many new arrivals were not assessed, delaying their chance for promotion to the enhanced level, although others, such as Maidstone, sensibly enabled prisoners to retain their previously earned enhanced status after transfer.

> Many prisoners were frustrated by new restrictions on access to their private cash and clothing… prisoners were more negative about the scheme than at the previous inspection, and it was no longer an effective tool for motivating good behaviour at the prison. Lowdham Grange

Too many prisoners said the scheme did not treat them fairly. Rules were not always applied consistently, and there was not enough exploration of the warnings presented during reviews, for example, at Hatfield and Wealstun. However, some prisons used the scheme well to address poor behaviour.

> The IEP policy was used appropriately, and staff and prisoners had a good knowledge of the scheme. Maidstone

We saw some evidence of regular reviews of prisoners' IEP levels and a focus on encouraging good behaviour in several prisons. However, in our survey of prisoners, only 43% overall said that the IEP scheme had encouraged them to change their behaviour.

The regime for prisoners on the basic level was generally reasonable, but time out of cell was minimal for some – leaving too few opportunities for prisoners to demonstrate improvement in their behaviour, as well as risking the health and well-being of some.

While IEP should not be used as a substitute for other forms of punishment, we found that some prisoners on the basic level were expected to wear specific prison clothing, which was unnecessary, and at Liverpool, prisoners on the basic regime were located on a specific wing akin to a segregation unit.

Use of force and segregation

Use of force by staff against prisoners should be proportionate to the threat posed. Strong governance is important to ensure that force is only used as a last resort, and oversight is required to reduce any unnecessary use of force. Outcomes for prisoners in this area had deteriorated. In half the prisons inspected we found inadequate governance and made main recommendations about the use of force.

In almost two-thirds of inspected prisons, the use of force was increasing and/or high. In many prisons we were not assured that all cases were warranted, proportionate or de-escalated quickly enough. However, we did find good governance and practice in some prisons, such as Brinsford, Manchester, Rye Hill and Wealstun.

> Use of force generally had increased considerably and was almost double that at similar prisons… The recording of use of force was weak and oversight was inadequate, making it difficult to assess whether force was justified on all occasions. Liverpool

We continue to have concerns about the use of solitary confinement and the isolation of prisoners, detention practices that do not stand up to international human rights standards. During the year, we examined such practices as part of a joint National Preventive Mechanism (NPM) project.

In almost half the prisons inspected we had concerns about the use of special

accommodation (usually designated unfurnished cells in segregation units, but can be any cell where furniture, bedding/clothing or sanitation has been removed), which should only be used in exceptional circumstances for the shortest possible time for persistent violent or refractory behaviour. We were not assured that all uses were warranted and were concerned that too many prisoners remained there for too long once they were calm. At Lowdham Grange, we were further concerned by the use of special accommodation and mechanical restraints for prisoners who were actively self-harming, which was inappropriate, disproportionate and demonstrated a lack of care for prisoners in crisis. By contrast, it was commendable that special accommodation had been de-commissioned at Brinsford, and had not been used for at least the six months before the inspections of Belmarsh, Littlehey and Rye Hill.

> Use of special accommodation was much higher than at the last inspection and than at similar prisons, at 21 occasions in the previous six months. Supporting documentation was often poorly completed… in one case, authorisation was given for a prisoner to spend a further 48 hours in this accommodation after he had become compliant. The reason given was to further test compliance, which was an unacceptable justification for use of this form of custody. Doncaster

In around a third of reports we were critical of inadequate governance and oversight of segregation. We continued to find high use of segregation, and were not assured that all uses were warranted. Prisoners were segregated for unacceptably long periods in some prisons, such as Aylesbury, Humber, Manchester and Woodhill. As reported in our last annual report, we continued to find many cases where prisoners had engineered their stay in segregation units. Many had been involved in incidents at height (where prisoners climb on to roofs and netting) in an attempt to secure a transfer from the prison because they felt unsafe. Too little was done to understand and address the issues underlying the rise in these acts of indiscipline. Reintegration planning to assist segregated prisoners back to normal locations remained inadequate in almost half the prisons we inspected, but was better at Highpoint, Leicester and Stocken.

Living conditions in many segregation units continued to be poor. In over a third of reports we were critical about one or more elements of the environment, including cells, toilets, exercise yards and showers. In Leicester, we recommended that the segregation unit be closed immediately.

> The fabric of the unit was appalling. Cells were exceptionally cold, damp and unfit for use. Two of the seven cells were out of use with significant damage. In the remaining cells, in-cell sanitation units and furniture were in a poor state of repair. Leicester

Segregation units continued to provide impoverished regimes – they were inadequate in two-thirds of the prisons inspected, with little access to constructive activity. Many prisoners did not have a radio and very few had access to a television, whatever the reason for their segregation. Most prisoners were locked up for more than 22 hours a day with nothing meaningful to occupy them. Some prisons even curtailed the already minimal access to showers and telephone calls as a punishment for minor rule breaking. Such isolation and lack of purposeful activity is almost bound to have a detrimental effect on the psychological welfare of prisoners.

> The daily regime was impoverished. It was unacceptable that most prisoners could only access showers and domestic telephone calls two or three times a week and that daily exercise periods were usually only 30 minutes long. Many prisoners did not have access to a radio. High Down

While dealing with some of the most challenging and disruptive individuals, relationships between segregation unit staff and prisoners remained broadly positive, which was pleasing to see and a strength. Prisoners were mostly complimentary about their treatment by segregation unit staff.

Safeguarding

All prisons should have procedures to help staff identify prisoners who could be at risk of harm from others because of their age, disability or ill health, as well as a code of conduct on how to raise legitimate concerns and local guidance about how to make safeguarding referrals to local authority services.

In general, we found that most staff were able to identify and provide good support to the prisoners most at risk. However, not all prisons had a comprehensive safeguarding policy and such prisoners were not always recognised sufficiently well, especially in busy local prisons. Not all operational staff understood their prison's arrangements to safeguard prisoners at risk, and some prisons had no links with the local safeguarding adults board. However, other establishments, such as Stocken and Humber, had evidence of developing multidisciplinary partnerships both inside the prison and externally.

In general, staff required more training in safeguarding within a prison context, and how to identify and work with prisoners at risk.

Changing patterns in drug use

The supply and misuse of synthetic cannabis, such as 'Spice' and 'Black Mamba', caused major problems in most adult male establishments we inspected, including medical emergencies, indiscipline, bullying and debt.

New drugs need to be tackled

Our substance misuse thematic report, published in December 2015, showed that many prisoners chose to use synthetic cannabis because it was not detectable, and this has resulted in high levels of misuse and large-scale organised supply chains – such as the use of drones at The Mount and elsewhere. The Psychoactive Substances Act 2016 is being introduced to address the production, supply and sale of harmful psychoactive substances, and will make possession of a psychoactive substance in a custodial setting an offence. Prisoner access to targeted education and support about synthetic cannabis had improved, as had prison staff awareness, and the training and resources provided by Public Health England during 2015–16 were an excellent initiative.

The thematic report made the following recommendation to Ministers for national action to tackle the problem.

The Prison Service should improve its response to current levels and types of drug misuse in prisons and ensure that its structures enable it to respond quickly and flexibly to the next trend. A national committee should be established, chaired by the Prisons Minister, with a membership of relevant operational experts from the public and private prison sectors, health services, law enforcement, substance misuse services and other relevant experts. The committee should be tasked to produce and publish an annual assessment of all aspects of drug use in prisons, based on all the available evidence and intelligence, and produce and keep under review a national prison drugs strategy.

Changing patterns of substance misuse in adult prisons and service responses (December 2015).[11]

Many prisons we inspected struggled to address illicit drug use effectively (both synthetic cannabis and traditional drugs) due to problems such as an ineffective strategic approach and inadequately resourced intelligence-led searching. Mandatory drug testing remained an ineffective deterrent due to the very limited range of drugs it could test for and inadequate resourcing of suspicion testing.

Figure 6: Is it easy/very easy to get illegal drugs in this prison?	
Local prisons	36%
Category B training prisons	31%
Category C training prisons	42%
Young adult prisons	31%
Open prisons	34%

11 http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/changing-patterns-of-substance-misuse-in-adult-prisons-and-service-responses/

> Prisoners' use of detectable drugs appeared to be low as the random mandatory drug testing (MDT) positive rate was only 4.4% for the six months to July 2015. However, drug finds and the high number of intoxication-related incidents evidenced a high level of drug availability, especially Spice… There had been over 30 recorded finds of NPS in the previous six months and almost 60 prisoners were recorded as being under the influence of these drugs in the same period; on one single day, 12 prisoners had had to be treated for the effects of these substances. Wealstun

Many prescribed sedative and mood-altering drugs are highly desirable and tradable in prison, including pregabalin (an anti-convulsant) and gabapentin (an anti-epileptic medication). HM Inspectorate of Prisons contributed to the Advisory Council on the Misuse of Drugs' pregabalin and gabapentin review, which recommended that these drugs be controlled under the Misuse of Drugs Act 1971 as class C substances due to the high risks of associated harm. Most establishments that we inspected prescribed and administered tradable medication, but inadequate officer supervision of medication queues, including for collection of opiate substitution treatment, all too often continued to contribute to bullying and diversion.

> The medication queue was… inadequately supervised. Prisoners crowded around the hatch and with only one officer unlocking prisoners and supervising the hatch, the observation of prisoners receiving medication was poor and at times non-existent. Lancaster Farms

Most prisons continued to offer effective and appropriate psychosocial drug services to substance misusers, although a minority, including High Down and Liverpool, provided poor services and inadequate access to group support for some prisoners.

> Drug recovery workers were well qualified but prisoners often had to wait too long to see them… The recovery wing had been closed for nearly a year and all recovery-based groupwork had ceased. Alcoholics Anonymous meetings were not available. The programmes team delivered lower intensity groupwork focusing on awareness of NPS, but this was not well integrated into an overall strategic approach to tackling drugs. Doncaster

In our substance misuse thematic (see box on p.26), we highlighted the importance of peer and family support to maximise positive outcomes. While some prisons had excellent provision, many had inadequate peer support, and most offered no family support.

> Each of the 13 peer supporters undertook an Open College Network level 2 qualification in substance awareness and peer mentoring. They had benefited from the effective recovery programmes in place, and could now pass on what they had learned. They received support from a dedicated worker, who ran a weekly mentors' support group and regular one-to-one supervision. Belmarsh

Opiate substitution for substance misusers was generally prescribed appropriately, but we remained concerned that some prisons did not offer buprenorphine as an option – this contravened national prescribing guidance and contributed to poorer outcomes for some prisoners.

> Buprenorphine (an opiate substitution medication) was not prescribed; prisoners arriving on this medication were transferred to methadone, which was contrary to national guidance… times of [controlled drugs] administration varied widely between weekdays and weekends, which resulted in some prisoners going well over 24 hours between doses of methadone, contrary to national guidance. Bullingdon


MEDICAL SERVICES
SEGREGATION UNIT
WORKSHOPS
HOUSEBLOCK 1
HOUSEBLOCK 2
HOUSEBLOCK 3
HOUSEBLOCK 4
CHAPLAINCY
PHYSICAL EDUCATIO
EDUCATION

Respect outcomes improve

- Outcomes for respect were better than previous years.
- However, overcrowding continued to be a major problem, and the effects of staff shortages compounded poor living conditions and prisoner access to provision such as health care.
- There was not enough support for prisoners from minority groups.
- Health services were generally of a good standard, but prisoners with mental health needs waited too long for transfer to hospital.

Overall this year, 78% of prisons achieved a good or reasonably good healthy prison score for respect. This had improved from the low of last year, when only 64% of prisons achieved one of these scores, and represents the best picture we have reported on for some years.

Outcome of previous recommendations

In the adult male prisons reported on in 2015–16, 36% of our previous recommendations (including main recommendations) in the area of respect had been achieved, 24% partially achieved and 40% not achieved.

Figure 7: Respect outcomes in establishments holding adult and young adult men

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	1	5	3	2
Category B training prisons	1	2	1	0
Category C training prisons	4	7	2	0
Open prisons	2	1	0	0
Young adult prisons	1	1	1	0
Total	**9**	**16**	**7**	**2**

Overcrowding still an issue

Overcrowding remained a significant problem in 56% of the prisons we reported on in 2015–16. Local prisons were still the most overcrowded. At Wandsworth, for instance, 1,630 men were held in cells designed for 963. While such overcrowding made their lives difficult, there had been improvements to the living accommodation and its cleanliness. However, conditions in some prisons were very poor.

> The amount of rubbish and dirt around the prison was shocking. Some of the cells were in an appalling state, and some external areas were strewn with clothing, bedding and general debris. Too many cells designed for one were overcrowded, with insufficient furniture and a lack of basic essential items. Some shower rooms were filthy, damp and unhygienic, and access to them was limited. Pentonville

In some prisons, poor conditions were exacerbated by missing or broken cell furniture, limited access to clean clothes, bedding and cleaning materials. However, conditions in some prisons were particularly good.

> The prison was spacious and external areas were well maintained. The cleanliness on all five house blocks was very good and prisoner accommodation continued to be some of the best we have seen… Most cells were single occupancy, a reasonable size and in good decorative condition. Lowdham Grange

Resolving prisoner problems

We regularly found poor processes to respond to prisoners' requests. In our survey, 76% overall felt it was easy to make an application, but only 52% said that it had been dealt with fairly and just 35% said it was answered within seven days. This inability to sort out many day-to-day concerns quickly was a considerable frustration for prisoners.

Many prisoners reported difficulty in getting staff to complete basic tasks on their behalf and said they had to resort to making a formal application or complaint. Humber

Establishments with electronic kiosk systems performed better. Rye Hill was intending to completely phase out paper applications in favour of kiosks, which prisoners could also use to track responses. Many prisons had set up prisoner information desks for dealing with applications. Lowdham Grange had also introduced a prisoner advice line run by prisoners – this was very well used, and 97% of calls did not require further staff assistance.

Prisoner perceptions about the outcome of their complaints were equally mixed; while 54% said that it was easy to make a complaint, only 30% felt their complaints were dealt with fairly. In too many prisons there were high volumes of complaints about minor matters, which could have been dealt with less formally. The quality of responses was variable, and management oversight was sometimes inadequate.

Data about the nature of complaints and the timeliness of responses were collected but it was not clear how well this information was used. Although the timeliness of responses was monitored in performance meetings, there was no evidence of managers reviewing the trends in types of complaint, to inform management action. Bullingdon

Elsewhere, robust quality assurance by managers helped to improve performance.

We frequently found poor staff response times to emergency cell call bells. This was a particular concern because of the obvious relevance to prisoner safety, and also caused frustration for prisoners. In our survey, only 30% of prisoners said their cell bell was answered within five minutes; this was very poor.

Staff-prisoner relationships

In our survey, 76% of prisoners said most staff treated them with respect and 70% said there was a member of staff they could turn to for help. However, in some prisons, particularly those where we found severe staffing shortages, staff did not know prisoners well and the quality of relationships was not as good.

Reductions in staff numbers had greatly reduced the capacity of officers to engage constructively with prisoners; many staff expressed frustration with this situation, and prisoners mostly understood it. Wandsworth

In our survey, only half of prisoners said that they had a personal officer. Such schemes worked well in some prisons, such as Isle of Wight, Lancaster Farms and Wealstun, but in too many they had either been abandoned or were not effective.

There was no active personal officer scheme and on some of the wings there appeared to be little interaction between staff and prisoners… Prisoners often expressed their frustrations at their inability to get things done, saying that staff often failed to get back to them or avoided dealing with a request for assistance. Pentonville

In most prisons managers had some general consultation with prisoners, but the quality varied greatly.

Equality and diversity work

Prisons still needed to make much more effort to ensure prisoners from all protected characteristic[12] groups received consistent support. Strategic management of this area of work had improved in a few prisons, such as Highpoint and Isle of Wight, but at too many equality work was weak.

> Most of the positive aspects of the management of equality and diversity found at the previous inspection had lapsed. The equality strategy was out of date, no needs analysis had been undertaken to inform a new strategy and there was no equality action plan to develop services. Bullingdon

In general, where there was equality monitoring, there was too little use of the data to help improve outcomes for protected groups.

> The data showed consistent and clear over-representation of black and minority ethnic prisoners in the use of force, adjudications, segregation and the basic regime, but these findings were not investigated robustly enough to address any underlying reasons for inequitable treatment. Manchester

Some prisons failed to identify prisoners from protected groups systematically, and too often the data were incomplete, and therefore any analysis was inaccurate.

Prisoners can raise complaints about discriminatory behaviour through submitting discrimination incident reporting forms (DIRFs). Investigations into DIRFs were generally adequate, but not always prompt, and external quality assurance was the exception rather than the rule.

In too many prisons we found limited or no consultation with protected groups and ineffective use of peer workers. These prisons failed to make the most of their resources to improve diversity outcomes.

As at 31 March 2015, prisoners from black and minority ethnic backgrounds made up 26% of the prison population.[13] In our survey, they were often more negative than white prisoners, particularly on issues of safety, victimisation by staff and respect (see Appendix 5).

The number of foreign national prisoners fell slightly from previous years, and at the end of 2015 comprised 10% of the adult male prison population.[14] The percentage of foreign nationals was often higher in local prisons in large cities. At Wandsworth, two out of five prisoners were foreign nationals, yet provision was inadequate.

> Prisoners who did not speak English largely relied on other prisoners to make themselves understood, and many were frustrated and anxious about their inability to get advice about their complex extradition or other immigration issues. Wandsworth

Conversely, provision at Pentonville for foreign national prisoners was good.

At the end of 2015, around 418 foreign nationals were held solely under immigration powers once they had completed their criminal sentence.[15] In our paper *People in prison: Immigration detainees*[16] we found that too many low risk detainees were held in prisons where the conditions they experienced were unacceptable.

12 The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).
13 Ministry of Justice (2015) Offender Management Statistics Bulletin, England and Wales. Quarterly January to March 2015. London: Ministry of Justice.
14 *Offender Management Statistics Bulletin* December 2015.
15 *Offender Management Statistics Bulletin* December 2015.
16 http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/people-in-prison-immigration-detainees/

In our survey, 5% of prisoners identified themselves as being Gypsy, Romany or Traveller. Prisons often failed to identify this particular group. Some prisons ran consultation forums, but only a few offered any external support agencies. Although our previous annual report highlighted the difficulties such prisoners had in maintaining family ties, only one prison we visited had attempted to address this.

> Arrangements had been made for them [Gypsy, Romany or Traveller prisoners] to apply for an additional £20 phone credit each week paid for from their own private money to keep in contact with relatives. Ranby

The proportion of prisoners declaring a disability in our survey remained steady at about one in five. As a group, they continued to be much more negative than prisoners without disabilities. Not surprisingly, the proportion who said that they had problems when they first arrived in prison was high, at 87%. A consistent finding during inspections this year was the lack of care plans.

> We met some prisoners who felt that their emotional or mental health needs were not well enough understood by wing staff. We saw an example of a simple care plan, but felt this system could have been more widely used and shared more proactively with wing staff to promote optimum care and understanding. Humber

Several prisons met the needs of prisoners with disabilities with the help of other prisoners. This had many benefits, although the role of the peer carers was not always well enough defined, and monitoring by staff was often insufficient, leaving disabled and elderly prisoners at possible risk of exploitation. A helpful Prison Service Instruction, P*risoners Assisting Other Prisoners* (17/2015), was published in 2015.

The proportion of prisoners aged over 50 was 15% by the end of March 2016.[17] There was still no national strategy for the management of older prisoners, and the reported experiences of this group of prisoners remained too variable. However, we found some good work in a few prisons.

> Age Concern visited every four–six weeks, offering lectures on pensions, finances, housing, care homes and work. The Mount

Support for gay and bisexual prisoners continued to be underdeveloped. In our survey, 3% of adult male prisoners self-identified as gay, homosexual or bisexual. Many were reluctant to declare sexual orientation in custody, and we often found that more prisoners self-identified in our surveys than to their prison. Support was mainly limited to ad hoc forums with little input from external agencies.

Although many prisons had a policy on the care to be given to transgender prisoners, some were totally unprepared to support these prisoners to live safely and with dignity. We found some good support, but also inconsistency.

> Care had been taken to accommodate transgender prisoners appropriately. All staff working directly with transgender prisoners had received specialist training. Dovegate

> There were two transgender prisoners… although most staff were trying to meet their particular needs, these prisoners felt that there was too much inconsistency in their treatment and that more could be done to help them live as women and ensure their privacy and dignity. Bullingdon

17 Ministry of Justice (2016) *Offender management statistics quarterly bulletin: October to December 2015 and annual 2015*. London: Ministry of Justice. https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2015

HM Inspectorate of Prisons has shared its concerns about the management of transgender prisoners in its contribution to the Ministry of Justice review, due to report in early 2016 (see p.18).

By the end of March 2016, the number of young adult men aged 18–20 in prison had remained broadly static at 4,547.[18] However, those who remained in custody were inevitably some of the most vulnerable and troubled young adults.

The Harris review into whether appropriate lessons had been learned from the self-inflicted deaths of 18–24-year-olds in custody was published on 1 July 2015.[19] It made 108 wide-ranging recommendations for changes to specific aspects of how young adults should be cared for. In July 2015, the Justice Committee announced its own inquiry into young adults, to assess the implications of the Harris review and examine the evidence on what might constitute more effective or appropriate treatment of young adults throughout the criminal justice process. HM Inspectorate of Prisons submitted written evidence to the committee in September 2015. This reiterated our view, previously put to the Harris review, that there should be a clear and coherent strategy to ensure the management of young adult men in the wider prison population, and that this needed to be based on the individual needs of the young adult men themselves.

Faith provision

Faith provision continued to be a positive feature across the male estate. Most prisons had sufficient areas for corporate worship. Chaplains were usually well integrated into prison life, and attended a range of meetings across prison departments, including ACCT reviews. Some chaplaincy teams assisted prisoners with family matters and their resettlement – for example, Belmarsh had strong links with faith communities.

Legal rights

There were no longer any dedicated staff to assist prisoners in accessing their legal rights. To find a solicitor, many prisoners now relied on word-of-mouth recommendations from other prisoners or prisoner newspapers, such as *Inside Times*.

Legal visiting arrangements were reasonably good but some prisoners could not consult their lawyer in a private interview room. Innovatively, Doncaster allowed prisoners to consult lawyers using video-link facilities.

Unconvicted prisoners became eligible to vote in the 2015 general election. Despite this, we found little evidence of staff assisting prisoners to register or vote.

Inquiry into prisoner communications

In July 2015, we published the second part of an inquiry into prisoner communications, requested by the former Justice Secretary following concerns that prisoners' telephone calls to MPs were being monitored.[20]

Our main conclusions were:

- the rules, policy and safeguards relating to the monitoring of calls to MPs were not sufficiently clear
- in a small number of cases, there was significant concern that confidential telephone calls between prisoners and their MPs might have been deliberately intercepted without proper cause or authorisation.

We made 19 recommendations aimed at improving the understanding of and compliance with the rules about 'confidential access' communications, which include MPs, lawyers and various other organisations.

18 Ministry of Justice (2016) *Offender management statistics quarterly bulletin: October to December 2015 and annual 2015*. London: Ministry of Justice. https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2015
19 http://iapdeathsincustody.independent.gov.uk/harris-review/
20 http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/prison-communications-inquiry/

Food and the shop

In our survey, prisoners remained extremely negative about the quality of food; only 29% said the food was good. Most prisons had £2.02 a day to feed each prisoner (according to the latest information from NOMS). Consultation about food in most prisons was good. However, menus were often monotonous and meals were sometimes served far too early. Very poor quality breakfast packs were the norm and usually issued the night before, which meant they were often consumed overnight. Many prisoners, particularly in local prisons, continued to have no choice but to eat in their cell, often next to an unscreened toilet.

With the exception of private prisons, which are not tied to the national prison shop contract, new arrivals in prison continued to experience significant delays in receiving their first prison shop order. In our survey, only 23% of prisoners said they had access to shop facilities immediately following reception.

Most prisons enabled prisoners to shop from catalogues. We also found good arrangements at Ashfield, Maidstone and Rochester that gave prisoners supervised access to online catalogues.

Prison health services

We continued to inspect prisons with our regulatory partners – the Care Quality Commission (CQC), the General Pharmaceutical Council and Healthcare Inspectorate Wales. In England, the CQC issued requirements for improvements where regulations were not met.

The majority of health services for prisoners continued to be of a reasonably good standard. We were able to record 45 points of good practice in the adult male prisons we visited, covering areas such as drug recovery wings, health promotion, mental health provision, palliative care, peer support and pharmacy clinics.

At 18 prisons, including Dovegate, Maidstone and Pentonville, the limited availability of prison officers continued to affect the efficient delivery of health care – for example, through late or missed appointments, cancelled external health appointments, curtailed inpatient therapeutic activities, and lack of supervision of prisoners at medicine times, with the potential for bullying and trading of medications.

> Primary care services had improved and were reasonably good, but provision was severely undermined by chronic difficulties escorting prisoners to their in-house and external health appointments. Non-attendance rates were excessive. Leicester

The net effect on health services was wasted clinical expertise and time, which contributed to underperformance against health targets.

While generally satisfactory, several prison health care environments were inadequate, including Liverpool, Peterborough and Rye Hill. Several of these services, and others, failed to meet minimum standards for infection control.

> The longstanding leak in the roof of the health care centre had damaged ceilings and caused the door frames to swell; the floor in the pharmacy room had had to be removed… The dental suite, including the decontamination room was not clean and neither dental room had sealed floors. We found no evidence to suggest infection control audits had been completed. Standford Hill

The care of older prisoners required improvement at several prisons, including Humber and Leicester, and health complaints management was not sufficiently robust (usually lacking medical confidentiality) at 11 prisons, including Aylesbury, Deerbolt and Stoke Heath.

Pharmacy services were good overall, with only a few exceptions.

Prisoners could see a pharmacist easily, medicines were reviewed regularly and all prescribing was informed by proactive clinical pharmacy advice. Ashfield

Although dental services were usually good, patients waited too long to see the dentist at 13 prisons.

Most prisons offered reasonably good mental health services but some were inadequate as they offered fewer therapeutic primary mental health opportunities to patients; these included Belmarsh, Doncaster and Pentonville. Patients with more severe mental illnesses had reduced treatment opportunities at Doncaster and Woodhill. However, there were some examples of good practice.

The mental awareness peer support scheme (MAPS navigator programme) trained prisoners to support men with concerns about their mental health. This was an effective, innovative approach to meeting mental health needs. Ranby

At half the prisons we visited this year, patients waited too long to be transferred to NHS mental health units, and were often left to languish in non-therapeutic segregation units for extended periods.

New Care Act takes effect

The Care Act 2014 became effective in English prisons from April 2015, placing an onus on local authorities to provide social care to prisoners in addition to assessing their needs. We observed the beginnings of different models of working between prisons and their partners, and providing help to prisoners with self-care needs. Some early models of care delivery were encouraging, such as those at Ashfield, Rochester, Rye Hill and Woodhill.

Duties under the Care Act 2014 had been implemented well. Complex case reviews and meetings to discuss terminally ill prisoners were held regularly and provided detailed information and planning for prisoners who needed additional support on the wings. Representatives of Northamptonshire County Council were present at these, to take forward concerns and referrals. Some prisoners had received support from community-based occupational therapists and had been provided with adaptations to their cell or other necessary equipment to improve their conditions on the wing. Rye Hill

Welsh prisons and policies

Although we did not report on any inspections of prisons in Wales during this year, we continued to monitor policy and other developments affecting prisoners held in Wales.

During inspections where Welsh prisoners are held, we routinely look at the Welsh language support offered. We will continue to monitor this once the new Welsh Language Standards Regulations 2015, which aim to encourage the use of Welsh by public authorities, come into effect in April 2016.

Welsh prisons were some of the first to introduce a smoking ban, with a pilot scheme that started in January 2016. All Welsh prisons became smoke-free on 2 May 2016. NOMS had extensive liaison with the Welsh Government and the health service in Wales to ensure that all parties were prepared for this significant change.

The new prison in North Wales, HMP Berwyn, is nearing completion and due to open in February 2017, eventually holding 2,106 prisoners.[21] NOMS in Wales has sought to learn lessons from the opening of other large prisons, and has started the recruitment and training of staff, with plans for a phased opening of accommodation at the prison.

The new Wales offender accommodation resettlement pathway came into effect in December 2015 and is the first of its kind in the UK. Welsh local authorities are now required to begin working with Welsh prisoners facing homelessness up to 56 days before they are due to be released. The pathway aims to provide secure housing on release, rather than unsatisfactory bed and breakfast accommodation.

21 Hansard 29.2.16.

Too much time locked up but some improvement in purposeful activity

- Activity outcomes for prisoners had improved overall, but were still only good or reasonably good in around half of prisons.
- The effectiveness of new standardised core days and increased activity had been affected by staff shortages in many prisons.
- Prisoners, including young adults, spent too much time locked in their cells.
- There were insufficient activity places in many prisons, and too many that were in place were unfilled, with prison staff not always supporting prisoner attendance.
- There continued to be insufficient focus on the role of education in prisoner rehabilitation.
- The quality of teaching and learning and achievements of prisoners had improved, but English and mathematics provision remained weak.

Outcome of previous recommendations

In the prisons reported on in 2015–16, 47% of our previous recommendations (including main recommendations) in the area of activity had been achieved, 26% partially achieved and 27% not achieved.

During 2015–16, we expected the new core days introduced in 2014–15 (which identify daily unlock times and provision of purposeful regime activities and association) to be fully operational. These new core days were standardised according to prison type with the intention of providing predictability for prisoners and maximising their time out of cell. Running alongside this new core day was a regime review aimed at increasing prisoner work, activity and learning.

In practice, we found a very mixed picture. Staff shortages in some prisons meant they were unable to implement the new core day fully. However, in most prisons without staff shortages, the new core day had been implemented, so prisoners knew when they would be unlocked, when domestic and association periods took place and when they would go to work. The new core days did not, however, increase prisoners' time unlocked, and few prisons offered any additional activity places.

Purposeful activity outcomes in adult male prisons had improved this year, but from a very low base. In 2015–16, we assessed 44% of prisons as good or reasonably good, compared with only a quarter in the previous year. Once again, the poor outcomes in one of the young adult establishments we inspected were of particular concern.

Figure 8: Purposeful activity outcomes in establishments holding adult and young adult men

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	0	2	7	2
Category B training prisons	1	2	1	0
Category C training prisons	1	5	7	0
Open prisons	3	0	0	0
Young adult prisons	0	1	1	1
Total	**5**	**10**	**16**	**3**

Too little time unlocked

When prisoners are unlocked, they are able to use their time in prison constructively, engage with resettlement service providers, and exercise in the open air. In most prisons, this time is also necessary for prisoners to shower, collect meals, clean their cell and telephone their families. Excessive time locked in a cell often leads to deterioration in mental health. We therefore expect prisoners to be unlocked for 10 hours a day. However, in our survey only 14% of prisoners said this was the case (the same as in 2014–15).

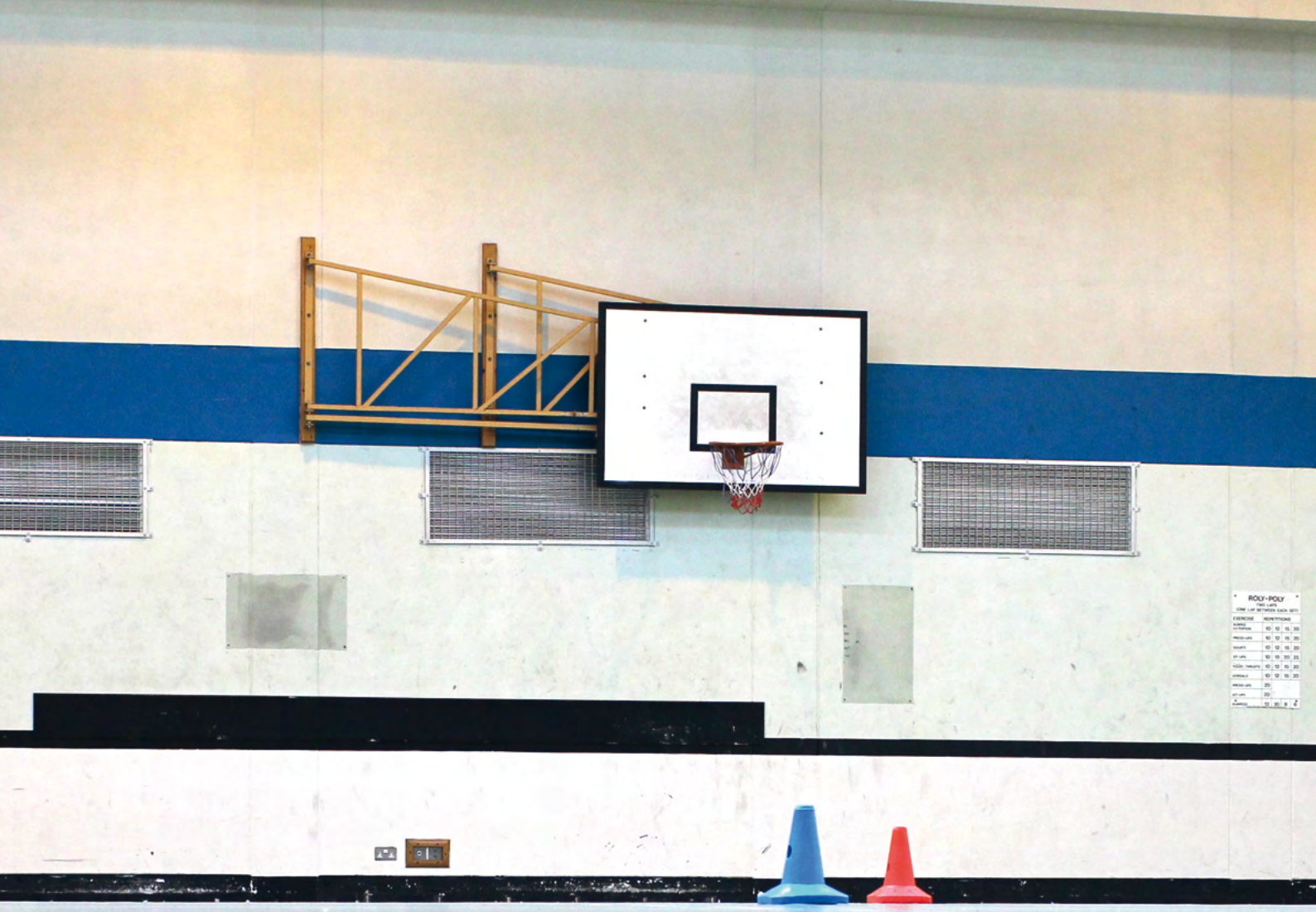

ROLY-POLY

Figure 9: How long do you spend out of your cell on a weekday?

	Spend more than 10 hours out of cell (weekday) (%)	Spend less than two hours out of cell (weekday) (%)
Local prisons	6	31
Category B training prisons	20	9
Category C training prisons	17	8
Young adult prisons	7	38
Open prisons	61	2
Average	**14**	**19**

Time out of cell was very limited in local prisons, and in our survey only 6% of prisoners in locals said they spent more than 10 hours unlocked. In some local prisons, such as Liverpool, Pentonville and Wandsworth, prisoners who were unemployed or on the basic regime had as little as one hour a day unlocked. We routinely found over 30% of prisoners locked up during core day activity periods, but at Doncaster and Leicester, this figure was closer to 50%.

Time out of cell for young adults continued to be very disappointing, and in our survey 38% said they spent less than two hours a day out of their cell. At Aylesbury, a young adult training prison, some prisoners spent 23 hours a day locked up.

> Unemployed prisoners on the basic level got little more than four and a half hours a week out of cell. Aylesbury

Figure 10: Rates of association, use of gym and exercise in establishments holding adult and young adult men

	Go on association more than five times each week (%)	Use the gym three or more times a week (%)	Go outside for exercise three or more times a week (%)
Local prisons	35	18	37
Category B training prisons	74	38	47
Category C training prisons	66	38	56
Young adult prisons	55	20	55
Open prisons	79	59	72
Average	**54**	**30**	**47**

In contrast, Deerbolt, another young adult prison, had secured improvements in time out of cell and most prisoners were unlocked for around nine hours a day.

Even in training prisons, where time unlocked was generally much longer, there were wide variations. At Littlehey, most prisoners had over nine hours a day out of cell (and some had 14 hours), but the 10% of prisoners who were unemployed only had two or three hours.

Some prisons still operated temporarily restricted regimes to cope with chronic staffing shortages, but others had established permanent standardised core day routines. These new core days delivered limited association time, particularly in the evenings – for example, prisoners in local prisons were locked up for the night at 6pm, and some prisoners struggled to find time to telephone their families and friends.

> Owing to staff shortages, the prison had been running a restricted regime for about 12 months. There was no evening association and no provision for late unlocks, which meant that there was no access to showers or telephones at these times, preventing full-time workers and those with working families from contacting their families during the evening. Bullingdon

Training prisons that provided short periods of evening association (such as Stocken) or facilitated evening access to telephones (such as Humber) avoided this problem.

We expect prisoners to have the opportunity for one hour a day in the open air, but most could still only have 30 minutes. At Wandsworth, exercise periods were unpredictable in length, and sometimes less than half an hour. In some prisons, men had to choose whether to go outside or undertake other essential activities, such as collect shop orders or medication.

In our survey, 47% of men said they went outside for exercise three or more times a week. Many exercise yards were featureless and uninviting, but a few had benches,

planted or grassed areas and exercise equipment.

Access to physical education is highly valued by many prisoners. It promotes physical and emotional health and can provide valuable resettlement employment opportunities. Some prisons continued to do this well.

> The PE department's sports academy was outstanding, providing an excellent range of vocational training qualifications from entry level up to level 3, which strongly supported personal well-being, and were clearly linked to future employability. Prisoner achievement on accredited courses was high. Lowdham Grange

However, too often lack of staff, including the redeployment of PE staff to other duties, meant that facilities were closed or limited. For example, at High Down, recruitment delays and sickness meant that the advertised programme was unworkable, and sessions were cancelled every day. On average in our survey, only 30% of men said they went to the gym three times a week, including only 20% of young adults.

Activity places

In 10 of the 34 adult male prisons inspected, there were not enough activity places to ensure all prisoners could access education or vocational training throughout the week. This problem was as prevalent in training prisons and young adult establishments as it was in locals.

Some prisons had sufficient activity places, which were used well:

> The prison provided sufficient learning, skills and work places to meet the needs of the population, who were all purposefully engaged in full-time activities. The allocations process was very efficient and effective… As a consequence, most prisoners were highly engaged and committed to skills training, prison work or external training and employment. Hatfield

Yet, we have continually reported on the widespread and unacceptable failure to fill the places that were available. Once again this continued and 21 of all prisons inspected failed to use their activity places, leaving prisoners without work, education or training when they need not have been.

The process of moving prisoners to learning and skills and work activities from wings was generally ineffective and poorly managed, and prisoners who were allocated to an activity often failed to turn up, or arrived late. Attendance and punctuality of prisoners often went unchallenged by prison staff, which failed to promote a good work ethic with prisoners.

> Custodial managers and wing officers did not always ensure that once prisoners were unlocked in the mornings and afternoons they actually arrived at their scheduled activity. In many cases, prison staff readily accepted the reason given by prisoners for returning to their cells when they should have been in learning, skills or work activities. Rochester

All too often, governors did not give sufficient priority to education and training as a means of reducing reoffending or rehabilitating offenders, and other activities were allowed to interrupt the working day.

> Too many prisoners attended other appointments in the prison when timetabled to attend learning skills and work activities. This disrupted learning. Liverpool

In several prisons, the contracted provider of learning and skills and work activities failed to provide cover for staff shortages, resulting in cancellations and closures, even in establishments holding long-term young adults.

> Too many classes and workshops were cancelled due to staff shortages and absences. The only courses provided were in English and mathematics. Personal and social development, employability and art were not provided due to staff shortages. Information and communication technology had only run intermittently for the past two years… barbering, brickwork, cookery and motor vehicle mechanic workshops were not offered due to lack of staff. Aylesbury

Acute shortages of uniformed staff meant prisons had to introduce reduced and restricted regimes, which further limited the availability of and prisoner access to learning and skills activities.

The role of prison education

In September 2015, the government launched its Review of Prison Education, led by Dame Sally Coates, to examine how prison education in England and Wales supports effective rehabilitation. HM Inspectorate of Prisons welcomes the government's increased focus on education in prisons and the important role this will play in reducing reoffending, particularly as our inspection reports in this and other recent years have shown serious concerns with the current provision of education in prisons. The final report setting out the review's findings and recommendations came out at the end of March 2016. We are committed to considering how we can best support its recommendations.

The quality of learning, skills and work

Our inspections of learning and skills and work in prisons are conducted in partnership with Ofsted (Office for Standards in Education, Children's Services and Skills) in England and Estyn in Wales. Both Ofsted and Estyn make assessments of learning and skills and work provision, although we did not inspect any Welsh adult prisons this year. Learning and skills and work in prisons has been the worst-performing area of the further education and skills sector for some time, and Ofsted has long been critical of this failure.

Figure 11: Ofsted assessments in establishments holding adult and young adult men in England

	Overall effectiveness of learning and skills and work	Achievements of prisoners engaged in learning and skills and work	Quality of learning and skills and work provision	Leadership and management of learning and skills and work
Outstanding	1	2	1	1
Good	10	14	16	11
Requires improvement	18	16	16	18
Inadequate	5	2	1	4
Total	**34**	**34**	**34**	**34**

This year Ofsted introduced a new assessment on the overall effectiveness of learning and skills and work – over two-thirds of prisons (68%) were found to be less than good in their overall effectiveness.

The overall standard of teaching and learning had improved and was rated as good or better in just over half the prisons inspected. Coaching on vocational courses was mainly good, and was reflected in good achievement of qualifications.

> In vocational training, training and individual coaching were good and contributed to prisoners' rapid skills development. Trainers… set high standards for prisoners to produce work to enhance their employability skills significantly. Stoke Heath

At Hatfield, we found 'outstanding individual coaching and motivational support to prepare prisoners for education and employment'.

Where the standard of teaching and learning was weak, the monitoring of prisoners' progress and the quality of target setting by teachers was often insufficient and prisoners were not clear about what they needed to do next. Prisoners frequently worked at levels below their capabilities and were insufficiently challenged to progress.

> Much of the teaching in education did not challenge the more able prisoners enough or plan individual learning effectively. Ashfield

Standards of prisoners' behaviour in learning sessions were generally good. Teachers and tutors managed inappropriate behaviour by learners well. There was a good level of mutual respect between prisoners and teachers and tutors in most prisons.

There had been no overall improvement in the teaching and learning of English, mathematics and English for speakers of other languages (ESOL). They remained particularly weak, with poor prisoner achievement of these accredited qualifications. There were also weaknesses in putting English and mathematics into appropriate contexts to help prisoners understand how they would use these skills. Too many teachers failed to check poor spelling and grammar in prisoners' written work. Generally, English and mathematics were not sufficiently well integrated into vocational courses.

> Teaching of mathematics and English was delivered through classroom provision, so learners who chose practical subjects often did not improve these skills… tutors did not identify learners with low functional skills ability, and did not incorporate English and mathematics in their teaching. Brinsford

The achievement of accredited qualifications in English and mathematics was also poor, with prisoners making slow progress in developing these skills. Too few prisoners progressed into higher qualifications, particularly in English and mathematics.

With the exception of English and mathematics, the overall achievement by prisoners had improved this year, with just under half graded as good or better. Skills development in vocational training remained good in most prisons, with good achievement of accredited qualifications.

In vocational training prisoners generally produced high quality work.

> Pass rates were very high on vocational courses and in some cases had risen significantly over the past two years. Pass rates were high or very high for prisoners who completed their classroom-based education courses. Kirklevington Grange

The use of peer mentors to support learning was generally good, and they provided valuable support to fellow prisoners, but in a minority of prisons, the skills they developed remained unrecognised or non-accredited.

In too many prisons, work remained mundane and repetitive. In the better prisons, where work was structured well, prisoners developed good work skills. However, these were mainly still unrecorded and so not able to help their employment prospects on release, and this work was rarely linked to resettlement objectives.

We expect prison libraries to support prisoners' personal development, particularly literacy and vocational training. Some prisons did this well, and many also ran activities that supported family relationships.

> Managers had introduced a number of activities to increase prisoners' literacy skills; these included: the Six-Book Challenge, reading groups, creative writing groups, stories for families, 'being a dad day', World Book Night and weekly visits to the library by ESOL and English groups. Highpoint

However, too often lack of staffing prevented regular access to the library; in our survey, only 35% of men said they went to the library once a week. Prisons needed to monitor library use more closely to ensure that all groups of prisoners had equity of access, and that the services provided met their diverse needs.

A new approach to prisoner resettlement

- The new approach to providing resettlement services had been introduced, but needed to be better integrated with offender management.
- The continuing lack of needs assessment for many prisoners affected their sentence planning and access to the right programmes to address their offending behaviour.
- The new arrangements for release on temporary licence had reduced failures, but also opportunities for prisoners.
- 'Through-the-gate' work was still being developed with variations in provision.
- The management of sex offenders lacked a national approach.

Outcome of previous recommendations

In the prisons reported on in 2015–16, 42% of our previous recommendations (including main recommendations) in the area of resettlement had been achieved, 17% partially achieved and 42% not achieved.

Of 34 assessments of adult male establishments reported on during the last year, 44% had outcomes for prisoners that were either not sufficiently good or poor. Outcomes were least good in local and category C training prisons.

Figure 12: Resettlement outcomes in establishments holding adult and young adult males

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	1	4	5	1
Category B training prisons	2	1	1	0
Category C training prisons	1	5	6	1
Open prisons	3	0	0	0
Young adult prisons	0	2	1	0
Total	**7**	**12**	**13**	**2**

A new model for rehabilitation

This year, prisons had to adapt their resettlement strategies to accommodate the new 'transforming rehabilitation' model, under which all prisoners are subject to a minimum of 12 months supervision and rehabilitation support on release. Since May 2015, community rehabilitation companies (CRCs) have been responsible for delivering rehabilitation services to medium- and low-risk offenders, while the National Probation Service has maintained responsibility for high- and very high-risk offenders.

This had mostly been managed reasonably well. However, because most prisons still organised their work on resettlement and offender management as separate functions, CRCs and offender management units (OMUs) were often not yet sufficiently integrated and there was a lack of clarity about respective responsibilities, for example, in Bullingdon and Rochester. Even when we inspected Bullingdon in mid-June, some weeks after the new arrangements took effect, we found that 'the reducing reoffending strategy had not been updated to reflect the new CRC arrangements'.

Most prisons continued to use 'dual function' officers in OMUs, which meant that prison officers divided their time between supervising officer duties on the wings and offender supervision. Because the operational demands of the prison were sometimes more urgent than offender supervision work, the latter was often neglected. This year, managers at both Belmarsh and High Down decided to revert to single function offender supervision staff to offset this conflict.

Offender management and resettlement

In most prisons, many prisoners either did not have an OASys (offender assessment system) assessment or had one that was out of date.

> Although the number of prisoners without a current OASys document had been reduced from 241 in January to 165 by the end of April, too many prisoners did not have one that was up to date. Lancaster Farms

Many local prisons failed to complete assessments on newly convicted men before allocating them to training prisons, which then struggled to complete work for which they were not resourced. At Stoke Heath, the head of offender management estimated that around one-third of all new arrivals did not have an OASys assessment. At Ranby, similar pressures were affecting key safety outcomes for prisoners.

> Prisoners expressed significant frustration about delays in offender management work and the impact this had on their progression, and this contributed to the general instability of the prison. Ranby

In recognition of these backlogs, NOMS had published an interim policy in January 2015 that prioritised full assessments for the most risky prisoners by permitting a shorter form of OASys. These 'risk reviews' did not include an assessment of the likelihood of reoffending or a sentence plan, and we found them inadequate as a long-term solution. Although this policy had been intended as a short-term measure pending a review of offender management arrangements, the review had still not been published as we went to press.

In some prisons, the majority of the OASys backlog were cases that were the responsibility of the National Probation Service. This was particularly concerning as these prisoners generally presented the highest risks, and the absence of an OASys assessment prevented their access to effective interventions.

> One hundred and sixteen prisoners did not have an up-to-date OASys document, of which 105 were the responsibility of offender managers… Processes for chasing these up and addressing the lack of offender management involvement were not sufficient. Dovegate

As we reported last year, the quality of OASys assessments varied considerably. Quality assurance processes were often absent or ineffective, and few establishments had systems to challenge poor quality or late work by offender managers. This year we did not see any examples of effective professional supervision for prison officer offender supervisors.

In too many prisons, contact between offender supervisors and prisoners only happened when a process needed to be completed, such as a basic custody screen, an OASys assessment or parole review. Few prisoners received regular contact to support and motivate them, and still fewer received one-to-one offending behaviour work. At Wandsworth, staffing shortages were so acute that 297 low- and medium-risk prisoners had not even been allocated an offender supervisor. Some training prisons managed better: at Lowdham Grange, offender supervisors used the in-cell telephone system to supplement face-to-face work; and at Rye Hill we found that:

Subsequent contact was also good, with a minimum of one meeting every six months, of which one was a sentence plan review. These meetings were recorded formally and communicated to offender managers in the community. Rye Hill

Home detention curfew (HDC) decisions were often made after the prisoner's earliest eligibility date. Delays were often due to prisoners being transferred during the assessment process and paperwork not following, and/or a slow response from the probation service about the suitability of a proposed HDC address. Belmarsh was trying hard to improve its processes, but only 26% of eligible cases had been considered in the three months before our inspection.

Addressing offending behaviour

The provision of offending behaviour programmes in local prisons varied. Although many were not funded to deliver programmes under the transforming rehabilitation model, there was some provision. At Wandsworth, we found an appropriate range of offending behaviour programmes, and the prison had applied to introduce the Resolve programme, which aims to reduce violence in medium-risk offenders. Peterborough was also delivering some unaccredited courses, including anger management, 'Caring Dads' (encouraging fathers to appreciate the impact on children of parental conflict) and 'Stop the Hurt' (for male perpetrators of domestic abuse). However, this was not the case in all local prisons.

The thinking skills programme (TSP) and Resolve were the only two accredited offending behaviour programmes provided, and the number of groups each year had been dramatically reduced… which was insufficient to meet need. Liverpool

The provision of offending behaviour programmes in training prisons was generally reasonable, and often included TSP and Resolve, as well as the healthy relationships programme (addressing domestic abuse) and a range of non-accredited interventions. Where prisons had conducted an up-to-date assessment of prisoner needs, this helped facilitate appropriate provision and identify gaps; by contrast, provision was limited where there had been no needs assessment. However, even where prisons had based provision on an evidenced need, the lack of an up-to-date OASys assessment hindered access for some, such as at Ranby, or obscured the true picture of programme need, such as at Wealstun.

No national approach to sex offenders

NOMS had commissioned several designated sex offender prisons to deliver the sex offender treatment programme (SOTP). However, a significant number of men in these prisons were not eligible for SOTP, either because they were in denial of their offence or because they were not assessed as sufficiently high risk. The national approach to managing these men was developing – new accredited programmes were being designed to be accessed by all, regardless of whether they admitted their offending. However, until the programmes are available, establishments have been developing their own approach, leading to inconsistency and varying provision.

At Rye Hill, where too many prisoners unsuitable for offender behaviour programmes had been received following a re-role, there were effective strategies to ensure that prisoners were now suitable for the treatment provided, as well as a well-constructed strategy to work with those who were resistant to participating in programmes. However, at Isle of Wight, we saw few sentence plan targets to address the risk of future sexual offending, other than through programmes, and there was no clear understanding among prison staff of the issue of denial. At Ashfield, about half the population denied responsibility for their offence, yet there was no structured programme to change their perceptions and address their offending behaviour, although the education and other departments provided a few lower level interventions.


VISITORS
PLEASE REPORT
TO THE
RESETTLEMENT
OFFICE
WELCOME TO
RESETTLEMENT
WARNING
KEEP HANDS AWAY FROM
EDGE OF GATE,
USE THE HANDLE

Categorisation

While most prisoners had a prompt initial categorisation, there were often delays with reviews, which hindered progression to less secure prisons. Allocations to training prisons from locals were usually forced by population pressures rather than to fulfil a sentence plan.

About 30 prisoners a week were transferred to other prisons but few of these were prioritised based on sentence plan targets and their need to progress. Some category B prisoners, particularly sex offenders, remained at the establishment too long because of the lack of spaces nationally. Liverpool

Release on temporary licence

New release on temporary licence (ROTL) practices, implemented last year after three catastrophic failures, had contributed to a 39% reduction in ROTL failures. This was welcome, although we still had concerns about the rigour of ROTL risk assessments in a few prisons.

ROTL assessments for category D prisoners working outside the prison were inadequate and did not provide assurance that risks had been assessed well or managed appropriately. There was a presumption in favour of these prisoners being allowed out on day release, without a formal risk assessment, an up-to-date OASys assessment, consultation with the offender supervisor or oversight by a board. Highpoint

The new arrangements had also brought about a 41% reduction in the number of ROTLs granted since the quarter ending June 2013.[22] In many prisons holding potentially suitable prisoners, ROTL was not used at all, such as Manchester. ROTL is an important tool in prisoner rehabilitation, yet although more prisoners were returning to resettlement prisons before release under the new through-the-gate arrangements, this had not resulted in an increase in ROTL provision. Open prisons continued to use ROTL well to support resettlement objectives.

ROTL innovation at Warren Hill

Men who have previously absconded, failed to return from release on temporary licence (ROTL), attempted to escape or been convicted of a criminal offence while in the community on licence can no longer be allocated to open prison conditions or be allowed ROTL. Without these opportunities, such men have struggled to demonstrate their suitability for release.

Warren Hill has developed a progression regime to provide a structured opportunity for indeterminate sentence prisoners in this position to demonstrate their suitability for release, through a programme of risk reduction and testing within a secure environment. Although the new regime was incomplete at the time of our inspection, it was already providing valuable opportunities for prisoners to demonstrate reduction in risk. Each prisoner had a key worker, as well as an offender supervisor and an offender manager who worked together using an enhanced behaviour tool to monitor behaviour relating to risk factors.

Since our inspection, some men have been granted release by the Parole Board, an early indication of the success of this innovative approach.

Public protection

Most public protection arrangements were reasonable and we identified some good practice.

22 http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2015-10-29/HL3129/

An assessment of all new prisoners by the public protection case administrator and by a public protection sift panel, which included OMU and security staff, was an excellent way to identify those who presented a risk of serious harm. The Mount

Restrictions applied to prisoners' mail, telephone calls and visits were usually well managed and proportionate.

In most prisons, we continued to report delays in confirming management levels for prisoners due to be released under public protection arrangements. Responsibility for deciding the management level lay with the national probation service but, as we reported last year, most prisons were not active enough in ensuring the work was done. This sometimes resulted in rushed release planning.

New approach to providing resettlement services

Since May 2015 and the introduction of CRCs to manage resettlement services, 89 prisons have been identified as resettlement prisons, including all local establishments, many category C and all category D prisons. Under this new model, CRC staff are based in all resettlement prisons, where they are responsible for the initial assessments of prisoner need, in conjunction with offender supervisors. CRCs are also responsible for the delivery of five mandatory areas of resettlement: accommodation support; finance, benefit and debt; victims of domestic violence; support for those previously involved in the sex industry; and employment guidance and advice. The CRC should review all aspects of resettlement at least 12 weeks before the prisoner's release, linking back to the community CRC or probation service responsible for post-release supervision. For this model to be effective, all prisoners should be returned to a resettlement prison serving their release area in their last three months of sentence.

Although there had been planning for this new model for some time before its formal introduction, we found that many prisons had still been slow to implement it. While most prisons managed basic custody screening reasonably well, at Wealstun in August 2015 we found men were still arriving without documents and 'in some cases we examined, the screening was incomplete and unhelpful'. In several cases, prisons remained unclear about the model or how it should be implemented.

Few wing staff we spoke to fully understood the new resettlement prison role and many staff and prisoners were confused about CRC provision. Liverpool

Despite this, some prisons had managed to develop reasonable services.

CRC staff were developing through-the-gate services to provide mentoring support and additional help to prisoners with complex needs being released to the South Yorkshire area. Hatfield

Accommodation support

As in previous years, the support for prisoners leaving custody without accommodation was variable. In some cases, such as at Liverpool, this issue was not monitored reliably, and at other establishments, we found that the number leaving with no fixed accommodation had risen – for example, at Rochester, the level had risen in the previous six months to 6%. While Stocken claimed that 93.3% had been released to settled accommodation, this information was, as at most prisons we visited, based purely on self-disclosure with no routine follow up to establish how accurate this figure was.

Under the new arrangements involving CRCs, the accommodation support service had, in some cases, deteriorated.

Formal arrangements to meet the housing needs of those from other CRC areas [outside Thames Valley] or managed by the NPS [national probation service] were not yet in place, which was a serious weakness. Bullingdon

Re-entering work and training

The quality of learning, employment and training advice provided by the National Careers Service was good in just over half the prisons inspected. However, the quality of advice was rarely linked with effective through-the-gate work. While we found good examples of productive partnership with employers to improve prisoners' opportunities for training and employment after release at Kirklevington Grange, this was not the case for most prisons. We rarely saw use of the 'virtual campus' – giving prisoners internet access to community education, training and employment opportunities – in supporting prisoners in job search and preparing for resettlement.

Support for substance misusers

Pre-release arrangements and through-the-gate support for prisoners with substance misuse needs were generally good, and some were excellent.

The drug and alcohol recovery team (DART) shared care plans for prisoners with substance misuse needs with the offender management department and had input into HDC and parole reports. The team had good links with the Cambridgeshire drug intervention programme (DIP)… Information was sent to families about prisoners' treatment and progress where appropriate, and there were meetings with family members in visits to help signpost to community services. Families were also invited to attend recovery programme reviews. The DART offered each prisoner up to eight weeks of telephone support post release. Littlehey

Contact with families

Families continue to play an important role in the successful resettlement of prisoners; in addition to providing emotional support, families can also be vital to the provision of accommodation and employment for those leaving custody.

In our survey, prisoners indicated some of the barriers to maintaining family ties – only 30% said it was easy for their friends and family to visit, nearly half said they had problems sending or receiving mail, and a quarter had problems getting access to the telephones. Furthermore, only a third reported that staff had helped them to maintain contact with family and friends.

Our inspections continued to find inconsistencies in the support for prisoners to rebuild and maintain relationships – too often, it was just not good enough.

The visits booking system was in disarray, and prisoners and visitors said that they had considerable difficulty in booking visits. There was a backlog of over 1,000 emails to the visits bookings team and yet there were still vacancies for visits during the inspection and for the following weekend. Wandsworth

In some prisons, prisoners told us that visitors were not always treated well by staff, and that their families and friends experienced long delays entering the prison, and our inspections confirmed this. For example, at Aylesbury we observed visitors entering the prison 45 minutes after the visit should have started, despite arriving early after long journeys.

There continued to be some good practice in family work. For example at Manchester, which also had good visits facilities, there was a wide range of services to support children and families, and well-developed links with appropriate community projects. Lowdham Grange offered particularly impressive relationship programmes, as well as in-cell telephones, which greatly increased prisoners' opportunity to contact their family.

4

Women in prison

This section draws on two full inspections of women's prisons – at Holloway and New Hall. The findings reported are based on *Expectations: Criteria for assessing the treatment of and conditions for women in prisons*, published in June 2014.

- Women's prisons continued to perform better than most prisons for men, but outcomes for purposeful activity were mixed, and not good enough at Holloway.
- Work with women with complex needs had improved, and staff-prisoner relationships were generally strong.
- Offender management and public protection arrangements were not good enough, but strong partnership working was upholding resettlement outcomes, despite the strains of the new service delivery.
- Children and families work continued to improve, and there was still support for women who had been abused, but funding for this was uncertain.

Outcomes for women in the two prisons were impressive, with seven of the eight healthy prison areas judged good or reasonably good. However, Holloway continued to struggle to deliver adequate purposeful activity.

We have compared the outcomes for the prisons we reported on in 2015–16 with those we reported the last time we inspected the same establishments. Outcomes in only one area – resettlement at New Hall – had deteriorated.

Outcome of previous recommendations

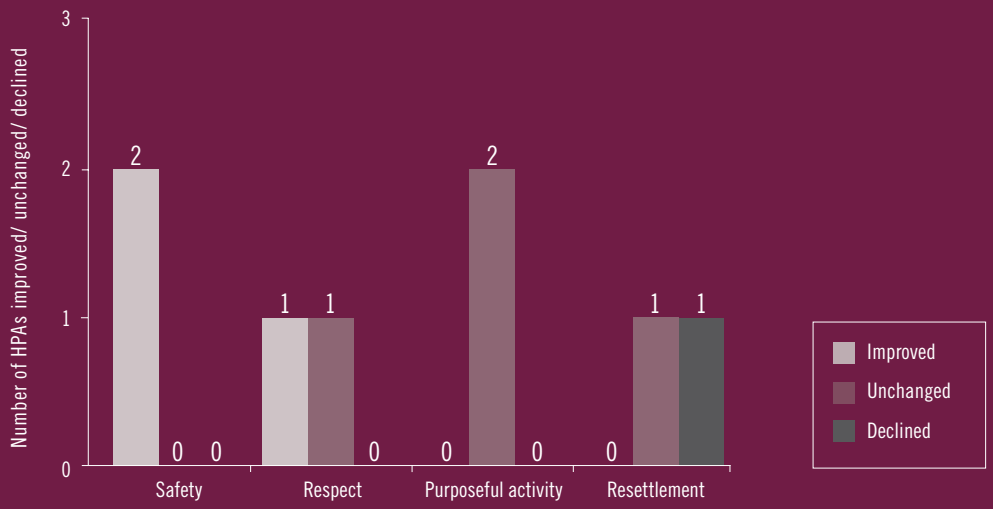
In the women's prisons reported on in 2015–16:

- 50% of our previous recommendations in the area of safety had been achieved, 16% partially achieved and 34% not achieved
- 52% of our previous recommendations in the area of respect had been achieved, 18% partially achieved and 30% not achieved
- 57% of our previous recommendations in the area of activity had been achieved, 14% partially achieved and 29% not achieved
- 46% of our previous recommendations in the area of resettlement had been achieved, 21% partially achieved and 33% not achieved.

Figure 14: Published outcomes in women's prisons inspected in 2015–16

	Safety	Respect	Purposeful activity	Resettlement
Holloway	Good	Reasonably good	Not sufficiently good	Reasonably good
New Hall	Good	Good	Good	Reasonably good

Figure 13: Outcome changes from previous inspection (women's prisons – 2)



Strategic context

Shortly after our inspection of Holloway in October 2015, the government announced that the prison would close in summer 2016. London women will be remanded to Bronzefield and sentenced women will go to Downview, which is being re-opened. Although Holloway's performance had improved in recent years, the physical environment would always limit its potential. One significant challenge will be to continue Holloway's wide array of specialist local resettlement services in a new location – many women from London have been able to work with the same provider both in and out of custody, and this will be difficult to replicate at Downview.

The two women's open prisons, Askham Grange and East Sutton Park, which have been earmarked for closure since the Women's Custodial Estate Review in October 2013,[23] remained open. There were small open resettlement units at Drake Hall and Styal.

To date, we have not inspected any women's prisons that have fully implemented benchmark staffing levels. We will monitor carefully the effect of changing staffing levels on performance.

In July 2015, NOMS established a centralised case supervision system for 'restricted status' women (equivalent to the male category A status), and others with the most complex needs. This is designed to assist governors in accessing the resources and interventions needed by this small group of particularly vulnerable women.

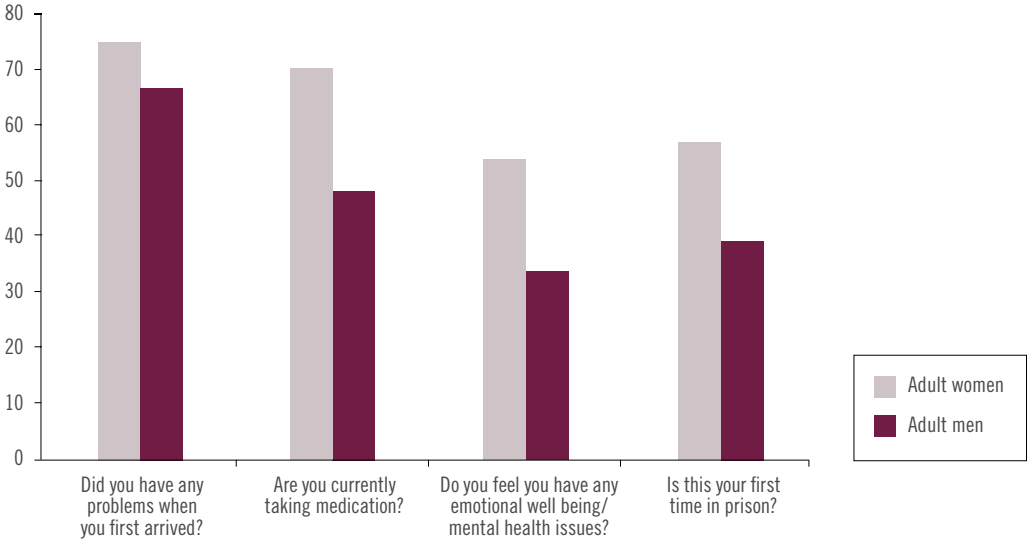
We continued to attend the Ministerial Advisory Board on Female Offenders as an observer. Over the last year, the board has focused mostly on the 'transforming rehabilitation' agenda and its impact in the community.

In autumn 2015, a large number of staff from women's prisons received training in creating 'trauma-informed' environments. Prisons were encouraged to review their processes from the perspective of women who had experienced trauma, such as rape, sexual abuse and domestic violence, and make changes where possible.

Safety and vulnerability

The population in women's prisons tends to be more vulnerable than in men's prisons. In this year's survey, 75% of women said they had a problem on arrival at the prison (compared with 66% of men), 70% were currently on

Figure 15: Vulnerability comparison between adult women and adult men



23 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252851/womens-custodial-estate-review.pdf

medication (compared with 48% of men) and 54% said they had emotional well-being or mental health issues (compared with 34% of men). For over half, it was their first time in prison (56% compared with 39% of men). It was unsurprising, therefore, that nearly half of women (more than in men's prisons) said they had felt unsafe at some time in prison. (See also Appendix 6.)

Escort arrangements for women to prisons remained poor; many women were held in court cells for too long, travelled in vans alongside male prisoners and arrived at their destination late at night. In the six months before our inspection of New Hall, 105 women had arrived at the prison after 7pm. Reception and induction arrangements were generally sound, but there were some delays.

The number of violent incidents was low and use of force was rare and usually proportionate. Governance of the use of force at Holloway was exceptionally good.

Staff at both prisons had a good understanding of adult safeguarding. Both held weekly multidisciplinary meetings to identify women needing support and to design individual care plans as necessary.

> Arrangements to safeguard at-risk women and those with complex needs were excellent. Staff had a good awareness of these issues and the weekly complex needs meeting focused on those who needed additional support or attention. Holloway

Women at risk of self-harm or suicide were generally well supported, but in both prisons there were problems with night time access to Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners). The rate of self-harm remained much higher than in the male estate, with 1,888 incidents per thousand women in the year to December 2015 (compared with 306 for men).[24] Although the trend over recent years has been downwards, this was an increase of 22% since the same period in 2013, which is worrying. Seven women killed themselves in prisons in England and Wales in 2015. This was the highest figure since 2007, and alongside recent increases in the number of self-harm incidents is a cause for serious concern. In addition, two transgender women held in men's prisons also killed themselves during the year.

In both prisons, very vulnerable women were sometimes segregated. At Holloway, we were not assured that this had always been appropriate. Holloway also placed some women with complex needs on the basic regime, which was not always in their best interests. In contrast, at New Hall:

> Staff had a good awareness of the need to consider the impact of sanctions on women at risk. New Hall

The assessment and inpatient unit and the Tillson Day Centre at Holloway and Holly House at New Hall provided care for the most vulnerable women. Both prisons had learned well from serious incidents and Prisons and Probation Ombudsman (PPO) reports, and Holloway's staff continued to identify women who were vulnerable or a risk by routinely collating risk-based information from across the prison and actively offering support.

There were no persistent drug supply problems at either Holloway or New Hall. New psychoactive substances had not emerged as a significant issue in women's prisons, although we saw evidence of them at New Hall for the first time in a women's prison.

In our survey, a much higher proportion of women prisoners than men said they had a problem on arrival with drugs (41% against 25%) or alcohol (30% against 16%), but fewer women said it was easy to get drugs

24 NOMS Safety in Custody statistics bulletin summary tables. https://www.gov.uk/government/collections/safety-in-custody-statistics

(31% against 37%) or alcohol (5% against 21%) in their prison. As reported in our previous annual reports, prescribed medicines remained the most frequently misused drugs in the women's estate. In our survey, more women prisoners than men said that they had developed a problem with diverted medication in their prison (10% against 6%).

> Survey results pointed to the high availability of illicit drugs and diverted medication… The diversion of medication continued to be an issue but appropriate steps were being taken to monitor and address it, although some aspects of supervision around medication queues needed to improve. Intelligence reports and finds had indicated that in the months prior to the inspection new psychoactive substances had emerged as a further concern. New Hall

Women were more positive then men about the support they had received.

> Building Futures (BF)… was supporting over half the population… BF offered over 50 modules of psychological and social support for alcohol and drugs issues, either individually or in groups, some of which were designed for women on remand or very short sentences. The modules educated women about addictions and how changes in their lifestyle and behaviour could help avoid dependence. Holloway

Good outcomes on respect

The women's population remained broadly stable during the year and, unlike many men's prisons, women's prisons were not overcrowded. Accommodation varied but was usually well maintained; some double cells at New Hall were cramped and Holloway's dormitories gave women little privacy.

Relationships between staff and prisoners were mainly decent, and 80% of women (compared with 70% in the male estate) said they had a member of staff they could talk to if they had a problem.

> Interactions we observed were friendly and appropriate, and staff also consistently challenged prisoners' poor or inappropriate behaviour. Some staff doing specialist jobs were exceptional, which led to some very good outcomes. New Hall

Diversity and equality outcomes were generally good. However, the foreign national prisoners at Holloway, who represented 28% of the population, did not have sufficient support, and access to independent legal advice was a problem. Foreign national women could only receive a free five-minute telephone call home a month if they had not had a social visit, which we considered punitive. For those with children, the five-minute allocation was not long enough.

The mother and baby unit at New Hall continued to offer good support, but it was inappropriate that women were expected to remain in their rooms with their babies after 7.30pm. Transfers to mother and baby units from Holloway (which no longer had its own unit) were frequently delayed beyond the planned 32 weeks of pregnancy, which meant women had to move very near to their due date.

Faith provision was good at Holloway and chaplains were particularly well engaged with wider prison processes.

> The team was integrated into prison life and attended some assessment, care in custody and teamwork (ACCT) case management reviews for prisoners at risk of suicide or self-harm; two chaplains were ACCT assessors. They also attended meetings covering the main policy areas including safer custody and the EAT [equality action team]. Holloway

New Hall lacked this kind of integration, but women were positive about the chaplaincy, and we noted that specific resettlement support was available for Muslim women.

Health care

Most women had prompt access to health services, and the care they received was generally very good, particularly at New Hall. At Holloway, staff took too long to answer patients' complaints and paid insufficient attention to the care of older women. Too many women requiring assessment in NHS mental health units waited too long for their transfers.

Activity and resettlement

Time out of cell was reasonable at New Hall, but at Holloway, 38% of women had less than four hours a day out of cell. We expect prisoners to have 10 hours a day out of cell, but on average, only 13% of women achieved this, similar to the adult male estate.

New Hall continued to provide excellent purposeful activity opportunities, including commercial-standard workshops for call centre operations, hairdressing and photography, where women could gain accredited qualifications. Ofsted rated it 'outstanding' in all its assessments.

> Outstanding partnership working between the prison and college managers had resulted in a well-planned coherent curriculum that met the population's needs… tailored to local skills gaps and employer requirements. New Hall

However, Holloway had failed to address some concerns identified at our previous inspection. Allocation to activities, attendance and punctuality were still weak, and as a result too many women were locked up or not purposefully engaged during the working day. Although vocational provision had been increased and there had been some rapid improvements in strategic focus and achievement since the start of a new learning and skills contract, some teaching was not sufficiently engaging. Ofsted rated Holloway as requiring improvement in all its assessments.

All women's prisons have now been designated as resettlement prisons, but the work of the community rehabilitation companies (CRCs) was still developing (see also p.49), and neither staff nor prisoners yet had sufficient understanding of the CRC function. More joint working was needed to ensure that the CRCs, the offender management unit (OMU) and the resettlement team worked effectively together.

Offender management arrangements in both prisons lacked coordination and governance. At Holloway this was compounded by serious staff shortages.

> Three of the 11 administrative posts were vacant, and not all staff were confident performing the complete range of tasks; some carried out the same tasks differently from others, resulting in inconsistencies. Shortages of prison officer offender supervisors had been compounded by redeployment and up to 30% of hours were lost in the previous three months. Holloway

Public protection arrangements were not robust enough at either prison; staff had insufficient understanding of their roles and management oversight was weak. There were delays in identifying public protection management levels before release, which potentially compromised the effectiveness of release planning.

Some staff did not have a sufficient awareness of multi-agency public protection arrangements (MAPPA) processes and, overall, the prison did not sufficiently prioritise the close management of MAPPA cases. Some prisoners had no confirmed MAPPA level despite being within six months of release. New Hall

At Holloway, women suitable for open conditions could have a more flexible and rehabilitative regime, with regular access to release on temporary licence (ROTL). However, there was no equivalent regime at New Hall, and some women were held in more restrictive security conditions than necessary. In addition, ROTL here was rare, and some resettlement opportunities were missed, particularly for women in the mother and baby unit.

'Transforming rehabilitation' works best where prisoners are in the prison closest to their home before release, where they will have much easier links with community support mechanisms, such as housing agencies, health and drugs services. At New Hall, around one-third of women were not from the local area and, unless they presented unusually high risk, most could not get transferred to the prison closest to their home before release. At Holloway, sentenced women regularly arrived from other parts of the country to relieve overcrowding elsewhere, and returning them was not always easy.

Despite this, resettlement pathway work remained very strong compared with men's prisons. At New Hall, the work was based around the 'Together Women Project Women's Centre', and at Holloway, the resettlement department had a pivotal role. Both were seeking to work collaboratively with the new CRC providers, but there was a sense of uncertainty that was disruptive. At Holloway, the 'Hub', based outside the prison, was an excellent and innovative new facility that provided a safe place immediately after release.

The centre was run by volunteers and staff from the major resettlement agencies working in the prison. Women could charge their telephones, use the internet, make calls and meet up with through-the-gate workers. There was a shower and a large stock of donated clothing. Around half of released women used the facility and feedback was very positive. Holloway

Children and families

We expect women's prisons to identify women's family circumstances and develop support plans to help them maintain contact. Both prisons had family support workers, who were making a positive impact on the lives of women and their families. At New Hall, this service was so popular that it was struggling to meet demand, and an additional worker was being employed. Encouragingly, 61% of women there said they had received help to maintain contact with family and friends.

All those who disclosed that they had children were seen by a PACT family engagement worker within two or five days of their arrival. The workers provided useful literature on keeping in touch, practical resources, such as a child-friendly explanation of search processes, and information about available services. Where necessary, they completed further casework over the following weeks, and the caseload was growing rapidly. Holloway

Arrangements for visits were reasonable in both prisons. At New Hall, women could go to the play area with their children, and at Holloway the family room had been redecorated and provided an excellent facility for visiting children. Not all women could have one visit a week, but Holloway provided a toddlers group and a homework club, which did not require a visiting order. Both prisons ran extended family visits, and New Hall was planning an overnight facility for women with children.

A residential, three-bedroom overnight facility was nearing completion outside the gate. It would allow women on ROTL to have overnight visits from their children. Currently ROTL was not used to help women maintain contact with their dependants. New Hall

Victimisation, abuse and trafficking

CRCs now provide support services in these areas, but only within the last 12 weeks of sentence. At New Hall, which we inspected early in the year, providers were anxious about continuing funding.

An impressive range of services supported women who had suffered trauma (74% of the population according to the prison's own needs analysis) although representatives from several of these services were uncertain about future funding arrangements. New Hall

At Holloway, the CRC had just begun to supply some services but the Eaves' Poppy Project (which supported potential victims of human trafficking) ceased to operate shortly after our inspection. Women are often slow to disclose needs in relation to victimisation, abuse and trafficking, so such services should be available from a woman's arrival in prison right through to discharge to maximise her opportunities to seek support.

Attitudes, thinking and behaviour

The variety and volume of programmes to help women address their offending behaviour and develop cognitive and social skills was broadly appropriate.

The Rivendell Unit at New Hall offered a joint NOMS-NHS treatment programme to women with personality disorders, with early evidence of improved institutional behaviour among the participants.

5

Children in custody

This section draws on five full inspections of young offender institutions (YOIs) holding boys aged 15 to 18 and, jointly with Ofsted (Estyn in Wales) and the Care Quality Commission, two inspections of secure training centres (STCs) holding children (boys and girls) aged 12 to 18. We also made an unscheduled visit to a further STC. All the findings from inspections in this section are based on *Expectations for children and young people*, published in June 2012, and the framework for inspecting STCs, published in February 2014.

Young offender institutions

- Outcomes for children in custody were not good enough during 2015–16.
- All but one YOI was judged to be not sufficiently safe, with poor behaviour management and high levels of violence prevalent.
- Poor control of behaviour also affected the purposeful activity provided, and too many children were locked up when they should have been in class.
- Outcomes in areas of respect and resettlement were generally better.

Outcome of previous recommendations

In the YOIs reported on in 2015–16:

- 29% of our previous recommendations in the area of safety had been achieved, 17% partially achieved and 55% not achieved
- 47% of our previous recommendations in the area of respect had been achieved, 19% partially achieved and 35% not achieved
- 25% of our previous recommendations in the area of purposeful activity had been achieved, 27% partially achieved and 48% not achieved
- 20% of our previous recommendations in the area of resettlement had been achieved, 30% partially achieved and 50% not achieved.

Figure 16: Outcome changes from previous inspection (YOIs – 5)

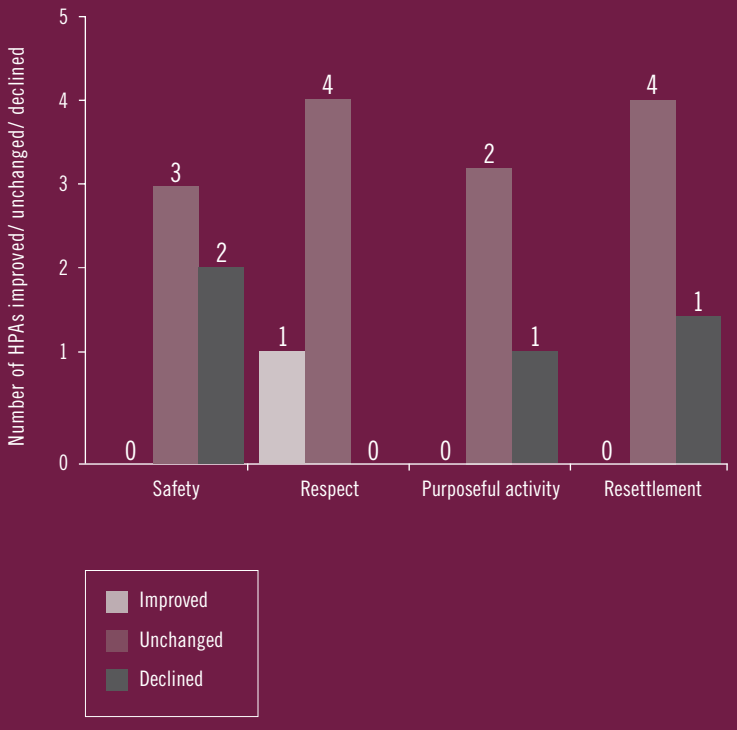


Figure 17: Published outcomes in YOIs inspected in 2015–16

	Safety	Respect	Purposeful activity	Resettlement
Cookham Wood	Not sufficiently good	Reasonably good	Not sufficiently good	Reasonably good
Feltham	Not sufficiently good	Good	Not sufficiently good	Reasonably good
Keppel Unit	Good	Good	Good	Good
Werrington	Not sufficiently good	Reasonably good	Reasonably good	Good
Wetherby	Not sufficiently good	Reasonably good	Reasonably good	Good

Who is in custody?
Demographic findings from our surveys of children in YOIs show that:

- 47% were from a black or minority ethnic group
- 5% were foreign nationals
- 23% were Muslim
- 8% considered themselves to be Gypsy/Romany/Traveller
- 20% considered themselves to have a disability
- 40% said they had been in local authority care
- 57% said it was their first time in custody in a YOI, STC or secure children's home
- 11% had children of their own
- 11% were 18 years old.

Early days in custody

Despite our recommendations over the past three years, all our YOI inspections found that children continued to experience unacceptable delays at court, some had convoluted journeys with adult prisoners and, as their return to the YOI was not prioritised, they often arrived late in the day. This avoidable delay inhibited their ability to settle in and added an unacceptable risk to the first few days in custody.

> Many boys attending court were left waiting too long in court cells after their case had been heard, including one whose case was completed at 9.40am who did not arrive at the establishment until 7.25pm. Two-thirds of boys arrived at the establishment after 7pm which was particularly difficult for new boys as they lost the chance to meet others on their wing and settle in before being locked up for the night. Cookham Wood

For many, their experience did not improve once they arrived on the first night unit. In our survey, 25% of boys said they felt unsafe on their first night. At Feltham, we found a fragmented induction with children spending long periods locked in their cell, at Wetherby they had to mix with disruptive and challenging boys, relocated from elsewhere, and at Cookham Wood and Werrington new arrivals experienced intimidating shouting from other boys. Even at Keppel (an enhanced support unit), where most boys were well supported, staff had not stopped the harassment of one boy and did not respond to another's request for bedding.

Behaviour management, violence and antisocial behaviour

Levels of violence remain far too high across the YOIs, and children felt unsafe as a result. In our survey, 44% of children told us they had felt unsafe, 19% felt unsafe at the time of the inspection and 27% reported victimisation by staff. For too many children, violence, bullying and intimidation were a regular feature of life in YOIs, and affected all other areas. We were particularly concerned for those boys who were too scared to come out of their cell.

> During the six months to March 2015, there had been 61 assaults on boys and 92 fights. Some of the incidents remained serious with multiple assailants on a single boy and the use of improvised weapons, which was not uncommon. There had been an increase in the number of boys requiring outside hospital attention, many with head injuries sustained by assailants jumping on their head. Staff assaults had nearly doubled since the last inspection. Cookham Wood

Across all establishments, 43% of children said shouting out of windows was a problem; at Cookham Wood, we observed aggressive shouting at night going unchallenged by staff.

Behaviour management strategies were generally ineffective in combating violence, bullying and antisocial behaviour.

> A common form of bullying, across the custodial estate, is forcing boys to hand over their canteen, which is the term given to goods they have bought from the prison shop. Some boys at Werrington were in possession of excessive amounts of canteen items. One case that we checked involved a boy who had created a display of a significant number of shower products in his cell… His canteen records showed that he had had not ordered the items from the prison shop, yet this had not been challenged by staff. Werrington

Less than half of boys told us the incentive scheme encouraged them to change their behaviour, and our findings supported this view. Support for victims also required improvement; only 29% of boys said they would tell staff if they were being victimised, and most were not confident staff would take their disclosure seriously.

There had been some positive initiatives at Feltham, where managers had established two 'violence and gang free' units, which had a positive impact on encouraging responsible behaviour. These units were unlocked for most of the day, and nearly all boys living there took part in purposeful activity.

More common, however, was the practice of physically separating boys, with the consequence that too many spent too long locked alone in their cells. Only in the smaller Keppel Unit was the situation different; levels of violence were lower, less serious in nature and all children received a good regime.

Children under restraint – poor staff practices

In November 2015 we published a thematic review of the implementation of 'minimising and managing physical restraint' (MMPR),[25] a new system of restraint applied across STCs and YOIs in England. The introduction of MMPR was the culmination of a long process initiated in response to the deaths of two boys in 2004. The new system places additional emphasis on the importance of staff using their relationships with children to de-escalate volatile incidents, and minimising the number of children who experience restraint.

Our review raised particular concerns about the restraint of children on the floor, the application of head holds and the use of pain-inducing techniques. We also found evidence of underreporting of the use of pain-inducing techniques and incidents resulting in injuries or warning signs.

Some accounts of staff and children were alarming; the circumstances leading to the death of Gareth Myatt in Rainsbrook STC in 2004 demonstrated the clear link between reported breathing difficulties and the fatal consequences that can occur if these warnings are not heeded, as revealed at his inquest. However, despite clear guidelines that staff should adjust or release holds if the child exhibits signs of breathing difficulties, many children told us this did not happen.

Children also told us that staff behaved differently when they knew they were under CCTV coverage. This was also exposed in January 2016 by BBC footage of staff in Medway STC apparently using inappropriate and excessive force in areas not covered by CCTV.

Despite the variation in local practice, we found significant improvements in national oversight and greater focus on communication and de-escalation as part of a wider approach to behaviour management. However, some of what we found was deeply disturbing. Despite significant effort and some good practice, we concluded that further work was needed to ensure that past tragedies associated with the application of force on children are not repeated.

25 Behaviour management and restraint of children in custody; http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/behaviour-management-and-restraint-of-children-in-custody/

Suicide and self-harm prevention

There had been no self-inflicted deaths in the children's estate during 2015–16, and none since January 2012. Levels of self-harm had reduced at Cookham Wood and Wetherby, increased at Feltham and Werrington, and remained high at Keppel. The standard of care for children at risk was generally good. Assessment, care in custody and teamwork (ACCT) case management for children with thoughts of self-harm and suicide were mostly of a good standard, and many staff demonstrated care in often challenging circumstances, such as at Keppel, a unit housing some of the most challenging and vulnerable children in the country.

> Staff did an excellent job of identifying and responding to the needs of boys who self-harmed, and in some cases keeping them safe required significant effort and skill. Keppel

However, we continued to find examples of poor care for some of the most vulnerable children.

> We also found examples of boys on ACCT documents who had been locked up for too long with nothing to do and a few cases where documents confirmed that isolation brought about by restricted regimes had contributed to their self-harm. Feltham

Segregation

In our survey, 26% of boys said they had spent a night in a segregation unit. The segregation units in YOIs remained poor environments, although their use had fallen at Cookham Wood, Werrington and Wetherby. In contrast, despite our previous recommendations, use of the segregation unit at Feltham had risen. This unit was grim and featureless; an unacceptable place to hold children. The units in the other YOIs were not much better, and the regime they offered boys was inadequate, amounting to over 22 hours a day locked up.

> [Separated] boys who behaved poorly were denied access to basic items, including showers, telephone calls and exercise, which was inappropriate. Werrington

Children segregated in Keppel and Wetherby could not shower daily. Stays in segregation were short for most children, but some were isolated for unacceptable periods – up to four months at Cookham Wood. Relationships between staff and children in segregation units were generally positive.

In Feltham and Cookham Wood, we were particularly concerned about the continued use of segregation and separation for those seeking protection from other children; we repeated our recommendations that children should not spend significant periods locked in cells.

Drugs and children

The demand for clinical support for physical dependence on drugs or alcohol remained low in the YOIs we inspected, but there was still high demand for low to medium intensity psychosocial support. Most establishments provided reasonable support, although staffing shortages severely reduced service provision at Wetherby. Tobacco remained the most sought-after drug, but there had been some finds of new psychoactive substances at Wetherby and Feltham.

> The assessment of clinical treatment needs had improved… Psychosocial services had also much improved. The Lifeline4U team worked with 71% of the population. About half of all boys (98 boys) were assessed as requiring specialist structured treatment – the highest level of intervention. Yet, in our survey, only 26% of boys against the comparator of 39% said they had arrived with drug problems, predominantly because boys had normalised cannabis use and did not see it as a problem… Boys with substance use issues and gang affiliations had access to a behaviour change mentor. Feltham

Living conditions and relationships

The living conditions in all sites were reasonable for most boys. At Keppel, the quality and cleanliness of the accommodation were exceptional. Boys at Cookham Wood lived in well-equipped modern single cells, but they were not expected to clean up after themselves in communal areas and so some of the landings were very dirty, with food on the floor and dirty tables. Living conditions had improved at Werrington but were more mixed at Feltham and Wetherby, where we found some grubby cells with offensive graffiti and stained shower rooms. Although access to showers and telephone calls was generally good, this was not the case everywhere.

> Many boys were subject to restrictions to their regimes following disciplinary procedures and the time taken to administer this prevented some boys from having access to a shower and a telephone call every day. Werrington

Relationships between boys and staff varied dramatically; at Keppel and Wetherby they were consistently strong, but at Feltham and Cookham Wood – which had significant numbers of 'detached duty' staff brought in from other prisons to cover staff shortfalls – they were more variable. Although at Feltham we saw mainly positive interactions, a small minority of staff continued to have low expectations of boys, spoke of them in a dismissive tone, and had a passive approach to dealing with reasonable requests. At Cookham Wood, many staff were not challenging poor behaviour. Boys there told us they would wait for helpful staff to be on duty before asking for something. In our survey, two-thirds of children said most staff treated them with respect, which was too low (and lower than in adult male prisons), and perceptions among boys from a black and minority ethnic or Muslim background were particularly poor. With the exception of Keppel, personal officer schemes had ceased to function.

Diversity

Work to address diversity and equality was reasonable at Cookham Wood and well developed elsewhere. At Feltham, equality and diversity work was particularly well developed and given a high priority by the senior management team, and external agencies contributed to provision for many groups. Regular cultural awareness events continued to be organised and were well promoted.

Despite this, perceptions of some groups were particularly poor in all the inspected establishments. Black and minority ethnic boys were far more negative than white boys about many aspects of respect and safety – for example, fewer said that staff treated them with respect, over a third reported victimisation from staff and over half said they had been restrained. This group was also more negative about behaviour management and complaints. Children with disabilities had very poor perceptions of their safety; 62% had felt unsafe in the establishment, and more than a third felt unsafe at the time of the inspection.

Health

Boys at Feltham, Werrington, Wetherby and Keppel had mainly good access to health services, but at Cookham Wood, problems escorting boys and the limited treatment rooms made access to health care unreliable, with unacceptable delays in treatment. However, we found good attention to assessment for learning disability and neurological problems, such as acquired brain injuries.

Children experienced disruption to their health care where a lack of prison officers meant that they were often not brought to appointments.

> In January 2015, clinicians had audited the time lost, which was 110 days, including 21 days of medical time, 31 days of psychology time and 59 days of nursing time – an alarming misuse of the resource. Cookham Wood

Access to dental care was also particularly poor at Cookham Wood; nearly half of all appointments were missed and we found 55 boys had been waiting too long for treatment – we were told this was because they had not been brought to their appointments.

Mental health services were mainly good and we found some examples of good practice.

> The CAMHS [child and adolescent mental health services] provision was impressive. It offered a range of individual and group sessions, including access to speech and language therapy, a learning disability nurse and joint working with the brain injury link worker service. Keppel

Children with mental health needs continued to wait too long to be transferred to hospitals in the community. At Werrington, one unwell boy needing 24-hour health care had to remain in segregation because another YOI with inpatient facilities said he could not be transferred there.

Time out of cell

High levels of violence and staffing shortages meant time out of cell was poor and unpredictable for most boys. At Cookham Wood, we found 36% of the population locked in their cell during the core day, at Feltham this figure was 38%, while at Wetherby and Werrington just under a third of boys were locked up during the core day. Many of these boys were on some form of restricted regime and received very little time out of cell. Only at Keppel was time out of cell acceptable.

In our survey, only 59% of children said they went on association every day and over a third said they did not usually go outside for exercise every day. Our findings supported this view, with association periods regularly cancelled at Werrington, Cookham Wood and Feltham. Access to exercise was inadequate at most establishments with boys entitled to only 30 minutes a day – and in practice many could not access this. At Feltham, exercise periods were less than 15 minutes, and we assessed that being deprived of time in the open air was seriously detrimental to the health, development and well-being of growing boys.

Taking part in activities

Figure 18: Ofsted assessments in YOIs holding children 2015–16

	Overall effectiveness of learning and skills and work	Outcomes for children and young people engaged in learning and skills and work	Quality of learning and skills and work activities	Effectiveness of leadership and management of learning and skills and work
Outstanding	0	0	0	0
Good	4	4	4	3
Requires improvement	1	1	1	2
Inadequate	0	0	0	0
Total	**5**	**5**	**5**	**5**

Boys in custody have often struggled in education. In our survey, 88% said they had been excluded from school before they came into detention, 73% had truanted at some time, and 39% were 14 or younger when they last attended school. For many of these children, their only opportunity to make progress will be in custody.

From August 2015, education providers began delivering 27 hours of education and three hours of PE a week at all public sector YOIs. Although we welcomed this expansion, our inspections found that problems with behaviour management, violence and staff shortages led to poor attendance, delayed start times and early finishes in many classes. As a consequence, on average children took part in only half the education provided, and many accessed far less than that. This was a significant failing, with a waste of resources and a missed opportunity to improve the life chances of children on release.

For those who did attend education, the quality of teaching and learning was mainly good and achievement rates were generally high in vocational subjects. However, achievement in core skills, including literacy and numeracy, was variable and poor at Feltham. At Wetherby, too many learners did not complete their qualification.

Provision for resettlement

Resettlement provision was more positive with outcomes judged as good or reasonably good at all five establishments. We found committed teams of caseworkers across many sites, and some positive improvements to practice, including the use of release on temporary licence (ROTL) to support resettlement at Feltham and Werrington. While systems to follow up outcomes for some children post-release were being established at Feltham, Cookham Wood and Wetherby, only Werrington systematically collected this information.

All our inspections highlighted the continued difficulties in providing accommodation for children on release. Although caseworkers and advocates were working actively to address this – sometimes taking legal action to get local authorities to meet their responsibilities – too many children did not know where they would be living until the day before release.

> We were told of one boy whose address had been confirmed at 5.15pm the day before his release. Feltham

In addition to reducing opportunities to check the suitability of accommodation, this uncertainty affected all other aspects of resettlement planning, including education and employment. This was a particular problem for looked-after children who did not have a family home to return to. The impact on individual children was clear; in addition to the needless anxiety in the weeks before release, too many children were released to inappropriate accommodation and had little to occupy them on release. It is hard to imagine anything more likely to ensure a swift return to custody.

Secure training centres

- We raised significant concerns about staff conduct in Rainsbrook and Medway STCs.
- We found significant failings affecting safety for children in one STC; at a follow-up inspection staff misconduct remained a concern, despite some improvement.

Secure training centres (STCs) hold younger boys and girls or those who are deemed more vulnerable and less likely to do well in a larger institution. All have clear needs to be addressed while in custody and require consistent support to do this.

In this reporting period Ofsted, with HM Inspectorate of Prisons, published two STC reports, which both detailed the outcome of inspections at the same STC, Rainsbrook. In the first inspection, we found significant failings that brought into question whether the centre could keep children safe. There had been serious incidents of gross misconduct by staff, and the poor care we reported on, some of which involved junior managers, was compounded by poor decision-making by senior managers. In most but not all cases senior managers took robust action to deal with inappropriate staff behaviour once aware of it. Of concern was the gap between what should have been happening and the reality for some children, and the failure by managers and others involved in overseeing the centre to identify and remedy this at an early stage.

Despite this, we found generally positive relationships between children and staff, and behaviour management was particularly good in education. Elsewhere, there was inconsistency in the application of behaviour management, and the level of child-on-child assaults was high. Achievements in education were good but, as we find in other establishments holding children, there were problems with securing services for them post-release. Often this was related to a lack of suitable accommodation and/or a starting date at college or work placements.

The serious nature of the concerns led us to change our inspection programme and re-inspect Rainsbrook seven months later. At this second inspection we found there had been some progress. The number of violent incidents involving children had decreased and there was stronger oversight of the behaviour management used with the children. Relationships with external agencies, such as children's social care and the police, had improved. The majority of children continued to make good progress in education. However, two incidents of staff misconduct again called into question the culture of the centre. In only one incident did other staff present make an appropriate challenge. The second incident was uncovered through the use of body-worn cameras that recorded audio as well as visual images. The staff involved were dealt with robustly, but children had again been exposed to risk, and internal safeguards, including whistle-blowing, were not sufficiently strong to prevent this.

Figure 19: Published outcomes in inspections of STCs inspected in 2015–16*

Secure training centre	Overall effectiveness	Safety	Behaviour	Well-being	Achievement	Resettlement	Leadership and management
Rainsbrook (February 2015)	Inadequate	Inadequate	Adequate	Inadequate	Good	Good	-
Rainsbrook (September 2015)	Requires improvement	Requires improvement	Good	Requires improvement**	Good	Requires improvement	Requires improvement

* The method of Ofsted assessment changed between the two inspections and so results are not strictly comparable.
**'Well-being' had been split into health and care, which were both assessed as 'requires improvement'.

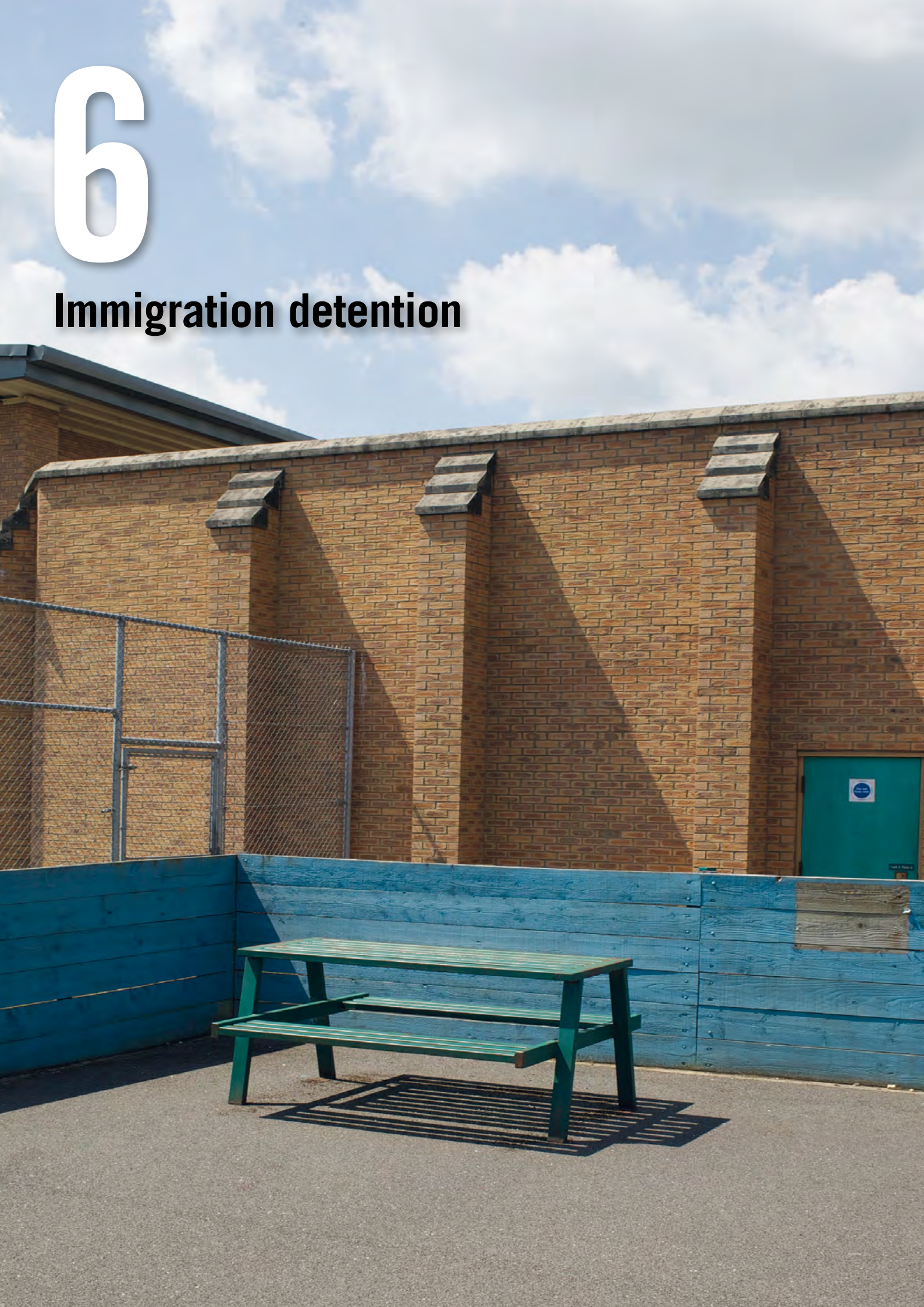
Sadly, the situation at this STC did not appear to be a one-off. HM Inspectorate of Prisons and Ofsted were made aware of emerging allegations of unacceptable practice uncovered by a BBC investigation at Medway STC, and a team of inspectors visited the centre in January 2016. While most children were positive about their experience at Medway a minority described some staff using insulting, aggressive or racist language and not always challenging poor behaviour, and said they felt unsafe in areas not covered by CCTV. These events echoed the findings of our 2015 thematic, *Behaviour management and restraint of children in custody*, which outlined significant differences between policy and practice across the estate.

We concluded that some staff must have been aware of unacceptable behaviour at the centre and were concerned that this went unreported to senior managers or external agencies. We made several recommendations to the Secretary of State for Justice,[26] including the establishment of a commissioner at Medway to provide increased oversight of the management of the safeguarding of young people. The inspectorates have since carried out additional visits to the other two STCs to ensure that the concerns raised at Medway were not more widespread; the reports will be published in 2016–17.

26 http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/medway-secure-training-centre-4/

6

Immigration detention



All the findings from inspections in this section are based on the third edition of our *Expectations: Criteria for assessing the conditions for and treatment of immigration detainees*, published in September 2012. This section draws on the inspection of five immigration removal centres (IRCs), eight short-term holding facilities (STHFs),[27] and two escorted overseas removals.

- We found better outcomes in smaller IRCs than in the larger ones, which tended to be less safe and respectful.
- The Rule 35 process, which is intended to protect detainees with serious health problems and those who have been tortured or trafficked, was not working consistently well at any IRC.
- Safeguarding processes at Yarl's Wood, which holds women detainees, were inadequate, and there was not enough account taken of this groups' vulnerability.
- Our continuing concerns about prolonged detention led us to recommend that detention should be time limited.
- IRC staff were generally respectful to detainees, and the atmosphere at most centres was relaxed, but too much accommodation remained prison-like.
- Conditions in the STHFs were generally appropriate, but not suitable for people detained for long periods. We were concerned to find a previously unknown facility that offered poor and insanitary conditions, with little regard for decency.
- The conduct of overseas escorts had improved, but several recurrent concerns had not been addressed.

Outcome of previous recommendations[28]

In the IRCs reported on in 2015–16:

- 30% of our previous recommendations in the area of safety had been achieved, 24% partially achieved and 46% not achieved
- 33% of our previous recommendations in the area of respect had been achieved, 35% partially achieved and 32% not achieved
- 15% of our previous recommendations in the area of activity had been achieved, 35% partially achieved and 50% not achieved
- 29% of our previous recommendations in the area of preparation for release had been achieved, 21% partially achieved and 50% not achieved.

In the year ending September 2015, 32,741 people entered immigration detention, an increase on the previous year of 11% and a 24% increase over the previous five years.[29] On any one day, there are around 4,000 immigration detainees in the UK. They are held mainly in one of nine immigration removal centres (IRCs),[30] a handful of residential short-term holding facilities (STHFs) or in prisons, which currently accommodate around 400 immigration detainees. There are also around 30 non-residential STHFs, which are near ports of entry into the UK or at Home Office reporting centres. This year, the reports of our inspections, as well as a findings paper on immigration detainees in prisons, were produced in the context of several major inquiries on immigration detention and concerns about the 'migration crisis', which has seen unprecedented numbers of migrants to Europe from parts of the Middle East and Africa affected by war and associated upheavals.

27 The residential short-term holding facility for men located in Yarl's Wood IRC was inspected at the same time as the main centre.
28 Excludes 13 recommendations that required no follow up.
29 Home Office Immigration Statistics July to September 2015 give the figures for immigration removal centres but do not include those held under immigration powers in non-residential short-term holding facilities, police stations or those held in prisons under immigration act powers. See https://www.gov.uk/government/publications/immigration-statistics-july-to-september-2015/detention (accessed 18.1.16).
30 Dover IRC closed during the year.

An All-Party Parliamentary Group report on immigration detention was published in March 2015. An external inquiry into Yarl's Wood IRC, commissioned by Serco, was published in January 2016,[31] on the same day as a major review of vulnerability in detention commissioned by the Home Office and led by Stephen Shaw, the former Prisons and Probation Ombudsman. A common theme in these reports was the need to improve protection for the most vulnerable detainees, including victims of sexual violence, people who have been trafficked, those with mental illnesses and pregnant women. This concern was in line with our own detailed findings in inspected detention centres.

Following on from these reports, in November 2015 all members of the UK National Preventive Mechanism (NPM) agreed to support the position that there should be a time limit on immigration detention. As part of the UK NPM, HM Inspectorate of Prisons supports this view.

Figure 20: Outcomes in inspections of IRCs 2015–16

IRC and contractor	Safety	Respect	Purposeful activity	Preparation for release
Dungavel [GEO]	Good	Good	Good	Good
Harmondsworth [Mitie]	Not sufficiently good	Not sufficiently good	Not sufficiently good	Good
Tinsley House [G4S]	Good	Reasonably good	Good	Good
The Verne [NOMS]	Not sufficiently good	Reasonably good	Reasonably good	Not sufficiently good
Yarl's Wood [Serco]	Not sufficiently good	Not sufficiently good	Reasonably good	Reasonably good

In the five IRCs inspected, we found sharply divergent outcomes between Tinsley House and Dungavel House, both relatively small centres that have traditionally ensured positive outcomes for detainees, and the larger centres, The Verne, Yarl's Wood and Harmondsworth. None of the latter was sufficiently safe, and only The Verne provided a reasonably respectful environment for detainees. In the centres where previous recommendations were followed up,[32] 59% were partially or fully achieved, but the overall figure masked wide variations: at Tinsley House, 82% of our previous recommendations were at least partially achieved, while at Yarl's Wood the figure was only 47%.

Repeated issues

Key repeated recommendations tended to relate to poor protection for the most vulnerable detainees, and the impact of lengthy detention. Another recommendation that was persistently not achieved across centres was on the night-time transfer of detainees between centres for reasons of administrative convenience. At both The Verne and Yarl's Wood, about a third of detainees had arrived in the early hours of the morning, leading to exhaustion and disorientation.

Poor protection for the most vulnerable

Rule 35 of the Detention Centre Rules requires medical practitioners to report any cases where they are concerned that a detainee may have been the victim of torture or suspects he or she has suicidal intentions, or where continued detention may be injurious to a detainee's health. The Home Office must then review the appropriateness of detention. We found the protections offered by the Rule 35 process, once again, to be inadequate in every inspected centre. Many Rule 35 reports were poor, simply repeating what detainees

31 The investigation was by Kate Lampard and Ed Marsden of Verita, a company with considerable experience of complex investigations.
32 Recommendations were not followed up at Dungavel and The Verne, as the last visits to these centres were not full inspections – the previous inspection of Dungavel was a short follow-up visit, and The Verne was not previously an IRC.

had said without providing a professional assessment. Although we saw a higher than usual number of releases in cases where Rule 35 reports had been submitted at Harmondsworth and Tinsley House, we were not therefore assured that all cases were properly assessed by doctors.

Many Home Office replies were equally poor. For example, in relation to a Rule 35 report at Dungavel IRC, the Home Office reply was 'you may have been a victim of torture. However, it has been decided that you will remain in detention'. The reply did not explain the very exceptional circumstances to justify continued detention. At Tinsley House, a doctor had assessed a detainee's multiple scarring as consistent with his account of torture, and the detainee was receiving treatment for post-traumatic stress disorder and counselling from a mental health nurse. Yet, the Home Office caseworker concluded that there was no 'independent medical evidence of torture'.

Concerns about Yarl's Wood

Yarl's Wood, which holds women detainees, is the most high profile immigration removal centre in the country. Our last inspection was preceded by allegations of physically and sexually abusive behaviour by Serco staff, an undercover television programme showing instances of inappropriate staff behaviour, and the announcement that Serco had itself commissioned an external inquiry focusing on staff culture at the centre.

In previous years, there had been proven instances of inappropriate sexual relationships between staff and detainees which, given the power imbalance and vulnerability of detained women, were clearly abusive. The staff involved had rightly been dismissed. As part of the inspection, we offered every woman in the centre a confidential interview with a female inspector and, with the help of voluntary sector support agencies, also interviewed women who had been released from Yarl's Wood in the previous six months. However, we found no evidence of a current widespread abusive or hostile culture among staff, although whistle-blowing processes were not good enough and there was insufficient account of the vulnerabilities of the women held in Yarl's Wood. Over half of women responding to our survey said they felt depressed or suicidal on arrival, and many reported histories of sexual violence.

There were not enough female staff and overall staffing levels were worryingly low. We had serious concerns about the capacity of the health care provider, and this was in the context of high levels of mental illness and self-harm. While we found that the centre had deteriorated, the fault for this did not lie primarily with the detention staff, many of whom worked hard to ameliorate the impact on detainees of detention. Most staff were doing their best in difficult circumstances[33] and were not helped by the detention of some particularly vulnerable women. Nearly 100 pregnant women had been held in 2014, although only nine had then been removed from the UK. We examined the cases of 12 pregnant women in detail, and the recorded evidence suggested that eight of them should either not have been detained or should have been released earlier.

Rule 35 reports were among the worst that we have seen, for example, giving wholly inadequate attention to the impact of rape and sexual violence.

33 The subsequent Verita inquiry report by Kate Lampard and Ed Marsden reached very similar conclusions.

Prolonged detention

Long periods of detention and lack of certainty about timescales exacerbated many of the concerns described above. While most detainees are held for no more than one to two months, in every centre a small number were held for very long periods of a year or more. For example, at The Verne, 39 men had been held for over a year and one man for over five years:

> … in one of the most shocking cases of prolonged detention we have seen… For years the Home Office had accused him of failing to cooperate with his re-documentation, but had not actively pursued a section 35 prosecution[34] to test this belief before a judge. The Verne

In our Yarl's Wood report, we recommended that detention should be time limited.

Many of the longest held detainees are ex-prisoners. Our findings paper, *People in prison: immigration detainees*,[35] showed that the 400 or so detainees in prisons are substantially disadvantaged compared with detainees in IRCs. For example, they are held in much more restrictive conditions, do not have the same opportunities for communication with lawyers and families, and have less access to legal advice and support from community organisations. Purposeful activity was the only area in which their experiences were better than those in IRCs.

What worked well

In general, at all IRCs, detainees were reasonably positive about the respect they received from staff. Security was generally proportionate at Dungavel, Tinsley House and Yarl's Wood and, with the exception of The Verne, levels of violence were low. At Dungavel, access to legal support was much better than we usually see as a result of more generous legal aid provision in Scotland than in England and Wales. This was clearly valued by detainees, who had continuing support with sometimes complex cases.

While there were some problems with the accommodation at Tinsley House and Dungavel, it was much less prison-like than at the other centres. The general environment in these centres was less forbidding and the atmosphere more relaxed, in line with the intention of the Detention Centre Rules.

The small number of women held at Dungavel were on a separate unit staffed by female officers, avoiding some of the problems seen at Yarl's Wood. They had freedom of movement around the centre and their individual needs were met. Similarly, at Tinsley House, particularly vulnerable women were held on the family unit and given good support.

Pre-release support provided at Harmondsworth was particularly good. Welfare and related services were co-located and detainees had good access to all staff. Every detainee was interviewed before release and community organisations, such as Hibiscus Initiatives, Detention Action, Bail for Immigration Detainees and the Jesuit Refugee Service, provided assistance to a large number of detainees.

34 Under section 35 of the Asylum and Immigration (Treatment of claimants, etc.) Act 2004, the Home Office can prosecute detainees who, without reasonable excuse, fail to comply with the re-documentation process.

35 http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/people-in-prison-immigration-detainees/

Short-term holding facilities

Outcome of previous recommendations

In the STHFs reported on in 2015–16:

- 35 of our previous recommendations in the area of safety had been achieved, six partially achieved and 37 not achieved
- 15 of our previous recommendations in the area of respect had been achieved, seven partially achieved and 23 not achieved
- two of our previous recommendations in the area of activity had been achieved, six not achieved and one was no longer relevant
- one of our previous recommendations in the area of preparation for release had been achieved, four partially achieved and five not achieved.

This year we reported on eight short-term holding facilities (STHFs).[36]

Common themes in STHFs were generally good treatment of detainees by staff and reasonable overall treatment of the majority who were held for short periods. However, the non-residential facilities were unsuitable for detainees held for more than a few hours, and many unmet recommendations related to these longer stay detainees. Too many detainees were held for up to and over 24 hours in facilities with nowhere to sleep or to have a shower, no access to the fresh air or natural light, and limited means of communication. For example, in the three inspected Heathrow facilities, 39 detainees, all adults, had been held for over 24 hours in the preceding three months. In the same period, 171 children had been detained at the inspected Heathrow facilities. It was clear that Home Office staff attempted to minimise the length of their detention, but the longest detained child was still held for over 19 hours. This child was accompanied by another family member.

One group of STHF inspections caused us particular concern. During a visit to Dover STHF and the overflow STHF at Folkestone, we discovered a temporary and previously unknown facility, the 'Longport Freight Shed', which was managed not by Tascor's trained detainee custody officers but by immigration enforcement officers. Men, women and children were held in extremely poor and insanitary conditions without sufficient food. This facility was created to help manage the unusually high numbers of migrants who had made their way through the Channel Tunnel, often hidden in freight vehicles, during what has become known as the migrant crisis. Many of them had been living in very poor conditions in makeshift camps in France before arriving in the UK. The increases in migration undoubtedly placed considerable pressure on the Home Office. However, this did not excuse the fact that appropriate standards of decency and regard for human dignity had been seriously compromised. Conditions at Longport were unacceptable and safeguarding duties were poorly met.

> Detainees were held overnight and/or for several hours with no clean or dry clothes, no food or hot drinks, and nowhere to sleep other than on a concrete floor… Some detainees had not eaten for very long periods and many were hungry. Detainees gestured to us that they were hungry by pointing to their open mouths… Detainees arrived with scabies, headaches and other conditions related to dehydration, such as diarrhoea. However, toilet and washing facilities were inadequate and blankets were not washed after each use. Longport

The Home Office is currently not detaining people in the Longport Freight Shed, which should in our view be closed permanently, unless it can be upgraded to acceptable standards.

36 The residential short-term holding facility for men in Yarl's Wood IRC was inspected at the same time as the main centre.

A more praiseworthy response to the pressure of numbers was found at Dover STHF, where local Home Office staff had opened the 'Atrium', an area where detainees released from the adjacent holding room received support from voluntary sector organisations. Both Migrant Help and the Refugee Council were contracted to work there, with the latter providing services to the large number of unaccompanied children who continue to arrive at the UK border from countries experiencing upheaval.

Overseas escorts

We inspected two escorted overseas charter removals last year, one to Pakistan and one covering both Nigeria and Ghana. Overall, we found some improvements. All staff had now received specialist training on use of force within the confined spaces of a coach or aircraft, something that we have recommended several times. We observed none of the inappropriate staff attitudes or behaviour that we had seen on previous overseas charter removals. Staff were generally experienced and calm.

However, some concerns continued to recur. We still found escort staff regularly sleeping while responsible for detainees, including those at risk of self-harm. Staff still depended entirely on other detainees to interpret for those without good English.

> It was unacceptable that, at a time when many detainees felt their future hung in the balance or when so much was uncertain, they should have been unable, in confidence, to understand what was said to them or say what was important to them. Pakistan escort

Restraints were still in place for too long and we were not assured that waist restraint belts were always justified. The length of already long journeys was avoidably extended; at one IRC, it took four hours to process about a dozen people. Overall, the treatment of detainees on these removal operations was reasonably safe and respectful, but we were concerned that a number of issues, which reports on overseas escorts have consistently pointed out, had not been addressed in two years. Standards had reached a plateau and the lack of progress suggested little aspiration to improve further.

7 Police custody

All the findings from inspections in this section are based on the second edition of *Expectations for police custody: Criteria for assessing the treatment of and conditions for detainees in police custody*, published jointly with HM Inspectorate of Constabulary (HMIC) in 2012. This section draws on 10 inspections of police custody suites in 10 counties and London boroughs – Cleveland, Cumbria, Gloucestershire, Hertfordshire, Lincolnshire, Metropolitan Police North West Cluster (London Boroughs of Barnet, Brent and Harrow), North Wales, North Yorkshire, Surrey and Warwickshire and West Mercia. During the year, we also inspected Border Force facilities (see Section 9).

- Management information was inadequate and not used to monitor outcomes for detainees, such as the number of strip searches or the effectiveness of partnership arrangements.
- There was inadequate and, in some cases, non-existent monitoring of the use of force in police custody suites. We had concerns that not all uses of force were reasonable or proportionate, with little staff accountability.
- Children charged and refused bail were held in custody overnight due to scarce provision of local authority accommodation in all forces inspected.
- There had been good progress in reducing the number of people detained in police custody under Section 136 of the Mental Health Act 1983, but still more needed to be done.
- Staff in some areas displayed good knowledge and confidence to refuse detention where appropriate, which we welcomed.

All inspections of police custody in England and Wales are conducted jointly with HMIC and are unannounced. We visit custody suites during the day and night, including early morning visits to observe transfers to court and shift handovers, and night-time and weekend visits to observe the range of detainees held in custody. All police custody inspections also include a documentary analysis of custody records.

Outcome of previous recommendations

In the police forces reported on in 2015–16:

- eight of our previous recommendations in the area of strategy had been achieved, six partially achieved and eight not achieved
- 33 of our previous recommendations in the area of treatment and conditions had been achieved, 24 partially achieved and 30 not achieved
- 14 of our previous recommendations in the area of individual rights had been achieved, 21 partially achieved and five not achieved
- 37 of our previous recommendations in the area of health care had been achieved, 10 partially achieved and five not achieved.

Leadership

There continued to be elements of good police leadership, management and partnerships with other agencies, but there needed to be a greater focus on working with partners to improve outcomes for detainees. For example, in Gloucestershire, strategic partners did not provide alternative accommodation for children charged and refused bail, resulting in them remaining in police custody overnight.

Many inspected forces did not collect or use management information to monitor outcomes for detainees. Quality assurance, including sampling of custody records, was inadequate in most of the forces inspected.

The force did not monitor or provide oversight on basic custody functions to ensure that standards were consistent and effective. It also did not monitor booking-in times, the number of strip-searches or allocation of local authority alternative accommodation for children who had been charged and refused bail. Data on custody provision was weak and not used to drive performance and outcomes for detainees. Cumbria

Despite our repeated recommendations, there were still no adequate arrangements to monitor the use of force in police custody suites. We made main recommendations in all our reports on the necessity to collect and analyse use of force data and use the findings appropriately to ensure safe custody for detainees. Mandatory use of force recording forms were introduced on 1 April 2016, and we will report on whether officers are completing them in future inspections.

Risk assessment and detainee safety

Care plans for detainees should be based on factors identified during their risk assessment. Many detainees posed risks of self-harm or suicide, and responses varied across inspected forces. There was generally good awareness of the levels of observation needed. However, forces also sometimes resorted to inappropriate strategies as a first response, such as replacing the detainee's own clothes with anti-rip suits (reinforced clothing that makes it more difficult, but not impossible, to tear and use as a ligature).

In Warwickshire and West Mercia, and North Yorkshire, anti-rip clothing was used frequently and inappropriately as a control measure for detainees who would not comply with the risk assessment process, and not specifically to prevent suicide and self-harm. By contrast, Cleveland managed risks well without resorting to removing detainees' clothes.

In our custody record analysis, we found pre-release risk assessments (PRRA) completed for all detainees released from custody, which was positive. However, there was wide variation in their quality and not all were focused on ensuring a safe release for detainees. In Cumbria, PRRAs were generally good and were enhanced for those charged with a sexual offence, whose risk of suicide or self-harm is known to increase.

In some forces, not all uses of force were reasonable or proportionate, and the presence of equipment to assist in the use of force varied greatly. There was generally no local policy for the use of equipment such as body cuffs, emergency restraint belts, spit hoods, Tasers and leg restraints in custody. It was positive that as a result of our inspection, Warwickshire and West Mercia had strengthened the oversight and governance arrangements for the use of such equipment.

We encountered some inadequate staffing levels (such as in Surrey, Hertfordshire, Cumbria and Warwickshire and West Mercia), which affected detainee care and welfare.

Custody suites operated below capacity for detention officers, which affected timely responses to cell call bells and detainee care, especially at Watford. At busy times we also observed operational officers, rather than custody trained officers, taking keys to alleviate the demands on custody staff, which was inappropriate. Hertfordshire

Protecting detainees from sanctions

During the reporting year, and as part of our National Preventive Mechanism duties, we worked with HMIC to develop a protocol to ensure that detainees held in police custody are protected from any sanctions that might arise as a result of communicating, or trying to communicate, with HM Inspectorate of Prisons or HMIC. The new protocol was published on 31 March 2016 and implemented in readiness for the 2016–17 reporting year.[37]

37 http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2016/03/HMIC-and-HMIP-sanctions-protocol.pdf

Children in police custody

The number of children arrested had fallen since 2014–15 and there were some positive examples of forces attempting to divert children from custody following arrest, such as in North Yorkshire, where inspectors found good efforts to try to bail children. However, this was not always replicated elsewhere, with too many children still detained in custody overnight due to limited provision of alternative accommodation or appropriate adult (AA) schemes – that often did not operate after midnight – and a failure by some custody officers to use bail and minimise children's stay in custody. In some forces, staff did not understand the needs of children coming into police custody.

There was little acknowledgement of the vulnerability of children; they were offered no specific support or care, and girls under 18 were not routinely assigned a named officer… a 16-year-old girl detained at Skegness… threatened self-harm and firstly had her bra removed by two female staff, who returned shortly afterwards with an anti-rip suit. Staff appeared to spend some time negotiating with the girl before she was restrained; staff then left the cell, inexplicably, taking the anti-rip suit with them, leaving the girl naked in her cell for a period of around 10 minutes. The next day, the girl complained to the sergeant that she had been 'violated'. Lincolnshire

In all the forces inspected we made a main recommendation on the need for engagement with local authorities to review their accommodation available for children under section 38(6) of the Police and Criminal Evidence Act 1984 (PACE), and to monitor performance data to ensure that children charged and refused bail were not detained unnecessarily in police cells.

Local authority accommodation for 17-year-olds

HM Inspectorate of Prisons has consistently challenged the incongruous treatment of 17-year-olds in police custody, insisting that they require the same safeguards as children, as defined in all other law relating to children under 18. An amendment to PACE Code C in October 2015 extended the definition of 'arrested juvenile' to include 17-year-olds in relation to accommodation matters. This change meant detainees under 18 charged and remanded must be transferred to local authority accommodation, or at least a request made for them to be transferred.

Appropriate adults

Our findings from inspected forces indicated shortfalls in the provision of AAs for children and vulnerable adults. We made main recommendations in three inspections (Surrey, Cumbria and Cleveland) to ensure AAs were available for the welfare and safety of children and vulnerable adults in custody. Custody staff were not always aware of their responsibilities to contact an AA when dealing with children under 18 or vulnerable adults. For instance, in some areas custody staff were found to contact AAs only in order that they be present for the detainee's interview, rather than at initial booking.

We saw police staff taking fingerprints, photographs and a DNA sample from a 17-year-old youth without an AA being present, which was a breach of PACE. Surrey

Health care

The Care Quality Commission (CQC) continued to accompany us on police inspections in England, and Healthcare Inspectorate Wales in Wales, as part of our partnership approach to inspecting health provision in places of detention.

In anticipation of the proposed transfer of police health services commissioning to NHS England in April 2016, many forces had made good improvements in local health needs assessments. However, this transfer of commissioning was cancelled. We are concerned that this will not address inconsistencies between forces in the quality of health care provided and its governance. We will monitor this policy carefully and report on any negative outcomes that might result.

Many detainees in police custody had pre-existing mental health issues of varying severity. Mental health liaison and diversion services in police custody had increased nationally and improved outcomes for detainees, but were still not universally available – for example, we did not find them in North Wales or Cumbria.

> The criminal liaison and diversion team provided direct community outreach support as well as work in court settings. It liaised closely with community mental health teams and GPs and could directly prompt emergency duty team referrals and arrange voluntary admission to hospital. Cleveland

Most forces we inspected experienced lengthy delays in Mental Health Act assessments, particularly out of hours. The pressure on acute mental health beds nationally meant some detainees had extended stays in custody.

> We came across a detainee with mental health issues who had spent four days in custody waiting for an appropriate secure hospital bed, which was unacceptable. Lincolnshire

Police custody is not an appropriate place for patients with severe mental health issues, and results in additional pressure on unqualified police custody staff caring for an extremely vulnerable person.

Mental health street triage schemes were available in some areas, such as North Yorkshire and Lincolnshire, where police and mental health staff responded together and diverted some individuals from custody and hospital.

> A street-based mental health triage service operated from 4pm to midnight every day and was a positive initiative, providing an emergency response to those in mental health crisis. Lincolnshire

The positive trend of fewer patients being detained in police custody under Section 136 of the Mental Health Act 1983 continued, and numbers were commendably low in Warwickshire and West Mercia, North Wales and the Metropolitan Police North West cluster. No patient had been detained in police custody under Section 136 in Hertfordshire for the previous three years. However, too many mental health patients continued to be detained in police custody in Lincolnshire, Gloucestershire, North Yorkshire and Cumbria.

During the year we contributed to the College of Policing consultation on Authorised Professional Practice (APP) – Mental health.

Police *Expectations* revised

HM Inspectorate of Prisons and HMIC reviewed and revised the *Expectations* for police custody during the year. The *Expectations* set out the assessment criteria for inspections of police custody. The revised draft drew on our seven years' experience of police custody inspections, and was informed by the findings from the thematic inspection of the welfare of vulnerable people in police custody, published by HMIC in March 2015, and consultation with our stakeholders.

The consultation process was completed in December 2015, with over 70 responses from police services across England and Wales, voluntary and statutory organisations, and other interested parties. All the responses were reviewed and the new third edition of our *Expectations* was published in April 2016, and applied to all police custody inspections from 2016–17.

In the revised *Expectations* there are a number of changes focusing on ensuring the welfare and safety of people who will be the most vulnerable in police custody. These include:

- an extension of the scope of inspection to include first contact and opportunities for diversion of vulnerable people
- criteria for inspecting forces on equalities duties as these affect custody
- focused inspection criteria on the use of force
- criteria reflecting strategic and operational outcomes on safeguarding the welfare of children (that is, all those under the age of 18) and vulnerable adults in police custody
- reporting on police cells used as a place of safety for people suffering acute mental ill health.

The *Expectations* are grouped under five inspection areas:

- leadership, accountability and partnerships
- pre-custody – first point of contact
- in the custody suite – booking in, individual needs and legal rights
- in the custody cell – safeguarding and health care
- release and transfer from custody.

8 Court custody

All the findings from inspections in this section are based on *Expectations: Criteria for assessing the treatment of and conditions for detainees in court custody*, published in June 2012. This section draws on inspections of court custody in two court areas, Humber and South Yorkshire, and Wales, covering seven Crown courts, 26 magistrates' and youth courts, six combined courts and an immigration tribunal centre.

- We found failures to manage detainee risk in court – including poor completion of person escort records, no systematic risk assessments on reception and no safeguarding policies or procedures.
- The oversight of the care and treatment of detainees in court custody continued to be widely neglected.
- Prison escort and custody officers were courteous and committed but lacked important training to support their work with detainees, including those with vulnerabilities.
- Some children stayed in court custody for longer than necessary, due to delays in identifying placements and inadequate escort arrangements.

Leadership, strategy and planning of court custody

Despite some good formal meetings between the organisations responsible for the strategic leadership and planning of court custody and escort services – HM Courts and Tribunals Service (HMCTS), NOMS and Prisoner Escort and Custody Services (PECS) contract monitors, and the escort contractor – court custody provision and the care and treatment of detainees continued to be neglected, with no one organisation having oversight.

In both the court areas inspected, court user groups tended to focus their discussions on the running of the courts' business rather than the welfare of detainees. As a result, the same concerns were repeatedly raised and went unresolved for too long. These included detainees experiencing long delays in court custody (even when identified as vulnerable) and children not being transported to secure accommodation because of delays.

The court contractors' quality control focused mainly on checking paperwork and security issues. This did not ensure good standards of detainee care across the courts or the correct and proportionate staff implementation of policies.

> A range of standard operating procedures (SOPs) outlined the expected practice of court custody staff and should have resulted in consistent practice across all court custody suites, but this was not the case… Children were almost always put in cells, searched frequently and handcuffed routinely, contrary to the contractors' SOP, which stated that children should only be handcuffed in exceptional circumstances and following a risk assessment. Wales

There was no HMCTS safeguarding policy or protocol in the two court areas inspected, despite the recommendations in four previous court custody inspections. Court custody staff received no guidance on ensuring that vulnerable detainees, including children, received appropriate care, that referrals were made where significant concerns were identified or that detainees were safely released or transferred.

The escort contractor had a safeguarding policy for children but none for adults, with one manager stating: 'It is not in the contract', which was unacceptable, particularly as some serious gaps in the knowledge and understanding of staff were highlighted during the inspection… Staff were not aware of the central reporting process regarding safeguarding concerns about children. Humber and South Yorkshire

Individual rights

The arrangements for presenting people arrested by court/civil enforcement officers (CEOs) before the court were inflexible, particularly for detainees who were compliant or who had been given an appointment to surrender themselves to the court. CEOs did not deliver compliant individuals straight to the courtroom to avoid unnecessary detention in cells or excessive handcuffing and searching procedures in the custody suites.

At Barnsley, a woman had voluntarily surrendered at court at 9.30am and had been taken promptly into custody by a CEO and lodged in the court cells. She had not appeared in court until 3.50pm, despite the efforts of custody officers to have her case prioritised. Humber and South Yorkshire

Court staff advice to detainees about their rights was improving. At many of the courts, custody staff asked detainees if they knew their rights, offered them information, and checked whether they could read the document or required it in a foreign language. Elsewhere, detainees were informed of their rights in a variety of ways, none of which would have assured staff that the detainee fully understood them.

Communication with non-English speaking detainees was unsatisfactory. Custody staff were reluctant to use professional telephone interpreting services because the telephones were in staff offices, and so could not ensure that such detainees were well and understood what was happening.

Detainees held in court custody facilities that were shared with police custody had poorer access to confidential consultation with legal advisers and other support agencies. At Scunthorpe Magistrates' Court, staff were not permitted to use the adequately equipped consultation and interview rooms in the police suite, and we saw legal representatives consulting with detainees in cells, with custody staff standing outside the open door. At Wrexham Magistrates' Court, where the court contractor was not permitted to use police interview rooms, legal representatives were locked into the detainee's cell, which needlessly exposed them to unacceptable risks. Where court facilities were shared with the police, these needed to include the use of interview and consultation rooms.

Treatment and conditions

Although most detainees we spoke to said they felt well treated by court custody staff, we observed poor staff practices in dealing with the diverse population that entered the custody suite. The court contractor offered very few training opportunities to improve custody staff understanding of and interactions with the diversity of detainees. Custody staff had no specific training on diversity, child protection or mental health awareness. They treated children the same as adult detainees; children were almost always put in cells, searched frequently and handcuffed routinely. Few staff knew how to treat transgender detainees, particularly how they would be searched, and the contractors' policies were unclear and outdated. Many custody staff we spoke to were keen to receive mental health awareness training and felt ill-equipped to deal with detainees with complex needs.


DEAD LOCK
DOOR WHEN
PARKED FOR
LONG PERIODS
PUSH DOOR
AND TURN KEY
TO OPEN
Cyclists
Beware of passing this
vehicle on the inside
serco

At Grimsby Crown Court, a very vulnerable detainee had made concerning disclosures that were not initially acted on by court custody staff. Although he was treated well by staff, there was no safeguarding policy or training, or support to assist court custody staff in responding adequately to this situation. Following guidance from an inspector, court staff and managers responded to the detainee's disclosures and the matter was investigated. Humber and South Yorkshire

We have growing concerns about children remaining in court custody cells longer than necessary, waiting for paperwork to arrive or for the escort contractor to take them to secure accommodation. In some cases, this resulted in children arriving at their final destination late in the day, distressed at having been held in court cells with very little interaction or distraction. In Wales, the long court wait for children was such a problem that the court contractor had sought the agreement of police to 'lodge' children in police cells after the courts were closed until they could be collected by the escort contractor. This arrangement was wholly unsuitable.

D, a 16-year-old boy appearing at Swansea Magistrates' Court, was sentenced to a detention and training order at 12.40pm. At approximately 1.11pm it was recorded that he would be moved to a vulnerable person's cell as he was getting upset; this was the first time he had been sentenced. At 2.40pm a custody officer was told that the young person's escort contractor would not arrive until 5.45pm. The notes stated: 'He will have been sitting in these cells for 5+ hours awaiting transport to take him 20 minutes down the road.' At 3.15pm it was recorded that D was 'getting upset and tearful, he knows where he is going and how far away it is and doesn't understand why the process of getting there is taking so long…' At 4.15pm D was handed over to GEOAmey escort staff to be transported to Swansea police station to be held in another cell while he waited for the young person's escort contractor to collect him. Wales

Despite our continued recommendations, there was still no systematic risk assessment for detainees arriving in the courts inspected. Detainees were often located in cells before a cell sharing risk assessment was completed, and custody staff did not routinely review documents arriving with the detainee that highlighted risk information relevant to their detention in court custody. There was also no pre-release risk assessment to ensure that detainees were released safely.

Many person escort records (PERs) accompanying detainees from local prisons and police stations were poorly completed, with vague or missing or potentially prejudicial risk information (such as 'HIV positive') that did not assist custody staff in looking after some very vulnerable detainees effectively. One PER that we saw in Humber and South Yorkshire was simply annotated with the words 'MH issues'. This particular detainee was on an open assessment, care in custody and teamwork (ACCT) case management document for prisoners at risk of suicide or self-harm, and began harming

himself in custody; his PER was of such poor quality that we reported it to the prison, as did the escort contractor.

> There was no formal systematic risk assessment at any of the courts to inform the care a detainee should receive and the contractor did not have a clear procedure for even a basic risk assessment… In North Wales, we saw custody staff discussing potential vulnerabilities with escort staff prior to disembarking detainees, which was good. Elsewhere, detainees were disembarked from vehicles individually and custody staff had a brief conversation with the detainee before placing them in cells; however, the conversation did not always focus on detainees' potential risks or welfare. Wales

Use of force in custody was recorded and we generally saw that custody staff were able to use their good interpersonal skills to calm down and reassure detainees. However, handcuffing was used routinely, regardless of the risk posed, and sometimes depended on how safe the member of staff felt.

The conditions in the court custody suites inspected were mostly good, and better than we have previously seen in court inspections, but there was still too much racist and offensive graffiti that had not been removed. Lay observers continued to highlight concerns but this information was not used by HMCTS, which was a missed opportunity.

Health care

Although the demand for a health care professional to attend court custody was low, we remained concerned that long agreed response times of up to four hours meant the service was underused, and lower level health problems went unresolved until the detainee left court custody. Access to mental health and substance misuse support was good.

In both inspections, we found that detainees on medication prescribed in police custody had not been given enough to last them at court, which created unacceptable risks, particularly for those experiencing alcohol withdrawal symptoms. Health interventions were recorded on the PERs but they were not always clear, and we found confidential medical information of a prejudicial nature recorded in some cases, which was unacceptable. Health risks recorded on the PERs were not always clear.

Court custody thematic – 'urgent improvement required'

In November 2015, we published our first thematic review of the first eight inspections of court custody in England, drawing together findings from inspections of 97 courthouses with custody facilities between August 2012 and August 2014.[38]

The review found that court custody facilities were among some of the worst detention conditions inspected. The treatment of detainees and the conditions in custody suites were very low priorities for the various organisations involved, which failed to coordinate their custody roles adequately. No single organisation exercised any effective leadership for court custody provision locally or nationally. The needs of women, children or other detainees with particular needs were often not understood or addressed. Routine security measures were often disproportionate or inconsistent. Health care was inadequate. Of most concern was the lack of any meaningful risk assessment when detainees arrived in custody or were released; although we had repeatedly raised this with HMCTS, we were not satisfied that this problem was being adequately addressed.

The report concluded that ministers should insist that HMCTS develops and publishes a strategy with clear performance measures for the rapid improvement of detainee treatment and custody conditions in courts.

38 http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/court-custody-urgent-improvement-required/

9

Border Force customs custody

In 2015–16, we published our second inspection of Border Force customs custody suites, following our first in 2012. These suites are inspected as part of one national two-week inspection undertaken jointly by HM Inspectorate of Prisons and HM Inspectorate of Constabulary (HMIC).

There were seven designated custody suites in Birmingham, Heathrow (Colnbrook), Gatwick, Stansted and Manchester airports, Dover and Harwich seaports and one custody suite in Scotland at Glasgow airport. All the findings from inspections in this section are based on *Expectations for Border Force custody: Criteria for assessing the treatment of and conditions for detainees in custody*, published in January 2015.

Outcome of previous recommendations

In the Border force customs custody suite inspection reported on in 2015–16, 29% of our previous recommendations had been achieved, 50% partially achieved and 21% not achieved.

Border Force operated eight custody suites. Of these two were designated as 'spine suites', which routinely accepted detainees from other locations. Some detainees held in Border Force cells were suspected of secreting or swallowing drugs, known as 'suspected internal drug traffickers' (SIDTs), and required specialist services and care. The throughput of detainees was generally low – in 2014, 792 detainees were held compared with an average of 1,000 in 2012.

There had been significant improvements since the last inspection. Border Force had adapted principles from the College of Policing Authorised Professional Practice (APP) for detention and custody, used by police services to develop safe custody policies and practices. There were improvements in the overall care and treatment of detainees. Some concerns were raised by staff who worked in less busy suites, fearing loss of skills through lack of practice.

Excellent work with partners in health care had helped develop a custody early warning system (CEWS) with Metropolitan Police Service health care, for use with detainees suspected of swallowing drugs.[39] This was a very good initiative to improve detainee safety, and was due to be operational in all suites by April 2015.

Custody suites were mostly clean, safe and in a good state of repair. Detainees were generally well cared for and staff knew how to cater for those with diverse needs, but facilities for detainees with disabilities remained poor (except at Gatwick).

All staff had received safeguarding training, and some at Manchester were members of the Safeguarding and Trafficking Team, which was able to provide specialist advice and support. This was a good initiative to ensure skills and knowledge were retained. Children accompanying adults who had been arrested were not located in cells, and custody staff worked with local authorities to place them with appropriate relatives or in local authority care.

39 Custody staff were trained to take pulse, blood pressure, temperature, count respirations and do a basic neurological examination. The resulting score prompted appropriate action, including seeking advice from a health care practitioner or calling the emergency services.

The use of handcuffs when transporting detainees was inconsistent. At Manchester, officers used a risk assessment to determine whether handcuffs should be used, while at Birmingham and Glasgow, officers told us they handcuffed all detainees. This seemed disproportionate.

Detainees who were suspected internal drug traffickers continued to be placed in one-piece paper suits. The practice of observing semi-naked female detainees using the specimen isolation unit – a transparent toilet to view and gather any drugs – remained unsatisfactory, and could have been resolved easily by providing appropriate two-piece suits.

All SIDTs using the specimen isolation unit had to lower their one-piece paper suite to use this toilet, rendering them effectively naked. We remained concerned about the lack of regard for the dignity of detainees, particularly women, when using the SIU. We acknowledged that officers needed to seize any evidence of criminality, but the practice of detainees being observed naked while using the SIU toilet, even by staff of the same gender, remained unsatisfactory.

We were also concerned that person escort records (PERs) were not always completed when detainees were transferred.

At Birmingham none of the 14 detainees held in 2014 had a PRRA [pre-release risk assessment] completed and no PERs had been completed on transfer to police stations. At Glasgow staff were unaware of the existence of PERs, which was concerning because there was a lack of consistency on how important information about detainees was being passed from one establishment to another. PRRAs that we looked at in Manchester and Dover were completed well.

10

The Inspectorate in 2015–16

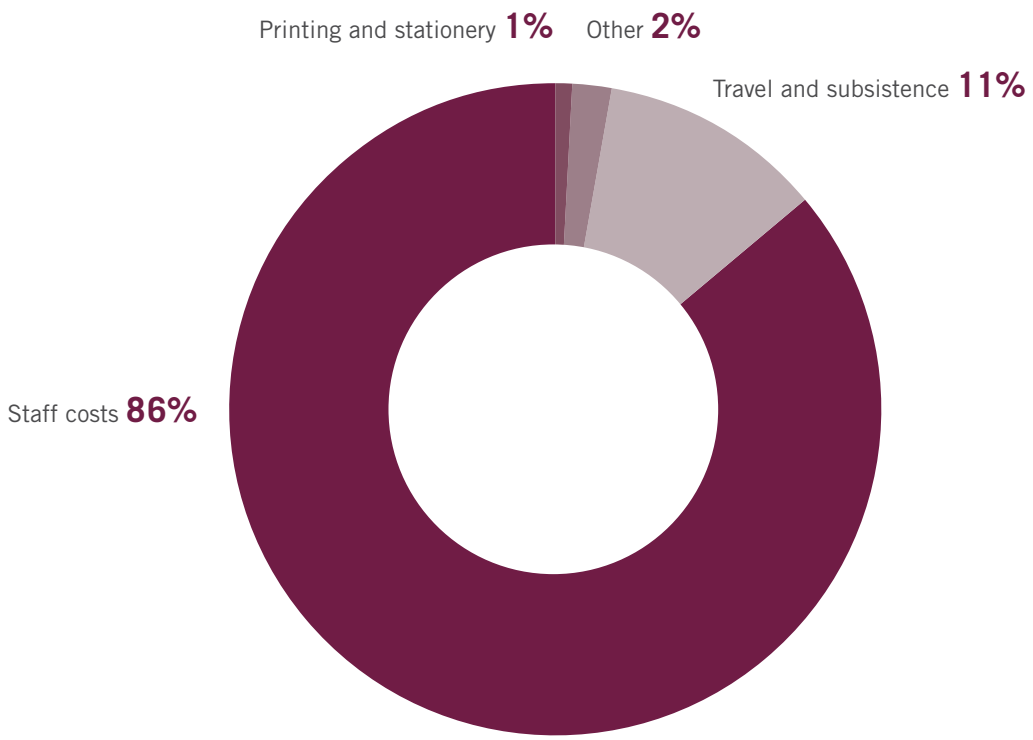
Income and expenditure – 1 April 2015 to 31 March 2016

Income	£
MOJ (prisons and court cells)	3,580,000
Home Office (immigration detention)	352,220
Home Office (HMIC/police custody)	350,000
Youth Justice Board (children's custody)	136,528
Other income (HMI Probation, Prisons and Probation Ombudsman, STC, Ministry of Defence, Border Force, Foreign and Commonwealth Office, Criminal Justice Inspectorate Northern Ireland, Government of the Cayman Islands)	202,170
TOTAL	4,620,918

Expenditure	£	%
Staffing costs[40]	3,821,982	86
Travel and subsistence	513,086	11
Printing and stationery	44,626	1
Information technology and telecommunications	48,031	1.08
Translators	5,060	0.11
Meetings and refreshments	1,026	0.02
Training and development	28,150	0.63
TOTAL	4,461,961	100

40 Includes fee-paid inspectors, secondees and joint inspection/partner organisations costs, such as General Pharmaceutical Council and contribution to secretariat support of the Joint Criminal Justice Inspection Chief Inspectors Group. There were also one-off additional costs during the handover of the Chief Inspector post, and funds allocated to employment tribunal proceedings.

Expenditure 1 April 2015 to 31 March 2016



Inspectorate staffing – 1 April 2015 to 31 March 2016

Our staff and fee-paid associates come from a range of professional backgrounds. While many have experience of working in prisons, others have expertise in social work, probation, law, youth justice, health care and drug treatment, social research and policy. The majority of staff are permanent, but we also take inspectors on loan from NOMS and other organisations. Currently, five staff are loaned from NOMS, and their experience and familiarity with current practice are invaluable.

Noting the recommendation of the Committee Against Torture (CAT) and the unique composition of the UK National Preventive Mechanism (NPM), we, along with other NPM members, have agreed to work progressively towards a reduction in our reliance on seconded staff for NPM work. Until this is achieved, and in the cases where it is ultimately not possible, we will implement procedures to avoid conflicts of interest, as a safeguard to preserve the independence of our work. As part of our efforts to achieve this, we have established clearer delineation of NOMS' ability to recall staff from loan at the Inspectorate.[41]

Staff and associate engagement

Every year we gather feedback from our staff and associates. In 2015, we once again participated in the Civil Service People Survey, commissioned by the Cabinet Office and carried out by ORC International. The survey was completed by 82% of HM Inspectorate of Prisons staff and associates, and survey results indicated a score of 87% on the staff engagement index. This was a very strong result; some 24% higher than even 'high performing units' across the civil service.

41 http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2015/05/NPM-guidance_Ensuring-the-independence-of-NPM-personnel.pdf

Staff and associates 2015–16

	Nick Hardwick	Chief Inspector (to February 2016)
	Peter Clarke	Chief Inspector (from February 2016)
	Martin Lomas	Deputy Chief Inspector
	Barbara Buchanan	Senior Personal Secretary to the Chief Inspector
	Jacqueline Ward	Personal Secretary to the Deputy Chief Inspector (Temporary)
A Team (adult males)	Alison Perry	A Team Leader
	Sandra Fieldhouse	Inspector
	Andrew Rooke	Inspector
	Paul Rowlands	Inspector
O Team (women)	Sean Sullivan	O Team Leader
	Francesca Cooney	Inspector
	Joss Crosbie	Inspector
	Paul Fenning	Inspector
	Jeanette Hall	Inspector
Y Team (children and young adults)	Deborah Butler	Y Team Leader
	Ian Dickens	Inspector
	Angela Johnson	Inspector
	Andrew Lund	Inspector
	Keith McInnis	Inspector
	Angus Mulready-Jones	Inspector
I Team (immigration detention)	Hindpal Singh Bhui	I Team Leader
	Beverley Alden	Inspector
	Colin Carroll	Inspector
	Fionnuala Gordon	Inspector
P team (police custody)	Maneer Afsar	P Team Leader
	Ian Macfadyen	Inspector
	Peter Dunn	Inspector
	Vinnett Pearcy	Inspector
	Kellie Reeve	Inspector
Health Services team	Paul Tarbuck	Head of Health Services Inspection
	Majella Pearce	Health Inspector
Research, Development and Thematics	Catherine Shaw	Head of Research, Development and Thematics
	Tim McSweeney	Senior Researcher
	Helen Ranns	Senior Researcher
	Michelle Bellham	Researcher
	Anna Fenton	Researcher
	Laura Green	Researcher
	Natalie-Anne Hall	Researcher
	Jessica Kelly	Researcher
	Rachel Murray	Researcher
	Rachel Prime	Researcher
	Alissa Redmond	Researcher
	Joe Simmonds	Researcher
	Patricia Taflan	Researcher
	Sophie Skinner	Research trainee
	Heidi Webb	Research trainee

Inspection Support	Anna O'Rourke	Head of Secretariat
	Lesley Young	Head of Finance, HR and Inspection Support
	Jane Parsons	Chief Communications Officer (part-time)
	Tamsin Williamson	Publications Manager (part-time)
	Stephen Seago	Inspection Support Manager
	Louise Finer	Senior Policy Officer
	Rosie Eatwell-White	Policy Officer
	Danielle Pearson	Policy Officer
	Vinota Karunasaagarar	Publications Assistant
	Mark McClenaghan	Inspection Support Officer
	Francette Montgry	Inspection Support Officer

Fee-paid associates	Hannah Bradbury	Publications Assistant
	Anne Clifford	Editor
	Sarah Cutler	Inspector
	Fay Deadman	Inspector
	Karen Dillon	Inspector
	Steve Eley	Health Inspector
	Sigrid Engelen	Drugs and Alcohol inspector
	Deri Hughes-Roberts	Inspector
	Maureen Jamieson	Health Inspector
	Martin Kettle	Inspector
	Brenda Kirsch	Editor
	Adrienne Penfield	Editor
	Yasmin Prabhudas	Editor
	Nicola Rabjohns	Health Inspector
	Gordon Riach	Inspector
	Paul Roberts	Drugs and Alcohol Inspector
	Fran Russell	Inspector
	Sharon Shalev	Inspector
	Fiona Shearlaw	Inspector
	Ian Thomson	Inspector
	Liz Walsh	Inspector

Staff and associates who left between 1 April 2015 and publication of the Annual Report 2014-15 (14 July 2015)	Gary Boughen
	Michael Bowen
	Colette Daoud
	Njilan Jarra-Morris
	Amy Radford
	Kieron Taylor
	Ian Thomson

Stakeholder feedback

We conduct an annual survey of stakeholders. In 2013 we changed our approach from directly mailing 'known' stakeholders to a broader strategy using an online survey publicised through direct emails, bulletins, a website link, Twitter alerts and footers on staff email messages. This strategy elicited increasing numbers of responses from a wider range of stakeholders. During November and December 2015 we received 309 responses to the survey. For the purposes of analysis, stakeholders were grouped into four broad categories: practitioners, managers, lay visitors and other stakeholders.

Feedback was generally very positive about a range of our communications. Over 70% of stakeholders had seen HM Inspectorate of Prisons represented in the national media. Ninety per cent of stakeholders said that it was easy or very easy to find what they were looking for on our website. Our reports were similarly positively received, with favourable scores of over 75% in relation to each of length, structure, language, quantity of information and treatment of diversity issues.

Feedback on our strategic themes indicated that overall 79% of stakeholders agreed or strongly agreed that we are independent, 74% that we are influential, 66% that we are accountable and 86% that we are capable.

Communications

Most stakeholders continued to use our website (launched in 2014, and on a shared platform with other justice inspectorates and independent from the government website, gov.uk) to access inspection and thematic reports. The number of people visiting our website each month increased from 5,300 in April 2015 to 6,900 in March 2016.

Our Twitter feed continued to attract new followers each month, rising from around 3,200 in April 2015 to 4,893 at end of March 2016. The feed allowed us to highlight the publication of new reports, advertise jobs within the Inspectorate and tell people which establishments our teams were inspecting each week. The findings of our reports continued to be reported in national, international, local and regional media, in print, online and through broadcast media. This ensured appropriate communication with key stakeholders, supporting our overall aim of improving outcomes for those in custody.

11

Appendices

Inspection reports published 1 April 2015 to 31 March 2016

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
North Wales police custody suites	Unannounced	12 May 2015
Manchester	Unannounced	13 May 2015
Deerbolt	Unannounced	14 May 2015
Belmarsh	Announced	19 May 2015
Warkwickshire and West Mercia police custody suites	Unannounced	20 May 2015
Rainsbrook STC	Unannounced	20 May 2015
Becket House STHF	Unannounced	22 May 2015
Cleveland police custody suites	Unannounced	27 May 2015
Tinsley House IRC	Unannounced	28 May 2015
Dovegate	Unannounced	29 May 2015
Metropolitan Police North West Cluster custody suites	Unannounced	2 June 2015
High Down	Unannounced	4 June 2015
Kirklevington Grange	Unannounced	9 June 2015
Wetherby	Unannounced	16 June 2015
Pentonville	Unannounced	23 June 2015
Surrey police custody suites	Unannounced	24 June 2015
Cayman Islands (prison)	Announced	25 June 2015
Cayman Islands (police/court custody)	Announced	25 June 2015
Peterborough (men)	Unannounced	30 June 2015
Dungavel IRC	Unannounced	7 July 2015
Border Force	Unannounced	17 July 2015
Brinsford	Announced	21 July 2015
Wandsworth	Unannounced	29 July 2015
Littlehey	Unannounced	31 July 2015
The Verne	Unannounced	11 August 2015
Yarl's Wood IRC	Unannounced	12 August 2015
Keppel Unit	Unannounced	18 August 2015
Stoke Heath	Unannounced	19 August 2015
The Mount	Unannounced	21 August 2015
Close Supervision Centres	Unannounced	25 August 2015
Humber and South Yorkshire court custody	Unannounced	26 August 2015
Gloucester police custody suites	Unannounced	2 September 2015
Lancaster Farms	Unannounced	3 September 2015
London City STHF	Unannounced	8 September 2015
Heathrow Terminal 3 STHF	Unannounced	8 September 2015
Heathrow Terminal 4 STHF	Unannounced	8 September 2015
Heathrow Terminal 5 STHF	Unannounced	8 September 2015
Cookham Wood	Unannounced	22 September 2015
Cumbria police custody suites	Unannounced	29 September 2015
Isle of Wight	Unannounced	1 October 2015
Aylesbury	Unannounced	6 October 2015
New Hall	Unannounced	13 October 2015
Liverpool	Unannounced	20 October 2015
Woodhill Protected Witness Unit	Unannounced	21 October 2015
Bullingdon	Unannounced	29 October 2015
Standford Hill	Unannounced	3 November 2015

Inspection reports published 1 April 2015 to 31 March 2016 *(Continued)*

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Maghaberry	Unannounced	5 November 2015
Hertfordshire police custody suites	Unannounced	10 November 2015
Lowdham Grange	Unannounced	11 November 2015
Stocken	Unannounced	17 November 2015
Humber	Unannounced	18 November 2015
Pakistan Escort	Unannounced	20 November 2015
Nigeria and Ghana Escort	Unannounced	20 November 2015
Feltham A	Unannounced	24 November 2015
Rainsbrook STC	Unannounced	2 December 2015
Maidstone	Unannounced	8 December 2015
Wealstun	Unannounced	9 December 2015
Rye Hill	Unannounced	17 December 2015
Ashfield	Unannounced	22 December 2015
Hatfield	Unannounced	12 January 2016
Rochester	Unannounced	13 January 2016
Medway STC	Unannounced	26 January 2016
Warren Hill	Unannounced	9 February 2016
Leicester	Unannounced	17 February 2016
Lincolnshire police custody suites	Unannounced	19 February 2016
Holloway	Unannounced	23 February 2016
Ranby	Announced	25 February 2016
Wales court custody	Unannounced	26 February 2016
Harmondsworth	Unannounced	1 March 2016
Werrington	Unannounced	2 March 2016
Dover Seaport, Frontier House and Longport Freight Shed STHF	Unannounced	8 March 2016
Doncaster	Unannounced	9 March 2016
Woodhill	Unannounced	15 March 2016
Highpoint	Unannounced	22 March 2016
North Yorkshire police custody suites	Unannounced	23 March 2016
Oakhill STC	Unannounced	24 March 2016

Healthy prison and establishment assessments 1 April 2015 to 31 March 2016

ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
LOCAL PRISONS					
Belmarsh	Announced	3	3	2	3
Bullingdon	Unannounced	2	3	2	1
Doncaster	Unannounced	1	1	2	3
High Down	Unannounced	3	3	2	2
Leicester	Unannounced	1	2	2	2
Liverpool	Unannounced	2	2	2	2
Manchester	Unannounced	3	3	3	3
Peterborough	Unannounced	4	4	2	4
Pentonville	Unannounced	1	1	1	2
Wandsworth	Unannounced	2	2	1	2
Woodhill	Unannounced	2	3	3	3
CATEGORY B TRAINING PRISONS					
Dovegate	Unannounced	2	3	2	3
Isle of Wight	Unannounced	3	4	3	2
Lowdham Grange	Unannounced	2	3	3	4
Rye Hill	Unannounced	4	2	4	4
CATEGORY C TRAINING PRISONS					
Ashfield	Unannounced	4	4	2	3
Highpoint	Unannounced	3	3	3	2
Humber	Unannounced	2	3	2	2
Lancaster Farms	Unannounced	3	3	2	2
Littlehey	Unannounced	4	4	2	2
Maidstone	Unannounced	3	2	2	1
Ranby	Announced	1	3	2	2
Rochester	Unannounced	2	2	2	2
Stocken	Unannounced	2	3	4	3
Stoke Heath	Unannounced	3	3	3	3
The Mount	Unannounced	3	3	3	3
Warren Hill	Unannounced	4	4	3	4
Wealstun	Unannounced	3	4	3	3
OPEN PRISONS					
Hatfield	Unannounced	4	4	4	4
Kirklevington Grange	Unannounced	4	4	4	4
Standford Hill	Unannounced	4	3	4	4
WOMEN'S PRISONS					
Holloway	Unannounced	4	3	2	3
New Hall	Unannounced	4	4	4	3

KEY TO TABLE

Numeric:

1 – Outcomes for prisoners/detainees are poor
2 – Outcomes for prisoners/detainees are not sufficiently good
3 – Outcomes for prisoners/detainees are reasonably good
4 – Outcomes for prisoners/detainees are good

Healthy prison and establishment assessments 1 April 2015 to 31 March 2016
(Continued)

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
YOUNG ADULT PRISONS					
Aylesbury	Unannounced	2	2	1	3
Brinsford	Announced	3	4	2	2
Deerbolt	Unannounced	3	3	3	3
CHILDREN AND YOUNG PEOPLE ESTABLISHMENTS					
Cookham Wood	Unannounced	2	3	2	3
Feltham A	Unannounced	2	4	2	3
Keppel Unit	Unannounced	4	4	4	4
Werrington	Unannounced	2	3	3	4
Wetherby	Unannounced	2	3	3	4
EXTRA-JURISDICTION					
Cayman Islands Fairbanks	Announced	2	2	1	1
Cayman Islands Northward	Announced	2	1	1	1
Maghaberry	Unannounced	1	1	1	3
IMMIGRATION REMOVAL CENTRES					
Dungavel	Unannounced	4	4	4	4
Harmondsworth	Unannounced	2	2	2	4
The Verne	Unannounced	2	3	3	2
Tinsley House	Unannounced	4	3	4	4
Yarl's Wood	Unannounced	2	2	3	3

KEY TO TABLE

Numeric:

1 – Outcomes for prisoners/detainees are poor
2 – Outcomes for prisoners/detainees are not sufficiently good
3 – Outcomes for prisoners/detainees are reasonably good
4 – Outcomes for prisoners/detainees are good

Recommendations accepted in action plans received 1 April 2015 to 31 March 2016

ESTABLISHMENT	RECOMMENDATIONS			ACCEPTED			PARTIALLY ACCEPTED (includes recommendations accepted in principle / accepted subject to resources)			REJECTED		
LOCAL PRISONS	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**
Belmarsh	5	54	59	5	48	53	0	4	4	0	2	2
Bullingdon	5	75	80	5	60	65	0	11	11	0	4	4
Doncaster	-	-	-	-	-	-	-	-	-	-	-	-
High Down	4	76	80	2	53	55	2	12	14	0	11	11
Leicester	-	-	-	-	-	-	-	-	-	-	-	-
Liverpool	5	84	89	5	72	77	0	7	7	0	5	5
Manchester	2	73	75	2	59	61	0	10	10	0	4	4
Pentonville	5	71	76	5	58	63	0	6	6	0	7	7
Peterborough (men)	1	40	41	1	31	32	0	4	4	0	5	5
Wandsworth	5	81	86	5	60	65	0	15	15	0	6	6
Woodhill	-	-	-	-	-	-	-	-	-	-	-	-
Total	**32**	**554**	**586**	**30 (94%)**	**441 (80%)**	**471 (80%)**	**2 (6%)**	**69 (12%)**	**71 (12%)**	**0 (0%)**	**44 (8%)**	**44 (8%)**
CATEGORY B TRAINING PRISONS												
Dovegate	5	54	59	5	46	51	0	5	5	0	3	3
Isle of Wight	3	68	71	3	41	44	0	24	24	0	3	3
Lowdham Grange	4	64	68	4	45	49	0	16	16	0	3	3
Rye Hill	2	55	57	1	47	48	1	6	7	0	2	2
Total	**14**	**241**	**255**	**13 (93%)**	**179 (74%)**	**192 (75%)**	**1 (7%)**	**51 (21%)**	**52 (20%)**	**0 (0%)**	**11 (5%)**	**11 (4%)**
CATEGORY C TRAINING PRISONS												
Ashfield	3	44	47	3	36	39	0	7	7	0	1	1
Highpoint	-	-	-	-	-	-	-	-	-	-	-	-
Humber	4	64	68	3	55	58	1	8	9	0	1	1
Lancaster Farms	4	62	66	4	45	49	0	12	12	0	5	5
Littlehey	3	54	57	3	47	50	0	4	4	0	3	3
Maidstone	3	52	55	2	42	44	1	10	11	0	0	0
Ranby	-	-	-	-	-	-	-	-	-	-	-	-
Rochester	5	61	66	5	55	60	0	6	6	0	0	0
Stocken	3	57	60	3	43	46	0	6	6	0	8	8
Stoke Heath	6	64	70	4	51	55	2	9	11	0	4	4
The Mount	5	61	66	5	49	54	0	5	5	0	7	7
Warren Hill	1	26	27	1	25	26	0	1	1	0	0	0
Wealstun	3	54	57	3	38	41	0	11	11	0	5	5
Total	**40**	**599**	**639**	**36 (90%)**	**486 (81%)**	**522 (82%)**	**4 (10%)**	**79 (13%)**	**83 (13%)**	**0 (0%)**	**34 (6%)**	**34 (5%)**

KEY TO TABLE

Hyphen (-) – Hyphen (-) indicates that outstanding action plans were not returned within the specified deadline following publication of the inspection report, or were not due until after the end of the annual reporting period. (31 March 2016).

MR – Main recommendations
R – Recommendations

Recommendations accepted in action plans received 1 April 2015 to 31 March 2016 *(Continued)*

ESTABLISHMENT	RECOMMENDATIONS			ACCEPTED			PARTIALLY ACCEPTED (includes recommendations accepted in principle / accepted subject to resources)			REJECTED		
OPEN PRISONS	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**
Hatfield	0	30	30	0	24	24	0	4	4	0	2	2
Kirklevington Grange	1	41	42	1	35	36	0	5	5	0	1	1
Standford Hill	1	38	39	1	32	33	0	6	6	0	0	0
Total	**2**	**109**	**111**	**2 (100%)**	**91 (83%)**	**93 (84%)**	**0 (0%)**	**15 (14%)**	**15 (14%)**	**0 (0%)**	**3 (3%)**	**3 (3%)**
YOUNG ADULT ESTABLISHMENTS												
Aylesbury	4	70	74	3	50	53	1	16	17	0	4	4
Brinsford	3	36	39	3	33	36	0	1	1	0	2	2
Deerbolt	4	57	61	3	40	43	1	12	13	0	5	5
Total	**11**	**163**	**174**	**9 (82%)**	**123 (75%)**	**132 (76%)**	**2 (18%)**	**29 (18%)**	**31 (18%)**	**0 (0%)**	**11 (7%)**	**11 (6%)**
WOMEN'S PRISONS												
Holloway	-	-	-	-	-	-	-	-	-	-	-	-
New Hall	2	49	51	2	37	39	0	10	10	0	2	2
Total	**2**	**49**	**51**	**2 (100%)**	**37 (76%)**	**39 (76%)**	**0 (0%)**	**10 (20%)**	**10 (20%)**	**0 (0%)**	**2 (4%)**	**2 (4%)**
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS												
Cookham Wood	4	75	79	4	64	68	0	6	6	0	5	5
Feltham CYP	4	51	55	3	46	49	1	1	2	0	4	4
Keppel Unit	0	42	42	0	33	33	0	6	6	0	3	3
Werrington	-	-	-	-	-	-	-	-	-	-	-	-
Wetherby	3	64[1]	67	2	53	55	1	6	7	0	5	5
Total	**11**	**232**	**243**	**9 (82%)**	**196 (84%)**	**205 (84%)**	**2 (18%)**	**19 (8%)**	**21 (9%)**	**0 (0%)**	**17 (7%)**	**17 (7%)**

KEY TO TABLE

Hyphen (-) – Hyphen (-) indicates that outstanding action plans were not returned within the specified deadline following publication of the inspection report, or were not due until after the end of the annual reporting period (31 March 2016).

1 This figure excludes one recommendation not responded to in the action plan from HMYOI Wetherby.

MR – Main recommendations
R – Recommendations

Recommendations achieved in inspection reports published 1 April 2015 to 31 March 2016

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant, housekeeping points and good practice)			ACHIEVED			PARTIALLY ACHIEVED			NOT ACHIEVED		
LOCAL PRISONS	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**
Belmarsh	7	72	79	3	30	33	3	22	25	1	20	21
Bullingdon	5	70	75	2	31	33	1	16	17	2	23	25
Doncaster	4	69	73	0	19	19	0	16	16	4	34	38
High Down	5	50	55	0	8	8	1	7	8	4	35	39
Leicester	4	75	79	1	17	18	0	7	7	3	51	54
Liverpool	4	69	73	1	21	22	1	14	15	2	34	36
Manchester	4	110	114	1	44	45	1	18	19	2	48	50
Pentonville	6	65	71	0	11	11	1	24	25	5	30	35
Peterborough (men)	6	78	84	3	45	48	2	19	21	1	14	15
Wandsworth	3	53	56	0	11	11	1	10	11	2	32	34
Woodhill	4	69	73	2	21	23	0	22	22	2	26	28
Total	**52**	**780**	**832**	**13 (25%)**	**258 (33%)**	**271 (33%)**	**11 (21%)**	**175 (22%)**	**186 (22%)**	**28 (54%)**	**347 (44%)**	**375 (45%)**
CATEGORY B TRAINING PRISONS												
Dovegate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Isle of Wight	9	80	89	3	36	39	3	12	15	3	32	35
Lowdham Grange	3	71	74	1	39	40	0	13	13	2	19	21
Rye Hill	6	92	98	4	55	59	2	16	18	0	21	21
Total	**18**	**243**	**261**	**8 (44%)**	**130 (53%)**	**138 (53%)**	**5 (28%)**	**41 (17%)**	**46 (18%)**	**5 (28%)**	**72 (30%)**	**77 (30%)**
CATEGORY C TRAINING PRISONS												
Ashfield	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Highpoint	5	58	63	1	24	25	3	9	12	1	25	26
Humber	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lancaster Farms	5	63	68	2	23	25	0	16	16	3	24	27
Littlehey	2	116	118	0	62	62	1	23	24	1	31	32
Maidstone	2	67	69	0	29	29	0	7	7	2	31	33
Ranby	7	67	74	1	32	33	3	14	17	3	21	24
Rochester	4	66	70	0	18	18	2	16	18	2	32	34
Stocken	3	61	64	1	26	27	1	14	15	1	21	22
Stoke Heath	4	62	66	1	29	30	2	10	12	1	23	24
The Mount	6	88	94	5	44	49	0	10	10	1	34	35
Warren Hill	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Wealstun	5	147	152	2	76	78	3	23	26	0	48	48
Total	**43**	**795**	**838**	**13 (30%)**	**363 (46%)**	**376 (45%)**	**15 (35%)**	**142 (18%)**	**157 (19%)**	**15 (35%)**	**290 (36%)**	**305 (36%)**
OPEN PRISONS												
Hatfield	3	41	44	1	20	21	0	11	11	2	10	12
Kirklevington Grange	3	22	25	2	10	12	0	6	6	1	6	7
Standford Hill	6	76	82	3	42	45	2	16	18	1	18	19
Total	**12**	**139**	**151**	**6 (50%)**	**72 (52%)**	**78 (52%)**	**2 (17%)**	**33 (24%)**	**35 (23%)**	**4 (33%)**	**34 (24%)**	**38 (25%)**

N.B. HMPs Dovegate, Ashfield and Warren Hill all rerolled; therefore the recommendations were not followed up and have been excluded from this data. Additionally, HMPs Everthorpe and Wolds merged to form HMP Humber, therefore recommendations from the individual establishments were not followed up and have been excluded from this data.

Recommendations achieved in inspection reports published 1 April 2015 to 31 March 2016 *(Continued)*

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant, housekeeping points and good practice)			ACHIEVED			PARTIALLY ACHIEVED			NOT ACHIEVED		
YOUNG ADULT ESTABLISHMENTS	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**
Aylesbury	4	75	79	1	20	21	1	25	26	2	30	32
Brinsford	9	74	83	2	38	40	7	20	27	0	16	16
Deerbolt	9	77	86	4	32	36	2	20	22	3	25	28
Total	**22**	**226**	**248**	**7 (32%)**	**90 (40%)**	**97 (39%)**	**10 (45%)**	**65 (29%)**	**75 (30%)**	**5 (23%)**	**71 (31%)**	**76 (31%)**
WOMEN'S PRISONS												
Holloway	5	48	53	3	23	26	0	11	11	2	14	16
New Hall	5	87	92	4	44	48	0	14	14	1	29	30
Total	**10**	**135**	**145**	**7 (70%)**	**67 (50%)**	**74 (51%)**	**0 (0%)**	**25 (19%)**	**25 (17%)**	**3 (30%)**	**43 (32%)**	**46 (32%)**
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS												
Cookham Wood	4	83	87	0	25	25	1	15	16	3	43	46
Feltham CYP	1	65	66	0	28	28	1	15	16	0	22	22
Keppel Unit	0	24	24	0	9	9	0	7	7	0	8	8
Werrington	2	45	47	0	16	16	0	9	9	2	20	22
Wetherby	2	52	54	0	16	16	0	11	11	2	25	27
Total	**9**	**269**	**278**	**0 (0%)**	**94 (35%)**	**94 (34%)**	**2 (22%)**	**57 (21%)**	**59 (21%)**	**7 (78%)**	**118 (44%)**	**125 (45%)**
PRISON TOTAL	**166**	**2,587**	**2,753**	**54 (33%)**	**1,074 (42%)**	**1,128 (41%)**	**45 (27%)**	**538 (21%)**	**583 (21%)**	**67 (40%)**	**975 (38%)**	**1,042 (38%)**
IMMIGRATION REMOVAL CENTRES												
Dungavel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Harmondsworth	4	90	94	0	26	26	4	21	25	0	43	43
The Verne	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tinsley House	3	54	57	0	23	23	0	21	21	3	10	13
Yarl's Wood	3	53	56	0	10	10	0	15	15	3	28	31
Total	**10**	**197**	**207**	**0 (0%)**	**59 (30%)**	**59 (29%)**	**4 (40%)**	**57 (29%)**	**61 (29%)**	**6 (60%)**	**81 (41%)**	**87 (42%)**
SHORT-TERM HOLDING FACILITIES												
Becket House	0	36	36	0	19	19	0	2	2	0	15	15
Dover, Frontier and Longport	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Heathrow Terminal 3	0	20	20	0	9	9	0	2	2	0	9	9
Heathrow Terminal 4	0	20	20	0	7	7	0	3	3	0	10	10
Heathrow Terminal 5	0	34	34	0	13	13	0	4	4	0	17	17
London City	0	28	28	0	5	5	0	6	6	0	17	17
Total	**0**	**138**	**138**	**0 (0%)**	**53 (38%)**	**53 (38%)**	**0 (0%)**	**17 (12%)**	**17 (12%)**	**0 (0%)**	**68 (49%)**	**68 (49%)**

N.B. Dungavel IRC and The Verne IRC were full inspections which followed short follow-up inspections. Consequently, progress against previous recommendations was not reported. There were no recommendations for the police custody suites in Gloucestershire, Barnet, Brent and Harrow and Warwickshire and West Mercia to follow up as there were no previous inspections to base judgements on. There were no recommendations to follow up for Dover, Frontier and Longport as this was the first time it had been inspected as a combined STHF.

MR – Main recommendations
R – Recommendations

Recommendations achieved in inspection reports published 1 April 2015 to 31 March 2016 *(Continued)*

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant, housekeeping points and good practice)			ACHIEVED			PARTIALLY ACHIEVED			NOT ACHIEVED		
POLICE CUSTODY SUITES	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**	**MR**	**R**	**Total**
Barnet, Brent and Harrow	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cleveland	3	22	25	1	7	8	2	4	6	0	11	11
Cumbria	0	51	51	0	24	24	0	19	19	0	8	8
Gloucestershire	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hertfordshire	0	42	42	0	25	25	0	12	12	0	5	5
Lincolnshire	4	19	23	0	4	4	3	6	9	1	9	10
North Wales	5	19	24	4	10	14	1	6	7	0	3	3
North Yorkshire	5	22	27	0	12	12	4	8	12	1	2	3
Surrey	4	22	26	2	12	14	1	3	4	1	7	8
Warwickshire and West Mercia	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total	**21**	**197**	**218**	**7 (33%)**	**94 (48%)**	**101 (46%)**	**11 (52%)**	**58 (29%)**	**69 (32%)**	**3 (14%)**	**45 (23%)**	**48 (22%)**
EXTRA JURISDICTIONS												
Cayman Islands police and court	2	36	38	0	16	16	0	5	5	2	15	17
Cayman Islands prison	10	73	83	0	22	22	7	15	22	3	36	39
Total	**12**	**109**	**121**	**0 (0%)**	**38 (35%)**	**38 (31%)**	**7 (58%)**	**20 (18%)**	**27 (22%)**	**5 (42%)**	**51 (47%)**	**56 (46%)**
BORDER FORCE												
UK Border Force	3	25	28	1	7	8	2	12	14	0	6	6
Total	**3**	**25**	**28**	**1 (28%)**	**7 (28%)**	**8 (29%)**	**2 (67%)**	**12 (48%)**	**14 (50%)**	**0 (0%)**	**6 (24%)**	**6 (21%)**
OVERALL TOTAL	**46**	**666**	**712**	**8 (17%)**	**251 (38%)**	**259 (36%)**	**24 (52%)**	**164 (25%)**	**188 (26%)**	**14 (30%)**	**251 (38%)**	**265 (37%)**

Prisoner survey responses (adult men): diversity analysis – ethnicity/nationality/religion

		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners
	Number of completed questionnaires returned	1,801	4,434	748	5,518	922	5,286
		%	%	%	%	%	%
	SECTION 1: General information						
1.2	Are you under 21 years of age?	10	5	5	7	10	6
1.3	Are you sentenced?	82	88	77	88	83	87
1.3	Are you on recall?	7	9	4	9	7	8
1.4	Is your sentence less than 12 months?	10	12	12	11	10	11
1.4	Are you here under an indeterminate sentence for public protection (IPP prisoner)?	5	6	4	6	4	6
1.5	Are you a foreign national?	21	10			23	11
1.6	Do you understand spoken English?	97	99	90	99	97	98
1.7	Do you understand written English?	96	98	84	99	95	97
1.8	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories.)			47	27	87	19
1.9	Do you consider yourself to be Gypsy/ Romany/ Traveller?	2	6	5	4	1	5
1.10	Are you Muslim?	45	3	27	13		
1.11	Are you homosexual/gay or bisexual?	1	3	2	3	1	3
1.12	Do you consider yourself to have a disability?	14	25	16	22	13	23
1.13	Are you a veteran (ex-armed services)?	3	6	8	5	2	6
1.14	Is this your first time in prison?	43	38	65	35	47	38
1.15	Do you have any children under the age of 18?	52	52	54	52	48	53
	SECTION 2: Transfers and escorts						
	On your most recent journey here:						
2.1	Did you spend more than two hours in the van?	42	40	44	40	45	40
2.5	Did you feel safe?	72	79	72	78	72	78
2.6	Were you treated well/very well by the escort staff?	62	71	63	69	60	70
2.7	Before you arrived here were you told that you were coming here?	58	62	48	63	55	62
2.8	When you first arrived here did your property arrive at the same time as you?	73	83	73	82	72	82
	SECTION 3: Reception, first night and induction						
3.1	Were you in reception for less than two hours?	46	50	45	49	48	49
3.2	When you were searched in reception, was this carried out in a respectful way?	72	85	73	82	69	83
3.3	Were you treated well/very well in reception?	60	73	61	71	60	71
	When you first arrived:						
3.4	Did you have any problems?	69	65	72	66	69	66
3.4	Did you have any problems with loss of property?	23	17	22	18	24	18
3.4	Did you have any housing problems?	17	16	15	17	14	17
3.4	Did you have any problems contacting employers?	4	4	6	3	4	4
3.4	Did you have any problems contacting family?	27	23	30	23	30	23
3.4	Did you have any problems ensuring dependants were being looked after?	3	2	6	2	2	2
3.4	Did you have any money worries?	18	18	21	17	18	18
3.4	Did you have any problems with feeling depressed or suicidal?	14	19	18	18	13	19
3.4	Did you have any physical health problems?	13	14	13	14	10	15
3.4	Did you have any mental health problems?	14	21	15	20	14	20
3.4	Did you have any problems with needing protection from other prisoners?	7	7	6	7	7	7
3.4	Did you have problems accessing phone numbers?	27	20	26	22	28	21

KEY TO TABLE

- Significantly better
- Significantly worse
- A significant difference in prisoners' background details
- No significant difference

Missing data have been excluded for each question. Please note: where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

1. Key questions from the survey include all questions with the exception of filtered questions. The following breakdowns are within sample comparisons so sample sizes are smaller; to include filtered questions would further reduce the number of responses.
2. The amalgamated functional types include: local prisons, training prisons, young offender institutions holding over 18s and open establishments published in the reporting period.
3. In order to appropriately adjust p-values in light of multiple testing, $p<.01$ was considered statistically significant for all comparisons undertaken.

Prisoner survey responses (adult men): diversity analysis – ethnicity/nationality/religion *(Continued)*

		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners
		%	%	%	%	%	%
	When you first arrived here, were you offered any of the following:						
3.6	Tobacco?	68	79	69	76	72	76
3.6	A shower?	27	27	28	27	27	27
3.6	A free telephone call?	47	48	42	49	48	48
3.6	Something to eat?	65	64	65	64	65	64
3.6	PIN phone credit?	52	51	52	51	50	51
3.6	Toiletries/basic items?	53	53	59	52	51	54
	When you first arrived here did you have access to the following people:						
3.7	The chaplain or a religious leader?	50	49	49	50	49	50
3.7	Someone from health services?	67	67	64	68	63	68
3.7	A Listener/Samaritans?	26	32	23	32	25	32
3.7	Prison shop/canteen?	23	24	27	23	23	24
	When you first arrived here were you offered information about any of the following:						
3.8	What was going to happen to you?	45	48	36	49	43	48
3.8	Support available for people feeling depressed or suicidal?	33	39	30	39	31	39
3.8	How to make routine requests?	38	40	32	41	37	40
3.8	Your entitlement to visits?	39	37	33	39	38	38
3.8	Health services?	48	49	46	49	45	50
3.8	The chaplaincy?	46	45	43	45	44	45
3.9	Did you feel safe on your first night here?	69	78	67	77	67	77
3.10	Have you been on an induction course?	85	84	86	84	86	84
3.12	Did you receive an education (skills for life) assessment?	81	79	79	80	81	80
	SECTION 4: Legal rights and respectful custody						
	In terms of your legal rights, is it easy/very easy to:						
4.1	Communicate with your solicitor or legal representative?	39	41	35	41	37	41
4.1	Attend legal visits?	44	47	41	47	44	47
4.1	Get bail information?	13	15	12	15	13	15
4.2	Have staff ever opened letters from your solicitor or legal representative when you were not with them?	44	39	36	41	42	40
4.3	Can you get legal books in the library?	36	39	35	39	34	39
	For the wing/unit you are currently on:						
4.4	Are you normally offered enough clean, suitable clothes for the week?	58	61	64	60	58	61
4.4	Are you normally able to have a shower every day?	76	83	75	82	75	82
4.4	Do you normally receive clean sheets every week?	64	67	67	66	65	66
4.4	Do you normally get cell cleaning materials every week?	59	61	59	61	59	61
4.4	Is your cell call bell normally answered within five minutes?	27	31	35	29	27	30
4.4	Is it normally quiet enough for you to be able to relax or sleep in your cell at night time?	63	62	63	63	59	63
4.4	Can you normally get your stored property, if you need to?	22	24	23	23	21	24
4.5	Is the food in this prison good/very good?	25	31	30	29	24	30
4.6	Does the shop/canteen sell a wide enough range of goods to meet your needs?	38	53	44	49	40	51
4.7	Are you able to speak to a Listener at any time, if you want to?	44	56	43	54	43	55
4.8	Are your religious beliefs respected?	60	49	64	50	67	49
4.9	Are you able to speak to a religious leader of your faith in private if you want to?	57	54	51	56	61	54
4.10	Is it easy/very easy to attend religious services?	61	43	58	47	70	44
	SECTION 5: Applications and complaints						
5.1	Is it easy to make an application?	70	78	69	77	68	77
5.3	Is it easy to make a complaint?	51	56	45	56	48	55
5.5	Have you ever been prevented from making a complaint when you wanted to?	24	19	24	20	25	20
5.6	Is it easy/very easy to see the Independent Monitoring Board?	20	27	19	26	19	26

Prisoner survey responses (adult men): diversity analysis – ethnicity/nationality/religion *(Continued)*

		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners
		%	%	%	%	%	%
	SECTION 6: Incentives and earned privileges scheme						
6.1	Do you feel you have been treated fairly in your experience of the IEP scheme?	35	48	31	46	35	46
6.2	Do the different levels of the IEP scheme encourage you to change your behaviour?	39	44	35	44	40	43
6.3	In the last six months have any members of staff physically restrained you (C&R)?	13	9	10	10	12	10
	SECTION 7: Relationships with staff						
7.1	Do most staff, in this prison, treat you with respect?	69	80	72	77	67	78
7.2	Is there a member of staff, in this prison, that you can turn to for help if you have a problem?	65	72	66	70	61	71
7.3	Has a member of staff checked on you personally in the last week to see how you are getting on?	22	32	24	29	21	30
7.4	Do staff normally speak to you most of the time/all of the time during association?	16	21	14	20	16	20
7.5	Do you have a personal officer?	48	52	53	50	50	51
	SECTION 8: Safety						
8.1	Have you ever felt unsafe here?	45	41	47	41	46	41
8.2	Do you feel unsafe now?	24	18	24	19	25	18
8.3	Have you been victimised by other prisoners here?	30	30	31	30	31	30
	Since you have been here, have other prisoners:						
8.5	Made insulting remarks about you, your family or friends?	10	13	9	12	12	12
8.5	Hit, kicked or assaulted you?	9	9	8	9	10	9
8.5	Sexually abused you?	1	2	2	2	1	2
8.5	Threatened or intimidated you?	14	18	11	18	15	17
8.5	Taken your canteen/property?	6	8	6	8	7	8
8.5	Victimised you because of medication?	3	5	3	4	3	4
8.5	Victimised you because of debt?	3	4	2	4	4	4
8.5	Victimised you because of drugs?	3	5	3	5	4	4
8.5	Victimised you because of your race or ethnic origin?	8	3	6	4	9	4
8.5	Victimised you because of your religion/religious beliefs?	7	2	4	4	8	3
8.5	Victimised you because of your nationality?	5	3	7	3	5	3
8.5	Victimised you because you were from a different part of the country?	3	4	3	4	3	4
8.5	Victimised you because you are from a traveller community?	1	1	1	1	1	1
8.5	Victimised you because of your sexual orientation?	1	2	2	2	1	2
8.5	Victimised you because of your age?	2	3	1	3	2	3
8.5	Victimised you because you have a disability?	3	4	2	3	2	3
8.5	Victimised you because you were new here?	5	6	6	5	6	5
8.5	Victimised you because of your offence/crime?	3	6	2	5	4	5
8.5	Victimised you because of gang-related issues?	6	5	4	6	8	5
8.6	Have you been victimised by staff here?	39	29	31	32	43	30
	Since you have been here, have staff:						
8.7	Made insulting remarks about you, your family or friends?	14	11	10	12	16	11
8.7	Hit, kicked or assaulted you?	7	5	5	5	8	5
8.7	Sexually abused you?	2	1	1	1	1	1
8.7	Threatened or intimidated you?	15	12	13	13	17	12
8.7	Victimised you because of medication?	3	4	4	4	3	4
8.7	Victimised you because of debt?	1	2	0	2	2	2
8.7	Victimised you because of drugs?	2	3	2	3	2	3
8.7	Victimised you because of your race or ethnic origin?	11	2	8	4	12	4
8.7	Victimised you because of your religion/religious beliefs?	10	2	5	4	14	2
8.7	Victimised you because of your nationality?	7	3	10	3	7	3
8.7	Victimised you because you were from a different part of the country?	3	3	3	3	2	3
8.7	Victimised you because you are from a traveller community?	1	1	1	1	1	1

Prisoner survey responses (adult men): diversity analysis – ethnicity/nationality/religion *(Continued)*

		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners
		%	%	%	%	%	%
8.7	Victimised you because of your sexual orientation?	1	1	1	1	1	1
8.7	Victimised you because of your age?	3	2	1	2	3	2
8.7	Victimised you because you have a disability?	3	3	2	3	3	3
8.7	Victimised you because you were new here?	7	4	5	5	7	5
8.7	Victimised you because of your offence/crime?	5	4	2	5	6	5
8.7	Victimised you because of gang-related issues?	4	3	2	3	5	3
	SECTION 9: Health services						
9.1	Is it easy/very easy to see the doctor?	25	29	24	28	24	28
9.1	Is it easy/very easy to see the nurse?	44	49	42	48	42	48
9.1	Is it easy/very easy to see the dentist?	12	15	11	14	11	14
9.4	Are you currently taking medication?	38	52	40	49	36	49
9.6	Do you have any emotional well being or mental health problems?	27	38	29	35	28	35
	SECTION 10: Drugs and alcohol						
10.1	Did you have a problem with drugs when you came into this prison?	18	28	15	26	19	26
10.2	Did you have a problem with alcohol when you came into this prison?	11	19	14	17	11	18
10.3	Is it easy/very easy to get illegal drugs in this prison?	29	41	23	40	32	38
10.4	Is it easy/very easy to get alcohol in this prison?	17	22	15	22	19%	21
10.5	Have you developed a problem with drugs since you have been in this prison?	6	10	7	9	8%	9%
10.6	Have you developed a problem with diverted medication since you have been in this prison?	4	7	7	6	5%	6%
	SECTION 11: Activities						
	Is it very easy/easy to get into the following activities:						
11.1	A prison job?	29	42	31	39	28	40
11.1	Vocational or skills training?	30	37	27	36	29	36
11.1	Education (including basic skills)?	47	52	44	52	46	52
11.1	Offending Behaviour Programmes?	19	24	22	22	20	23
	Are you currently involved in any of the following activities:						
11.2	A prison job?	46	56	47	54	44	54
11.2	Vocational or skills training?	12	11	11	12	11	11
11.2	Education (including basic skills)?	30	22	31	23	32	23
11.2	Offending Behaviour Programmes?	9	10	5	10	9	9
11.4	Do you go to the library at least once a week?	36	34	40	34	35	35
11.5	Does the library have a wide enough range of materials to meet your needs?	30	40	30	38	27	39
11.6	Do you go to the gym three or more times a week?	33	28	24	30	32	29
11.7	Do you go outside for exercise three or more times a week?	49	47	49	47	53	46
11.8	Do you go on association more than five times each week?	48	58	46	56	48	56
11.9	Do you spend 10 or more hours out of your cell on a weekday?	11	16	9	15	11	15
	SECTION 12: Friends and family						
12.1	Have staff supported you and helped you to maintain contact with family/friends while in this prison?	28	36	33	34	29	35
12.2	Have you had any problems with sending or receiving mail?	48	45	42	46	46	46
12.3	Have you had any problems getting access to the telephones?	31	24	30	25	33	24
12.4	Is it easy/very easy for your friends and family to get here?	31	30	20	32	30	31
	SECTION 13: Preparation for release						
13.3	Do you have a named offender supervisor in this prison?	52	60	42	60	52	58
13.10	Do you have a needs-based custody plan?	8	6	9	6	8	6
13.11	Do you feel that any member of staff has helped you to prepare for release?	13	14	14	14	13	14

Prisoner survey responses (adult men): diversity analysis – disability/age

		Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50	Prisoners aged under 21	Prisoners aged 21 and over
	Number of completed questionnaires returned	1,343	4,929	962	5,358	562	5,758
		%	%	%	%	%	%
	SECTION 1: General information						
1.2	Are you under 21 years of age?	6	7	0	8		
1.3	Are you sentenced?	85	87	91	86	78	87
1.3	Are you on recall?	10	8	6	9	7	8
1.4	Is your sentence less than 12 months?	12	11	5	12	15	11
1.4	Are you here under an indeterminate sentence for public protection (IPP prisoner)?	7	6	9	5	1	6
1.5	Are you a foreign national?	10	14	9	14	11	13
1.6	Do you understand spoken English?	98	98	98	98	99	98
1.7	Do you understand written English?	97	97	97	97	99	97
1.8	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories.)	19	32	19	31	43	29
1.9	Do you consider yourself to be Gypsy/ Romany/ Traveller?	7	4	3	5	4	5
1.10	Are you Muslim?	9	17	7	17	24	15
1.11	Are you homosexual/gay or bisexual?	5	2	4	2	1	3
1.12	Do you consider yourself to have a disability?			34	20	18	22
1.13	Are you a veteran (ex-armed services)?	9	5	15	4	1	6
1.14	Is this your first time in prison?	33	41	52	37	53	38
1.15	Do you have any children under the age of 18?	48	53	29	56	24	54
	SECTION 2: Transfers and escorts						
	On your most recent journey here:						
2.1	Did you spend more than two hours in the van?	41	40	48	39	42	40
2.5	Did you feel safe?	70	79	78	77	79	77
2.6	Were you treated well/very well by the escort staff?	67	69	79	67	58	69
2.7	Before you arrived here were you told that you were coming here?	58	62	64	60	59	61
2.8	When you first arrived here did your property arrive at the same time as you?	80	80	85	80	81	80
	SECTION 3: Reception, first night and induction						
3.1	Were you in reception for less than two hours?	44	50	54	48	60	48
3.2	When you were searched in reception, was this carried out in a respectful way?	78	82	88	80	79	81
3.3	Were you treated well/very well in reception?	68	70	81	68	64	70
	When you first arrived:						
3.4	Did you have any problems?	87	61	64	67	60	67
3.4	Did you have any problems with loss of property?	20	18	17	19	16	19
3.4	Did you have any housing problems?	26	14	15	17	12	17
3.4	Did you have any problems contacting employers?	4	4	3	4	3	4
3.4	Did you have any problems contacting family?	29	23	21	25	28	24
3.4	Did you have any problems ensuring dependants were being looked after?	3	2	1	2	2	2
3.4	Did you have any money worries?	26	15	15	18	18	18
3.4	Did you have any problems with feeling depressed or suicidal?	35	13	16	18	15	18
3.4	Did you have any physical health problems?	34	8	26	12	6	15
3.4	Did you have any mental health problems?	49	11	13	20	16	19
3.4	Did you have any problems with needing protection from other prisoners?	12	5	6	7	9	6
3.4	Did you have problems accessing phone numbers?	25	22	22	22	26	22
	When you first arrived here, were you offered any of the following:						
3.6	Tobacco?	78	75	56	79	86	75
3.6	A shower?	25	27	20	28	38	26
3.6	A free telephone call?	47	48	37	50	64	47
3.6	Something to eat?	63	65	59	65	66	64
3.6	PIN phone credit?	48	52	41	53	57	51
3.6	Toiletries/basic items?	52	54	55	53	61	53

Prisoner survey responses (adult men): diversity analysis – disability/age *(Continued)*

		Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50	Prisoners aged under 21	Prisoners aged 21 and over
		%	%	%	%	%	%
	When you first arrived here did you have access to the following people:						
3.7	The chaplain or a religious leader?	46	51	41	51	54	49
3.7	Someone from health services?	67	67	69	67	62	68
3.7	A Listener/Samaritans?	29	31	33	30	24	31
3.7	Prison shop/canteen?	23	24	21	24	23	23
	When you first arrived here were you offered information about any of the following:						
3.8	What was going to happen to you?	42	48	50	47	45	47
3.8	Support available for people feeling depressed or suicidal?	37	38	37	37	33	38
3.8	How to make routine requests?	35	41	43	39	37	40
3.8	Your entitlement to visits?	33	39	38	38	43	37
3.8	Health services?	46	49	55	48	47	49
3.8	The chaplaincy?	41	46	42	45	48	45
3.9	Did you feel safe on your first night here?	67	78	82	75	73	76
3.10	Have you been on an induction course?	80	85	87	84	79	84
3.12	Did you receive an education (skills for life) assessment?	75	81	83	79	77	80
	SECTION 4: Legal rights and respectful custody						
	In terms of your legal rights, is it easy/very easy to:						
4.1	Communicate with your solicitor or legal representative?	36	42	43	40	29	41
4.1	Attend legal visits?	41	47	41	47	43	46
4.1	Get bail information?	13	15	10	15	16	14
4.2	Have staff ever opened letters from your solicitor or legal representative when you were not with them?	46	39	35	41	39	40
4.3	Can you get legal books in the library?	37	39	45	37	23	39
	For the wing/unit you are currently on:						
4.4	Are you normally offered enough clean, suitable clothes for the week?	56	62	79	57	49	61
4.4	Are you normally able to have a shower every day?	78	82	87	81	66	83
4.4	Do you normally receive clean sheets every week?	64	66	80	64	66	66
4.4	Do you normally get cell cleaning materials every week?	59	61	71	59	44	62
4.4	Is your cell call bell normally answered within five minutes?	26	31	42	28	24	30
4.4	Is it normally quiet enough for you to be able to relax or sleep in your cell at night time?	53	65	70	61	54	63
4.4	Can you normally get your stored property, if you need to?	21	24	30	22	19	23
4.5	Is the food in this prison good/very good?	30	29	43	27	22	30
4.6	Does the shop/canteen sell a wide enough range of goods to meet your needs?	47	49	60	47	43	49
4.7	Are you able to speak to a Listener at any time, if you want to?	56	52	67	50	34	54
4.8	Are your religious beliefs respected?	49	53	65	50	49	52
4.9	Are you able to speak to a religious leader of your faith in private if you want to?	56	55	60	54	50	55
4.10	Is it easy/very easy to attend religious services?	43	50	54	47	42	49
	SECTION 5: Applications and complaints						
5.1	Is it easy to make an application?	70	77	84	74	71	76
5.3	Is it easy to make a complaint?	52	55	58	53	48	55
5.5	Have you ever been prevented from making a complaint when you wanted to?	27	19	10	22	22	20
5.6	Is it easy/very easy to see the Independent Monitoring Board?	23	25	31	24	13	26

KEY TO TABLE

- Significantly better
- Significantly worse
- A significant difference in prisoners' background details
- No significant difference

Missing data have been excluded for each question. Please note: where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

1. Key questions from the survey include all questions with the exception of filtered questions. The following breakdowns are within sample comparisons so sample sizes are smaller; to include filtered questions would further reduce the number of responses.
2. The amalgamated functional type includes: local prisons, training prisons, young offender institutions holding over 18s and open establishments published in the reporting period.
3. In order to appropriately adjust p-values in light of multiple testing, $p<.01$ was considered statistically significant for all comparisons undertaken.

Prisoner survey responses (adult men): diversity analysis – disability/age *(Continued)*

		Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50	Prisoners aged under 21	Prisoners aged 21 and over
		%	%	%	%	%	%
	SECTION 6: Incentives and earned privileges scheme						
6.1	Do you feel you have been treated fairly in your experience of the IEP scheme?	40	45	57	42	35	44
6.2	Do the different levels of the IEP scheme encourage you to change your behaviour?	39	43	48	42	42	42
6.3	In the last six months have any members of staff physically restrained you (C&R)?	13	10	3	11	26	9
	SECTION 7: Relationships with staff						
7.1	Do most staff, in this prison, treat you with respect?	75	77	91	74	62	77
7.2	Is there a member of staff, in this prison, that you can turn to for help if you have a problem?	68	70	82	68	56	71
7.3	Has a member of staff checked on you personally in the last week to see how you are getting on?	35	27	38	27	23	29
7.4	Do staff normally speak to you most of the time/all of the time during association?	18	20	25	18	16	20
7.5	Do you have a personal officer?	47	52	63	49	46	51
	SECTION 8: Safety						
8.1	Have you ever felt unsafe here?	56	38	34	43	46	42
8.2	Do you feel unsafe now?	29	17	12	21	22	19
8.4	Have you been victimised by other prisoners here?	45	26	28	30	33	30
	Since you have been here, have other prisoners:						
8.5	Made insulting remarks about you, your family or friends?	19	10	10	12	14	12
8.5	Hit, kicked or assaulted you?	13	8	6	9	16	8
8.5	Sexually abused you?	3	1	2	2	2	2
8.5	Threatened or intimidated you?	26	14	15	17	18	16
8.5	Taken your canteen/property?	12	6	6	8	10	7
8.5	Victimised you because of medication?	10	3	4	4	4	4
8.5	Victimised you because of debt?	6	3	1	5	7	4
8.5	Victimised you because of drugs?	7	4	1	5	6	4
8.5	Victimised you because of your race or ethnic origin?	6	4	3	5	4	4
8.5	Victimised you because of your religion/religious beliefs?	5	3	3	4	3	4
8.5	Victimised you because of your nationality?	5	3	2	3	3	3
8.5	Victimised you because you were from a different part of the country?	6	3	2	4	6	4
8.5	Victimised you because you are from a traveller community?	2	1	1	1	1	1
8.5	Victimised you because of your sexual orientation?	3	1	2	2	1	2
8.5	Victimised you because of your age?	6	2	6	2	2	2
8.5	Victimised you because you have a disability?	12	1	5	3	3	3
8.5	Victimised you because you were new here?	8	5	4	6	9	5
8.5	Victimised you because of your offence/crime?	9	4	7	5	7	5
8.5	Victimised you because of gang-related issues?	8	5	2	6	9	5
8.6	Have you been victimised by staff here?	44	29	22	33	35	32
	Since you have been here, have staff:						
8.7	Made insulting remarks about you, your family or friends?	16	10	7	12	16	11
8.7	Hit, kicked or assaulted you?	8	4	3	6	10	5
8.7	Sexually abused you?	2	1	1	1	2	1
8.7	Threatened or intimidated you?	20	11	10	13	14	13
8.7	Victimised you because of medication?	9	3	4	4	2	4
8.7	Victimised you because of debt?	3	1	0	2	2	2
8.7	Victimised you because of drugs?	4	2	1	3	2	3
8.7	Victimised you because of your race or ethnic origin?	6	5	2	5	5	5
8.7	Victimised you because of your religion/religious beliefs?	5	4	2	4	5	4
8.7	Victimised you because of your nationality?	4	3	2	4	4	4

Prisoner survey responses (adult men): diversity analysis – disability/age *(Continued)*

		Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50	Prisoners aged under 21	Prisoners aged 21 and over
		%	%	%	%	%	%
8.7	Victimised you because you were from a different part of the country?	4	2	1	3	5	3
8.7	Victimised you because you are from a traveller community?	2	1	1	1	1	1
8.7	Victimised you because of your sexual orientation?	2	1	1	1	1	1
8.7	Victimised you because of your age?	4	2	4	2	5	2
8.7	Victimised you because you have a disability?	12	1	4	3	3	3
8.7	Victimised you because you were new here?	7	5	3	5	7	5
8.7	Victimised you because of your offence/crime?	7	4	5	5	7	5
8.7	Victimised you because of gang-related issues?	5	3	1	3	7	3
	SECTION 9: Health services						
9.1	Is it easy/very easy to see the doctor?	28	28	38	26	31	28
9.1	Is it easy/very easy to see the nurse?	50	47	58	46	49	47
9.1	Is it easy/very easy to see the dentist?	14	14	19	13	21	14
9.4	Are you currently taking medication?	78	39	75	43	23	49
9.6	Do you have any emotional well being or mental health problems?	70	25	27	36	31	35
	SECTION 10: Drugs and alcohol						
10.1	Did you have a problem with drugs when you came into this prison?	33	23	8	28	27	25
10.2	Did you have a problem with alcohol when you came into this prison?	22	15	11	17	12	17
10.3	Is it easy/very easy to get illegal drugs in this prison?	44	35	27	39	31	38
10.4	Is it easy/very easy to get alcohol in this prison?	25	20	14	22	14	21
10.5	Have you developed a problem with drugs since you have been in this prison?	12	8	2	10	10	9
10.6	Have you developed a problem with diverted medication since you have been in this prison?	11	5	4	6	4	6
	SECTION 11: Activities						
	Is it very easy/easy to get involved in the following activities:						
11.1	A prison job?	32	40	46	37	23	39
11.1	Vocational or skills training?	29	37	39	34	29	35
11.1	Education (including basic skills)?	46	52	55	50	48	51
11.1	Offending Behaviour Programmes?	19	23	24	22	22	22
	Are you currently involved in any of the following activities:						
11.2	A prison job?	49	54	62	51	30	54
11.2	Vocational or skills training?	9	12	12	11	10	11
11.2	Education (including basic skills)?	24	24	25	24	29	24
11.2	Offending Behaviour Programmes?	9	9	9	9	6	9
11.4	Do you go to the library at least once a week?	30	36	47	33	24	36
11.5	Does the library have a wide enough range of materials to meet your needs?	34	38	47	35	26	38
11.6	Do you go to the gym three or more times a week?	17	33	19	31	19	30
11.7	Do you go outside for exercise three or more times a week?	37	50	44	48	53	47
11.8	Do you go on association more than five times each week?	50	56	54	55	49	55
11.9	Do you spend 10 or more hours out of your cell on a weekday?	13	15	19	14	5	15
	SECTION 12: Friends and family						
12.1	Have staff supported you and helped you to maintain contact with family/friends while in this prison?	31	34	40	33	31	34
12.2	Have you had any problems with sending or receiving mail?	49	45	33	48	51	45
12.3	Have you had any problems getting access to the telephones?	29	25	16	27	37	25
12.4	Is it easy/very easy for your friends and family to get here?	23	32	25	31	33	30
	SECTION 13: Preparation for release						
13.3	Do you have a named offender supervisor in this prison?	56	58	68	55	46	58
13.10	Do you have a needs-based custody plan?	8	6	5	7	6	7
13.11	Do you feel that any member of staff has helped you to prepare for release?	14	14	16	13	13	14

Prisoner survey responses: key questions responses – women/men		Women	Men
	Number of completed questionnaires returned	343	6,362
		%	%
1.2	Are you under 21 years of age?	7	6
1.3	Are you sentenced?	84	86
1.5	Are you a foreign national?	16	13
1.6	Do you understand spoken English?	97	98
1.7	Do you understand written English?	96	97
1.8	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories.)	27	30
1.9	Do you consider yourself to be Gypsy/ Romany/ Traveller?	6	5
1.10	Are you Muslim?	10	15
1.11	Are you homosexual/gay or bisexual?	29	3
1.12	Do you consider yourself to have a disability?	29	22
1.14	Is this your first time in prison?	56	39
1.15	Do you have any children under the age of 18?	55	52
2.6	Were you treated well/very well by the escort staff?	76	68
2.7	Before you arrived here were you told that you were coming here?	69	61
3.2	When you were searched in reception, was this carried out in a respectful way?	85	81
3.3	Were you treated well/very well in reception?	73	69
3.4	Did you have any problems when you first arrived?	75	66
3.7	Did you have access to someone from health care when you first arrived here?	68	67
3.9	Did you feel safe on your first night here?	66	76
3.10	Have you been on an induction course?	88	84
4.1	Is it easy/very easy to communicate with your solicitor or legal representative?	38	40
4.4	Are you normally offered enough clean, suitable clothes for the week?	68	60
4.4	Are you normally able to have a shower every day?	82	81
4.4	Is your cell call bell normally answered within five minutes?	43	30
4.5	Is the food in this prison good/very good?	28	29
4.6	Does the shop/canteen sell a wide enough range of goods to meet your needs?	49	49
4.7	Are you able to speak to a Listener at any time, if you want to?	66	53
4.8	Do you feel your religious beliefs are respected?	58	52
4.9	Are you able to speak to a religious leader of your faith in private if you want to?	62	55
5.1	Is it easy to make an application?	84	76
5.3	Is it easy to make a complaint?	62	54
6.1	Do you feel you have been treated fairly in your experience of the IEP scheme?	51	44
6.2	Do the different levels of the IEP scheme encourage you to change your behaviour?	51	43
6.3	In the last six months have any members of staff physically restrained you (C&R)?	8	10
7.1	Do most staff, in this prison, treat you with respect?	74	76
7.2	Is there a member of staff you can turn to for help if you have a problem in this prison?	80	70
7.3	Do staff normally speak to you at least most of the time during association time? (Most/all of the time)	23	19
7.4	Do you have a personal officer?	64	51
8.1	Have you ever felt unsafe here?	49	42
8.2	Do you feel unsafe now?	17	20
8.3	Have you been victimised by other prisoners?	38	30
	Since you have been here, have other prisoners:		
8.5	Hit, kicked or assaulted you?	12	9
8.5	Sexually abused you?	1	2
8.5	Threatened or intimidated you?	25	17
8.5	Victimised you because of medication?	5	4
8.5	Victimised you because of drugs?	4	4
8.5	Victimised you because you were from a different part of the country?	4	4
8.5	Victimised you because of your sexual orientation?	2	2
8.6	Have you been victimised by a member of staff?	30	32

Prisoner survey responses: key questions reponses – women/men		Women	Men
		%	%
	Since you have been here, have staff:		
8.7	Hit, kicked or assaulted you?	3	5
8.7	Sexually abused you?	2	1
8.7	Threatened or intimidated you?	13	13
8.7	Victimised you because of medication?	3	4
8.7	Victimised you because of drugs?	2	3
8.7	Victimised you because you were from a different part of the country?	1	3
8.7	Victimised you because of your sexual orientation?	3	1
9.1	Is it easy/very easy to see the doctor?	27	28
9.1	Is it easy/very easy to see the nurse?	54	47
9.4	Are you currently taking medication?	70	48
9.6	Do you feel you have any emotional well being/mental health issues?	54	34
10.3	Is it easy/very easy to get illegal drugs in this prison?	31	37
10.4	Is it easy/very easy to get alcohol in this prison?	5	21
11.2	Are you currently working in the prison?	63	53
11.2	Are you currently undertaking vocational or skills training?	16	11
11.2	Are you currently in education (including basic skills)?	35	24
11.2	Are you currently taking part in an offending behaviour programme?	14	9
11.4	Do you go to the library at least once a week?	41	35
11.6	Do you go to the gym three or more times a week?	20	30
11.7	Do you go outside for exercise three or more times a week?	32	47
11.8	On average, do you go on association more than five times each week?	43	54
11.9	Do you spend 10 or more hours out of your cell on a weekday? (This includes hours at education, at work etc)	13	14
12.2	Have you had any problems sending or receiving mail?	44	46
12.3	Have you had any problems getting access to the telephones?	27	26
12.4	Is it easy/very easy for your friends and family to get here?	35	30

KEY TO TABLE

- Significantly better
- Significantly worse
- A significant difference in prisoners' background details
- No significant difference

Missing data have been excluded for each question. Please note: where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Her Majesty's Inspectorate of Prisons
Victory House
6th floor
30-34 Kingsway
London
WC2B 6EX

Telephone: 020 3681 2770
Press enquiries: 020 3681 2775
General enquiries: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

Chief Inspector of Prisons
Peter Clarke CVO OBE QPM

ISBN 978-1-4741-3631-0

9 781474 136310

DESIGN102 | This Annual Report was produced by DESIGN102
Contact us at: design102@justice.gsi.gov.uk