Annual Report of

HM Chief Inspector of Prisons for England and Wales

Presented pursuant to Act. Eliz II 1952

c.52 s.5A (5)

Ordered by the House of Commons
to be printed 26 January 2005

240
London: The Stationery Office

£14.75

2003
2004

Statement of purpose

To provide independent scrutiny of the conditions for and treatment of prisoners and other detainees, promoting the concept of 'healthy prisons' in which staff work effectively to support prisoners and detainees to reduce reoffending or achieve other agreed outcomes.

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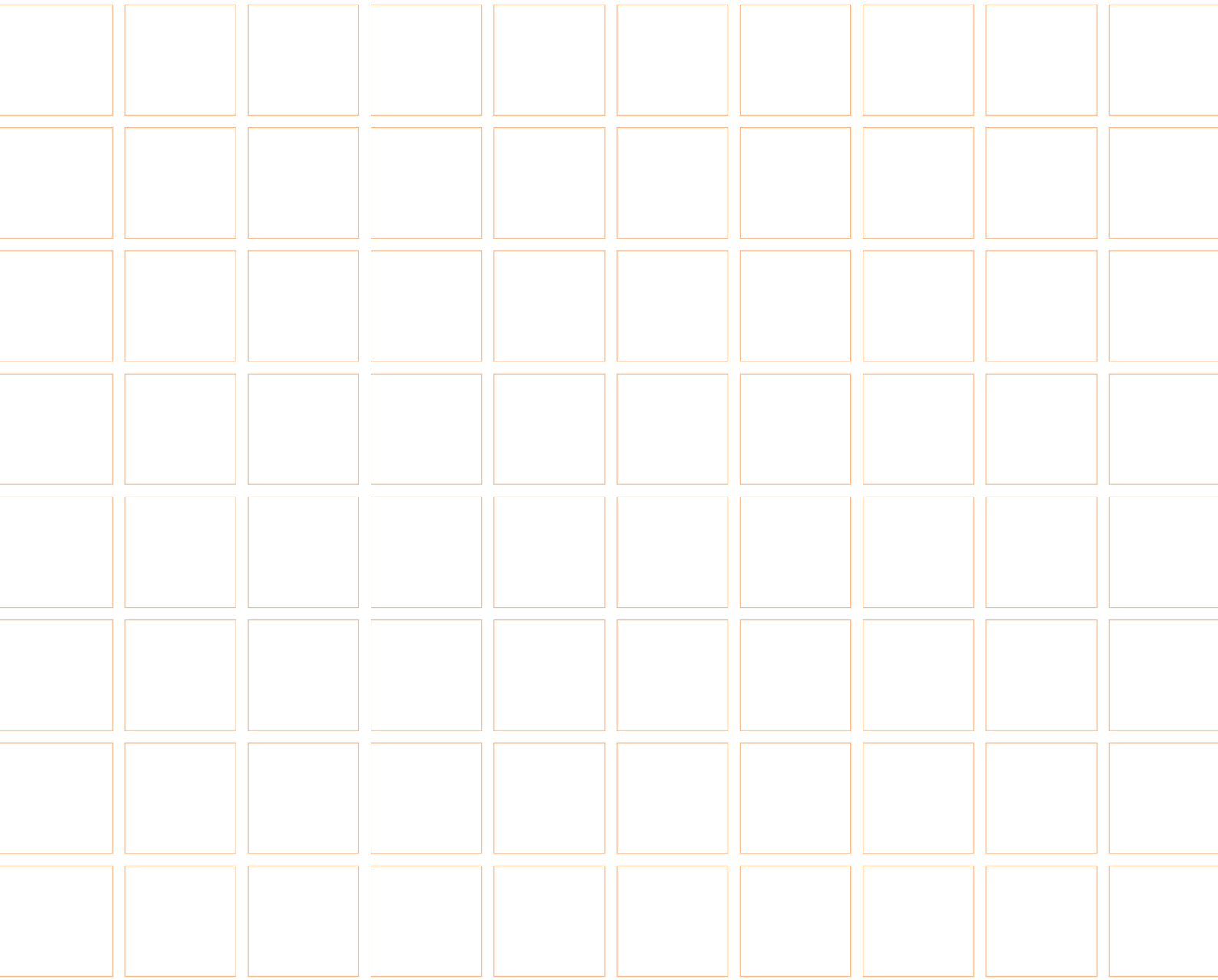
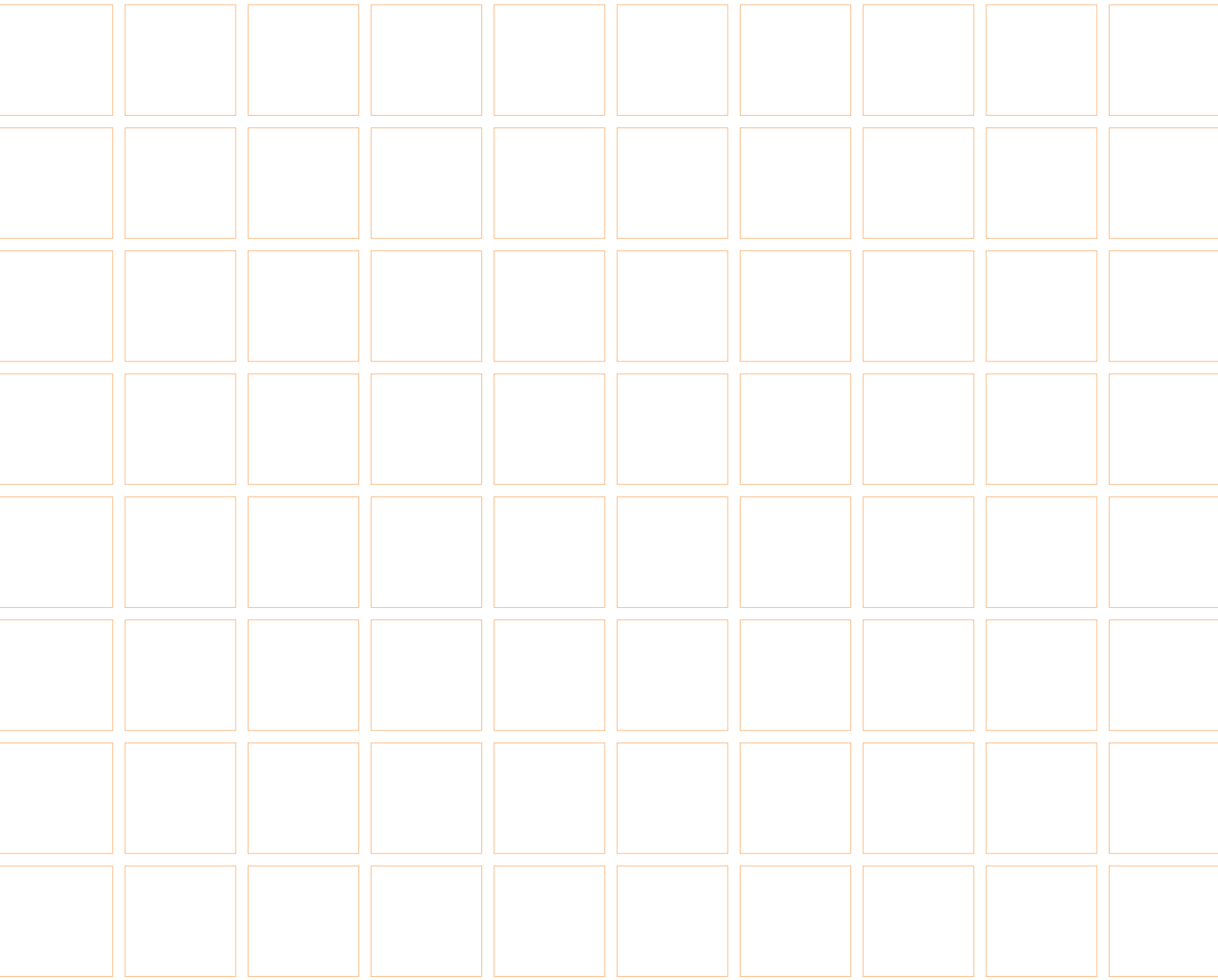


Introduction



This annual report, like its predecessors, charts the progress of a prison system that is trying to deliver positive outcomes for prisoners and society – under the considerable strain of more, and often challenging, prisoners. That strain should not be underestimated. The prison population has levelled off in the last nine months, at around 75,000. That is a welcome achievement, but it is by no means a cause for complacency.

Anne Owers CBE
Chief Inspector

Our prisons are still 24% overcrowded, and are operating perilously close to full capacity: they are still recording nearly two self-inflicted deaths a week; they are still discharging prisoners who have been unable to benefit from the education, training and resettlement support they need. The levelling off of the prison population is, in reality, the difference between a manageable crisis and an unmanageable one.

The key message of this report is that ours is a prison system that has progressed in many areas, and which is capable of making even more progress. But it is trying to sustain those improvements against an undertow of continuing, unremitting pressure, and an increasingly needy and demanding population.

Progress and pressure

The struggle between progress and pressure is charted in many areas we report on. Six in particular deserve mention.

- There has been a noticeable **culture change** in many prisons, driven by the Prison Service's decency agenda, the persistence of senior managers and the support of key staff. This is also reflected in the requirements placed on prisons by the new National Offender Management Service. But there are still cultural backwaters where this has not penetrated; and even more prisons where this is still a fragile construct, vulnerable to a change of governor, a cutback in resources or an increase in pressure.
- Much work has gone into procedures for managing those at risk of **suicide and self-harm**. Nevertheless, there were 95 self-inflicted deaths in 2004: nearly two a week. This is the tip of an iceberg: in the reporting year, 228 prisoners were resuscitated by prison staff, and there were 17,678 recorded self-harm incidents. Women are particularly vulnerable: over twice as likely to kill themselves and 14 times as likely to harm themselves. Some prisons have still not put in place essential protective measures; and few have a genuinely multi-disciplinary approach to self-harm and suicide. But the challenge is even greater than this. Our reports, and the recent report of the Joint Parliamentary Human Rights Committee, highlight two underlying and critical factors: the scale of mental illness in prisons, and the extent to which the overall culture of a prison supports a safe environment.

There were 95 self-inflicted deaths; 228 prisoners were resuscitated and 17,678 self-harm incidents were recorded

- Prison **healthcare** has shown considerable improvement. It has moved from a shamingly inadequate service to one that increasingly bears comparison with practice outside. It has benefited from the skills, resources and professionalism of the National Health Service; though it is important that this is integrated into prison management and culture. But here too healthcare staff struggle with the scale of the task. Mental health in-reach teams in some prisons can do little but skim the surface of the severity and breadth of mental illness contained in prisons.

- **Education and training** has benefited from inward investment and outside professionalism. Heads of learning and skills are refining practice, importing skills into workplaces and seeking partnerships with local employers and skills councils. In spite of this, only five of the 18 training prisons we inspected were providing sufficient work and training for their prisoners. Our reports, jointly with the education inspectorates, record weaknesses within prisons: education curricula that are too narrowly focused; insufficient access to qualifications; regimes that do not deliver prisoners to available training places; regime monitoring figures that disguise under-employment. But they also record the pressure on training prisons as they expand to meet population pressure. The units put up to house the growing population are quick to build; but the resources and personnel to provide purposeful activity for those in them are slower to materialise. And the situation is far worse for short-term prisoners in the transit camps that are our local prisons.

- **Drug work** is improving in many prisons. Properly managed treatment for drug withdrawal is a key part of safe custody. The women's estate led the way in improving detoxification; the men's estate still lags significantly behind. Treatment and resettlement work, however, remain patchy: though we have found some excellent initiatives, and the Drug Intervention Programmes offer the possibility of essential post-custodial support. In some prisons, the availability of drugs raises serious concerns. In open prisons, it fuels absconds; in closed prisons it undermines safety, raising the level of debt, bullying and intimidation.

- **Resettlement** is now core business for most prisons, and we have recorded some good practice. Many prisons are focusing on the needs of short-term prisoners, and identifying their needs at reception. But it is rare to find the kind of integrated approach that means that these needs are then actively addressed throughout sentence, rather than just before release, when it may be too late. And the missing link remains post-release support. Area strategies, though, are seeking to integrate prison activity with the needs and support networks in the local area, and there is much that can be built on.

The prison system, like individual prisons, is organic, not static. If it ceases to move forward, it will slip back

These changes should not be understated; but neither should they be over-sold. They are all developing areas that need nurturing, and which face considerable challenges. There is much to be gained by building on them; equally, there is much to be lost if they are not built on. The prison system, like individual prisons, is organic, not static. If it ceases to move forward, it will slip back.

A pivotal point

Much rides on the back of the embryonic National Offender Management Service (NOMS). At best, it can refocus and reinvest in community penalties, reversing the rise in the number in custody; and ensure that there are joined-up, offender-focused interventions that drive down reoffending rates. At worst, it can insert another layer of bureaucracy, and divert energy and resources from managing what there is: 75,000 people in prison. At best, 'contestability' can encourage innovation and best practice, as private sector prisons have often been able to do, under experienced public sector management. At worst, the new competitive landscape can result in variable, even contradictory, practices; or be a vehicle for cutting costs and corners. Managing this

process so as to achieve lasting, incremental progress, at a time of resource constraints in public finance, will be a challenge for NOMS and its regional offender managers.

Prisons, and the prison system, are therefore at a pivotal point. The need for an independent, robust Prisons Inspectorate, to chart these developments and report them directly and fearlessly, has never been more evident. Our unique methodology and criteria, now reworked, reissued and referenced against international human rights standards, are accepted as a yardstick for assessing conditions and treatment in all kinds of custodial settings, from prisons to army detention facilities – and have been shared with those seeking to improve detention conditions in other countries. They measure quality, not quantity; what is important, not what is easily measurable. The Joint Parliamentary Human Rights Committee, in its recently-published inquiry into deaths in custody, saw this as a key preventive function:

> *'The culture of a prison, the extent to which people are treated with dignity, the quality of relationships between prisoners and staff, are all critically important. [This is] reflected in the standards against which the Chief Inspector of Prisons inspects, of a "healthy prison", which meets standards of decency, safety and respect. This culture, as research appears to confirm, is fundamental to prisoner safety, and therefore to the protection of rights under Article 2 [the right to life]'*

The role of the Inspectorate

Inspections can show up practices that could put lives at risk or undermine decency. Sometimes this reinforces what Prison Service managers already know; sometimes it challenges those perceptions. We hold up what is actually happening against what is thought to be going on in the governor's office, in Prison Service headquarters, or in the Minister's red box.

We apply the same principles to the inspection of other custodial settings, including immigration removal centres (IRCs) and, most recently, the Military Corrective and Training Centre in Colchester. Reports into IRCs highlighted the need for robust procedures to protect more vulnerable detainees facing imminent removal, and the need to implement agreed systems to safeguard children. In closed institutions, there is always the potential for poor practice to survive unchallenged. Independent, detailed inspection of each custodial environment is an essential part of the prevention of abuse and the protection of the human rights of those detained.

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Our methods are both effective and robust. They conform to the government's 10 principles of inspection. Ninety-seven per cent of our recommendations were accepted wholly, partially or in principle. Seventy per cent were wholly or partly achieved when we returned for an unannounced reinspection. This year, we inspected 65 establishments: just as importantly, anyone running a prison or immigration removal centre knows that at any time, we can appear without warning.

Last year, I recorded concerns about the future of the inspectorate. Earlier this year, we worked together with colleagues in the Probation Inspectorate to see whether we could develop a joint inspectorate that focused equally on the treatment and conditions of those in custodial and community settings, and the management of

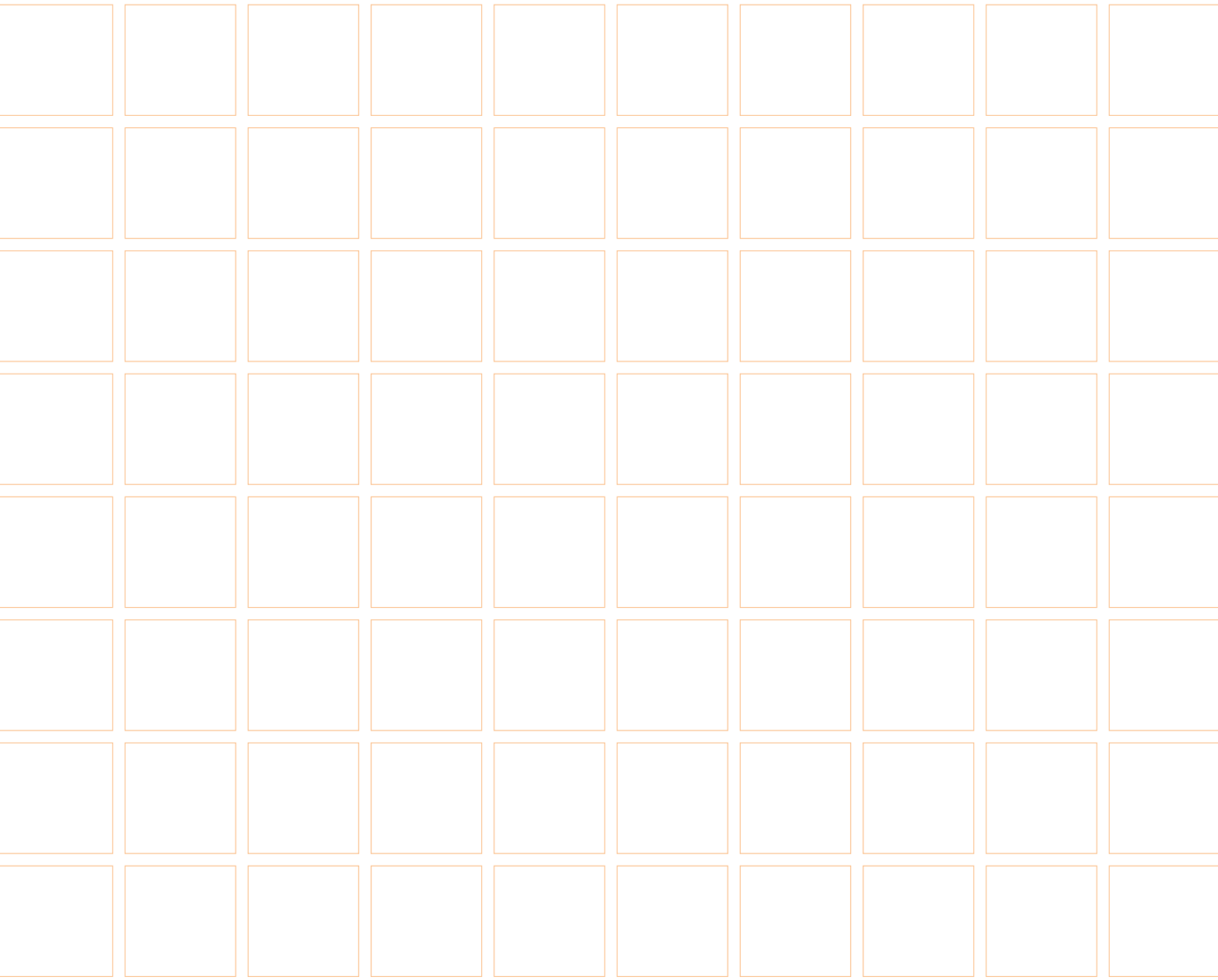
offenders. That two-pronged approach was one we felt able to commend as an effective model that secured and sufficiently prioritised the principles and objectives of this inspectorate.

Consideration is now being given to the creation of a single criminal justice inspectorate, covering the work of police, courts, CPS, probation and prisons. There are undoubtedly gains to be made by examining the criminal justice process as a whole: modelling the kind of cross-cutting approach that is being commended to the criminal justice agencies themselves. But it is difficult to see how the inspection of places of custody, as an end in itself, fits into such a broad objective. Custodial inspection focuses on the culture and detail of individual establishments, not the system as a whole; it employs human rights based criteria, not service standards or government targets; it speaks directly to Ministers, Parliament and the public about what is going on in hidden custodial institutions.

Ministers have continued to assure me, and Parliament, that nothing that is planned will affect our methodology, the frequency and choice of inspections of individual places of detention, or the ability at any time to carry out unannounced inspections. It is seen by NOMS as key to improving the decency and morality of prisons. Most recently, Baroness Scotland confirmed in the House of Lords that planned changes would not alter the 'nature, extent or efficacy' of this inspectorate. However, I have consistently made clear my serious concern as to whether this can be guaranteed within a unified criminal justice inspectorate – in which our approach, methodology and focus will be peripheral and potentially incongruous. I remain concerned that, over time and in practice, the sharp focus and robustly independent voice of the Prisons Inspectorate may be lost or muffled within a larger whole.

January 2005

Themes



Escorts

It is well known that the early days in custody, or in a prison, are the most risky: and transfer from court and between prisons is therefore a critical time for prisoners' safety. Reports show the need for systematic improvement in this area.

The revised *Expectations* document contains specific expectations on the treatment of and conditions for prisoners under escort which are used in inspections. We also examined court and escort arrangements, with colleagues from the Magistrates' Courts Inspectorate, during a joint criminal justice area inspection of Gloucestershire.

The most striking and consistent finding in our prison inspection reports was prisoners' positive view of the escort staff, and their negative view of the vans. Over 70% of prisoners surveyed said that staff treated them well. Some prisons had developed particularly good relationships: at Brixton and Belmarsh, contractors' staff actively assisted in the discharge of prisoners. At other prisons, such as Cookham Wood and Bedford, escort staff attended prison operational meetings or safer custody meetings. There were, however, exceptions: allegations of unprofessional behaviour from both prisoners and reception staff; and complaints by women of sexual harassment by male prisoners and though complaints procedures exist, we found that prisoners were in general unaware of this.

In almost all cases, prisoners reported poor conditions and cleanliness in vans, particularly those going to training or women's prisons where journeys are longer. Eighty-two per cent of women in New Hall, and 73% in Downview said that vans were bad or very bad; as did 77% of men in Featherstone and Haverigg. At Castington, some young men were handcuffed during their journeys; inherently dangerous in vans that have no seatbelts.

Prisoners often receive no written information in advance about the journey, or their destination – even when, as at New Hall, the prison had provided laminated information to be given to women at court.

Prisoners routinely experience both long days (when going to court from prison) and long journeys. They may be prepared for travel before 7am, and not return to prison until the evening: after lengthy round trips and waits in court. As the Gloucester area inspection found, no single agency is responsible for providing a main meal; and this particularly affects prisoners in long trials appearing in court every day. Video links for pre-trial issues are under-used.

> *"Why is a vulnerable prisoner taken out at 6.45am held in a single cell in reception until after 10am, the court is held up for 40 minutes while he is taken through to Crown Court. After a three minute adjournment you know about beforehand he is left until 5.15pm and then delivered back to Belmarsh to wait in reception until he is taken back to his cell at 7.30pm – inhumane. A 13 hour day for three minutes 200m away."* (Belmarsh)

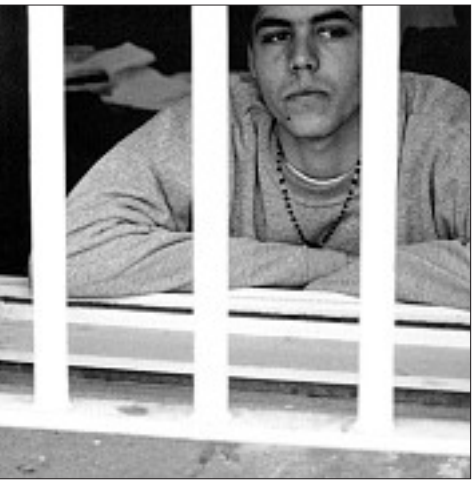
Many prisoners reported lengthy journeys; compounded in some cases by the fact that prison receptions closed for up to two hours for staff meal breaks. Garth, commendably, had changed staffing arrangements to ensure that reception remained open at lunchtime to prevent prisoners waiting on vans. Deerbolt, however, had a reception that closed over both the lunch and tea breaks; so that young prisoners waited outside and some had to urinate in bags while waiting. Women and young offenders were particularly subject to long journeys: journeys of over four hours were recorded at Ashfield, Huntercombe, New Hall, Styal and Downview. And, in the area inspection of Gloucestershire, we found that the contractor had no awareness of statutory child protection responsibilities.

Long journeys and lack of information also meant that prisoners were not offered, or did not know how to ask for, comfort breaks; and were therefore reduced to urinating in property bags or so-called portable toilet bags. Again, this was most noticeable for women and young offenders: nearly two-thirds of women complained of inadequate toilet stops.

> *Some staff recollected incidents of young people alighting from the escort vehicles with plastic bags in which they had urinated. This was not frequent, but in our survey, 78% of young adult respondents said that frequency of toilet stops on escort journeys was bad or very bad.* (Castington)

New escort contracts for journeys to and from court came into effect at the end of August 2004. Though they were designed to improve the service, initial reports in some areas are extremely troubling. We are now preparing for a thematic review of courts and escorts (see cross-cutting and thematic work section).

Anti-bullying



Anti-bullying and violence reduction strategies are a key part of safer custody; but they need to be integrated into the life and culture of the prison.

Our surveys show that, on average 33% of men in local prisons, 19% in training prisons, 29% of women, 32% of young adults and 40% of juveniles had at some time felt unsafe. But these figures disguise significant variations between and within establishments (see tables in Establishments section).

In almost all prisons there are anti-bullying committees and coordinators. But some exist in name only: the Dovegate committee had never met; Downview had no record of any anti-bullying measures; Haverigg appeared to have no coordinator, and no procedures for dealing with bullying, in spite of the fact that it was recognised as a problem.

Many coordinators have no specific profiled time for this work; and staff in general often lack training. This was the case in all types of prison – locals like Wormwood

Scrubs and Brixton, women's prisons like Styal and young offender institutions like Castington. But there were examples of good practice.

> *There was no anti-bullying coordinator and very few prisoners had been placed on anti-bullying measures despite the numerous security reports that related to bullying. The design of the billets facilitated bullying and staff believed prisoners got into debt as a result of low wages and delays in receiving their first delivery of canteen goods.* (Haverigg)
>
> *A good anti-bullying coordinator was leading some proactive work in tackling bullying. An excellent range of locally devised posters was raising the awareness of staff and prisoners. Unexplained injuries were investigated. There were three levels of intervention, and a modular intervention programme delivered by the psychology department.* (Hull)

In general, we found insufficient provision of programmed interventions for either bullies or victims in adult prisons. The 14-day programme for bullies in Durham segregation unit was an exception; and we saw no equivalent for victims. This is an area that the developing violence reduction strategy should address.

The management of prisoners who are vulnerable because of the nature of their offence, or because they find it hard to cope, is a key test of safety. Most prisons have a separate vulnerable prisoners' wing or unit. This identifies and stigmatises certain prisoners, and opens them up to abuse when they are seen by, or in contact with, other prisoners, as at Leicester. Reintegration to normal location can also be a problem, even for well-run units like Cardiff's. Two prisons inspected were trying to run integrated regimes, managing vulnerable prisoners on normal wings. This was working at Durham, but was clearly failing at Risley. Our reports linked this to the culture of the two prisons, and the effectiveness of anti-bullying strategies.

Cell sharing risk assessments, to determine whether it is safe for a prisoner to share with another, are critical: there have been two apparent occasions this year when prisoners have been killed by their cell-mates. At many local prisons, we report staff struggling to make these assessments, in the face of large numbers of new prisoners and little information about them. A few, however, are still not undertaking this task, either on reception, or when prisoners move location within the prison.

We also reported concerns about particular groups of prisoners: young adults who mix with adults (in Cookham Wood, Belmarsh and Hollesley Bay); and older prisoners at Wakefield.

Bullying is often of particular concern in young offender institutions. We found two – Huntercombe and Deerbolt – which were still operating the extremely unsafe practice of locking young people together in showers, though both were supposed to have discontinued this following previous inspection reports. We found others, like Lancaster Farms, which had excellent and effective anti-bullying procedures (see section on juveniles). Some establishments, like Ashfield, showed great improvements in providing a safe environment; others, like Huntercombe, had deteriorated.

Anti-bullying procedures were excellent and, more importantly, were being followed by staff. There was a 14-day programme where young people had to complete a detailed workbook; a logbook accompanied them wherever they moved. Levels of bullying had reduced significantly. (Ashfield)

There was little support for implementing the bullying programme; the strategy was more alive in theory than in practice. 56% of young people said they had felt unsafe; in the last seven months there had been 150 proven assault adjudications, mostly on the residential units. A combined review of all disciplinary procedures was needed, to set and enforce proper boundaries for children and young people. (Huntercombe)

There are two factors that contribute to bullying within prisons, and which prisons need to tackle robustly. They are debt and drugs: often connected. In relation to debt, prisons need to ensure that newly arrived prisoners have access to their own funds, and to the prison shop, immediately after arrival. If this does not happen (as at Haverigg above) prisoners will acquire debts, usually for tobacco, which lay them open to continued bullying.

Drugs are a more difficult, and in our view, growing problem. During the reporting year, we drew attention to the increased availability of drugs in open prisons, as more short-term, recently sentenced prisoners are sent there. This is one factor which appears to have contributed to the growing rate of absconds. But more recently, we have become aware of increased drug availability in some closed prisons. The consequence, in a closed establishment, is heightened levels of debt, bullying and intimidation.

Suicide and self-harm

In spite of strengthened procedures, improvements in detoxification, and the efforts of many prison staff, the rate of self-inflicted deaths in prisons continues to run at nearly two a week. This is the tip of an iceberg of distress: in the reporting year, 228 prisoners were resuscitated and there were 17,678 self-harm incidents.

Inspections this year record in detail the attempts made in establishments to prevent suicide and deal with self-harm. Many prisons have improved first night procedures, to deal with the vulnerability of early days in custody. This is particularly important in local prisons, receiving large numbers of prisoners, often new to custody.

The percentage of prisoners feeling safe on the first night had risen from 63% at the last inspection to 81%. We agreed with managers and staff that this increase was attributable almost entirely to the dedicated first night centre; in the 10 months since January 2003, just over 3,000 prisoners had spent their first night in the centre. (Wormwood Scrubs)

Some prisons, however, still made inadequate provision. Styal, which had had six deaths in the early days of custody in the year prior to the inspection, had no formal first night system, even though over a third of women were in prison for the first time. Nearly half of the women we surveyed said that they had received no help or support from staff within the first 24 hours of arrival. Dispersal prisons have not traditionally prioritised first night procedures, assuming that this will have been dealt with earlier. But the two we inspected this year, Long Lartin and Wakefield, were now receiving remanded category A prisoners straight from court; without any formal first night process.

The importance of good detoxification procedures in the early days of custody is highlighted in the sections on substance use and women's prisons.

A new suicide and self-harm review process, the ACCT (assessment, care in custody and teamwork), is being piloted in five prisons, to replace the F2052SH. It aims to be a less process-driven and more interactive process. Our inspections show that in many prisons, this is much-needed. Some F2052SHs merely record observations of prisoners' behaviour and demeanour, sometimes at all too predictable intervals, rather than any qualitative contact. Support plans, in too many cases, are simply a list of departments or agencies that may help: 'chaplaincy, healthcare, Listeners, all staff'; and reviews are often carried out superficially, in wing offices, with too few participants from all relevant disciplines and an untrained chair. To some extent this is a reflection of the pressure of need, particularly in women's prisons, with extremely high levels of self-harm, often dangerously involving ligatures. But it is also sometimes because these documents are used as a way of protecting staff, rather than supporting prisoners. Other prisons, such as Cardiff and Hindley, had developed excellent procedures.

> *The coordinator reviewed every open F2052SH daily against a matrix of required content. He then attended the senior management meeting to brief and update managers. A full operational manual written in plain language was clearly available throughout the prison. It was clearly being used and staff were primed to respond sensitively to needs and concerns. A system of 'observation cards' had been introduced for staff to use in education, visits and workplaces. This raised awareness and enabled daily monitoring to extend effectively into all key areas. The notion of suicide being 'everyone's concern' was becoming embedded.* (Hindley)

We continue to find examples of prisoners or detainees being transferred, while vulnerable, without proper notice or information. Bullwood Hall received an extremely disturbed girl, with little more than an hour's warning, no medical records and no background information except a voluminous self-harm watch. Dover IRC received transfers from prisons of detainees on open F2052SH forms, without either escort or reception staff being made aware of their vulnerability; their perception was that this was deliberate, for fear that they would refuse the transfer. Equally, in some open prisons, such as Hewell Grange, there was evidence of a belief among staff and prisoners that prisoners were afraid to disclose suicidal or self-harm problems in case they were transferred back to closed conditions.

The extreme vulnerability of many women in prison is discussed in the section on women's prisons. Instances of self-harm are exceptionally high in women's prisons, as better recording now shows.

There had been 325 incidents of self-harm over the year in the women's prison, in a population of only 96; this compared with 209 for the male prison which held 585. In the last six months, there had been an average of 39 incidents a month. (Durham)

Buckley Hall, a women's prison operating under a Service Level Agreement, suffered financial penalties because of this differential: it was fined if self-harm levels exceeded the number set in the original contract, when it held men. We found variable levels of practice in relation to supporting suicidal women: ranging from close and supportive interaction with a woman on constant watch in Durham, to routinely blocked observation panels of women at risk in Cookham Wood.

We continued to find unacceptable practice in responding to cell alarm bells.

One call bell went unanswered after 12 minutes; landing staff walked past cells with activated call bells, without checking. (Brixton)

We asked some detainees where the alarm bell was but they were unable to show us. We got no response from the bell and were later told it was out of order. (Lindholme IRC)

Inspectors tested staff response to call bells, but aborted the exercise when there was no response after 10 minutes. (Leicester)

Safer custody committees, and suicide prevention coordinators, are now common practice. Some, such as Cardiff, Castington and Leicester, bring in other professional disciplines. Good suicide prevention coordinators clearly improve practice. But it is equally important to ensure ownership among all residential staff. And staff training is sometimes deficient. Training in suicide and self-harm is no longer mandatory: some prisons keep up to date with training; but others had done none in the previous year or failed to meet targets.

Prisoner Listeners continue to provide invaluable support, but themselves need to be supported by the rest of the prison. In some prisons, Listeners told us that they were valued, and had free access throughout the prison and at all times. But at others, there was restricted access, for example to segregated prisoners, who may be the most in need. At Styal and Gloucester, there were no Listeners on the most vulnerable wings that held newly arrived prisoners. Some schemes were failing for lack of support, and other prisons, particularly locals, found it hard to retain Listeners. Another valuable initiative is the growth in Insider schemes – prisoners, often located in reception, who provide advice and support to new arrivals.

The scale of mental illness among prisoners is referred to elsewhere in this report. This is often linked to self-harm and suicide; and in most prisons there is inadequate provision to look after mentally ill prisoners. There is a need for daycare facilities, particularly for those whose mental disorder is not sufficiently severe to be dealt

with by hard-pressed mental health in-reach teams. Too often, disturbed and ill prisoners are moved around within the prison system, or moved into segregated conditions within prisons.

Last year, we expressed concern about the 'merry-go-round' movement of prisoners in the high security estate from one segregation unit to another. This has now been stopped. Guidance from the then operational manager of the women's estate also restricted the use of segregation and special cells for suicidal and self-harming women. However, we have found it continuing in many women's prisons. In two, Styal and Durham, we found women who had been adjudicated upon, and in one case punished, for self-harm. All immigration removal centres that we inspected this year were holding suicidal detainees, in strip conditions, in separation units. This practice stopped during inspections. In the section on juveniles, we deal with the concern about the use of segregation and strip conditions for young people.

This year, the Prisons and Probation Ombudsman began investigating deaths in custody, and will shortly be given statutory responsibility for doing so. This will provide an opportunity not only for independent investigation, but also for consistent quality and thoroughness. It is also to be hoped that it is a speedier process. We found Durham women's prison still awaiting a report, a year after the death; and eight month delays in reports reaching New Hall, Bullwood Hall and Eastwood Park. There is a need, at a minimum, for swift interim reports detailing immediate action to be taken. Recommendations will need to be followed up: our inspections sometimes find that key recommendations have not been implemented.

Inspection reports also regularly call for a better analysis of near-death incidents, to inform safer custody policy and practice. We found examples of this, for example at Cardiff and Hindley, but none in women's prisons, even though there were documented occasions when oxygen had had to be used for resuscitation.

It is not only preventive procedures that are important: it is the whole environment of the prison

What is clear from our reports is that it is not only the preventive procedures that are important: it is the whole environment of the prison. Recent studies have shown the correlation between prisoners' feelings of distress and suicide levels. Our inspections confirm this, and also point to deficiencies in the built environment, such as inadequate reception areas, or wings that cannot be properly patrolled at night because of night sanitation systems. We have also noted a slippage in personal officer schemes, for example at Leeds, with consequently less individual contact for vulnerable prisoners. At few prisons is there the opportunity for individual counselling, or for family involvement in reviews.

Counsellors offered 24-hour one to one counselling: the second most common reason for referral, after bereavement, was childhood abuse: physical and emotional, as well as sexual. (Rye Hill)

There were insufficient resources to meet the needs of women who self-harmed and for whom past sexual abuse was a factor. There had previously been counselling for women who had been raped, but this was no longer available. (Styal)

Foreign nationals

In spite of the growing number of foreign national prisoners, there is still no national strategy, and too few prisons have their own local foreign national policies.

There are 9,000 foreign national prisoners spread across nearly every Prison Service establishment in England and Wales. Their number has increased at three times the rate of British prisoners: they now represent 2% of the prison population, and more than 20% of the female prison population. Despite this, in last year's annual report, we noted that few prisons had effective foreign national policies. Regrettably, with few exceptions, the situation has improved little over the last year. Only eight out of 38 prisons in full inspections had foreign national policies, and of these only two London prisons (Brixton and Wormwood Scrubs) could be described as making reasonable progress in implementing them.

The distinct issues facing foreign national prisoners are now well established. They include: immigration-related difficulties; lack of communication with distant families, which means a greater reliance on phone contact and visits; discrimination connected with national and cultural identity; a lack of preparation for release, particularly for deportees; and language difficulties, which exacerbate all other problems.

Of these, communication difficulties, the expense of international telephone calls and poor access to telephones were consistent themes in our inspections. There was under-use of translation services: few establishments made adequate use of the Language Line telephone interpreting service.

> *A prisoner had submitted a complaint in Arabic as he could not express himself adequately in English. The complaint had been translated but the reply was sent to him in English.* (Rye Hill)

At Cookham Wood, Language Line had been used only three times in the nine months prior to inspection. In Belmarsh, which held 240 foreign national prisoners, £41,012 was spent on translation and interpreting services for the benefit of the prison (for security purposes), while only £108 had been spent on Language Line to communicate with foreign national prisoners.

Avoidable immigration detention and a lack of appropriate immigration advice for prisoners were also prominent issues. Detention often appeared to be the result of delays in instituting deportation action. These delays were in turn caused by poor communication between the Immigration and Nationality Directorate (IND) and individual prisons, and inefficient practices within IND itself.

Five of the 24 foreign nationals were held beyond their sentence expiry date. There was no evidence that contact with the Immigration and Nationality Directorate had been initiated on their behalf. (Leicester)

A specialist immigration worker visited fortnightly to provide advice on individual cases, and the diversity team reported that this had helped to halve the number of foreign national prisoners held after sentence. (Brixton)

A revised Prison Service Order entitled 'Immigration and Foreign Nationals in Prisons' has recently been issued and, if implemented, should help to improve the level of communication between prisons and IND. Unfortunately, it provides no guidance to prisons on work with foreign nationals beyond their status as potential immigration detainees.

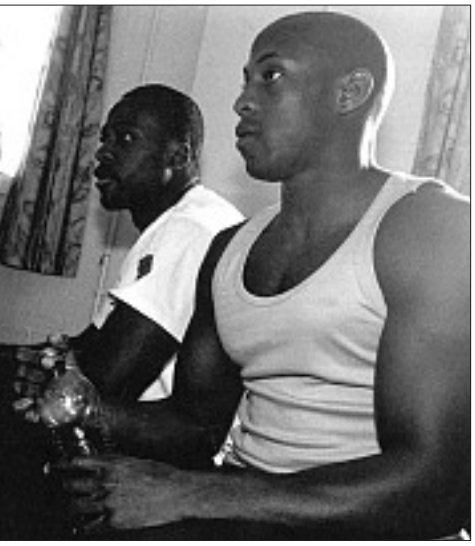
There were some encouraging signs that progress was being made in prisons such as Brixton, where a full time foreign nationals coordinator provided extensive support to foreign national prisoners, and Belmarsh, where fortnightly foreign national groups had become firmly established. Both establishments also made good use of voluntary sector organisations and had contracted the Detention Advice Service to provide immigration advice for prisoners. Similarly, some establishments, like Hollesley Bay and Wormwood Scrubs, had started to develop properly constructed foreign national policies, and therefore had some basis for coherent practice development.

However, the more typical picture was of a lack of awareness of the distinct needs of foreign national prisoners. Few prisons had developed foreign national policies, and those that had were not consistently delivering on them. There was little long-term strategic work being done with foreign nationals across the prison estate, and a palpable lack of guidance from Prison Service Headquarters. The limited scope of the new Prison Service Order is a missed opportunity. It seems unlikely that sustainable and effective practices will replace the uncoordinated initiatives that currently predominate without clear guidance and auditable standards.

Race relations

As the Prison Service begins to implement the action plan agreed with the Commission for Racial Equality (CRE), inspections continue to show that practice in prisons is variable. Black and minority ethnic prisoners consistently report worse treatment than white prisoners.

During the year, the CRE published the final report of its investigation into race in the Prison Service. It found that the Prison Service had 'committed acts of unlawful discrimination … against individual members of staff and prisoners [and] in respect of the overall standards of the job it was created to perform, the care of prisoners.' As a consequence, the Prison Service agreed to an action plan, with the advice and assistance of the CRE. This Inspectorate has also set in train a thematic review of race relations in prison, mapping the current state of race relations in prisons of different types and identifying barriers to progress. This report will be issued next year.



The inspection reports published this year show a mixed picture. On the one hand, processes and procedures to manage and monitor race and discrimination were generally evident. The great majority of prisons had race relations policies, committees, officers and monitoring. Some were impressive: for example, the race relations liaison officer who produced a detailed local pack to assist staff; a management team that invited in local race equality councils; close examination of ethnic monitoring data to identify and take action on trends; follow-up interviews with complainants. But some were much less so: management teams that were poorly attended and met rarely; liaison officers with little facility time or who were too junior to effect real change; no analysis of or action on monitoring data. It was rare to have prisoner representation on management teams, and even rarer for prisoners' comments to be acted upon. Wellingborough and Brixton were at extreme ends of this spectrum, illustrating the variation in practice throughout the system.

The race relations policy was out of date and the race relations management team did not meet regularly. There was no ethnic monitoring, no confidential complaints system and no management scrutiny of complaints investigation. Unsurprisingly, black and minority ethnic prisoners lacked faith in the system and complained of occasional overt racism and discrimination. This area needs urgent attention, and it is surprising that its weaknesses had not been noted earlier. (Wellingborough)

Race relations had improved significantly. There was a proactive diversity team with wide membership and a wide focus. Prisoners were actively involved in the team and sub-committees. Ethnic monitoring was of a high standard, and there was rapid response to any areas of concern. Racial investigations were conducted thoroughly, and prisoners had confidence in the system. There was also a rich and growing celebration of diversity. Fewer black and minority ethnic prisoners than white claimed to be victimised by staff and prisoners; and more claimed to be treated with respect. (Brixton)

A great deal depended upon the seniority of the race relations liaison officer, and the extent to which he or she was resourced and supported. Most are senior or principal officers, lacking the status, and sometimes the experience and training, to affect practice throughout the establishment. It was noticeable that at Brixton, where the most significant changes had been made, the diversity manager was a member of the senior management team, and had the active support of the Governor.

The investigation of racial incidents was also variable. In most prisons, forms were available, with confidential access. Some, however, had significant backlogs and little evidence of thorough investigation, with a proper understanding of indirect discrimination. In most prisons, the number of complaints had increased; but in many, they were over-used by staff as a protective measure against prisoners who had complained about their racist language or attitudes. Few prisoners had confidence in the system, and some expressed this openly. In a sample of 155 racial incident complaints at Leeds, no complaints against staff had been upheld.

Prisoners at Wealstun said they feared being 'shipped out' if they complained. Prisoner moves could result in complaints not being investigated: as in the case of three

prisoners at Hollesley Bay, whose complaints were not progressed after they were transferred out for unrelated reasons. At Huntercombe, 99% of complaints were resolved informally and not recorded. But there were also examples of good practice.

Complaints were dealt with swiftly. There was evidence of witnesses being sought and interviewed, and conclusions and resolutions were fair, practical and fully explained. Of particular note was the practice of following up many investigations with an interview with the victims about two weeks later to ensure that the situation was resolved and that complainants were content with the investigation. Brief notes of these interviews were provided to the chair of the management team. (Styal)

In too many prisons, we find that the catering, and the items available in the shop, do not properly reflect the full diversity of the population; and in some that halal and non-halal food is stored together. However, there is also evidence of a greater promotion of diversity: religious festivals are regularly celebrated, many prisons celebrate black history month, and more staff visibly support race equality, by wearing RESPECT badges. In one prison, we found an Asian mentoring service for local prisoners; in another a Caribbean poetry workshop.

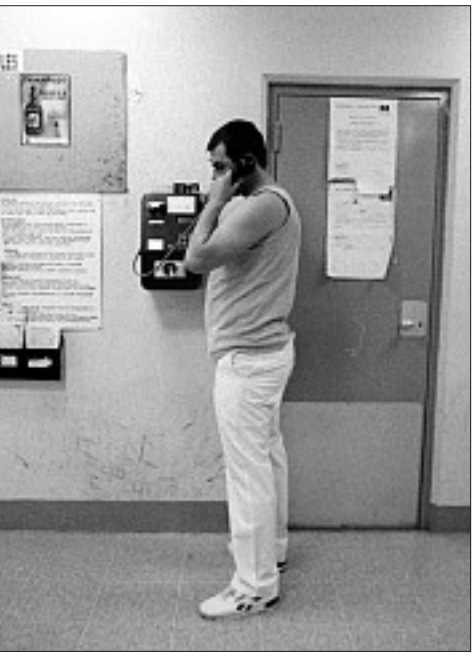
But this needs to be reflected in the culture of the whole prison, all year round. This is not yet evident in most prisons. In most prisons, our prisoner surveys found that responses from black and minority ethnic prisoners were significantly more negative than those for white prisoners, across a range of key areas of prison life – even when the prison's ethnic monitoring statistics did not pick up any apparent discriminatory treatment. Our race thematic is seeking to explore and explain these findings, in order to assist the Prison Service to understand and tackle this issue.

In many prisons, black prisoners reported remarks and behaviour that were at best insensitive and at worst racist. In most cases, they attributed this to a lack of understanding, rather than deliberate and overt racism; and to a minority of officers. But at some prisons, there were clearly endemic problems; and on some occasions, the gulf between officers and black prisoners was so great that it constituted a security risk.

Around 28% of Long Lartin's prisoners were from black or minority ethnic communities. Some complaints were handled well, others badly; monitoring data were unreliable. We detected underlying tensions among prisoners and a lack of confidence among staff and managers, which could lead to serious problems if left unattended.

The attitudes and approach of staff are key. Many prisons holding significant numbers of black and minority ethnic prisoners are in almost exclusively white areas. Training and support are vital; but, with no requirement for mandatory or off-site training, this is often either not a priority, or delivered by staff who themselves have an imperfect understanding of the issues. The percentage of staff trained in race and diversity varied from 87% at Wakefield to 7% at Hindley.

Family and friends



The extent to which prisons promote and help to maintain family links is critical to resettlement: it can also be an important component of safety. But not all prisons see this as a core task.

On arrival, many prisoners rate anxieties about contacting family as high on their list of concerns: this was the case for up to two-thirds of men in our prisoner surveys, and around a third of women. Yet, in many prisons inspected, prisoners were unable to have free access to phones on the day of arrival. Juveniles and young prisoners were in general well catered for; but provision elsewhere in the prison estate was often poor. Fewer than one in five prisoners in some prisons said they could have a free phone call on arrival.

> *'It took me a week to let my family know where I was. They didn't need to be put through that.'* (Wakefield)
>
> *There was no telephone in reception and this was often not available on the wings if association was cancelled.* (Cookham Wood)

In some prisons, it could take some time to obtain and credit PIN numbers. Once settled in the establishment, most prisoners reported reasonable access to phones, but there were exceptions – such as Belmarsh, Brixton and Haverigg: often a combination of insufficient time out of cell and too few phones.

> *Queues for the use of phones were permanent features of association… When we questioned why a small number of prisoners could not be unlocked during the day to allow access to showers and phones, one member of staff told us 'they'll come to expect it'.* (Belmarsh)

We were particularly critical of young offender institutions, like Deerbolt and Huntercombe, where young people were unable to have daily phone contact with families. At Askham Grange, women benefited greatly from the fact that they were allowed to receive incoming calls. Some prisons had installed proper privacy booths; but in nine prisons, we found that it was impossible to make phone calls in private.

Distance from home seriously hampered regular visits, particularly for women and young offenders

Cancellations of association were particularly problematic when plans to phone families had been made. Three women's prisons, Bullwood Hall, Cookham Wood and Downview, regularly cancelled association because of staff shortages. At Bullwood Hall this was done predictably and allowed women to arrange to make calls, whereas at Cookham Wood and Downview cancellations happened with no warning.

Distance from home was a serious problem in relation to regular visits, particularly for women and young offenders.

'I cannot get a visit 'cos it's a long way from here to where I live and it's Christmas soon and I feel down.' (Young prisoner at Lancaster Farms)

'Local women are shipped out too far away, preventing visits, and women from southern jails are shipped here to replace them, preventing their visits too.' (New Hall)

'Sent here against our will from 150 miles away. My people can't travel here. I told people I need to be near my family. Just get on with it is what we're told. That's why prisoners kill themselves.' (Wellingborough)

Many reports commented on the difficulty of accessing the visits booking line: we made recommendations on this point at 11 establishments. At Belmarsh, we made six attempts to book a visit at different times of the day, but the line was constantly engaged on four occasions. In six prisons, however, access had been improved, with freephone lines or opportunities for pre-booking: they included busy local prisons like Leeds, Brixton and Leicester. There is no reason why other prisons should not also prioritise this.

Many prisons inspected had visitors' centres, often very well run by charities. In previous inspections, we strongly criticised the unacceptable or non-existent facilities at Eastwood Park and Gloucester; on reinspection we were pleased to see that both now had good visitors' centres. But some prisons that clearly needed this facility still did not have it: families visiting women at Cookham Wood had to wait outside even in bad weather; as did those visiting the young men at Deerbolt and Hollesley Bay, neither of which was easily accessible by public transport.

Too few prisons in remote locations provide transport for visitors. Rye Hill was an exception, as it was contractually obliged to do so; Hollesley Bay and Huntercombe, however, did not.

The great majority of visitors told us that they were well treated by staff during visits. But the timing of visits varied considerably: with lengthy waits and late starts in some prisons. In eight prisons, including three women's prisons, visits failed to start at the published time: at Bullwood Hall, Cookham Wood and Downview, visits could start half an hour late. At Hull some visitors were still waiting to go into the visits hall an hour after their arrival and long after the official start time.

We estimated that for some visitors the length of time spent waiting and being processed was more than twice that actually spent in the visit. (Leeds)

By contrast, at Rye Hill and Buckley Hall, visits were timed from when the visitor was seated in the visits hall.

We found four prisons (Downview, Leicester, Wakefield and Wymott), where prisoners on the basic level of the incentives scheme received only 30 minute visits, though the legal minimum is one hour. Eight prisons had no evening visits.

At Featherstone, 63 visitors, including on one occasion a two-year-old girl, had been strip-searched during the previous year – though no unauthorised items were found.

Provision for children and families is also variable. Ten prisons had supervised play areas, such as the excellent one at New Hall; others did not, even when this had been recommended in previous inspection reports. Not all prisons held children's days or family visits: at Durham, men had family visits, while women did not. Low Newton had weekly mother and child visits and the 'millennium mother' programme provided a full day visit with activities and lunch for up to 20 children once a month; by contrast Styal, where 57% of prisoners were mothers, had very limited facilities for family visits, and New Hall, with 67% mothers, had none. At very few prisons did women know that they were entitled to free letters to their children.

Family contact and support is also inconsistent. We recommend that there should be officers specifically tasked to liaise with families, particularly in women's prisons, to assist with the emotional as well as the practical issues that arise. And support for prisoners as parents can have a positive impact on the whole family. We have seen good practice in some prisons, which others could emulate.

Springhill had a part-time visits coordinator with extensive contacts with agencies supporting family contact for prisoners.

An experienced worker from York Family Centre was in the prison for 20 hours each week…to assist in child care issues and to liaise with other agencies. (Askham Grange)

Everthorpe ran a 3-day parenting course to improve skills in communication with children and coping with emotional stress. Prisoners were then eligible for day-long 'father day visits' with their children, supervised by qualified play leaders.

Following a recommendation in a previous inspection report, a relationship counsellor discussed possible changes in relationships with partners, children and other family members. Prisoners said this had made them consider their situation with relationships more realistically. (Latchmere House)

Healthcare

Prison healthcare has undergone a period of transition in the past year. In April 2004 18 Primary Care Trusts (PCTs) took the lead in commissioning healthcare for 34 prisons across the country. We undertook inspections in 12 of these in the year before commissioning, and record a generally improving picture.

Generally, we found that PCTs are aware of their responsibilities in relation to prison health. In the great majority of reports relationships between the prison and the local PCT are described as good or developing well, or as offering the opportunity for much-needed improvement.

Healthcare had improved considerably, with such close relationships with the local Primary Care Trust that the new healthcare manager was a joint appointment: this improvement was supported by our prisoner survey, where twice as many prisoners found the service good or very good. (Leeds)

However, there were exceptions.

Links with the Northamptonshire Hartlands Primary Care Trust were tenuous and there appeared to be minimal joint working between the trust and the prison at all levels. (Wellingborough)

We found wide variations in the provision of clinical supervision for staff. In most prisons, no time was allocated for supervision, or staff did it in their own time. Others, such as Featherstone and Brixton, ensured that there was protected time: indeed, Brixton had eight trained supervisors in the healthcare team.

Dental waiting lists were unacceptably long in the majority of establishments. At Eastwood Park, 65% of women surveyed stated that the quality of care provided by the dentist was either bad or very bad, and Lincoln had no dentist and no procedures for prisoners needing urgent treatment. By contrast, Wormwood Scrubs, Brixton and Spring Hill had accessible and well managed systems.

There was a distinct lack of chronic disease registers in the majority of establishments that we visited. Some had not thought about the need for registers, others blamed a lack of IT equipment. Where they were used, for example at Wymott and Garth, there was good follow up for patients with long term conditions such as heart disease and diabetes.

Nurse staffing shortages, which affected delivery of service and care, were evident in a number of establishments; Wakefield, Long Lartin and New Hall all had 50% vacancies at the time of the inspections. However, action has been taken to resolve some of the long delays in obtaining security clearance, highlighted in our last report.

Though the majority of establishments claimed to undertake nurse triage when assessing patients, none had any formal protocols or algorithms. This is of concern, as prisoners may not be receiving consistent advice and care. Leicester was typical: quality was variable, and depended on the prior experience of staff rather than defined protocols and policies.

During the year we have noted some significant improvements in healthcare overall; but many prisons are unable to meet the scale of mental health need

During the year, we have noted some significant improvements in healthcare overall. Most doctors now have qualifications in general practice, often operating from local GP practices. To that extent, there is equivalence with care outside prisons. However, in some cases, salaried doctors were supplemented by a number of locums, so that continuity of care was compromised.

Most prisons now have the services of a mental health in-reach team. This has provided much-needed additional support for mentally disordered prisoners. However, in many cases, the scale of need means that the teams are only able to see patients with 'severe and enduring' mental illness: the most acute cases. Especially if their work is not fully integrated into the prison as a whole, this leaves a majority of mentally disordered prisoners without additional support.

The majority of prisoners had some form of mental disorder. Many had complex needs, were seriously ill, and would be subject to the care programme approach in the community. (Brixton)

Since it was set up, the mental health in-reach team had received 321 referrals, of which nearly half were urgent. Though it had been set up to treat women with more complex and severe mental health problems, in practice the team also treated prisoners in mild to moderate distress. This was unsustainable, particularly as the future of the team was not secure beyond April 2004. (Styal)

There remains a lack of primary mental health provision in a number of establishments. There was also a general lack of any service that could begin to meet the needs of the many prisoners (both male and female) who might want to disclose histories of significant physical, emotional or sexual abuse and the relationship of that to subsequent offending behaviour.

We found that the three-month target for transferring patients assessed as requiring NHS secure care was being met. However, we also found that there were significant delays, in some areas, in making the assessment following a referral: so that the total length of time before transfer remained unacceptably long. At Brixton, at the time of the inspection, five patients awaited transfer and 11 others were awaiting referral or assessment.

Of concern were the particular mental health care needs of young people, for whom there is very little provision in the community.

Severely mentally ill young people were held in the healthcare centre or the reorientation unit (effectively in segregation). Though staff were doing all they could for these very disturbed young men, it was not enough. They did not have access either to sufficient specialist care and therapy for their mental illness, or programmes to address their offending behaviour, which in two cases was sexually motivated. (Ashfield)

Most establishments now recognise the need for administrative staff to work in healthcare, so that nursing staff can concentrate on clinical rather than administrative tasks: most had at least 25 hours per week, and some, like Durham, had an administrative team.

Medicines management was improving, particularly in prisons where there was active involvement of the PCT pharmacy adviser. There were, however, notable exceptions, for example Brixton. The absence of IT systems often hampered the ability of pharmacy

staff to collect quality aggregated prescribing data to inform effective medicines management. Often prescriptions were routinely transcribed or photocopied for subsequent faxing to a remote pharmacy site: with the obvious potential for error.

During the year, we came across many examples of good practice, which deserve replicating in other establishments.

Examples of good practice:

- Critical incident analysis and risk management. (Wealstun)
- Active health promotion work. (Garth)
- Examples of holistic care, such as leg ulcer clinics (Wymott and Garth) and open discussion of self-harm. (Styal)
- A 'coffee club', where prisoners in need of support could discuss their anxieties. (Wellingborough)
- A healthcare users' forum. (Cookham Wood)
- A system to combine the clinical record with a nursing care plan, with comprehensive entries and a clear audit trail. (Brixton)

Activities

We inspect education and training jointly with the education inspectorates. Though there has been progress, it is hampered by other factors, particularly population pressure and prison culture.

Throughout the prison system, the appointment of Heads of Learning and Skills, funded by the Offenders' Learning and Skills Unit, has undoubtedly assisted the strategic planning of education and skills-based training. Increasingly, learning is being delivered in the workplace in learning pods and attempts are being made to provide more work-based qualifications, as well as the large number of basic skills certificates achieved.

The initial target figure of 93 accreditations had been exceeded, and 290 recorded. Basic skills education was being delivered by teaching staff in vocational training workshops and new facilities were being built in some workshops to expand this. Newly built classroom accommodation, including an IT unit, was due to open soon. (Deerbolt)

Almost half of all prisoners were involved in some form of educational activity. The prison was using prisoner learning support assistants and providing them with qualifications. (Lowdham Grange)

However, there are three barriers to this progress. The first is population pressure; the second can be an unsupportive environment in the prison as a whole; the third is the narrowness of focus and targets set.

The Adult Learning Inspectorate (ALI) inspects all over-18 education and training, and Ofsted the under-18 education, as part of the inspection of the prison as a whole. This is important, as it is the culture of the prison as a whole that determines whether education and training opportunities are maximised, and fully used. In his current annual report, the Chief Inspector of ALI notes that in over 60% of prisons and YOIs, the overall education and training provision was inadequate. This is a slight improvement on the previous year, though still considerably lower than that found in educational settings outside prison: although with a different learner population. However, the quality of learning had declined since 2002-3: 29% of areas were unsatisfactory or very weak, compared with 18% the previous year.

The effects, or threats, of population pressure were apparent in reports this year.

> *Cardiff had doubled its population without a corresponding injection of funding to develop regime activities to meet the needs of the increased numbers. There was an insufficient range of work and skills training to provide activities for the whole prisoner population, which had a variety of learning abilities, mobility problems and difficulties associated with their health.*
>
> *There were insufficient activity spaces at Dovegate, and this had been exacerbated by the arrival of 60 additional prisoners.*

But inspection reports also show that too many prisons were not using fully the resources that they had, because education and training was not seen as a core task. Poor attendance and punctuality; missed opportunities for accreditation; high levels of low grade work; poor allocation processes; weak links between education, work and sentence planning; pay disincentives for participating in education and training – these are still too common in all types of prison establishments, even training and open prisons. But some prisons are seeking to relate work and training to opportunities outside (see training prisons section).

> *Prisoners in some workshops could earn £45 a week on average whereas those in education earned only £8 to £9 a week.* (Rye Hill)
>
> *Work allocation was not related to sentence planning.* (Hollesley Bay open prison)
>
> *Sufficient work was provided to keep prisoners busy, but it was of low quality.* (Bullwood Hall)
>
> *In the construction workshop, a conscious decision had been taken to equip prisoners with work skills that could gain them employment…this was the most successful means of getting prisoners straight into paid employment on discharge.* (Hewell Grange open prison)

Considerable amounts of money are wasted when prisoners are delivered late, or not at all, to classes and workshops. Long Lartin was an extreme example of an all too frequent inspection finding: only a quarter of available work and education spaces were being used.

Education provision at many prisons remains very narrow, even in open prisons where the prisoner population clearly needs greater variety. Prisons' key performance targets are inflexible: focusing on the majority population's needs for basic skills, and sometimes resulting in prisoners being put through courses they do not need. It would be better to develop value added measures to accurately reflect the progress that a prisoner had made during sentence. This would require improved induction and needs assessment procedures, which at present are often inadequate to properly inform individual learning plans for prisoners.

The education syllabus was narrow, and was mainly restricted to level two on basic skills. Many prisoners who arrived at Springhill were already above that educational level, but could not access classes appropriate to their needs.

Purposeful activity at Whatton continued to be of a high standard. Work was in hand with offenders' learning and skills specialists to broaden the quantity and quality of education and training available.

Many establishments significantly over-estimate the number of prisoners involved in genuinely purposeful activities or the amount of time prisoners spend out of their cells. Some obvious discrepancies between what is recorded and what is actually happening are picked up in our spot checks, but have not been picked up by managers.

Managers estimated that 194 of the 303 prisoners were engaged in what was described as purposeful activity. However, our own calculations revealed that only about 90 were involved in any kind of work or education that could be described as meaningful. (Gloucester)

There was not enough work available for prisoners and, although official figures indicated 76 unemployed at any time, we saw up to 200 prisoners on the wings during the main part of the day and only some of these were engaged in domestic work. (Lowdham Grange)

Prisoners without access to work, or those in healthcare centres, frequently have very poor regimes. At some establishments, association was cancelled at short notice; and access to exercise in the fresh air is often irregular, particularly in YOIs, where it is rarely specifically provided for (see section on young adults). Prisoners in some establishments had to choose between competing demands in the small amount of time they were out of their cells: showers, phone calls, breakfast and exercise.

Resettlement

Resettlement is now an accepted part of prisons' core business. Some progress has been made but it is rare to find prisoners' needs being planned for and addressed actively throughout sentence, or support continued after release.

Most prisons have resettlement policy committees, which in many cases draw from a regional resettlement strategy. However, inspections during the year continued to reveal a very patchy picture, with limitations both in approach and funding.

Resettlement policy committees usually concentrated on staffing and operational issues, rather than providing strategic overview or direction. We rarely found adequate monitoring of outcomes and performance, or the integration of resettlement work, often provided by a multiplicity of agencies and funding streams.

At Lancaster Castle, the resettlement committee took a 'whole prison' approach, involving all departments, and was seeking to develop an integrated strategy to include the new Custody to Work funding.

The Prison Service Plus scheme at Haverigg was isolated physically and managerially from the other resettlement services and had not placed any prisoners into employment or housing during its seven months of operation.

Very few prisons had drawn up detailed action plans, based upon an analysis of the needs of their prisoner population, to implement any regional strategy. Indeed, many prisons' knowledge of their prisoner population was limited: some had real difficulty in completing our prisoner profile, and, when they did so, this could reveal statistics that countered the prison's own assumptions about its population make-up.

Where funding had been secured, or resources acquired, this too often resulted in work that was not well integrated into the rest of the prison, and was time-limited. At the end of the first phase of Prison Service Plus, for example, many prisons lost a major component of resettlement work, without having created the expertise or resources to follow it up.

Many prisons pick up reintegration issues at induction, and deal with immediate problems; but there is often no consistent follow-up

Many prisons are now alert to the need to pick up reintegration issues (such as housing, debt and employment) at induction. However, we have frequently found that, after dealing with immediate problems, underlying issues remain unaddressed until soon before a prisoner's release, when it may be too late. In most cases, unless prisoners themselves are active in seeking help, there is no consistent follow-up; and in some cases pre-release programmes have been dropped because of other pressures. Nevertheless, there is a visible growth in expertise, particularly in housing and employment advice; and some interesting developments in peer support, with prisoners themselves becoming advisers.

The assessment and resettlement centre at Wormwood Scrubs took an integrated approach to assessment and referral. All resettlement related services worked together under a single management structure, using shared systems with dedicated administrative support.

At Leeds, 90% of sentence plans were uncompleted. Most short-term prisoners had a custody care plan at induction, but there was no evidence that this was subsequently used by staff on the residential units to inform or guide a prisoner through custody, and no one was responsible for updating the plan.

Release on temporary licence as part of a staged preparation for release is used sparingly in the great majority of prisons: it is not actively promoted, and most prisoners do not see it as a realistic option. Everthorpe was a notable exception, with 57 temporary licences issued during six months, 60% of them related to preparing prisoners for release.

We found sentence planning in disarray in many prisons. Some had taken decisions not even to complete plans; others struggled with redeployed staff and poor administrative support systems. Plans themselves too frequently had targets relating to what the prison could offer, rather than what the prisoner needed; and there was little evidence of structured case management to motivate prisoners to meet targets. Nevertheless, when sentence planning boards were held, they were usually of good quality, with prisoner involvement.

At Belmarsh, the resettlement policy committee had been suspended. No offending behaviour programmes were offered. Prisoners were contacted by a voluntary agency 14 days before release, too late to adequately address reintegration needs. Sentence plans had not been completed for the 10 months preceding the inspection.

At Hewell Grange, Latchmere House and Spring Hill open prisons, resettlement was synonymous with the working out schemes. Hewell Grange did no sentence plans for prisoners serving under four years.

Two major deficiencies remained the absence of custody plans for short-term or remanded prisoners; and a failure to respond to the specific needs of the increasing number of prisoners recalled to prison. Leeds was unusual in knowing how many licence recalls it held (8% of the population); but nevertheless excluded them from custody planning.

OASys – the common assessment tool for prisons and probation – is presenting a considerable challenge in the prisons where it has been introduced. Assessments are taking longer than anticipated to complete, and backlogs are developing. The lack of common IT systems between prisons and probation means that work is duplicated. The value of an integrated assessment system can also be undermined by the plethora of other assessments and action plans (such as education or substance use assessments) some of which are completed before the OASys target date of 8-12 weeks.

Many prisons are achieving good completion rates and high quality scores for offending behaviour programmes. However, there are often long waiting lists (sometimes the result of unimaginative sentence plan targets); and it is rare to find environments and attitudes on the residential wings that meet our expectation that they 'encourage, support and reinforce the objectives of treatment programmes'. Furthermore, gridlock in population management means that there is no guarantee that prisoners who need a particular programme will be able to transfer to a prison that provides it and complete the programme before release.

Next year, we will be developing a joint methodology with the Probation Inspectorate for inspecting the management of offenders 'through the gate'. This will provide a much clearer focus on the links (or lack of them) between what happens in prison and what happens outside.

Substance use

Properly managed detoxification is a crucial part of safety in the early days of custody. Reports showed that this is now better in women's prisons than in men's. Treatment and support, continued after release, is critical to resettlement, and this is still patchy, though improving.

In male local prisons, detoxification was often poor. There was no consistent pattern of effective treatment in line with clinical guidelines and standards, and many prisons offered only symptomatic relief. Some, like Wormwood Scrubs and Durham, were implementing new and effective policies; most were not. There was often insufficient liaison between treatment, healthcare and throughcare.

- At Leicester, 63% of prisoners had not received the help they needed to detox safely.
- At Cardiff, Listeners were concerned about prisoners in withdrawal.
- At Leeds, only symptomatic relief was available in the form of dihydrocodeine, which was being traded among prisoners.
- At Belmarsh, in spite of a £1 million budget, provision was poor and was not integrated into healthcare or CARATs.

By contrast, in women's prisons, we found that clinical management guidelines were consistently implemented: as a consequence, women reported feeling safer, more comfortable and less likely to self-harm. We noted the improvements in Styal as a result of a proper methadone prescribing regime. However, prescribing is not enough: it needs to be supported by a proper regime. In Styal, many women were spending 19 hours a day in their cells (see women's section). But in New Hall, a specialist team provided support during and after detox, worked effectively with healthcare and CARATs, and developed care plans for every woman. Counselling and mental health in-reach was available on the detox unit.

Women's prisons were also introducing methadone maintenance programmes for short-term prisoners, to reduce the danger of overdose on release. However,

securing continuation prescribing in the community was often a problem, as was aftercare generally, as women were usually held at considerable distance from home.

There was very little provision across the prison estate of treatment for crack and cocaine users.

The Prison Service has now introduced standards for the clinical management of drug dependence. This should help secure consistency of treatment, and greater use of maintenance prescribing. It also prioritises linked working within prisons and with community providers.

In the last annual report, we also expressed concern that the work of CARATs teams was dominated by the need to meet the Key Performance Targets for assessments: this remains the case. CARATs teams also commonly experienced difficulty in recruiting and retaining staff; and sometimes lacked supervision and training. But there was also good work, for example, on harm minimisation and relapse prevention. Bedford was running good harm reduction workshops, and at Wymott, in-cell booklets were used to raise awareness of drug overdose.

Resettlement and throughcare remained very patchy; though some prisons had developed close working relationships with drug action teams. Last year saw the arrival of Criminal Justice Intervention Partnerships (CJIPs), designed to retain offenders in treatment and co-ordinate care from arrest through sentence and post-release. It is as yet too early to comment on outcomes for prisoners, though we welcome the additional resources for hitherto unmet needs. However, there is evidence of a two-tier system, with prisoners from CJIP areas having priority: for example, seeing a CARAT worker within three days, regardless of need.

There were also some good non-CJIP initiatives.

- At Brixton, the Pathways project offered one-to-one and group based pre-release work and three months post-release support.
- At Wellingborough, the HOPE programme was a multi-agency initiative, offering intensive supervision for six months to prolific offenders whose offences were drug-related.

We recorded examples of many different kinds of rehabilitation programmes: including 12-step programmes, cognitive behaviour approaches and therapeutic communities. Availability varied; indeed some category C prisons offered no group work. And there were gaps: insufficient short-term programmes for short sentenced or remanded prisoners, though these are now being introduced, and we welcome the roll-out of P-ASRO (prisoners addressing substance related offending); no programmes designed specifically for women; and a lack of relapse prevention work on completion of programmes. In general, prisons' drug strategies did not sufficiently address diversity issues.

> *The prison had acted on all the recommendations made in the last inspection. Drug strategy and CARAT staff worked closely together to ensure speedy access to services. Interventions included one-to-one casework, group work and good links with community agencies. Prisoners benefited from a 10-week rehabilitation programme.* (Wormwood Scrubs)

Some prisons were, however, delivering specialist work: New Hall and Bullwood Hall had designed programmes for young women, Ashfield for juveniles, and Wakefield was running the high security estate's Focus programme, aimed at serious offenders. A new national specification for substance misuse work with juveniles is being introduced by the Youth Justice Board. It is welcome that it includes alcohol. However, it does not cover provision for young offenders (aged 18-21). It needs to be supported by guidelines and advice for clinicians treating drug dependent young people.

Supply reduction and monitoring was an issue in all prisons. We found gaps in mandatory drug testing (MDT) in many prisons: with no, or little, weekend testing, and inconsistent target testing. The majority of MDT positives related to cannabis (now a class C drug); but the key performance target does not distinguish between this and class A drugs, and is therefore a limited measure of the scale of the problem. In some establishments, there were issues around the reliability of particular drug dogs; and we continued to find closed visits imposed on a single dog indication, without any supporting intelligence. Establishments that integrated supply and demand reduction were more likely to be successful in reducing the availability of illegal drugs.

All prisons had voluntary drug testing and many had voluntary testing units (VTUs). There were often, however, confused approaches. Sometimes, the same staff or facilities were used for mandatory and voluntary testing; or there was no distinction between voluntary and compliance testing. The role of VTUs was also often unclear: some were drug-free environments, with many prisoners who had not used drugs; others were designed as support units for prisoners who had come off them.

In spite of the publication of the national alcohol harm reduction strategy, no specific funding is yet available for alcohol services in prisons. Some CARAT teams continued to provide support, particularly to young adults, though it fell outside their contractual remit. Some establishments, like Wormwood Scrubs, had developed an integrated alcohol strategy. But overall, provision was patchy, with no coherent strategy or specific resources.

Immigration removal centres

During the year, we published four inspection reports into immigration removal centres (IRCs): two were the first unannounced follow-up inspections.

With a specialist immigration team in place, we were able to begin a regular round of IRC inspections. Every IRC will be inspected fully every three years: sometimes announced and sometimes unannounced. In the interim period we will carry out a follow-up unannounced inspection to check on progress. Those reports are published approximately four months after the inspection. In the next reporting year, we will also establish a round of inspections of short-term holding facilities (STHFs), both residential and non-residential.

We have also prepared a set of Expectations for IRCs. They have been used, and refined, during the course of this year's inspections, and will be published in spring

2005, cross-referenced against human rights instruments. Expectations for STHFs are included as an annex.

Around 1700 people are held at any time under Immigration Act powers in prisons, IRCs and STHFs. Over 70% of detainees are held for two months or less; but nearly 5% are detained for a year or more. Our inspections are the only independent assessment of their treatment and conditions.

While the average length of detention is reducing, the insecurity of detainees, often facing imminent removal, appears to be rising. This year saw three deaths in custody: two of them apparently suicides. Our reports recorded some improvements in on-site immigration officers' contact with detainees; but also recorded considerable frustration, both from staff and detainees, because of their limited role in, and knowledge about, detainees' cases.

There were some improvements in the documentation provided to detainees, but reasons for detention remained general and in summary form. Lack of access to competent and qualified advice remained a consistent theme. Though centres now stocked a leaflet from the Office of the Immigration Services Commissioner, assisting detainees to recognise and obtain qualified advisers, its utility was undermined by the shrinkage in the availability of free legal advice, with cutbacks in legal aid. Detainees' ability to locate legal assistance, or try to help themselves, was greatly hampered by their inability to use email or have restricted access to the internet.

Most centres recorded a high level of detainee insecurity, in spite of relatively positive relationships between staff and detainees. Systems for detecting and preventing suicide and self-harm were well established in most centres, but in all of them we reported an inappropriate use of strip conditions and special segregated cells for those at risk of self-harm. Harmondsworth, at the time of the inspection, was an essentially unsafe place, with an average of 10 incidents a month, and seven assaults and one self-harm incident each week. Less than a year later, it suffered serious disturbances and was temporarily closed.

Two Prison Service centres inspected offered a complete contrast. At Dover, staff had risen to the challenge of operating a completely different regime from that of a prison. Staff were aware of the particular sensitivities of detainees, and most detainees felt safe. However, little had changed at Lindholme since our last critical inspection report. It operated under a prison culture, much of the living accommodation was filthy and in disrepair; many staff lacked knowledge and understanding of detainees; detainees were routinely transferred to the adjacent prison's segregation unit. We do not believe that Lindholme can or should operate as part prison, part IRC.

Dover had come a considerable way in making the transition from a prison to a removal centre. Helped by a conversion course, and with the active encouragement of managers, staff were aware of the particular sensitivities and needs of those in their care. This went some way to mitigating the forbidding effect of the physical surroundings. (Dover)

The establishment was still locked into a Prison Service culture: in relation to officers' attitudes, reference to 'prison rules' and policies, and regimes that fitted officers' shift patterns, rather than the needs of detainees. Many of the detainees' communal areas were filthy and dilapidated, with peeling paint, ingrained dirt and telephone rooms in a disgraceful state. By contrast, areas used by staff were in excellent condition. (Lindholme)

Haslar had improved since our last inspection, but much of the accommodation there remained unsafe and unacceptable; and there were gaps and deficiencies in suicide prevention work. All centres are now dealing with more vulnerable and challenging populations, facing the reality of imminent removal. Systems for supporting and managing them safely need to be strengthened.

All centres are dealing with more vulnerable and challenging detainees and need to strengthen systems for supporting and managing them

Movement of detainees around the estate emerged as a concern during the year: it was not unusual for detainees to be moved around the estate on a number of occasions during a short stay, sometimes during the night and often with little notice. Most reported a lack of information about where they were going and what would happen.

One young Turkish man detained in Dover spent nearly 18 hours in a van, including during the night, during a 45-hour period, without adequate food, sleep or comfort breaks. The recorded purpose of the trip was to deliver him to and from the Turkish consulate in London for interview even though he was a refused asylum-seeker.

In this reporting year, we did not issue reports on any centres holding children, though we note with concern that the detention of children continues and their number has risen. No formal mechanisms yet exist, as recommended in our 2003 reports, for independent assessment of detained children's welfare.

Two other general concerns remain unaddressed:

- The prohibition on paid work means that detainees do not have enough to do. This raises detainees' stress and anxiety, and has implications for security. Contracted-in catering and cleaning services are quite often below standard.
- There is no independent welfare advice, to deal with practical problems on detention and after release. This was highlighted as a deficiency in the inquiry into the suicide of a detainee at Haslar in January 2003. Ad hoc schemes, or initiatives by individual staff, are insufficient to meet the need.

These are matters that the Immigration and Nationality Directorate should review, across the detention estate.

Cross-cutting and thematic work

During the year, we took part in the first joint inspection of a criminal justice area, contributed to a report on persistent offenders and began to develop a joint methodology, with HMI Probation, for inspecting offender management. In addition, we undertook work towards thematics on older prisoners, race relations, and courts and escorts.

Joint Inspection of the Gloucestershire Criminal Justice Area (February 2004)

Joint Inspection Report into Persistent and Prolific Offenders (May 2004)

The first area inspection carried out by all the criminal justice inspectorates, examined interface issues across agencies in the Gloucestershire criminal justice area.

We focused particularly on resettlement and the treatment of prisoners under escort and in court custody. It was difficult to draw any clear conclusions on resettlement: too few of the prisoners held in Gloucestershire prisons would be returning to the county. Only 10% of the resettlement caseload of the local probation area was held in prisons within the county. In the four prisons in the county only 40% of prisoners in the local prison, 8% in the open prison, 2% in the women's prison, and 1% in the juvenile establishment were released to Gloucestershire. Little resettlement attention was given to released prisoners who had not been identified as posing a high risk of harm, and a significant number were released to no fixed abode.

With colleagues from the Magistrates' Courts Service Inspectorate, we also for the first time examined the treatment and conditions of those held in court cells and under escort.

This is the first experience of custody for some prisoners. Our findings in relation to escorts are reported in the escort section of this report. In relation to court cells, we found that court custody suites contrasted poorly with police custody suites. Safety was compromised by cell sharing, low staffing levels and poor facilities and there were no national standards to regulate these aspects of custody. Prisoners were sometimes dressed and discharged in paper evidential suits.

> *We had significant concerns about health and safety in the Crown Court cell area. There was a low level of decorative order, cleanliness and ventilation; cell overcrowding (up to four people in a cell meant for one); no fire alarm point in the cell complex; inadequate affray alarms; and inadequate heating and toilet facilities.* (Gloucester)

This work contributed to the production of draft 'expectations' for future joint area inspections, and resulted in further plans for HMMCSI and HMI Prisons to work together on a shared thematic into escorts and court custody nationally.

We are carrying out a joint thematic, with HM Magistrates Court Service Inspectorate, on escorts and court custody nationally

In preparation for this thematic, which will be carried out in 2005, we collected data on the length of prisoner days when under escort to court and between prisons, to be published in early 2005.

A joint report on persistent offenders was published in May by the inspectorates of constabulary, probation, magistrates courts service and prisons, together with the Audit Commission. It examined strategies for dealing with persistent offenders under the government's Narrowing the Justice Gap programme. A key finding was that the definition needed to be changed. Persistent offenders were not necessarily those identified as priority or prolific offenders by most agencies or local communities. There were too many of them to focus on intensively, and many had committed low level offences, principally shoplifting.

Intensive interventions with persistent and prolific offenders, driven by agencies with a shared agenda, showed promising results. Though there was in general little engagement from the Prison Service, schemes in Wellingborough, Bristol and Blakenhurst prisons were examined and commended.

The report supported a redefinition of the persistent offender criteria to identify locally a more limited number of priority offenders. There should be shared work between the police and the correctional agencies, supported by local crime and disorder reduction partnerships, which are best placed to deliver the necessary range of rehabilitative services, including, for example, housing.

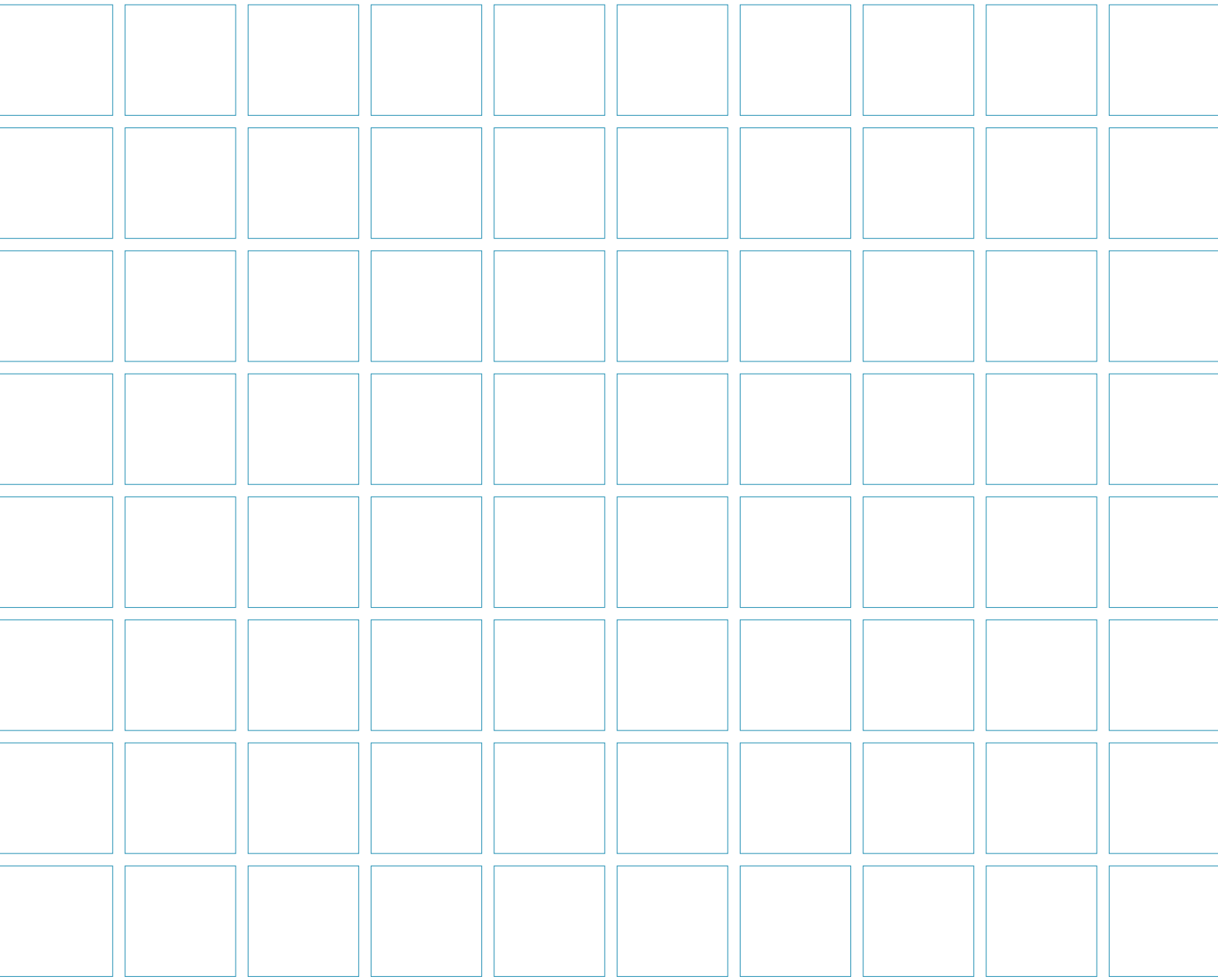
In the wake of the CRE findings reported in February, scoping work was begun on a national race relations thematic (see race relations section). Fieldwork is complete, and the report will be issued in 2005.

During the year, we also carried out research for a thematic review of older prisoners in England and Wales (now published). Older prisoners are one of the fastest-growing parts of the prison population; and some are in failing health. As the Prison Service becomes subject to the Disability Discrimination Act, prison managers will need to show that they have made every effort to meet the needs of older and less able prisoners. The review assesses the conditions for and treatment of older prisoners: specifically focusing on the built environment, regimes, healthcare and resettlement.

The review makes recommendations for the National Offender Management Service (NOMS) and other services; and identifies good practice.

Finally, the inspectorates of prisons and probation have been working closely together to identify effective ways of inspecting offender management, under the new NOMS framework. Scoping work has been done on a shared methodology for the inspection of resettlement, which was piloted in late 2004 and will be refined and rolled out in 2005.

Establishments



Local prisons

We published reports on 10 of the 37 male local prisons, varying in size from Gloucester (303 prisoners) to Leeds (1254 prisoners).

Bedford, Brixton, Cardiff, Elmley, Gloucester, Hull, Leeds, Leicester, Lincoln, Wormwood Scrubs

Our reports record three positive developments in many local prisons. First, many showed, or were maintaining, improved cultures: better and more positive relationships between staff and prisoners. Improvements were evident at Brixton, Bedford, Gloucester and Wormwood Scrubs; progress was being maintained at Leeds, Elmley and Cardiff. Lincoln was an exception to this: the aftermath of the disturbances the previous year still evident in poor treatment of prisoners. But it is an indication of the general direction of travel that this was the exception, rather than the rule.

> *Prison officers on each of the wings addressed prisoners by their first name or title and surname. Staff knew many of their prisoners and dealt with their issues professionally and courteously.* (Bedford)
>
> *Most noticeable was the change in attitude and approach of prison officers. Seventy-five percent of prisoners said that staff treated them with respect. Staff took time to speak to prisoners when they were performing their routine tasks.* (Wormwood Scrubs)

Second, many local prisons had significantly improved first night and early days of custody arrangements, when prisoners are particularly vulnerable. They ranged from well-established arrangements at Leeds and Wormwood Scrubs (where four out of five prisoners felt safe on their first night) to very new procedures at Brixton and Lincoln, about which staff were still unsure. Elmley had no first night arrangements: again, this was exceptional.

But inspection reports also showed that one key factor in vulnerability in the early stages of custody, detoxification, was not adequately dealt with. Practices varied widely and detoxification regimes were often poorly developed or insufficient to meet the needs of the population. Brixton, with a very high intake of crack cocaine users, had no discrete detoxification unit; nor did Gloucester, in spite of recommendations from the Inspectorate and an external review. Much work has been done to improve and standardise detox regimes in women's prisons; by contrast, these services are seriously underdeveloped and underfunded in the male prison estate.

Third, resettlement was clearly now on the agenda of all the local prisons we inspected. Some prisons were tackling this strategically – identifying needs at induction and seeking to meet them before release. Wormwood Scrubs, Bedford and Elmley were examples of this strategic approach, and of coherent work with other agencies. In other prisons, though, work was uncoordinated and inconsistent – often reflecting fragmented or short-term funding, or the absence of strategic management

or assessment of need. All local prisons struggled to meet the needs of prisoners who would not be released locally. None had effective personal officer schemes to motivate prisoners and manage them through sentence or custody plans.

However, the positive developments that we record were significantly offset, in all local prisons, by the damage caused by overcrowding. As a whole, the local prisons we inspected were nearly 20% overcrowded. In some, the problem was acute: Leeds was 60% over its 'normal' accommodation, Leicester 70%. The two prisons suffered problems of scale at both ends of the spectrum: Leeds was settling in 436 new prisoners a month; Leicester had to manage its inflated population on one wing. At Cardiff, refurbishment of one wing meant that another held nearly twice as many prisoners as its certified normal number.

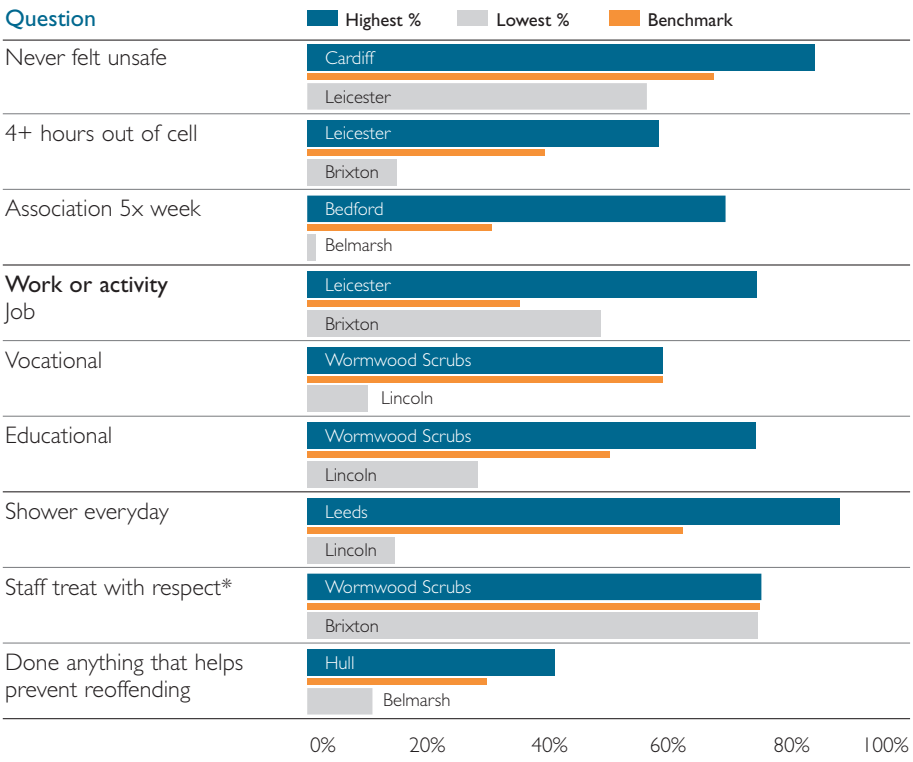
Leeds held 1250 prisoners, 60% more than its certified normal accommodation; almost all of them were two to a cell designed for one; and in one month alone 436 new prisoners had to be settled in.

E wing had a certified normal accommodation of 96 but was holding up to 184 prisoners. This meant that cells – barely adequate for one prisoner – were being occupied by two. (Cardiff)

A further chronic aspect of overcrowding was the absence of sufficient activity. No local prison that we inspected was able to offer enough proper work and training for its population. That is partly a function of a transient population, some of it remanded and recalled prisoners with uncertain lengths of custody – but it is largely the result of too many prisoners, moved around too much. Some prisons, like Hull and Cardiff, had doubled their populations, without a corresponding injection of funding to meet the need. Others, like the small Victorian locals, had neither the space nor the infrastructure to expand provision. Two thirds of prisoners at Brixton, and a third at Lincoln, had no work at all: and many of the remainder were under-occupied in routine domestic tasks. Other prisons fared slightly better, and some spread the misery by offering part-time work; but this still meant that at any one time, a third of prisoners at Leeds, Wormwood Scrubs and Elmley, and nearly two-thirds at Hull, were locked behind their doors. Where work was available, prisoners were rarely able to acquire marketable skills: four out of the 10 prisons had no accredited training at all.

The absence of activity often led to lengthy periods spent locked up. In local prisons overall, our prisoner surveys show that only 45% of prisoners spend four or more hours out of their cells every day. Many prisons – such as Gloucester, Lincoln and Bedford – fell well below this. Predictability of time out of cell had improved at Wormwood Scrubs, though the time itself had decreased. Leeds, however, was unusual in managing to ensure that 60% of its prisoners had access to five or more periods of association.

Many prisoners had mental health needs, some so acute that they were awaiting transfer to NHS acute psychiatric care. At Brixton, 30 of the 33 inpatient beds were occupied by mentally ill prisoners, five awaiting sectioning and transfer. Some prisons, like Hull and Bedford, had improved mental health care, but the work was overloaded and sometimes insufficiently supported by NHS or counselling services.



* This question only applies to 4 surveys – Wormwood Scrubs, Bedford, Brixton & Hull – all had a 74%–75% response on this question

Training prisons

This year, we published reports on 18 male training prisons. Four were category B training prisons, holding more serious and long-term offenders; 14 were lower security category C prisons.

Some prisons – such as Everthorpe and Garth – showed significant improvement, and others – like Stafford – were clearly on an upward path. Others, however, were failing to meet the challenge of population pressure: the number of unemployed prisoners at Acklington had doubled, increased overcrowding at Camp Hill was a contributory factor to the inadequate number of work spaces, and, perhaps most disappointing of all, Coldingley, once a flagship industrial prison, had deteriorated in work, education and sentence planning.

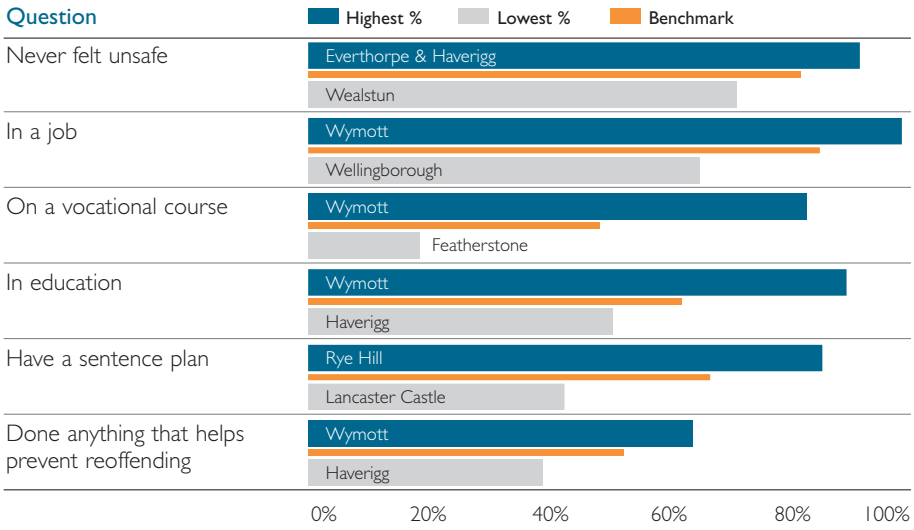
Most of the category C prisons were safe and respectful environments at the time of the inspection; this has not always been the case in such establishments.

However, many were struggling with a more transient and demanding population; and in addition some were facing significant increases in size, as quick-build units went up to accommodate the increased prisoner population.

The picture in category B trainers was more mixed. We had serious concerns about the mix of inexperienced staff and experienced prisoners in the two privately-managed prisons at Rye Hill and Dovegate, opened around three years previously.

Cat B: *Garth, Dovegate, Rye Hill, Lowdham Grange*

Cat C: *Everthorpe, Wellingborough, Wealstun, Haverigg, Wymott, Lancaster Castle, Featherstone, Camp Hill, Coldingley, Acklington, Risley, Stafford, Whatton, Shepton Mallet*



However, this was not the case at the third privately-run prison, Lowdham Grange, six years into its contract, where, in spite of a 30% staffing turnover, we recorded staff dealing professionally and calmly with prisoners. At Garth (a public sector prison), we found high levels of safety and respect.

> *Most officers were fairly new and young, often with far less experience of prison than the long-term prisoners in their care; and there were relatively few of them.* (Rye Hill)
>
> *Garth was an impressively safe and secure establishment. Staff treated their often difficult and challenging charges with the requisite balance of care, respect and professional distance.*

It is to be expected that training prisons provide a better quantity and quality of education, work and training than local prisons. By and large, this is the case: but often provision could not match demand, and too many prisoners were unemployed, or employed in mundane tasks that brought no qualifications.

- At Lowdham Grange, on average 100 prisoners were on the houseblocks during the working day.
- At Wellingborough, half the prisoners were locked in their cells for considerable periods.
- At Camp Hill, 170 out of the 570 prisoners did not have a job and spent long periods locked up.
- At any one time at Garth about a quarter of all prisoners were not engaged in activity.
- At Featherstone, it was usual for around 100 prisoners to be without work.

In almost all prisons, there were missed opportunities to accredit the work that was available, to ensure that prisoners gained qualifications. Wealstun, Wymott and Rye Hill had virtually full employment, but too few qualifications on offer.

There were, however, some signs of innovation. Wymott was hosting a Transco course to train a few prisoners in gas fitting; Stafford had designed a course in waste management, consulting local employers about the skills they required. In both cases, this could lead directly to jobs on release. Garth's work allocation procedures involved an assessment of previous work and training experience.

Most prisons had well-managed education departments, but in some cases, had difficulty meeting demand. At Wymott, 80% of prisoners had basic skills needs, but only 20% at any time could benefit from basic skills tuition. Pay disincentives for education, such as at Rye Hill and Wellingborough, were particularly inexcusable in what was meant to be a training environment.

However, during the reporting period, there was evident progress in many establishments, in delivering basic skills in the workplace, with learning pods being set up in workshops.

In most training prisons, resettlement was receiving attention, but it was fairly recent, and in need of considerable development. A common theme was that prisons had a new policy, and ambitious plans, but these were not yet impacting on prisoners.

Again, in some prisons, individual projects and initiatives were addressing key resettlement issues. Wellingborough had innovative partnerships with community agencies and the police to support prolific offenders whose offences were related to substance abuse. Wymott organised family resettlement days for prisoners approaching release.

At only six of the training prisons was sentence planning up to date and effective. Eight prisons had significant delays in sentence planning, which inevitably affected prisoners' progression through the system; at three others, plans were not driving prisoners through sentence. Privately managed prisons performed consistently better than public sector prisons in this area – all three had up to date and effective systems – no doubt because of their contractual obligations.

There was a backlog of at least 181 sentence plan reviews, and we came across reviews that had been outstanding for 18 months. There was little evidence that sentence plans were treated as live documents driving prisoners' activities and there were few links with education and workshops. Many targets were vague and inadequate, such as 'use time at Featherstone in a constructive way' or 'gain employment in prison'. (Featherstone)

All newly sentenced prisoners were seen within six weeks and others within three months. There were good quality contributions to sentence planning and the boards were well organised. Relevant targets were set and copies sent to participating departments and prisoners. (Lowdham Grange)

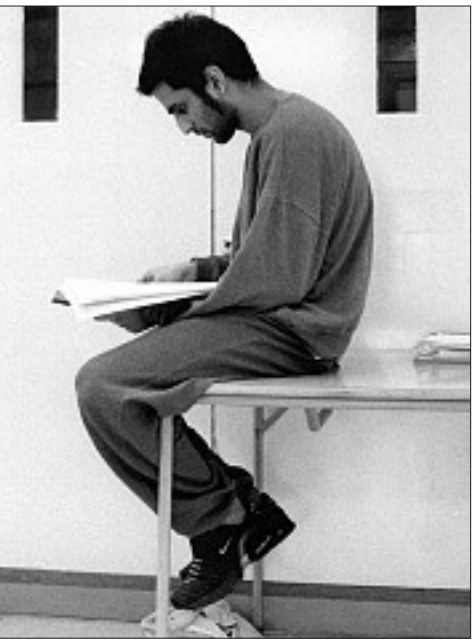
Overall, there is still need for considerable improvement: at only five prisons did we find that the quantity and quality of purposeful activity, which should be at the heart of what is provided, was at an acceptable level; and only seven were performing sufficiently well on resettlement. There has been appreciable progress in many training prisons – but this will need to be sustained in the face of significant new challenges, as their populations expand and become more demanding.

Open and resettlement prisons

Hewell Grange, Springhill, Hollesley Bay, Wealstun, East Sutton Park, Latchmere House

During the reporting year, we published reports on five open prisons and one resettlement prison.

Open and resettlement prisons continue to struggle with a different and less stable prisoner population. Population pressure means that these prisons, often in unsuitable buildings and with low staffing ratios, are housing more prisoners, for shorter periods and earlier in sentence. By definition, the entry of drugs and the exit of prisoners are both hard to control, and are dependent upon relationships of trust and responsibility.



We found numerous examples of short-term prisoners with only weeks to serve, therefore with too little time to complete meaningful resettlement work, and little investment in maintaining the norms of an open prison. (Springhill)

Over half the prisoners lived in wholly unacceptable conditions: in dormitories that lacked smoke and fire alarms, were open to vermin infestation and in a state of disrepair. Ninety-five per cent of prisoners told us that drugs were freely available; and indeed some dormitories had notices saying 'no salesmen' in order to discourage dealers. (Wealstun)

In spite of the open environment, we found little evidence of bullying in these prisons. Relationships between staff and prisoners were good, but rarely proactive: for example, personal officer schemes were underdeveloped in all prisons inspected.

The physical environment in most of these prisons is unsatisfactory: condemned buildings at Wealstun, no in-cell power at Latchmere House, and a lack of proper screening in the dormitories at Hewell Grange. The benefits for prisoners are therefore active preparation for release, and the provision of sufficient work opportunities outside the prison.

In last year's report, our principal concern was the weakness of resettlement work, in establishments whose whole purpose is to prepare prisoners for return to the community. This year's reports record some improvements, but progress is still patchy. Hewell Grange and Hollesley Bay had succeeded in increasing the number of prisoners working outside the establishment. At Springhill, nearly a third of prisoners were able to work in the local community. Yet Latchmere House, the only resettlement prison inspected, still lacked an effective resettlement strategy, and its education provision was seriously inadequate for the needs of the population. It was, however, successful at getting prisoners into paid work. East Sutton Park, one of the only two women's open prisons, was particularly disappointing: with only 24 women working outside the prison, and too many being deployed on domestic and catering work within it.

Resettlement had progressed well, based on a needs analysis that identified what a relatively isolated open prison could achieve. Paid employment opportunities were being added to the more established voluntary work; accommodation employment and benefits advice services were being put in place; drug counselling, assessment and throughcare services were good. (Hollesley Bay)

High security estate

This year, we inspected four prisons in the high security estate. Two, were dispersal prisons, holding long-sentenced serious offenders. Two were 'core' locals, holding those remanded on serious charges, but where the great majority of prisoners are the low security remanded or short-sentenced prisoners who can be found in any local prison.

Long Lartin, Wakefield, Belmarsh, Durham

Security is necessarily a priority for prisons which hold some of the most serious and dangerous offenders in the country. The high security estate has invested a great deal of money and effort to ensure that those prisoners are held securely; and dispersal prisons are undoubtedly more safe for prisoners and the general public as a consequence.

However, our inspections reveal that, in certain important respects, the estate has not moved beyond that. Relationships between staff and prisoners, and fundamental aspects of a decent regime, were not present in two prisons inspected. And in all the prisons inspected, there was far too little activity for prisoners who would spend many years in prison: in spite of the resources available in this part of the prison estate. Decency and activity are important in themselves; but both also affect the dynamic security that is an important part of ensuring a safe environment.

Belmarsh and Durham, the two core locals, presented a contrasting picture. Durham was aware of its role as essentially a local prison, with the need to provide sufficient security for a small number of category A remand prisoners. Resettlement was relatively well-developed; and dynamic security was sufficiently good for vulnerable prisoners, including sex offenders, to be managed on normal wings. Belmarsh, by contrast, provided a restricted regime, not only as a result of staff shortage, but also because of staff inertia. Security was produced as the reason for limitations on activity and resettlement; and yet it was inconsistently applied, with searching being done ineffectively. Resettlement was poor and badly directed.

Long Lartin and Wakefield were also contrasting environments. Relationships between staff and prisoners at Long Lartin were appropriate, with proper boundaries – except in the area of race. At Wakefield, however, we recorded a culture of 'over-control and disrespect'. The former was evident in the fact that a prisoner on crutches was handcuffed for movement within the secure perimeter; the latter in the failure of staff to engage with prisoners in their care. The experience of Wakefield prisoners, in our survey, was well below the benchmark for other dispersal prisons.

Fifty per cent of prisoners in our survey said that staff did not speak to them on association and this was confirmed in our own observations. Forty-five per cent of prisoners told us that they had felt unsafe in the prison, and this rose to 64% for older prisoners. Thirty-four per cent of all prisoners, and 54% of older prisoners, claimed to have been victimised by staff. (Wakefield)

At none of the high security prisons were race and foreign nationals issues tackled effectively. It was a very poorly developed area in Belmarsh, with clear indications of discriminatory outcomes; a major concern at Long Lartin, where there were significant failings; and at Wakefield we recorded that black and minority ethnic prisoners 'expressed a lack of confidence in having their voices heard, or in the complaints system'.

Throughout all the four prisons we inspected, there was insufficient focused and purposeful activity.

Purposeful activity was the major area of deficit. (Durham)

Belmarsh was offering too little in terms of meaningful activity and time out of cell.

As in our reports of 1999 and 2002, there was insufficient activity for prisoners at Long Lartin.

At Wakefield, little activity had been happening for several months, and the time available for prisoners to spend in work was limited due to security requirements of deploying staff to line the route to work.

The high security estate has shown that it is able to consolidate and sustain the gains that it has undoubtedly made in security and control. It now also needs to pay more attention to the other aspects of the Prison Service's statement of purpose: and ensure that high security prisons, within the necessary constraints, provide a sufficiently purposeful and decent environment for all the prisoners they hold.

Women's prisons

Low Newton, Eastwood Park, Styal, New Hall, Cookham Wood, Bullwood Hall, Downview, Buckley Hall, East Sutton Park, Durham

We inspected 10 of the 13 women's prisons during the year, ranging from the open prison at East Sutton Park to the high security facility at Durham.

Overall, our reports record the extent of the distress and vulnerability in the women's prison population. This is most evident in the local prisons that receive women directly from court; but managing severely damaged and self-harming women is part of the core business of all the closed prisons we inspected. It is hard to meet that level of need – as the number of self-inflicted deaths among women testifies. It is equally hard to provide a positive, interactive regime for less damaged women who nevertheless need support to overcome their difficulties.

There had been four self-inflicted deaths in 2002-3; but there were many more occasions, as witnessed during the inspection, where staff vigilance had saved lives. An average of 75 suicide watch forms were opened each month; there had been 124 incidents of self-harm in the month before the inspection; all inpatients in the healthcare centre were seriously mentally ill. (New Hall)

An average of 70-80 self-harm incidents occurred each month, involving around 20 prisoners. In May 2003 there had been 140 incidents, 80 involving ligatures: one prisoner had harmed herself on 36 occasions over a seven-day period. In July 2003, oxygen had been used 11 times to resuscitate prisoners. All women inpatients in the healthcare centre had severe psychiatric disorders. (Eastwood Park)

Acute distress was by no means confined to women's local prisons. At Cookham Wood, we found that women were arriving earlier in sentence, many with significant mental health or substance use problems. Around 80% of those seen by mental health services were victims of sexual abuse. At Buckley Hall, an estimated 40% of women had serious mental health and substance use problems. Bullwood Hall recorded an average of 56 self-harm incidents and 20 suicide attempts a month: it had developed some innovative strategies, such as activity boxes, drawing out 'key learning points' from reviews of F2052SH forms, and counselling services. One counsellor worked specifically with women who had suffered sexual violence and nearly a third of referrals for longer term counselling related to abuse issues.

Our reports record the extent of the distress and vulnerability in the women's prison population

Durham, the only high security women's prison, had had six suicides among its small population of 124 women in the year before the inspection: over half the women there had at some time been on suicide watch. We strongly recommended that it be closed, as it was an unsuitably restricted environment, with insufficient management attention to the specific needs of women. This has since happened, except for a small number of high risk women who will move out next year; the Prison Service is to be commended both for this decision, and for the careful way in which transfers were carried out.

Overall, there has been considerable progress over the last year in tackling the substance use problems that the great majority of women prisoners face. Under the leadership of a national coordinator, detoxification, maintenance and preparation for support on release have all improved.

This threw into relief the inordinate delay in providing effective detoxification at Styal, as recommended urgently in our previous inspection in January 2002. Since then, in the absence of such a regime, there had been six self-inflected deaths: all of them women who were within the first month of custody and who had had a serious drug habit. Methadone detoxification had, belatedly, been introduced just before the reinspection two years later; but it was not yet supported by a positive and active regime, or by procedures to identify and support the most vulnerable women.

In almost all women's prisons inspected, we found that relationships between staff and prisoners were good. But, given the needs of many of the women, this is not enough. It needs to be supported by well managed and appropriate systems that can

ensure that caring is translated into real outcomes for prisoners, and that can ensure that needs are identified and met. This was not always the case.

Women are more likely than men to arrive at prisons with acute problems and needs – particularly in relation to family support and contact; and 42% of women, compared to around 28% of men, were experiencing prison for the first time. Provision in some prisons was inadequate to meet those needs.

60% of respondents in our survey who had problems when they arrived said that they did not receive held or support from any member of staff in dealing with these. (Cookham Wood)

The reception area was unsuitable, cramped, untidy and uncared for. It could be intimidating for new prisoners. Three-quarters of prisoners said they had received no information about what would happen to them. We found one prisoner, the day after her arrival, who did not know when she would get something to eat, and another who had no shoes. (Styal)

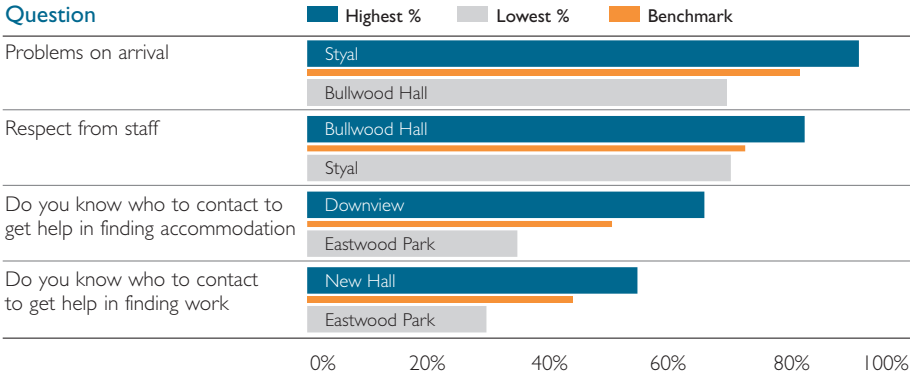
The coordinated strategy for managing new prisoners was commendable; practical arrangements were well thought out and the induction programme was delivered on the wing by residential staff. (Low Newton)

In five of the 10 prisons, we found that legal services were insufficient or ineffective. This could prevent women from obtaining bail, pursuing an appeal or challenging a recall. Training prisons in particular had not adapted to the needs of their more recently sentenced populations, and around half the women in them said they could not access legal services.

Purposeful activity is important in women's prisons, not only to provide skills and training, but also to alleviate stress and depression. Most of the women's prisons we inspected had sufficient purposeful activity, though it was often of low quality, and sometimes, as at Buckley Hall, not well managed. Opportunities to acquire useful qualifications were often missed. However, there was virtually no activity available on the remand wing at Styal, where the recent suicides had taken place and where women could spend 19 hours in their cells each weekday. Inconsistent access to association there, and in Cookham Wood, prevented women from being able to phone families. Loss of regime was a major factor in aggravating distress and depression. By contrast, Eastwood Park, in spite of being a local prison, ensured that nearly all women had association three times a week, and had activity spaces for three-quarters of its population.

Women have particular, and acute, resettlement needs. Many will have lost homes and partners during imprisonment; many will need continued support with drug and mental health problems. Many are held at considerable distance from their homes and families: 60% of women in our surveys were more than 50 miles from home. We comment in the section on family and friends on the consequences for visits.

Reintegration needs are therefore more difficult to meet, but all the more important. Resettlement policies were under-developed in all women's prisons we inspected. Some were beginning to develop coherent policies; others were not. In all prisons, the need for personal officer and family liaison support is evident, but often not met.



There was no evidence of an established, effective and overarching resettlement strategy. (Downview)

Reintegration planning was unsystematic and lacked focus. In particular, there was a shortage of housing advice and formal assessment of resettlement needs. (Cookham Wood)

There was no evidence of any structured resettlement strategy for women; sentence planning was not being undertaken. (Durham)

During the year, the women's prison estate, as such, was disbanded and management of women's prisons reverted to their local areas. This raised significant concerns: as our inspections record, the development of policies and procedures specific to women was beginning to show an impact – in detoxification, suicide and self-harm strategies and healthcare. Assurances were given that resettlement opportunities would be easier to provide within an area framework, and that the women's group would continue to develop and promote policies specific to women. But it is not yet clear whether the relatively tiny women's estate will have the leverage, and resources, necessary to convert those policies into effective practice.

We have made clear to the Prison Service that in inspections we will be looking to see those promises realised, in a way that recognises the specific needs of women.

Young adults

During the year, we published nine reports on establishments holding young adults aged 18-21. Only one, Deerbolt, was exclusively for that age-group. Four were 'split sites', also holding under-18s. Four were primarily adult prisons: three local prisons, holding remanded young adults, and one open prison.

Deerbolt (YOI); Ashfield, Castington, Hindley, Lancaster Farms (split sites); Belmarsh, Elmley, Hull (locals); Hollesley Bay (open)

In all but one of the establishments inspected, young adults were 'add-ons' to another population: which was sometimes better funded (juveniles on split sites) or in the great majority (men in adult prisons). Young adults were often held at some distance

from home; and were liable to be moved between sites, at short notice and for short periods, in response to pressures elsewhere in the system.

As inspections show, they still remain some of the most overlooked and under-resourced prisoners. Our reports record significant gaps between the provision for juveniles and young adults on split sites. Some establishments, such as Lancaster Farms and Hindley, took pains to try to spread what was available, and use the juvenile provision as a means of attracting resources for the whole population. Most, however, did not succeed in this.

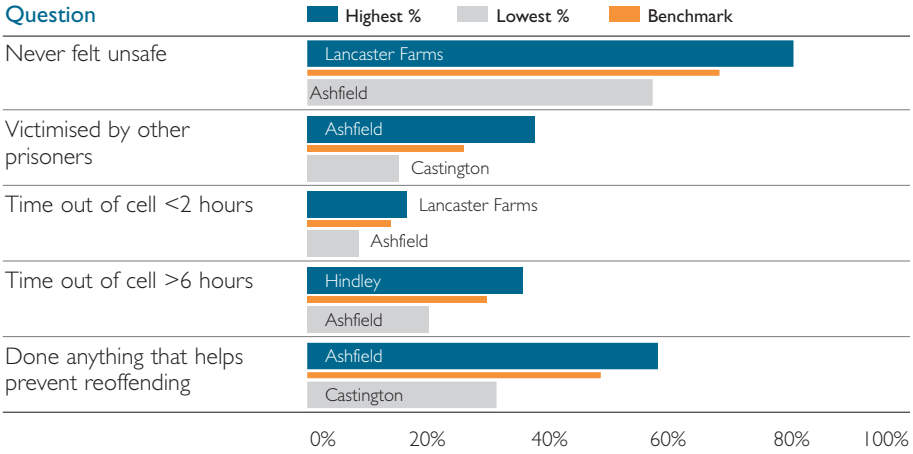
There was full employment and extensive education. This was particularly true on the juvenile side; but it was commendable that, in spite of the differential in resources, we found only 39 out of 320 young adults unoccupied during the core day. (Hindley)

Vocational training provision for the juveniles was of a high standard. In contrast, the young adults had no access to vocational training that offered any form of accreditation or was relevant to their resettlement needs, apart from the recently-introduced catering NVQ. Many young adults who we spoke to expressed a preference for vocational or skills training rather than education, and they were both disappointed and resentful of the juveniles who could access this provision while they could not. (Castington)

These problems were exacerbated by population pressure, which meant that young adults were often moved, sometimes at short notice and at considerable distance from home. At Lancaster Farms, in the construction workshop, only 7% of young adults managed to complete a qualification. Some establishments resembled transit camps, rather than effective young offender institutions. Ashfield had experienced 161 transfers for overcrowding reasons in the past seven months, often of young men nearing the end of sentence, or midway through courses. Castington, just before the inspection, had had transfers in from Feltham.

Many young adults spent only a matter of days in the establishment. In the last three months, 303 had been transferred out to other establishments; this was a greater turnover than the entire young adult population of the prison. (Lancaster Farms)

This also affected sentence planning. In spite of effective systems, Lancaster Farms could not cope with the needs of its large remand population, and the short stays of the sentenced population: none had stayed long enough to be eligible for the three-month review of their initial OASys sentence plan assessment. In nine months, there had been 852 new receptions, the majority staying for less than a month. Other establishments had virtually given up on sentence planning – only 20% of young adults at Castington even had a sentence plan. Deerbolt, by contrast, had good sentence planning systems – but, like many young adult establishments, it lacked an effective personal officer scheme.



The problems we record in relation to escorts were particularly pronounced in relation to young adults (see section on courts and escorts). Because of the limited number of establishments, they were more likely to experience long journeys and late arrivals. This was exacerbated when prison receptions closed over the lunch-break, leaving young people in vans or inappropriate locations. Deerbolt's reception closed over lunch and between 4.30pm and 5.30pm; and some young people held in vans over that period alighted with the bags they had used to urinate in. At Lancaster Farms, one in four young adults arrived after the cut-off time of 7pm.

Many establishments made no specific provision for outdoor exercise. They assumed that young men had access to fresh air in the course of their daily movements to and from work and activities. This is in any event insufficient, but unavailable for those who are unemployed. Deerbolt, for example, has extensive and well maintained grounds; but those without allocated activity had no access to them, and spent most of the day locked in their cells. Association was also limited to every other evening. By contrast, young men at Ashfield had good access to outside facilities and daily association. For those young adults who did not have access to education and training – a majority in some establishments – time out of cell was limited.

> *There was a need to ensure that those young people who did not have access to activity at particular times in their sentence did not spend the majority of their time locked in their cells.* (Deerbolt)
>
> *With fewer work opportunities and in some cases a reluctance to engage in formal education, young adults spent far too much time in their cells, around a third of them told us that they were out of their cell less than two hours a day.* (Castington)

Bullying is a particular concern for this age-group. Establishments had mixed records in dealing with this: effective systems were in place at Lancaster Farms, Ashfield and Castington, but this was much less so at Hindley and Deerbolt. At Hindley, around a quarter of young people said they had experienced bullying, but they had no faith in the systems to protect them from it: three-quarters of them said that they would not even report it. No attempt had been made by the prison to quantify the extent of the problem.

Juveniles

Bullwood Hall, New Hall and Eastwood Park; Castington, Lancaster Farms, Ashfield and Hindley; Huntercombe, Thorn Cross

We published full inspection reports of eight establishments holding juveniles: three women's prisons holding girls, four split sites, holding juvenile and young adult males, and one solely juvenile establishment. We also published nine follow-up inspections, focusing mainly on education and training.

Our specialist juvenile team visits each juvenile establishment every year. Three main issues arise from this year's inspection reports: safety, the use of force, and education and training.

During the year, some of the effects of Inspectorate recommendations, and the consequences of the Howard League judgment on the Children Act in relation to children in prison, began to be felt. The Prison Service and Youth Justice Board (YJB) reviewed children's safeguards in all juvenile establishments; and a working party of the Association of Directors of Social Services, the Local Government Association and the YJB resulted in a circular to all local authorities setting out their responsibilities towards children in prison.

In practice, support from Area Child Protection Committees remains patchy. Wakefield and Essex improved their support after critical inspection reports: in the latter case, at Bullwood Hall, we expressed particular concern about six pregnant girls there, and the child protection issues that arose for both mother and baby.

We continue to express concern about the effect of large units, at some distance from home, on the safety and well-being of young people. Two thirds of juveniles at Lancaster Farms were more than 50 miles from home, and over half said it was difficult for their families to visit – as did half of those at Ashfield. Overall, however, 69% of young people were within 50 miles of home (see Annex 5). We remain concerned about safety in large units, for example at Huntercombe, where we had significant concerns about safety, even though it was operating at three-quarters capacity. Though the establishment had implemented many necessary improvements by the time of a follow-up inspection, we remained concerned about its ability to sustain them, and provide a positive regime for young people, now that it was operating to maximum capacity. Some governors appear to be making pragmatic decisions to reduce the number of children out on association at any one time, so that safety is not compromised. This means that young people have too little time to make phone calls, shower, or spend time with each other and staff.

> *Fifty-six per cent of young people told us they had felt unsafe; nearly a quarter said that they had been hit, kicked or assaulted by another young person. This was supported by the establishment's own figures. There had been 150 proven assaults in eight months; over the last month 22% of young people claimed to have been threatened with violence.* (Huntercombe)

Nearly 80% of young people said they had never or rarely felt unsafe. The systems to detect and prevent bullying were particularly good, involving all staff. The recently developed violence reduction strategy identified and monitored 'hot spots' for assaults and assailants. (Lancaster Farms)

Some establishments had developed effective systems to tackle assaults and victimisation, using combined safer custody strategies – suicide and self-harm, anti-bullying and child protection. However, bullying is still usually tackled with workbooks, monitoring and separation, rather than a coordinated programme of behaviour management.

Some young people are not safe, or present risks to other prisoners and staff, simply because they should not be there. At Ashfield, New Hall and Eastwood Park, we found children who could have been considered as at risk of serious harm within the meaning of the Children Act, and thus required investigation by the local authority.

A 17-year-old girl with Asperger's syndrome was in the healthcare department, where she was associating with disturbed adults. Her condition meant that she was prone to copycat behaviour, and she was self-harming, saying that she had seen other women do it. She needed to be protected from adults, but also other patients needed to be protected from her violent behaviour. The alternative was to isolate her from other patients, which was not compatible with good management of her condition. (Eastwood Park)

Ashfield was trying to look after some juveniles with particularly challenging mental health problems. These children should not be in prison. Healthcare and reorientation unit staff worked closely together to look after these very damaged young people in a humane and caring way, but despite their best efforts children deteriorated while in their care.

Another focus during the year has been separation and the use of force. Most segregation units have been re-named care and separation units, and combine the roles of accommodating young people removed from the wing and those who are vulnerable: these different functions were not always clear. But in some places there was innovative multi-disciplinary care planning; 'inclusion rooms' to assist personal development; or 'cooling-off' rooms on wings. At Lancaster Farms, staff worked hard to reintegrate young people in normal location; and one young man, after counselling, had successfully completed an education course.

Prison Service rules and standards on the use of force and strip-searching have not yet been adapted to take account of child protection considerations. We have expressed particular concerns about routine strip-searching of children on arrival, forcibly in some cases. There are inconsistencies in recording practice, which make it difficult to establish levels of use of force, though it does appear to be more prevalent in some establishments than others. The methods used also raise concerns: at Hindley, these

had on three occasions resulted in fractured bones. However, the methods used in Secure Training Centres are also of concern, following a tragic death at Rainsbrook. We welcome the fact that use of force throughout the secure estate is now under review.

Our reports also recommend much tighter control on the use of special cells – unfurnished accommodation where young people can be held in strip conditions, sometimes routinely. Most usages are only for short periods. We would like to see initial authorisation for a maximum of only 30 minutes and continual engagement with the young person, with the aim of removing them as soon as possible; and without the routine use of strip clothing.

Ofsted take part in our inspections to examine education and training. They recorded improvements in many establishments during the year, but there were still problems of insufficient provision or poor coordination. The quality of teaching varied from good to unsatisfactory. With the average length of stay in custody less than five months and the movement between establishments, it was difficult for teaching and support staff to provide continuity, particularly in mixed ability groups of a wide age range. Establishments were working towards, but experiencing some difficulty in meeting, the YJB's specification and standards.

There were problems with recruitment and retention of qualified teachers; though most establishments had been able to recruit Learning and Support Assistants (LSAs). As in other areas of education, the curriculum was too narrow for children who need higher level provision; and outreach provision for those reluctant to attend was variable, though there was some good practice.

In one establishment, regular visits were made to those young people not attending classes. Effective one-to-one work was carried on in the residential units. One establishment had established a Nurture Group of five young people who met twice a week for breakfast and discussion. They learned to work cooperatively and appropriately before returning to mainstream classes. Clear objectives for behaviour were set, and reviewed after each session.

Too many establishments still appointed young people as cleaners, in spite of the fact that this means they cannot meet YJB education requirements. Few establishments were delivering 'enrichment activities' (focused activity work at evenings and weekends) as specified by the Youth Justice Board.

Links between the custodial and community element of the DTO remained underdeveloped. Support from local Connexions partnerships ranged from good to poor, but was generally unsatisfactory. In one establishment with a population of 300 and over 400 movements each month, Connexions made a total of only 150 individual contacts and met 100 young people in group sessions over a year.

Training planning arrangements remained variable, with inconsistent chairing, a lack of specialist input and, in some establishments, poor communication between residential staff and caseworkers. Attendance levels by education staff were increasing, with some improvement in the quality of target setting.

Relationships in many establishments were improving, but in many the role of personal officers (and residential staff in general) remained undeveloped and unsatisfactory. The personal officer system at Feltham was in decline during the recent reinspection; and the gap between caseworkers and residential staff still all too pronounced at Huntercombe. At Brinsford, personal officers did not attend any training plan meetings observed. The recent arrival of seconded youth offending team workers in many juvenile establishments is likely to improve relationships with YOTs, but there is a danger that this, together with the arrival of advocates and social work support, will disempower residential staff further.

We recorded some improving practice on issues highlighted in previous inspection reports.

- The YJB's guidance and national standards for remand management had improved conditions for remanded young people in many establishments; but there was still insufficient provision in others.
- Following criticisms of the arbitrary movement of children between establishments, movements are now being routed through the Youth Justice Board's placement team: though this does not always happen with some of the most troubled and troublesome children.
- The YJB has set up a hotline for establishments who do not receive all the necessary documentation when a child first arrives.

Some concerns, however, remain:

- The lack of nationally available sex offender programmes though the Lucy Faithfull Foundation is providing a programme for a small number of young people at two establishments.
- Late arrivals from court (see section on courts and escorts).
- The absence of sufficient training for staff dealing with this difficult and distinctive population. The Prison Service has now developed a training package – but it lasts for only seven days and, even then, establishments are expressing concern about how they will facilitate this.

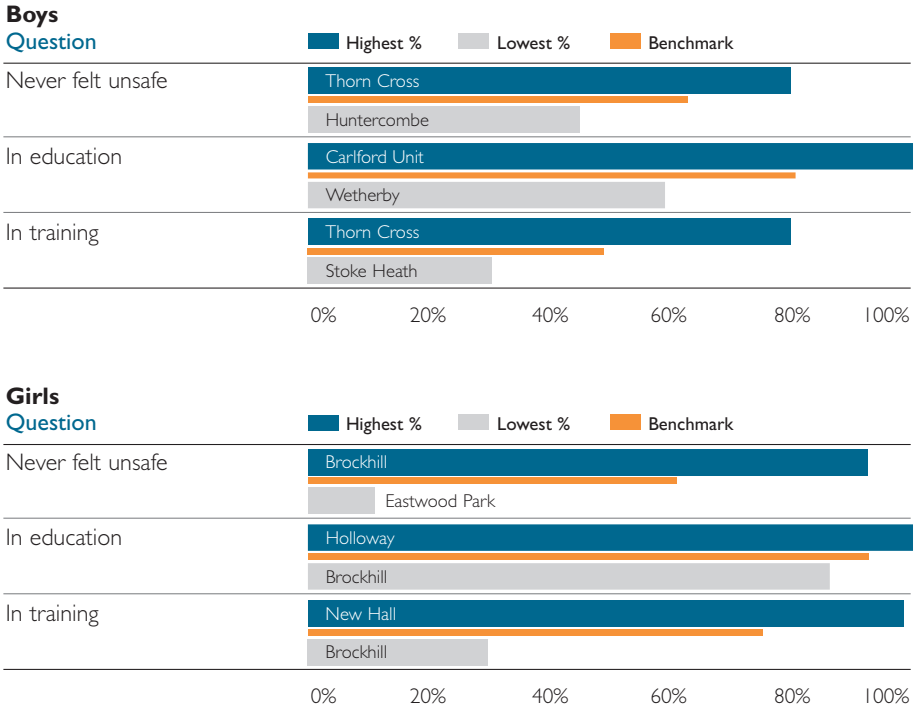
One of our major concerns, in this and other years, has been the treatment of the small number of girls in custody; always held in establishments that hold adult women. This year, we inspected the three main establishments holding girls, New Hall, Bullwood Hall and Eastwood Park. All had improved their provision during the year; but all were dealing with some extremely damaged and difficult young women, without adequate resources to do so.

All establishments holding girls had improved, but were dealing with some extremely damaged and difficult young women without adequate resources

The thematic report on girls in prison, produced jointly with Ofsted, examined in detail the experience of some young women in custody. It made depressing reading, in relation both to the experience in prison and the support available outside.

The establishments were still unable to provide sufficient quality and quantity of training and education. But this provision, however inadequate, was still better than they had received before custody, or would be likely to receive on return to the community. Ill-equipped for their return to society, they were inadequately supported when they did so. (Girls in prison: A thematic report)

The YJB and Prison Service are now planning five small discrete units for girls in five women's prisons. They will be run separately from the main establishment, with a multi-disciplinary staff team. The first, Downview opened on 30 December 2004. While we remain of the view that girls should not be held in Prison Service custody; we will examine closely these new units – which could carry lessons for the whole of the juvenile estate.



Annexes

Inspections undertaken

1 September 2003 – 31 August 2004

Establishment	Type of inspection	Inspection dates
Ashfield	Full announced	22-26 Sept 03
Askham Grange	Full announced	15-19 Mar 04
Bedford	Full announced	5-9 Jan 04
Birmingham	Short unannounced	11-13 May 04
Brinsford	Education monitoring	6-7 Oct 03
Brixton	Full announced	9-13 Feb 04
Buckley Hall	Full announced	16-20 Feb 04
Bullingdon	Short unannounced	21-24 Jun 04
Bullwood Hall	Full announced	8-12 Dec 03
Camp Hill	Short unannounced	1-3 Sept 03
Campsfield House IRC	Short unannounced	3-5 Aug 04
Castington	Juvenile follow up	26-27 May 04
Chelmsford	Short unannounced	23-26 Aug 04
Coldingley	Short unannounced	19-21 April 04
Cookham Wood	Full announced	6-10 Oct 03
Dorchester	Full announced	19-23 April 04
Dovegate TC	Full announced	29 Mar – 2 Apr 04
Dover IRC	Full announced	1-5 Mar 04
Durham (women)	Full unannounced	5-9 Jan 04
Eastwood Park	Full announced	22-26 Sept 03
Everthorpe	Full announced	29 Mar – 2 Apr 04
Featherstone	Full announced	20-25 Oct 03
Feltham	Education monitoring	24-25 Feb 04
Foston Hall	Full announced	10-14 May 04
Garth	Full announced	2-6 Feb 04
Gloucester	Full announced	22-26 Sept 03
Grendon	Full announced	1-5 Mar 04
Haslar IRC	Short unannounced	29-31 Mar 04
Hindley	Full announced	17-21 Nov 03
Hollesley Bay	Full announced	8-12 Dec 03
Hull	Full announced	15-19 Mar 04
Huntercombe	Juvenile follow up	1-2 July 04
Lancaster Farms	Full announced	12-16 Jan 04

Establishment	Type of inspection	Inspection dates
Leyhill	Short unannounced	6-8 Jul 04
Lincoln	Full announced	6-10 Oct 03
Lindholme IRC	Short unannounced	2-4 Feb 04
Lindholme	Short unannounced	21-23 Jun 04
Lowdham Grange	Short unannounced	1-3 Mar 04
Manchester	Full unannounced	5-9 Jul 04
MCTC	Full announced	14-18 Jun 04
New Hall	Full announced	10-14 Nov 03
North Sea Camp	Full announced	19-23 April 04
Oakington IRC	Full announced	21-25 Jun 04
Onley	Education monitoring	2-5 Feb 04
Parc	Education monitoring	16-19 Feb 04
Portland	Full announced	12-16 July 04
Preston	Full announced	26-30 Jul 04
Reading	Full announced	7-11 Jun 04
Shepton Mallet	Short unannounced	18-19 Nov 03
Shrewsbury	Short unannounced	9-11 Aug 04
Standford Hill	Short unannounced	2-5 Aug 04
Stoke Heath	Education monitoring	20-23 Oct 03
Styal	Full unannounced	19-23 Jan 04
Thorn Cross	Education monitoring	15-16 Mar 04
Wakefield	Full unannounced	13-17 Oct 03
Wandsworth	Full announced	17-21 May 04
Warren Hill	Education monitoring	1-2 Dec 03
Wayland	Short unannounced	8-10 Jan 04
Wealstun	Full announced	27-31 Oct 03
Weare	Full announced	7-11 Jun 04
Werrington	Juvenile follow up	5-6 Jul 04
Wetherby	Full announced	19-22 Jul 04
Whatton	Short unannounced	17-18 Feb 04
Wormwood Scrubs	Full announced	3-7 Nov 03
Wymott	Full announced	1-5 Dec 03
Joint Area Inspection		22-26 Sept 03

Total inspections undertaken: 66

Inspection reports published

1 September 2003 – 31 August 2004

Establishment	Type of inspection	Publication date
Acklington	Short unannounced	9-Sept-03
Ashfield	Full announced	21-Jan-04
Bedford	Full announced	30-Apr-04
Belmarsh	Full announced	7-Oct-03
Brinsford	Education monitoring	4-Dec-04
Brixton	Full announced	15-Jun-04
Buckely Hall	Full announced	20-Aug-04
Bullwood Hall	Full announced	5-May-04
Camp Hill	Short unannounced	23-Dec-03
Cardiff	Full announced	2-Sept-03
Castington	Full announced	8-Oct-03
Coldingley	Short unannounced	24-Aug-04
Cookham Wood	Full announced	6-Feb-04
Deerbolt	Short unannounced	29-Oct-03
Dovegate	Full announced	3-Sept-03
Dover IRC	Full announced	27-Jul-04
Downview	Announced	28-Oct-03
Durham	Full unannounced	13-Jan-04
Durham (women)	Unannounced	27-May-04
East Sutton Park	Unannounced	9-Dec-03
Eastwood Park	Full announced	17-Mar-04
Elmley	Short unannounced	11-Sept-03
Everthorpe	Full announced	7-Jul-04
Featherstone	Full announced	19-Mar-04
Feltham	Education monitoring	23-Jul-04 (website only)
Garth	Full announced	27-May-04
Gloucester	Announced follow-up	19-Dec-03
Harmondsworth IRC	Announced	29-Sep-03
Haslar IRC	Unannounced	27-Jul-04
Haverigg	Full announced	30-Sept-03
Hewell Grange	Unannounced	10-Oct-03

Establishment	Type of inspection	Publication date
Hindley	Full announced	25-May-04
Hollesley Bay	Announced	15-Jun-04
Hull	Announced	13-Jul-04
Huntercombe	Full announced	4-Nov-03
Lancaster Castle	Full announced	25-Sept-03
Lancaster Farms	Announced	20-Jul-04
Latchmere House	Unannounced	28-Nov-03
Leeds	Full unannounced	17-Oct-03
Leicester	Full announced	6-Nov-03
Lincoln	Announced	29-Jan-04
Lindholme IRC	Unannounced	16-Jun-04
Long Lartin	Full announced	19-Nov-03
Low Newton	Short unannounced	18-Nov-03
Lowdham Grange	Unannounced	23-Jun-04
New Hall	Full announced	28-Apr-04
Onley	Education monitoring	w/b 2-Aug-04 (website only)
Parc	Education monitoring	19-Jul-04 (website only)
Risley	Short unannounced	12-Sept-03
Rye Hill	Full announced	22-Oct-03
Shepton Mallet	Short unannounced	17-Mar-04
Springhill	Full announced	5-Nov-03
Stafford	Short unannounced	3-Oct-03
Stoke Heath	Education monitoring	4-Dec-04
Styal	Full unannounced	12-Jun-04
Wakefield	Full unannounced	25-Mar-04
Warren Hill	Education monitoring	26-Apr-04 (website only)
Wealstun	Full announced	25-Feb-04
Wellingborough	Full announced	16-Dec-03
Whatton	Unannounced	1-Jul-04
Wormwood Scrubs	Full announced	23-Mar-04
Wymott	Full announced	14-Apr-04

Gloucester Joint Area Inspection Report	25-Feb-04
Annual report	19-Jan-04
Thematic review: Girls in Prison	20-Apr-04
Thematic review: Juveniles in Custody	20-Apr-04
Joint Inspection Report into Persistent and Prolific Offenders	17-May-04 (website only)

Total reports published: 67

Recommendations assessed in follow-up inspections

Breakdown of recommendations which were assessed in follow-up visits 2003-2004

Establishment	Recommendations	Achieved	Partly achieved	Not achieved
Acklington	151	107	18	26
Elmley	99	58	13	28
Risley	107	66	15	26
Stafford	130	71	28	31
Hewell Grange	77	35	14	28
Deerbolt	151	78	27	46
Low Newton	125	84	18	23
Latchmere House	64	25	11	28
East Sutton Park	100	56	15	29
Gloucester	97	43	17	37
Camp Hill	90	38	17	35
Shepton Mallet	114	72	16	26
Lindholme IRC	114	20	33	61
Lowdham Grange	72	41	12	19
Whatton	72	40	13	19
Haslar IRC	109	40	35	34
Coldingley	129	62	27	40
Total	**1801**	**936 (52%)**	**329 (18%)**	**536 (30%)**

Total percentage of recommendations achieved or partly achieved 70%.

Outcome of recommendations

Outcome of recommendations in action plans received for full inspections published 2003-2004

Establishment	Recommendations	Accepted	Partially accepted	Accepted in principle	Rejected
Ashfield	115	69	0	42	4
Bedford	87	79	2	4	2
Brixton	161	153	1	4	3
Buckley Hall	129	93	6	25	5
Bullwood Hall	162	129	5	23	5
Cardiff	123	87	4	32	0
Castington	117	93	5	16	3
Cookham Wood	163	132	3	26	2
Dovegate	135	70	18	35	12
Downview	137	125	2	9	1
Eastwood Park	151	113	1	22	15
Everthorpe	114	94	2	17	1
Featherstone	171	116	6	40	9
Garth	90	72	0	17	1
Harmondsworth IRC	114	70	5	26	13
Haverigg	127	102	4	19	2
Hollesley Bay	114	96	2	13	3
Hull	129	106	4	19	0
Huntercombe	112	82	0	20	10
Lancaster Castle	67	57	1	7	2
Lancaster Farms	124	77	10	30	7
Leeds	77	61	0	14	2
Leicester	105	90	6	9	0
Lincoln	111	89	0	22	0
New Hall	156	93	8	50	5
Rye Hill	82	58	8	11	5
Springhill	84	63	1	20	0
Styal	173	108	2	63	0
Wealstun	135	99	7	26	3
Wellingborough	115	90	6	16	3
Wormwood Scrubs	137	103	8	21	5
Wymott	100	97	0	1	2
Total	**3917**	**2966 (76%)**	**127 (3%)**	**699 (18%)**	**125 (3%)**

Distance between youth offending team (YOT) and young offender institution (YOI)

The following table categorises the distance between a child/young person's youth offending team base (used as a proxy for home area) and the young offender institution in which the child/young person was held (as at 18/6/04 according to YJB data).

Establishment	Distance				Total population size
	50 miles or less	50 to 100 miles	Over 100 miles	Missing information	
Ashfield	157	76	24	12	269
Brinsford	187	7	0	1	195
Bullwood Hall*	17	9	5	0	31
Castington	54	29	44	14	141
Eastwood Park*	3	3	2	1	9
Feltham	232	6	6	19	263
Hindley	151	6	1	13	171
Holloway*	9	1	0	0	10
Huntercombe	283	42	7	18	350
Lancaster Farms	115	25	18	61	219
New Hall*	19	19	4	3	45
Parc	18	1	0	1	20
Stoke Heath	80	90	5	5	180
Thorn Cross	39	17	0	5	61
Warren Hill	51	134	16	5	206
Werrington	122	11	4	1	138
Wetherby	256	29	1	4	290
Total	**1793 (69%)**	**505 (19%)**	**137 (5%)**	**163 (6%)**	**2598**

* female establishments

Expenditure

for April 2003 – March 2004

Staff costs	2,080,476
Recruitment	10,600
Prof. subscriptions	166
Training and development	17,379
Travel and subsistence	297,498
Conferences	3,986
Meetings and refreshments	8,384
Printing and reprographics	87,062
Publicity	3,621
IT and telecommunications	24,748
Office equipment	2,372
Books and stationery	29,732
Postage	6,161
Translators	26,694
Consultancies	5,500
Accommodation/fuel/utilities	365
	2,604,744

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Editorial support: Inspection reports have been edited by Emily Wood and Brenda Kirsch

The Inspectorate teams have been accompanied by members from Ofsted (led by Bill Massam) and the Adult Learning Inspectorate. Specialist inspectors have also been provided by the British Pharmaceutical Society and the Dental Practice Board.

Printed in the UK for The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
ID,175977, 65536, 01/05