Report on an unannounced short follow-up inspection of

HMP Ford

27–29 October 2008

by HM Chief Inspector of Prisons

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Introduction

Ford is an open prison in Sussex, which now holds around 550 prisoners in ex-naval billets. Previous inspections have referred to the inadequacy of the prison's physical environment, the poor staff-prisoner relationships, and the inadequate resettlement focus. It is disappointing that none of these concerns had been properly addressed at the time of this follow-up inspection.

The accommodation at Ford will never be ideal, but it can at least be kept clean. This was not always the case, and previous deep-cleaning routines had lapsed. The reception area remained inadequate, with consequences for prisoners arriving and leaving. The prison's extensive perimeter made night supervision extremely difficult, without additional staffing. This contributed to the smuggling in of alcohol, especially at night, which had become a significant problem and contributed to some prisoners' feelings of insecurity. Nevertheless, most prisoners reported feeling safe, and both anti-bullying and suicide prevention procedures were good.

Many staff at Ford were caring and committed, but they found their efforts undermined by those who remained negative and obstructive. In general, staff were not sufficiently proactive, and personal officer work was virtually non-existent. This did not help to monitor problems, or support prisoners preparing for release. Managers needed to be much more active in supporting the efforts of good staff and challenging those who were disengaged or negative.

There was a range of educational and work activities within the prison, and all prisoners could be engaged in activity. However, the range of educational provision needed to be expanded, and more vocational training provided. Due to a lack of instructors, some workshops were overfilled and prisoners underoccupied.

It was particularly disappointing that resettlement, Ford's principal role, remained a weakness. None of the main recommendations in the previous report had been met. The resettlement strategy was not aligned to the assessed needs of prisoners, and not yet fully implemented. The offender management unit (OMU) was not yet effective and had particularly poor communication with prisoners. Some work was beginning to create links with outside employers, both around the prison and in the communities from which prisoners came, and this was much needed.

Some of the areas of continuing weakness identified in this report require an investment of resources or support from outside the prison. However, in most cases, what is needed is better management oversight and drive, and the engagement of all residential staff in the task of preparing prisoners for release. Ford has a great deal of potential, and many good and committed staff. This is not yet being properly harnessed, and as a consequence the prison is underperforming in its key and important resettlement function.

Anne Owers
HM Chief Inspector of Prisons

February 2009

Fact page

Task of the establishment
Category D male prison

Area organisation
Kent and Sussex

Number held
541

Certified normal accommodation
557

Operational capacity
557

Last inspection
Full inspection: 7-11 November 2005

Brief history
HMP Ford is a category D training establishment with an emphasis on resettlement. A former Fleet Air Arm station, it converted to an open prison in 1960.

Description of residential units
Huts and landings with single or double rooms.

Section 1: Healthy prison assessment

Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2005 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

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

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

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

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

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable

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

Safety

HP4 In 2005, Ford was performing reasonably well against this healthy prison test. Of the 25 recommendations in this area, 14 were assessed as achieved, six partially achieved and five not achieved.

HP5 The cramped reception area was unchanged and still inadequate for the large throughput of prisoners. It closed at lunchtimes, which meant that some new arrivals had to wait outside in vans. Several prisoners had been transferred to Ford with little notice and without all their property. New arrivals were not always given a free telephone call on arrival. Prisoners were positive about the assistance from prisoner orderlies during and after induction. However, an induction orderly filled out the prisoner's disability questionnaire, which included confidential health information.

HP6 Some prisoners felt insecure because of recent violent incidents and a significant alcohol problem in the prison, but most we spoke to said they felt safe. Anti-bullying management and identification systems were reasonably good, and most recommendations in this area had been achieved. There was little evidence of bullying between prisoners.

HP7 Suicide prevention was well managed. Assessments and multidisciplinary reviews were of good quality, demonstrating engagement with vulnerable prisoners, who were managed in the prison rather than transferred. Prisoners at risk said they felt supported by staff, and post-closure reviews were routine.

HP8 The high number of security information reports suggested a vigilant staff group. There was still some overuse of adjudications for trivial offences for which the incentives scheme may have been more appropriate. Apart from some ethnic monitoring, detailed data on adjudications was not collected.

HP9 Force appeared to be used only as a last resort, and there was evidence of attempts at de-escalation. The quality of some of the segregation safety algorithms was poor, and prisoner details and the governor's section were not always completed.

HP10 Counselling, assessment, referral, advice and throughcare (CARAT) services had a caseload of up to 300 prisoners. Drug and alcohol use were both significant problems. Group and individual interventions, alcohol workshops and relapse prevention groups were available. Short duration programme completions substantially exceeded the annual target.

HP11 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Respect

HP12 In 2005, Ford was not performing sufficiently well against this healthy prison test. Of the 48 recommendations in this area, 28 were assessed as achieved, 13 partially achieved and seven not achieved.

HP13 The living accommodation was reasonable, but the fabric of many buildings was deteriorating and needed some investment. The standard of cleanliness on the units varied, despite more oversight by cleaning officers. Some were diligently cleaned, but we saw ingrained dirt in others. A previous programme of deep cleaning had lapsed, and a steam cleaner had been ordered to allow a more frequent cleaning schedule. Some shower and toilet areas needed refurbishment.

HP14 Disrespectful treatment and poor relationships with staff were key concerns reported by prisoners. This perception was supported by some of the many committed staff, who felt that their own efforts were undermined by the more obstructive element. We were told that the poorer staff were fewer in number and known to managers, but they continued to have a substantial impact on the atmosphere.

HP15 Prisoner history sheets had irregular and minimal entries, demonstrating little staff engagement with prisoners, despite frequent management checks. In-depth offender consultative committee meetings were useful, but they were attended by a handful of orderlies, who did not necessarily consult with their colleagues. Other formal staff-prisoner communications remained limited. The personal officer scheme was underdeveloped, and few prisoners said they saw their personal officers regularly.

HP16 Most prisoners were on the enhanced level of the incentives scheme. There remained little difference between the enhanced and standard levels, and the scheme seemed underused to promote good behaviour.

HP17 There had been some improvements in catering, with new equipment and regular consultation with prisoners. However, the kitchen needed refurbishment, and a large number of prisoners worked there without opportunity for accredited training.

HP18 Prisoners reported few concerns about racism in the prison. Racist incident report investigations were usually of reasonable quality, but not always timely. The diversity and race equality action team (DREAT) met monthly and was chaired by the governor, but there was no comprehensive diversity policy. The diversity and race equality officer was responsible for most of the extensive diversity agenda, but was often absent from the prison and cover arrangements were insufficient. Diversity work was over-reliant on a team of six diversity representatives, who had little supervision or guidance. There was a disability policy and some recognition of the needs of prisoners with disabilities, most of whom were housed on a dedicated billet, but no systematic needs assessments.

HP19 There was some provision for a smaller population of foreign national prisoners, but it had deteriorated since the last inspection following the national decision in 2006 to remove foreign nationals from open prisons. The foreign national prisoners resource pack was good, and foreign national prisoner issues were routinely considered at DREAT meetings, but there was little coordination of the work, which was generally picked up by the diversity representatives. Regular immigration surgeries took place,

although there was no independent immigration advice. Offender management unit (OMU) staff linked well with the UK Border Agency (UKBA), but the latter still informed some prisoners of decisions to detain only very shortly before their release. Managers made appropriate individual risk assessments to inform decisions on temporary release.

HP20 There was a range of chaplains and the coordinating chaplain had a high profile in the prison. Facilities for worship were good, and prisoners reported positively on the faith provision.

HP21 Health services were good, with excellent access to most services in the prison or those available through community providers. GP clinics were held every weekday, and there was a good out-of-hours service. The pharmacy service had improved significantly, and prisoners were encouraged to manage their own medication. Mental health services were well structured and effective. Dental services were pressurised because of high demand, and additional sessions were needed to reduce waiting lists.

HP22 On the basis of this short follow-up inspection, we considered that the prison was still not performing sufficiently well against this healthy prison test.

Purposeful activity

HP23 In 2005, Ford was performing reasonably well against this healthy prison test. Of the eight recommendations in this area, four were assessed as achieved, one partially achieved, and three not achieved.

HP24 There were a large number of education places, and the education department was funded to deliver accredited and vocational courses at level two and below, although some prisoners were on a range of Open University courses. The prison was due to commence offering qualifications up to level three in information, advice and guidance and in customer service. An annual education survey had identified that many short-term prisoners needed resources, and a range of popular short taster courses had been established.

HP25 The amount of vocational training was similar to the last inspection. There was a shortage of workshop instructors, and some of the industries workshops were overfilled with little work for the participants. There was a reasonable range of work, but prisoners criticised the low pay in the prison.

HP26 The gym was appreciated by prisoners, but staffing shortages sometimes affected opening times and limited opportunities to develop accredited qualifications.

HP27 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Resettlement

HP28 In 2005, Ford was not performing sufficiently well against this healthy prison test. Of the 19 recommendations in this area, five were assessed as achieved, three partially achieved, and 11 not achieved.

HP29 Not all prisoners were subject to sentence or custody planning, and the sentence planning boards that took place had poor representation from across the prison. Life-sentenced prisoners continued to be appropriately managed and supported.

HP30 Many prisoners felt the work of the OMU was inconsistent and uncommunicative. Managers were aware of this perception and had taken some remedial action with the introduction of a fast-track application system and a range of weekly surgeries to enhance communication and speed up responses. However, at the time of inspection, these changes had achieved limited success. A planned change of shift patterns was due to ring fence OMU staff, but they were often redeployed, which affected their ability to prioritise resettlement work.

HP31 The reducing reoffending policy had been completed, but was not yet published. It provided a good framework for progress, though it was not fully informed by a needs analysis. Review meetings took place for each of the seven resettlement pathways, and action plans had been developed, but were not yet implemented.

HP32 There had been an informal review of the working out scheme, but this had not been documented, and it was not informed by a clear knowledge of the number of prisoners who met the criteria for stage one of community work. A job club that had previously lapsed as a result of funding problems was about to be reinstated.

HP33 Apart from the short duration programme, there were no offending behaviour programmes in the prison, although prisoners could access them in the local probation area.

HP34 On the basis of this short follow-up inspection, we considered that the prison was still not performing sufficiently well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 The reception area of the prison should be made fit for purpose. (HP32)

Not achieved. The reception area was little altered, and its size and layout were still unsuited to the daily movements passing through (see paragraph and recommendation 2.11). However, a kitchen had been added, which meant there was now a stock of microwave meals for any arrivals after mealtimes, and facilities to offer hot drinks.

2.2 Prisoners found guilty on adjudication should not routinely have their risk assessment suspended for 28 days. (HP33)

Achieved. Risk assessments were no longer automatically suspended following a proven adjudication. A proven adjudication resulted in a review of the risk assessment. The risk assessment board considered all cases individually, and only amended the risk if the proven adjudication indicated an increase in risk. The minutes of the adjudication standardisation meeting showed that the presumption was that any adjudication involving drugs or alcohol would lead to the suspension of the prisoner's risk assessment. Prisoners were informed of this at the adjudication, but were advised that any change to their risk assessment was the decision of the board.

2.3 There should be a resettlement policy that encompasses and leads all of the work done within and outside the prison. (HP34)

Partially achieved. A reducing reoffending policy had been written in October 2008, but had not been signed off by the area manager or distributed to staff, so it did not yet lead all the resettlement work. However, elements of the policy had been implemented just before the inspection, such as the use of prisoner logs and sentence management assessment (PLASMA), and it provided a good basis for development (see also paragraphs 2.5 and 2.168). We repeat the recommendation.

2.4 All prisoners should be subject to sentence or custody planning. (HP35)

Not achieved. Prisoners in scope under the offender management model were subject to formal sentence planning, but their sentence planning boards did not always take place within the set timescales. The manager of the offender management unit (OMU) told us that this had been due to staffing problems and a lack of progress in establishing a clear framework under the offender management model. Approximately 10% of the population were sentenced to less than two years and a further 11% to less than 12 months. The needs of these prisoners were assessed during their induction, and any resettlement issues identified. However, they had no written custody plans or targets, there was no mechanism to track if they had been seen by the reintegration services, and no document for staff or prisoners to monitor that identified needs and targets had been met. The prison relied on the pre-discharge board four weeks before the prisoner's release to address any outstanding resettlement needs. The reducing reoffending action plan had set a target of December 2008 for all prisoners to have sentence plans. Prisoners told us that they did not have a sentence plan or were unsure about this, and the

OMU manager confirmed that the unit was behind on developing sentence planning targets for prisoners.
We repeat the recommendation.

Additional information

2.5 The PLASMA (prisoner logs and sentence management assessment) system had been introduced the week before the inspection and was being piloted. The assessment tool generated initial sentence and custody planning targets and triggered referrals to specialist staff and reintegration services based on information gained from the prisoner. All staff could access the document so custody plans, particularly for prisoners serving short sentences, could be monitored and appointments to reintegration services and specialist staff could be prioritised and tracked.

2.6 There should be sufficient accredited training courses to meet the needs of the population, and the range of workplaces should be appropriate to the resettlement role of the prison. (HP36)

Achieved. The education department reviewed the curriculum annually and undertook an annual education needs analysis, although there were only 102 respondents (20%) in 2008. As 60% of the respondents were below level two, much of the curriculum was tailored to this need. The range of accredited training courses had expanded since the last inspection and included painting and decorating and carpentry, as well as plans to introduce information, advice and guidance and customer services up to level three. The prison also delivered accreditation for the Prisons Information Communication Technology Academy (PICTA). Prisoners serving shorter sentences could attend taster courses that included carpentry, tiling and plumbing.

2.7 Employment was offered in engineering, the laundry, plastic injection moulding and textile recycling. There were four vocational workshops, offering the British Institute of Cleaning Sciences (BICS) award, painting and decorating, PICTA, and a national vocational qualification (NVQ) in the staff mess kitchen where three or four prisoners could undertake the qualification at any one time. There were insufficient workplaces to meet the needs of the population, primarily due to instructor vacancies. There were 175 full-time jobs in industries and up to 95 full-time jobs on the estates. However, there were four instructor vacancies – in the engineering workshop, induction packaging workshop and the laundry – and the prison was overfilling classes in the engineering workshop and in the main kitchen to ensure that every prisoner had a job. As a consequence, there was not enough work for prisoners in some workshops. The induction workshop could accommodate up to 60 prisoners, but the work was mundane and required very little skill. Prisoners stayed there for up to two weeks before they were allocated other employment.

Further recommendation

2.8 The range of workplaces should be appropriate to the resettlement role of the prison.

Recommendation — To the director general

Courts, escorts and transfers

2.9 The Prison Service should ensure that prisoners being transferred to Ford should be provided with information in advance, and should have the opportunity to notify family and legal representatives of their transfer. (1.4)

Partially achieved. Some prisoners had a day's notice of transfer, or knew they were likely to be transferred even if they did not know when or where until shortly beforehand. However, we continued to meet prisoners who had been told to pack the same day, setting off without a chance to inform family or legal advisers or gather all their property, and sometimes not knowing where they were going until the escort explained. Population pressures aggravated unplanned movements, and full London local prisons were obliged to vacate beds so that they could accept new remands from the London courts. At the beginning of the inspection, reception staff were chasing missing property for six prisoners who had arrived the previous Friday, from four different prisons (see also paragraph 2.11).
We repeat the recommendation.

Recommendation — To the area manager

2.10 The number of prisoners arriving at Ford without an OASys assessment should be reduced. (8.14)

Achieved. The prison monitored the number of prisoners who arrived without an OASys (offender assessment system) assessment. In a review of a random sample of prisoners, 91% had an OASys, which was an increase on the previous year. The principal officer in the OMU had reviewed prisoners' files for August 2008 and approximately 20 prisoners had arrived that month without an assessment, though it was not clear if all were eligible for OASys. The prison collected figures on prisoners who arrived without an assessment and their sending establishments in order to make representations to the National Offender Management Service (NOMS).

Recommendations — To the governor

First days in custody

2.11 The prison should have a bigger and better designed reception, suitable for the prison's throughput. (1.21)

Not achieved. The small reception building had scarcely altered (see paragraph 2.1). Reception was open morning to evening on weekdays, with occasional weekend movements, and dealt with nearly 4,000 movements a month. Most were prisoners coming and going on licence, which caused bottlenecks at the beginning and end of the day. Delays in reception happened for a number of reasons. Prisoners who arrived in escort vehicles during the reception lunch closure were particularly affected. They had to stay on the vehicle until reception reopened, regardless of how long they had been travelling. This could be for more than an hour, as healthcare staff had to check their clinical records before they could disembark. Orderly flow was held up if new arrivals had a lot of possessions, accumulated over

a long sentence, which had to be checked. Communication gaps between the different departments arranging release on licence also interrupted orderly departures, for example, if money needed for fares had not been cleared for release to the departing prisoner. Licence-holders were anxious that delays could affect their punctuality at their work or college placements, affecting future prospects. There were only two small holding rooms, and the limitations of the space made it difficult to separate completely prisoners who had been checked and searched and those who had not. There was scarcely room in reception for more than two officers, although they sometimes had additional help at busy times. Searches were conducted behind a partition in the cramped reception area, which was also a thoroughfare. The single toilet, for prisoners and staff, male and female, was off the reception area. Despite the restrictions, the area was clean.
We repeat the recommendation.

Further recommendation

2.12 New arrivals should not be kept waiting for long periods in cellular vehicles.

2.13 Prisoners should be able to make a free telephone call, in private, when they arrive in a new prison. (1.22)

Partially achieved. Although electronic transfer of accounts should have allowed new arrivals to make telephone calls soon after their arrival, some prisoners told us that their accounts were not activated within 24 hours, especially if they arrived on a Friday afternoon. Reception staff could offer a free £2 telephone credit where necessary. We saw a list of those issued with this free credit, but the recent arrivals we spoke to said they were unaware of the option and were expected to await account transfer.
We repeat the recommendation.

Additional information

2.14 Prisoner orderlies contributed effectively to the two-week induction programme, which was integrated into a regime of work and assessment. They showed new arrivals around, delivered structured information, and their office, the Focus office, continued to be a point of information and referral. A brief disability questionnaire was included in the information gathered on new arrivals. Diversity representatives used this during their part of the induction programme, although it was inappropriate for them to gather such confidential information.

Further recommendation

2.15 Prisoner orderlies' induction duties should not include gathering confidential information about new arrivals' special needs.

Residential units

2.16 The establishment should once again approach the local council to install a pedestrian crossing to allow safe crossing of the road between the two sites. (2.12)

Partially achieved. Although the prison had made such an approach, there had been little progress. There were plans to erect fencing on one side of the road, but nothing to slow down fast-moving traffic. Many pedestrians crossed this stretch of road, and there remained a

significant risk of serious accident.
We repeat the recommendation.

2.17 The residential accommodation should be deep cleaned, including communal bathrooms. (2.13)

Partially achieved. There had been a programme of deep cleaning two landings a week, in which each landing and bathrooms was cleaned every 18 weeks. However, this had lapsed pending delivery of a new steam cleaner, and in the meantime ingrained dirt had clearly accumulated in some of the units.

Further recommendation

2.18 A regular deep cleaning programme should be reinstated as soon as possible.

2.19 Floors should be regularly polished. (2.14)

Not achieved. The reason given for not polishing floors was that the deep cleaning damaged any polish. However, given the infrequent (and currently suspended) schedule of deep cleaning, this did not seem sufficient reason for not polishing floors.
We repeat the recommendation.

2.20 The rooms in B-wing should only be used for single occupancy. (2.15)

Not achieved. Current population pressures meant that this was not considered to be a realistic proposition.
We repeat the recommendation.

2.21 Cleaners should be properly supervised by cleaning officers, and should remain on the units they are responsible for until that shift's work has been signed off. (2.16)

Partially achieved. There was now more effective and regular supervision of cleaners by cleaning officers, who signed off the cleaners' work each day. However, cleanliness still varied considerably across the units, with visible dirt and dust in many. There was to be a new system whereby cleaners would be given single rooms on all units and have sole responsibility for keeping them clean. This was likely to promote more ownership and accountability.

Further recommendation

2.22 Cleaning officers should ensure that unit cleaners do an effective job.

2.23 A painting programme should be introduced to improve the internal appearance of prisoners' accommodation. (2.17)

Partially achieved. A painting programme had been introduced and some, but not all, of A wing had benefited from this. However, the rolling programme had lapsed, and although there were ad hoc painters, there was no systematic painting programme.
We repeat the recommendation.

2.24 Payphones should be installed in conditions ensuring privacy. (3.73)

Partially achieved. A few payphones were in private booths, but most had little privacy. However, some privacy hoods were awaiting installation at the time of inspection, and more were on order.

Further recommendation

2.25 Privacy hoods should be fitted to all payphones as soon as possible.

Additional information

2.26 Although the condition of the living accommodation was reasonable, the fabric of many buildings, mainly the billets in B wing, needed significant investment to prevent deterioration to unacceptable levels. Some showers and toilet areas also needed refurbishment.

Further recommendation

2.27 There should be a refurbishment or rebuilding programme to ensure that the living accommodation remains in a decent condition.

Staff-prisoner relationships

2.28 Managers should work with staff and prisoners consultative groups to understand and change the negative perceptions held by prisoners about many staff. (2.23)

Partially achieved. Although the offender consultative committee provided a forum for in-depth discussion and consultation on a range of issues, staff-prisoner relationships were rarely mentioned in the minutes. Additionally, the meetings were generally attended by prisoner orderlies, who did not necessarily consult with other prisoners, many of whom said they knew nothing of these meetings. A middle managers' forum went some way to increasing communication between this group and senior managers, but again the bulk of prison staff were not included in consultative meetings.
We repeat the recommendation.

Additional information

2.29 Prisoners in our groups reported concerns about disrespectful treatment by staff, particularly by a few. This perception was supported by both uniformed and civilian staff, many of whom felt that their commitment to promoting a decent approach was undermined by the more obstructive element. We were told that there were fewer poorer staff, and they were known to managers, but they continued to have a substantial negative impact on the atmosphere in the establishment.

Further recommendation

2.30 Managers should closely monitor and challenge any disrespectful behaviour by staff.

Personal officers

2.31 An effective personal officer scheme should be developed and implemented. This should be complemented by a programme of staff training. (2.29)

Not achieved. The personal officer scheme was underdeveloped. While many prisoners could name their personal officer, few said they saw them regularly or found them helpful. Wing history sheets had regular management checks, but irregular and minimal staff entries, including from personal officers, suggested little engagement with prisoners. Prisoners said that it was possible to 'keep clear' of staff for many weeks (see recommendation at paragraph 2.82). There had been no specific personal officer training, though there was staff pro-social modelling training.
We repeat the recommendation.

Bullying and violence reduction

2.32 The safer custody committee should regularly assess the need for a dedicated anti-bullying committee. (3.11)

Achieved. Managers and the safer custody committee had considered a separate anti-bullying committee, and had concluded that bullying was best managed as part of the work of the safer custody committee. The meetings were well attended and it was clear from the minutes that bullying was given appropriate consideration. Two full-time violence reduction prisoner representatives had recently been recruited, and there were plans to increase the number. The anti-bullying coordinator had reassured prisoners that the primary role of violence reduction representatives was to bring general issues to the notice of staff and to promote anti-bullying. The representatives attended the safer custody meeting, as did Listener and Focus orderlies. Focus orderlies were peer support workers who provided support and advice to prisoners on a range of issues.

2.33 The anti-bullying survey should be conducted on an annual basis, and should be used to inform development of strategy. (3.12)

Achieved. A range of sources was used to establish the level of bullying. The last anti-bullying survey had been completed six weeks before our inspection. The number of completed surveys returned by prisoners was low at 25. The anti-bullying coordinator had suggested options for improving the response level for future surveys by offering an incentive to prisoners for completion. The safer custody committee was considering how this could be achieved while maintaining confidence in the anonymity of the survey. A full analysis of the survey had not yet taken place, but initial indications were that few prisoners had experienced bullying at Ford. The ongoing exit survey also revealed little evidence of bullying. A separate survey in preparation for a resettlement needs analysis had included questions relating to bullying, and the responses also indicated that few prisoners suffered bullying. Minutes of the safer custody committee meeting indicated that issues raised in exit surveys, complaints and by representatives were discussed and acted upon. For example, prisoners had expressed concerns about pushing in at queues for meals and the gymnasium. Managers had taken action to increase supervision of queues and to limit the number of gym sessions prisoners could attend (see paragraph 2.123) to prevent additional access by queue jumping.

2.34 Security staff should ensure that all SIRs linked to bullying are referred to the coordinator for investigation, and managers should make regular quality checks of a sample of SIRs to monitor whether this is being done. (3.13)

Achieved. There were excellent links between the security department and the anti-bullying coordinator. Information reports related to bullying were referred to the anti-bullying coordinator for investigation. The security manager and the anti-bullying coordinator regularly compared the anti-bullying register and security information report (SIR) log to ensure that no reports had been overlooked.

2.35 All bullying incident reports should be recorded in the anti-bullying log. (3.14)

Achieved. The anti-bullying strategy was well understood by staff, who had been given an easy-to-understand booklet that summarised the strategy and procedures for managing bullying. Any information about bullying was recorded on a bullying information report. Each report was given a number and recorded in the anti-bullying log. A check of the records confirmed that all reports had been correctly logged.

2.36 Formal procedures for managing bullies and supporting victims should be used in all appropriate cases. (3.15)

Achieved. All anti-bullying reports were investigated by the wing manager. The outcome of the investigation was reported to the anti-bullying coordinator, who recorded the action taken. Our review of wing observation books confirmed that entries relating to bullying had been dealt with under the bullying procedures. Where bullies were identified, formal management procedures were instigated. All staff spoken to were aware of the need to protect and support victims. If it was necessary to separate the bully and victim, staff tried to ensure that the victim's views on their location took precedence. If it became impossible for a victim to remain at Ford, there were reciprocal arrangements with HMP Standford Hill to transfer prisoners there so that they could remain in open conditions.

2.37 All bullying incidents should be fully investigated. (3.16)

Achieved. As indicated above, all bullying reports were investigated. The quality of the investigations we inspected was good. At the time of our inspection, only one prisoner was subject to anti-bullying measures. A detailed investigation had been conducted and the prisoner had been appropriately challenged and monitored.

2.38 Anti-bullying training statistics should indicate how many staff remain to be trained at any given time. (3.17)

Not achieved. All new officers received anti-bullying awareness training as part of their initial training course, but there was no programme of refresher training. The anti-bullying coordinator had carried out some ad hoc training with residential staff, but this had not been recorded.

Further recommendation

2.39 All staff should receive refresher anti-bullying training, and this should be recorded.

Additional information

2.40 The message on the anti-bullying telephone line appeared unchanged from our last inspection. It was unwelcoming and gave no information about the support available to victims of bullying.

Further recommendation

2.41 The message on the anti-bullying telephone line should include details of the support available to victims of bullying.

Self-harm and suicide

2.42 Prisoners with opened F2052SHs should only be transferred out following a clear risk assessment establishing that they are unable to cope in Ford. (3.29)

Achieved. During the previous 18 months, only one prisoner had been transferred back to closed conditions due to concerns about a risk of self-harm or suicide. In that case, the decision had been multidisciplinary and was clearly in the prisoner's best interests.

2.43 The safer custody committee should ensure that prisoners are reassured that they will not be automatically transferred if they reveal their vulnerability. (3.30)

Achieved. A number of at-risk prisoners had been managed successfully under assessment, care in custody and teamwork (ACCT) self-harm monitoring since it had been introduced at Ford (see paragraph 2.47). Greater staff awareness and skills had increased the confidence of prisoners that revealing their vulnerability would not result in a transfer to closed conditions. Listeners and Focus orderlies were fully aware that the policy was to manage prisoners at risk of self-harm or suicide at the prison. As a result, they were able to reassure prisoners and encourage them to talk to staff about their problems.

2.44 Documentary evidence of the reasons for transferring prisoners subject to F2052SHs should be retained in the prison, and the safer custody committee should consider a system of exit interviews for people transferred as a result of F2052SHs. (3.31)

Achieved. In the previous 18 months, there had only been one example of a prisoner transferred while on an ACCT (which replaced F2052SH self-harm monitoring). A copy of the ACCT had been retained, which gave full details of the reasons for the transfer.

2.45 Copies of F2052SHs should be kept on-site for audit purposes, as outlined in the prison's local suicide-prevention policy. (3.32)

Achieved. Copies of all ACCT documents were retained on site.

2.46 F2052SH reviews should be carried out by multi-disciplinary boards. (3.33)

Achieved. ACCT reviews were multidisciplinary. Registered mental health nurses attended most reviews, and attendance from other departments was based on the individual needs of the prisoner. It was clear from the records of the reviews that there had been some thought to who should attend them, and counselling, assessment, referral, advice and throughcare service (CARATs) workers and others attended when they could add value to the review and

offer support or interventions to the prisoner. The system for providing ongoing support for prisoners after closure of the ACCT was well organised, and there had been post-closure reviews in all the ACCT documents we examined.

Additional information

2.47 The introduction of ACCT self-harm monitoring had been accompanied by staff training in managing prisoners at risk of self-harm or suicide, which had increased staff awareness and skills in this area. Out of the 170 staff, 126 had received the foundation training and 22 had been trained as case managers. We spoke to several prisoners subject to ACCT procedures who told us that they had been well supported by staff.

Diversity

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

Additional information

2.48 There was no overarching diversity policy, although there were policies on race, equal opportunities and disability, and a foreign national prisoners strategy. All staff received some diversity training on induction and more than two-thirds had received further diversity training, with more planned. Diversity representatives received at least a talk from the diversity and race equality officer (DREO), and some had received training at previous prisons.

2.49 The site was not suitable for people with significant mobility difficulties, who were not accepted at Ford. A nine-bed hut had been designated for prisoners with a range of disabilities, including some with limited or varying mobility. Entrance was accessible and there was a suitably equipped wet room, but there was little else. This was partly because of a plan to relocate prisoners with disabilities to another billet, with increased capacity and closer to some of the facilities. The kitchen had nothing more than a sink and boiler. Another general purpose room had only a table, chairs, washing line and ironing board. There was no bench outside the door for those unable to take recreation easily, and no special social activities, even though some residents had difficulty getting to the dining room, gym or library. The gym offered remedial sessions, but the library was upstairs. The library orderly brought residents newspapers at the end of every day, and an allocated orderly fetched things from other parts of the site, including meals delivered in a vacuum trolley. However, the designated orderly did not work weekends, when residents had to forgo the cooked breakfast on offer. Nonetheless, residents spoke positively about the mutual support in the unit and support from some staff, notably healthcare and the DREO, who regularly checked and tried to meet their needs.

2.50 Some prisoners with disabilities could still work, for which they were paid. Those who were more incapacitated spent most of the time in their single rooms, watching television. If they had no one to send them money, they had to get by on a bare allowance of £3.25 a week, from which £1 was deducted for the television.

Further recommendations

2.51 A diversity manager should ensure that the role and functions of the diversity and race equality officer are adequately covered at all times.

2.52 The designated disabled accommodation should have basic kitchen equipment, an association room, a stock of reading material and outside benches.

2.53 Prisoners with long-term or permanent incapacity should not have television costs deducted from their basic allowance.

2.54 There should be a disability impact assessment to improve access to facilities for prisoners with disabilities and enable them to be as independent as possible.

Race equality

2.55 Comprehensive ethnic monitoring should be carried out. The race relations management team meeting should interrogate the results, and they should be used to monitor and inform the development of policy and practice. (3.46)

Partially achieved. Ethnic monitoring was conducted in key areas. This was routinely reported to the monthly diversity and race equality action team (DREAT) meetings and was used to inform adjustment of the race equality action plan and development of policy and practice. Some of the recent records indicated occasional, but not sustained, variances in how some arrangements affected different groups. However, investigation into these did not always appear to be prompt or thorough. Some staff appeared to lack confidence in interpreting or investigating variations in the results of ethnic monitoring.

Further recommendation

2.56 All staff should receive guidance to improve application of ethnic monitoring.

2.57 All racist incident complaints should be promptly and fully investigated, and the log should be accurately completed. (3.47)

Partially achieved. In the previous 10 months, 49 racist incident report forms had been submitted, which was similar to the number reported at our last inspection. They were posted into the general complaints boxes for referral to the DREO, and there were ample stocks of forms. Investigations that had been had been completed showed evidence of thorough investigation, with issues clearly identified, relevant people interviewed, and notes and responses neatly typed up. Findings indicated understanding of the issues. However, investigations had been delayed with the recent absence of the DREO, and the log was not fully completed. Some of the sheets in the report to summarise steps taken were filled out inconsistently or confusingly. The log was signed off by the governor and area manager. Recent links with community groups were due to include external checks on racist incident report investigation.
We repeat the recommendation.

2.58 The diversity manager should seek the advice of the race and equalities advisory group at Prison Service headquarters, and attend training as necessary. (3.49)

Achieved. The DREO was experienced, had received relevant training, and sought the advice of the race and equalities advisory group as appropriate.

Additional information

2.59 More than a third of the population were from black or minority ethnic backgrounds. Those we spoke to shared the general lack of confidence in relationships with some staff, rather than

identifying discriminatory treatment. The 2007 measuring the quality of prison life (MQPL) survey at Ford reported relatively positively on perceptions of race equality, including by black and minority ethnic interviewees. The structure of race equality had some strengths and some weaknesses. The DREAT oversaw a range of issues, including foreign national prisoners, disability and some initiatives for Travellers, as well as the race equality action plan. It met monthly, was chaired by the governor, and attendees included the team of six diversity representatives. However, its link with the rest of the prison was not consistently robust.

2.60 The DREO, a senior officer, was suitably trained and experienced, but his workload had become increasingly demanding. Although the post was full time, he was sometimes detailed to cover other posts. In his absence during the inspection there was no cover, and no notice on his office door explaining when he might be available. An assistant DREO had not yet received training to undertake much of the workload, and her allocation of time was unspecified. There was too much reliance on the prisoner diversity representatives, but they lacked guidance and supervision, did not have regular meetings, and were not always sure how to refer on queries. The diversity representatives had their own office, but it was not always open at the published times.

Further recommendations

2.61 There should be effective cover for the diversity and race equality officer.

2.62 Prisoner diversity representatives should have guidance on how to perform their role, and regular staff supervision.

2.63 The diversity representatives' resource office should be open at the published times.

Foreign national prisoners

2.64 The diversity manager's plan to distinguish between the duties of general diversity and foreign national representatives should be carried out, and the latter should be given clear job descriptions. (3.48)

Not achieved. One of the team of six diversity representatives had recently been designated foreign national prisoners orderly, although he continued with a wider range of tasks as diversity representative. The representatives could not recall specific job descriptions. The DREO had given them an explanatory talk, and some had received training in similar roles at previous prisons.

Further recommendation

2.65 There should be separate foreign national prisoner representatives with clear job descriptions and training for the role.

2.66 The foreign national orderlies and diversity manager should run more support and information groups for the substantial foreign national population. (3.58)

Not achieved. At our previous inspection, 30% of the population had been foreign nationals and had held meetings. Since the move of most foreign national prisoners from open to closed

prisons in 2006, foreign national peer support meetings no longer took place, although their number had started to build up again (see below).

Further recommendation

2.67 Regular peer support meetings for foreign national prisoners should be resumed.

2.68 The foreign national orderlies should proactively target prisoner with language difficulties for support, and refer on to staff as appropriate those needing professional interpretation. (3.59)

Achieved. Language needs were identified during reception and induction, in which diversity representatives participated. Needs and abilities were recorded and passed on to staff. The DREO had a list of prisoners and staff who spoke foreign languages. The six diversity representatives spoke a dozen languages between them and were able to assist in many situations. There was evidence of some use of a professional telephone interpreting service.

2.69 There should be a dedicated foreign nationals committee, and/or foreign national issues should be a specific agenda item in other important committees to help clarify distinct foreign national policy objectives. (3.60)

Partially achieved. Foreign national prisoners were a regular item on the agenda of the DREAT meeting, which met monthly and was chaired by the governor. The DREO and prisoner diversity representatives also attended. However, the discussion would benefit from information raised in meetings of diversity representatives and foreign national prisoners (see recommendation 2.67).

2.70 Effort should be made to obtain independent immigration advice for the benefit of prisoners – for example, through the local law centre or a national advice agency. (3.61)

Not achieved. Although an immigration officer held regular surgeries for foreign national prisoners, there was no established link with a source of independent specialist legal advice. Prisoners without family able to find advisers on their behalf had some difficulty locating suitable advisers. It was difficult for prisoners to approach solicitors themselves because they could only call permitted numbers and were normally only permitted five legal advisers' numbers, which might be exceeded before they could find someone to act for them.
We repeat the recommendation.

Additional information

2.71 The number of foreign national prisoners had built up again since their removal in 2006, and there were currently 50 (9% of the population). Some previous provision remained in place, and the DREO was also the foreign nationals coordinator. A foreign national prisoner resource pack, dated 2006, included a strategy to inform and support foreign nationals, although it had not been updated recently. A multilingual member of the diversity representatives team had recently been designated foreign nationals orderly and he regularly patrolled the site, with his resource pack, to answer queries or publicise events, such as a planned visit by an immigration officer. Useful contact had been made with the Portsmouth immigration office and an officer visited more than once a month to run surgeries.

2.72 All the foreign national prisoners were serving sentences. The prison only occasionally retained someone after their release date solely as an Immigration Act detainee, and they were quickly transferred back to closed conditions or to an immigration removal centre. Some, although still serving prisoners, were also subject to immigration detention. The prison did not operate a blanket policy to deny release on temporary licence to foreign nationals, which would have obstructed the resettlement process and could have been unlawful discrimination.

2.73 The governor risk assessed foreign national prisoners in the normal way, but additionally consulted the UK Border Agency (UKBA). UKBA responses were often late or the agency had to be reminded, which meant that the assessment had to be postponed. Sometimes contact details were missing from the response, which made it difficult to follow up. UKBA respondents did not understand the process, and some replied negatively without indicating either that removal was imminent or that consideration had been applied. For example, the UKBA response to a recent inquiry, after a month's delay, was that:

'The subject is an FNP [foreign national prisoner] who has no leave to remain in the UK and is liable to deportation. He is aware that a decision is currently being made regarding whether deportation action will be pursued. The risk of absconding is considered to be high and CCD do *not* [emphasis in original] support any form of release at this time.'

The subject had been a year in open conditions at Ford without problem, and the prison considered him low risk and suitable for licence. The UKBA response had the effect of denying him this rehabilitative opportunity.

Further recommendations

2.74 The foreign national prisoner strategy and resource pack should be updated, taking into account the assessed needs of the current population.

2.75 UKBA caseholders should respond promptly to inquiries from prisons concerning prisoners and detainees and should include contact details on all communications.

2.76 When commenting on the governor's proposal to grant release on temporary licence within sentence planning, UKBA should contribute constructively to risk assessment by providing material reasons taking account of all relevant circumstances.

Applications and complaints

2.77 All prison officers should be encouraged to use their discretion when dealing with minor applications, and should not require a written application form unless absolutely necessary. (3.80)

Partially achieved. We observed staff in the unit offices dealing with a wide range of prisoners' queries, and to some extent this obviated the need to make applications. Prisoner orderlies also did a good job in dealing with many queries that might normally result in applications, which helped to reduce the formal approaches to staff. However, a significant number of prisoners said that some staff were unwilling to assist them unless they completed application forms, and felt that this was a way of deterring requests and avoiding work. We repeat the recommendation.

Legal rights

2.78 Copies of all new Prison Service Orders and Instructions should be placed in the library as soon as possible. (3.89)

Achieved. A large legal reference section included copies of Prison Service Orders and instructions. One of two computers nearby was dedicated to 'inside information', and the librarian regularly loaded it with legal reference information, and updated and extended its content.

2.79 New arrivals should be asked on reception if they have any outstanding legal problems, so that steps can be taken to deal with them as soon as possible, and so that trends can be monitored. (3.90)

Partially achieved. The competent team of orderlies who delivered much of the regular induction programme and collected information for referral asked new arrivals if they had outstanding legal problems and referred them to the legal services officer or other source of advice. We did not see evidence that the range of legal issues arising was monitored.

Further recommendation

2.80 Legal problems raised by new arrivals should be logged and trends should be monitored.

Substance use

2.81 There was evidence of a significant problem of illicit alcohol coming into the prison (see paragraph 2.131). The prison had made strenuous efforts to eliminate the use of alcohol within the prison, with a degree of success. The year-to-date random mandatory drug testing rate was 17.9%. Counselling, assessment, referral, advice and throughcare (CARAT) workers provided a good service to prisoners, despite shortcomings in accommodation and administrative support (see paragraphs 2.196-198).

Further recommendation

2.82 The prison should make renewed efforts to limit illicit substance use, particularly by strengthening dynamic security, based on proactive staff engagement with prisoners.

Health services

2.83 Healthcare security should be reviewed as a matter of urgency to ensure that access to all clinical and administrative areas is restricted to healthcare staff. Access to the department by non-healthcare staff should be controlled and recorded. (4.38)

Achieved. Only healthcare staff could access these areas during opening hours, when all room doors were kept closed. The department was alarmed when closed and could only be accessed by the orderly officer who was responsible for signing out the keys to the department. A record of when keys were taken out was kept at the main gate.

2.84 Therapeutic group work should be available to prisoners during the working day. (4.39)

Not achieved. There was no therapeutic activity for prisoners not actively engaged in work or education or those with low level mental health needs. A request for funding for a therapist to introduce activities such as art or music therapy had been made to the primary care trust (PCT).
We repeat the recommendation.

2.85 The emergency equipment should be checked after use and every week, and there should be records of checks made. (4.40)

Achieved. All emergency equipment was checked weekly and records of checks maintained. Some pharmaceutical items were held in the grab bag, and we found all these items to be in date. All healthcare staff had completed annual cardiopulmonary resuscitation (CPR) training.

2.86 The clinical nurse manager should be part of the senior management team. (4.41)

Achieved. The clinical nurse manager was a member of the senior management team (SMT) and attended all relevant meetings.

2.87 Ford should request that the PCT conduct a skill mix review to determine the numbers and qualifications of nursing staff, in order to meet the needs of patients more effectively. (4.42)

Achieved. The PCT had completed a staffing skill mix review. A small but very professional team of registered general nurses (RGNs) and registered mental health nurses (RMNs) provided excellent clinical care to prisoners, and it was evident that the team met their clinical needs.

2.88 There should be a review of the non-clinical administrative duties undertaken by nursing staff and, if necessary, additional administrative staff employed by the prison to complete prison documentation. (4.43)

Achieved. The PCT had reviewed administrative duties and had increased administrative support staff. Nursing staff no longer undertook administrative tasks, apart from time-consuming administrative work on pharmacy matters.

Further recommendation

2.89 There should be regular additional pharmacy support for administrative functions in the management and record keeping of pharmaceutical preparations.

2.90 Ford should request that the PCT should review the service level agreement with the pharmacy to establish clear responsibilities for the professional and supply aspects of the pharmaceutical service. (4.44)

Achieved. The current pharmacy contract was due for renewal in April 2009. A pharmacist came to the prison for one morning a fortnight to check stocks and review prescriptions. There was good pharmacy support, and items ordered were delivered the next day.

2.91 The pharmacist should be part of the medicine management committee. (4.45)

Achieved. The provider pharmacist was a member of the medicines management committee and regularly attended meetings.

2.92 The current wooden cupboards used for storing medicines should be replaced with purpose-built secure lockable metal drug cupboards. (4.46)

Achieved. New secure metal cabinets had been installed. The keys to the cupboards were stored in a wall safe and only accessed by healthcare staff.

2.93 Stock levels of medicines should be reviewed, and a revised list and levels established. When medicines are issued from stock, a record should be made in a log book. The usage of medication should be periodically reconciled against the drug chart by the pharmacist. (4.47)

Achieved. The provider pharmacist was responsible for overall management of medicines. All medicines were issued against a prescription. Any medication issued from stock was recorded on the patient's electronic prescription chart. All matters relating to the health management of prisoners were recorded on the prison's electronic patient management system, System One. The pharmacist checked prescriptions, including controlled drugs, on their fortnightly visit.

2.94 All medicines supplied to patients must be labelled in accordance with the Medicines Act. (4.48)

Achieved. All medication was correctly labelled in accordance with the Medicines Act and, where possible, patient information leaflets about the medicine were included in the package.

2.95 The prison should consider the option of simple medications being available through the prison shop, or being held by wing staff. (4.49)

Achieved. A limited number of over-the-counter medications were available through the prison shop, although most prisoners obtained such medicines from the healthcare centre.

2.96 Patients' drug and administration charts should be securely stored, and accessed only by healthcare staff. (4.50)

Achieved. Patient drug administration charts were held securely on the computerised clinical management system. Drug records were only accessible to healthcare staff.

2.97 As a matter of urgency, the medicines management committee should continue to develop pharmacy policies, including in-possession, special sick and patient group directions. An evidence-based drug formulary should be established. (4.51)

Achieved. There was a comprehensive set of PCT pharmacy policies and protocols. These included a documented in-possession risk assessment and policy, and patient group directions. There was access to the *British National Formulary* in hard copy as well as online.

2.98 The pharmacist and staff from the pharmacy in Arundel should visit the prison regularly. (4.52)

Achieved. The provider pharmacist visited regularly to check stock, but the day-to-day

ordering and management of all pharmacy items remained the responsibility of nursing staff. The PCT pharmacist also visited the prison.

2.99 There should be collaboration with the out-of-hours nurse advice scheme operated by the local GP deputising service to reduce the burden on staff at weekends. (4.53)

Achieved. Nurses were no longer on call, and there was a new out-of-hours contract with an external health provider who covered the prison when the GPs were not on site. The system worked well, but the emergency services were called if there was an emergency.

2.100 Oxygen should be available in the surgery and cardio-pulmonary resuscitation (CPR) training should be provided to the dentist. (4.54)

Achieved. Oxygen and emergency equipment were held in the main treatment room near the dental surgery, and CPR training was available to the dentist.

2.101 The prison should review its management of disabled prisoners to ensure that their physical needs are met. Accommodation for wheelchair users should be larger than at present, and there should be disabled access to both the front and rear of the department. (4.55)

Partially achieved. Access to the healthcare department for prisoners with disabilities was satisfactory, with ramps at both ends of the building. The accommodation block for disabled and older prisoners provided disabled-access baths and wheelchair access, although the cells were small and difficult to negotiate in a wheelchair. The dining room was too far from the accommodation for some residents, many of whom were unable to have the cooked breakfast at the weekend (see paragraph 2.49). The prison was looking at alternative accommodation nearer the dining room for prisoners with disabilities.

Additional information

2.102 The healthcare team was led by a clinical nurse manager who was a band 7 RMN. She was supported by two part-time band 6 RGNs, who were also independent nurse prescribers, two full-time band 5 RGNs, and a full-time band 6 RMN. A full-time operational practice manager, supported by 1.5 whole time equivalent administrators, undertook all non-clinical duties. The system worked well and the team was professional and competent.

2.103 The manager represented healthcare at many prison meetings, such as safer custody and health and safety. There was a good relationship between healthcare and other departments, with evidence of some excellent joint working. Prisoners praised the healthcare staff and their support.

2.104 Prisoners had access to a wide array of health services from in-house and visiting health professionals. Doctors were in the prison every weekday, and the presence of two nurse prescribers meant that prisoners were seen and diagnosed quickly, resulting in early treatment. Chronic disease management was excellent, and the standard of mental health provision was extremely good. Although 87 prisoners were over 50, there was no nominated healthcare lead to focus on the physical and mental health needs of older prisoners.

2.105 Dental services were good, but the waiting list was long with an eight-week wait for routine treatment. The waiting list was managed by the dentist who continued to use paper records rather than the electronic system, which made it difficult for doctors and nurses to access

dental information, and also meant that the dentist could not access prisoners' health records before treatment.

2.106 Mental health support was very good, with cover from two RMNs during opening hours. The RMNs managed prisoners and referred to the GP wherever necessary. Referrals were accepted from across the prison, including from prisoners themselves. The RMNs had a caseload of 45 prisoners and were also supported by the community mental health team, although there was no formal service level agreement. All prisoners already known to community teams were referred back to them on release.

Further recommendations

2.107 The clinical nurse manager should nominate a healthcare worker to provide health support for older prisoners.

2.108 A nominated health worker should develop links with the disability officer to ensure the health needs of prisoners with disabilities are met.

2.109 There should be additional dental sessions to reduce the waiting list for routine treatment.

2.110 The dentist should record all dental treatment on the electronic medical information system.

2.111 The PCT should assess the need for community mental health support to the prison, and formalise an agreement to ensure that support is available whenever necessary.

Learning and skills and work activities

2.112 A wider range of accredited vocational training should be provided. (5.8)

Not achieved. See paragraph 2.116.

2.113 The education curriculum should be further developed to offer more qualifications above level 2. (5.9)

Achieved. The curriculum delivered by Northbrook College continued to offer qualifications up to level two, based on a needs analysis and an annual review of the curriculum (see also paragraph 2.6). However, during the review the college identified some prisoners who had been on Open University courses at previous establishments, as well as those whose attainment level was above level two. The college facilitated Open University and distance learning courses to meet the needs of these prisoners, who had access to good resources to support their learning. There were 25 prisoners undertaking 31 Open University courses, 25 on distance learning, and a further 23 attending courses in outside colleges. The prison was due to commence offering qualifications up to level three in information, advice and guidance, and in customer service.

Further recommendation

2.114 The education contract should include the delivery of qualifications above level two.

2.115 The number of books available in different languages should be increased. (5.10)

Achieved. Library staff consulted with the diversity representatives to ensure that the library met the needs of the population. It had increased the stock of foreign language books for a foreign national population that was smaller than at the previous inspection. The library had effective links with West Sussex Library Service and could also order books that were not available or in stock. Prisoners had good access to the library five evenings a week and during the weekend.

2.116 A wider range of accredited vocational qualifications should be introduced and developed. (5.14)

Partially achieved. There was a limited range of vocational training, mainly due to a lack of instructors, but also because of the emphasis on prisoners securing relevant work and training during stage two of their resettlement. There were National Proficiency Test Council (NPTC) level one qualifications in horticultural skills and NPTC level two certificates of competence in horticultural machinery, and additional qualifications in the industrial cleaning workshop. There were also plans to expand the vocational training, including a national vocational qualification in warehouse/packaging. Although an NVQ level one was available to prisoners employed in the laundry (up to 32 full-time places), none had been delivered in the last year. On one day of the inspection, there were 79 prisoners employed in the estates, 35 at work and the remainder in education (40) or attending appointments.
We repeat the recommendation.

Additional information

2.117 During the inspection, there were 150 prisoners in part-time and 54 in full-time education. The education department's summary of programme delivery indicated that there were 407 part-time and 57 full-time places across the 40 courses delivered.

2.118 The new community engagement manager's role was aimed at working with organisations to raise the profile of the establishment, identify employment opportunities and develop partnerships to improve prisoners' access to employment. Because of the high number of prisoners from outside the local area, links were being made with London boroughs to provide mentoring and pathway support on release. Two prisoners were training at a biofuel project, and further training and employment opportunities at other projects were anticipated. Prisoners complained about low pay in the prison.

Further recommendation

2.119 Prisoner pay should be increased.

Physical education and health promotion

2.120 An appropriate programme of accredited sport and recreational qualifications should be developed. (5.19)

Not achieved. The programme of accredited sport and recreational qualifications had not developed further. Prisoners were trained in manual handling as part of their gym induction, and some were recruited for Heartstart and British Amateur Weight Lifting Association (BAWLA) programmes. Staff said there was a lack of support from managers for further

accredited sport and recreational qualifications, while managers said prisoners could undertake such courses at local colleges.
We repeat the recommendation.

2.121 Indoor activities and outdoor facilities should be made accessible at the same time. (5.20)

Achieved. There had been an increase in sessional staff, which meant that prisoners could be adequately supervised in the gym while other activities took place outside. The outdoor facilities were good, and included football, bowls and cricket.

Additional information

2.122 There were two full-time physical education instructors (PEI), supported by three sessional workers. Current staffing was insufficient, and a business case to recruit more staff had been prepared. On one day during the inspection, the gym had to be closed due to lack of staff. Staff in the gym were frustrated at their inability to provide a more comprehensive programme of accredited sport and recreational qualifications.

2.123 Over-50s classes and over-40s five-a-side football took place, staffing permitting. Prisoners told us that, because the gym could take only a maximum of 50 prisoners, they often could not get in to use it as it had reached its capacity. PEI staff confirmed this and had implemented a system to log users during the day to ensure fair access for all prisoners.

Further recommendation

2.124 The gym should be adequately staffed at all times.

Faith and religious activity

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

Additional information

2.125 A highly visible coordinating chaplain was supported by an adequate range of visiting chaplains. Facilities for worship remained good, and prisoners named the chaplaincy as one of the most positive things about life at Ford. Prisoners could obtain a key to the inner door of the multi-faith area whenever they wanted. However, the outer door to this area was sometimes not unlocked by staff in the morning, which meant that prisoners could not use it or had to find a member of staff to assist them.

Housekeeping point

2.126 The outer door to the multi-faith area should always be unlocked by staff at the start of the day.

Time out of cell

2.127 Association facilities should be kept open longer in the evenings to maximise usage. (5.31)

Achieved. The popular pool/snooker and table tennis rooms, the gym and library were all open until prisoners were required to return to their billets at about 8.30pm. The fellowship room in the chaplaincy was also available for association until this time.

Security and rules

2.128 The physical security of the perimeter should be reassessed, and countermeasures to ingress and egress should be installed in identified 'hot spots'. (6.8)

Partially achieved. The prison had reviewed the perimeter security and submitted a bid to increase the number of CCTV cameras, but this had been rejected due to the cost. The size of the site – spread over approximately 100 acres – made it difficult to monitor the perimeter. At night, there were only two officers and four operational support grade (OSG) staff on duty. The low fence that surrounded most of the site was easily breached, and some perimeter lights had been vandalised and were out of action. As an open prison, Ford's perimeter security was not designed or intended to make it impossible for prisoners to abscond. However, the ease with which prisoners were able to leave and return undetected during the night was a significant concern (see paragraph 2.131 and recommendation at paragraph 2.134).

Further recommendation

2.129 Damaged perimeter lighting should be replaced and protected from further vandalism.

2.130 The inefficient batteries used in staff radios should be replaced. (6.9)

Achieved. There was now a supply of radios and batteries, and an ongoing programme of replacement. A separate radio network for works staff had reduced the radio traffic that had to be managed by the control room.

Additional information

2.131 The main security problems were the smuggling of alcohol, drugs and mobile phones into the prison. In addition to the difficulty of monitoring the extensive perimeter (see above), the size of the site and low staffing level at night meant that it was relatively easy for prisoners to leave residential areas at night and return with alcohol and other contraband purchased locally or left on the edge of the perimeter by accomplices. After the Easter weekend in 2008, staff had found 30 bottles of vodka, and finds of large amounts of alcohol were not uncommon.

2.132 In the week before our inspection, there had been two incidents at night. One involved five unidentified prisoners wearing balaclavas who allegedly attacked another prisoner. The second, which occurred the night before our inspection, involved two prisoners who were violently drunk and had to be relocated under restraint to the segregation unit, where they caused significant damage to the cells. These incidents and the availability of alcohol had increased some prisoners' concerns about safety.

2.133 The security department received a high volume of security information reports (SIRs) and the number of these had increased significantly over the previous year. There had been 1,079 SIRs submitted since January 2008, which was a significant increase of approximately 200 since the same period in 2007. Staff were aware of security issues and reported these to the security department conscientiously. Security reports indicated that staff were able to glean

information from prisoners about security issues. However, better engagement between prisoners and staff would improve dynamic security (see paragraph 2.82).

Further recommendation

2.134 There should be increased patrolling of residential areas at night.

Discipline

2.135 The practice of suspending all prisoners' risk assessments for 28 days following a proven adjudication amounts to double jeopardy, and should cease. All risk assessments should be considered on their individual merits. (6.21)

Achieved. See paragraph 2.2.

2.136 Staff should be encouraged to make greater use of the IEP scheme, rather than resorting to placing prisoners on report for relatively trivial offences. (6.22)

Partially achieved. The number of adjudications remained high, at 14 a month over the previous six months. This was an increase since our last inspection, but the average population had also increased in the same period. In most cases, the offence warranted use of the disciplinary system, but there were still some instances where use of the incentives and earned privileges (IEP) scheme would have been more appropriate.

Further recommendation

2.137 Quality checking of adjudications should include the appropriateness of the use of disciplinary procedures for the nature and seriousness of the offence.

2.138 All charges should be fully investigated. (6.23)

Partially achieved. We reviewed a large sample of adjudications from the previous six months, and the standard of nearly all investigations was satisfactory or better. However, in one case a prisoner had pleaded not guilty and the adjudicator had not called the reporting officer to give their evidence.

Further recommendation

2.139 Prisoners who plead not guilty should be given the opportunity to question witness evidence during an adjudication.

2.140 The governor should quality-assure a percentage of completed monthly adjudication records. (6.24)

Not achieved. At some adjudication standardisation meetings, a sample of completed adjudications was given to senior managers to undertake a quality check. The meetings were scheduled to be quarterly, but there had been only two full meetings in 2008.
We repeat the recommendation.

2.141 Monthly statistical data about adjudications should be collated and analysed. (6.25)

Not achieved. There was no evidence that monthly adjudication statistics were routinely collated and analysed. Data collected for ethnic monitoring recorded the number of adjudications and how many had been proven, dismissed or referred to the independent adjudicator by ethnic group, but gave no analysis of charges. The absence of detailed information made it impossible for managers to monitor trends or patterns.
We repeat the recommendation.

Additional information

2.142 There had been 11 use of force incidents in 2008 to date. We reviewed the paperwork for all incidents, and it appeared that force had been used appropriately in each case. The documentation also demonstrated that the incidents had been de-escalated at the earliest opportunity.

2.143 The small segregation unit was primarily used to hold prisoners pending transfer to closed conditions. Records indicated that prisoners were rarely held for more than 24 hours. At the time of our inspection, one cell was out of use due to damage caused by a prisoner the night before our arrival. The quality of some of the initial segregation safety screen documents was poor. On some, the prisoner's details had not been completed. In other cases, governors had failed to follow correct procedures and had signed the document before healthcare staff had completed the initial safety algorithm.

Further recommendations

2.144 Initial segregation safety screen documents should be completed in full, including safety algorithms.

2.145 Governors should not sign the initial segregation safety screen document before healthcare staff have completed the initial safety algorithm.

Incentives and earned privileges

2.146 The IEP scheme should include clearly defined and substantive differences between the privileges available to those on each level. (6.33)

Partially achieved. The incentives and earned privileges (IEP) policy, which was revised in January 2008, clearly stated the differences in the privilege levels. Despite this, prisoners felt that there was little difference between the standard and enhanced levels.

Additional information

2.147 At the time of our inspection, 66% of prisoners were on the enhanced level of the scheme and none was on basic. There was limited movement between the levels of the scheme. A review of wing files indicated that there was little engagement between prisoners and their personal officers. This lack of involvement led to underuse of the IEP scheme to encourage and promote good behaviour.

2.148 Prisoners said that some staff issued IEP warnings for trivial matters. We noted little evidence of unjustified warnings, and the records of IEP boards indicated that prisoners were not downgraded unreasonably.

Further recommendation

2.149 The privileges available on the different levels of the incentives and earned privileges (IEP) scheme should be revised, in consultation with prisoners, and publicised to encourage prisoners to gain enhanced status.

Catering

2.150 The quality and quantity of food should be reviewed in close consultation with the prisoner food consultative committee. (7.9)

Achieved. A catering committee, which included the catering manager, healthcare staff and prisoner representatives, discussed catering improvements. One minuted suggestion for improving standards had been improved training for kitchen workers. Currently, more than 40 prisoners worked shifts in the kitchen, but only a few who worked in the staff mess were undertaking national vocational qualifications (NVQs), and few kitchen staff were accredited assessors.

Further recommendation

2.151 More accredited training should be available to prisoners working in the kitchen.

2.152 The size of the servery and the labour-intensive system of serving meals should be reviewed to allow the serving of meals as quickly as possible. (7.10)

Achieved. Some new equipment had contributed to a better service (see paragraph 2.154).

2.153 The kitchen should be effectively deep-cleaned. (7.11)

Achieved. The kitchen was deep cleaned twice a year. When we inspected it at the end of the day, surfaces were clean and no food was left lying about.

2.154 Out-of-use cooking equipment and items in need of repair should be replaced or repaired. (7.12)

Achieved. Some of the equipment had been replaced. New equipment included a new freezer and a new servery.

2.155 The quality of the pre-packed main meal items should be improved. (7.13)

Achieved. The evening meal was no longer served in pre-packed containers, and food was kept hot in the new servery. Some long-term prisoners and staff reported an improvement in quality, although we still received complaints about food. In the most recent food survey, to which half the population had responded, the main outcome was that it was average, rather than good or poor.

2.156 There should be a greater variety of vegetable and salads available daily. (7.14)

Achieved. A selection of vegetables was included in the evening meal options. Salads were usually offered three evenings a week, and there was some salad in some baguette fillings at lunch time. Fresh fruit was offered with every evening meal. The kitchen benefited from increased fresh produce grown on site.

2.157 The reusable plastic plates should be taken out of service and a hygienic and functional alternative provided. (7.15)

Partially achieved. The old scratched plastic plates had been replaced, and the plastic plates we saw in use were in good condition. Prisoners could buy their own plates. However, rather than handing them in for cleaning at high temperature with the prison stock, they rinsed them under a hot water tap in a sink in the dining room and took them back to their cells. There was no detergent available at the sink.

Housekeeping point

2.158 Prisoners who retain their own plates should be able to wash them hygienically with a suitable cleaning agent.

2.159 The catering manager should ensure that there is no cross-contamination of halal food when in storage or on the servery. (7.16)

Partially achieved. The kitchen had a new freezer designated for halal foods, and a stock of dedicated utensils. Halal options were available at every meal and marked on the pre-select menu. One evening during the inspection, the designated utensils were not used to serve halal food.

Further recommendation

2.160 Staff supervising meals should ensure that the designated utensils are used to serve halal food to avoid cross-contamination.

Additional information

2.161 A recent report by Arun District Council environmental health confirmed progress in kitchen repair and cleaning. However, it noted that the present structure – particularly the layout, wall and floor surfaces, and humidity – did not meet current expectations of facilities used for large-scale catering operations, and suggested that serious consideration be given to rebuilding or upgrading the kitchen.

2.162 In the dining hall, the servery, tables and floors were routinely cleaned after every meal. Some of the plastic chairs were grubby.

Further recommendation

2.163 The prison should meet the recommendations of the environmental health authority on the kitchen.

Housekeeping point

2.164 Chairs in the dining hall should be regularly cleaned.

Prison shop

2.165 More proactive consultation with prisoners should take place about the canteen product list, and regular surveys should be carried out. (7.21)

Achieved. The prison conducted a twice-yearly survey and a canteen committee, including prisoner representatives, met every two months. As a result, some items were removed from or added to the list. Other avenues of consultation included the offender consultative committee and the team of diversity representatives.

2.166 A review of the pricing structure should be carried out, and a wider selection of cheaper, generic products should be made available. (7.22)

Achieved. The contractor had changed since the last inspection. The current contractor, Aramark, offered a list of 350 items and had recently introduced a selection of cheaper generic products.

2.167 The range of BME [black and minority ethnic]-specific products should be increased in consultation with BME prisoners. (7.23)

Achieved. Since the contract had been given to Aramark, the shop list was longer, and subject to consultation with prisoners. Various toiletries and foodstuffs requested by black and minority ethnic prisoners were included on the current Aramark list.

Strategic management of resettlement

2.168 The resettlement strategy and policy document should:
– be based on an up-to-date needs analysis of the resettlement needs of the population;
– specifically address the resettlement needs of the various groups represented within the prisoner population;
– incorporate area resettlement objectives and targets, when these become available. (8.6)

Not achieved. Although the education department had conducted a needs analysis in spring 2008, this had not been used to inform the reducing reoffending policy document. The needs analysis was based on responses from just over a third of the population (34%). It highlighted some key issues, which could have been used better to target reintegration services for prisoners. For example, a large number of prisoners had their own property to return to; nearly half the respondents said their financial circumstances were not healthy and they needed assistance with loans and bank accounts; and over half said they had a trade or profession before prison. The reducing reoffending policy documented the management of specific groups – such as short-term prisoners, lifers, and those who came under the offender management model – but not their specific resettlement needs. It did not address any diversity issues specific to the black and minority ethnic population (who made up a third of the population) or prisoners over 50 (30%) or foreign national prisoners. There were detailed objectives for the seven resettlement pathways, and each pathway had a lead officer. There were quarterly pathway review meetings to identify the needs of the population, and develop and implement

action plans. All the pathway leads (except accommodation) had met their specific voluntary and community organisations. It was too early to assess the effectiveness of the policy or the reintegration services, but they needed to refer to the needs analysis to ensure that prisoners' needs were sufficiently met.
We repeat the recommendation.

2.169 The representation, frequency and agenda of the resettlement policy committee should be sufficient to enable it to implement and monitor the resettlement strategy. (8.7)

Achieved. The reducing reoffending policy meeting met quarterly and was chaired by the head of the offender management unit (OMU). It had been relaunched to ensure that the membership was appropriate and to reaffirm developments in relation to the offender management and resettlement needs of prisoners. The function of the policy meeting was clearly defined in the strategy document. Membership was from various departments and well attended, but the minutes were limited. The agenda appropriately monitored the reducing reoffending action plan, and pathway champions provided feedback at the meetings. There was also a reducing reoffending strategy meeting, chaired by the governor. This managed the overall implementation of all the resettlement policies and monitored their performance in meeting the needs of the population and the various standards and key performance targets. It also monitored the overall effectiveness of the policy group meetings. The meeting was well attended by the key functional heads, and was also re-establishing its role and remit and taking a fresh look at the strategic direction of the offender management model, resettlement arrangements for prisoners, and identifying the key priorities.

Housekeeping point

2.170 Reducing reoffending policy meeting minutes should record the designation of attendees and absentee guests.

2.171 The recording and analysis of resettlement data should be improved to enable good quality performance monitoring, and to inform management decisions. (8.8)

Not achieved. The management and collation of data still needed to be improved. The information we requested during the inspection either had to be collated by hand or was not available during the inspection. Managers anticipated that the introduction of PLASMA (prisoner logs and sentence management assessment) had the potential to provide useful information about the prisoner population (see also paragraph 2.5).
We repeat the recommendation.

Offender management and planning

2.172 Those prisoners who will not receive an OASys assessment should have their resettlement needs assessed, managed and reviewed. (8.15)

Not achieved. Priority was given to those prisoners in scope under the offender management model. Prisoners not eligible for an offender assessment system (OASys) assessment did not have their needs sufficiently assessed, managed and reviewed.
We repeat the recommendation.

2.173 The contribution to the sentence-planning process expected from departments other than resettlement should be clearly defined. (8.16)

Achieved. The reducing reoffending policy clearly defined what was expected from personal officers, key workers and intervention providers. Personal officers were expected to attend sentence planning boards and encourage prisoners to attend offending behaviour courses, among other expectations. The policy had not yet been distributed, so key staff were not yet aware of these clearly defined expectations.

Further recommendation

2.174 The reducing reoffending policy document should be distributed to all staff and fully implemented.

2.175 Where appropriate, prisoners' family or friends should participate in sentence planning and in preparation for release. (8.17)

Not achieved. Family and friends were not invited to sentence planning boards, and the reducing reoffending policy did not include family or friends in the list of those who should be involved in sentencing planning boards or pre-release boards.
We repeat the recommendation.

2.176 Life-sentenced prisoners should be able to read reports to be used in their reviews at least 24 hours beforehand. (8.24)

Achieved. There were 32 life-sentenced prisoners and two on indeterminate sentences for public protection (IPP) who were all managed by the lifer team and allocated to offender supervisors (probation officers). We reviewed some of the case files and met a small group of lifer prisoners, who confirmed that they had the opportunity to review reports before sentence planning meetings and reviews.

2.177 A minimum of two lifer days should be held each year. (8.25)

Not achieved. As at the last inspection, lifers did not receive any additional services. The lifer manager said there had been an informal verbal survey of whether lifer prisoners wanted lifer days, and they did not. Lifer prisoners told us that lifer days were more important in the establishments from which they had transferred and that, now they had the opportunity to work out in the community and undertake town and home visits, lifer days at Ford were not their priority. Lifers also had access to the family days arranged at the prison.

2.178 Life-sentenced prisoners should have some opportunity to cook for themselves. (8.26)

Not achieved. Lifers were dispersed across the different accommodation units and there were no facilities for them to cook.
We repeat the recommendation.

Additional information

2.179 The head of the OMU, previously the head of interventions, had been in post for a month. The OMU had four teams, each with an offender supervisor, prison officer and case administrator.

Cases were allocated to teams alphabetically. Not all prisoners were aware of who their offender supervisor was, but were told which team they were allocated to. This allocation of cases was still fairly new, and some teams had a disproportionate number of cases.

2.180 The prison officers allocated to the teams were not ring fenced and, due to the small number of staff, they were often redeployed to other duties. This affected their ability to prioritise tasks and manage their workload. We were told by the deputy governor that in January 2009 their offender management work would be ring fenced to improve the sentence planning process for prisoners.

2.181 Prisoners had negative perceptions about the OMU and said that they were rarely able to get their queries resolved. In acknowledgement of some of the communication problems, there was a fast-track application system for prisoners to submit an application about specific offender management issues, which would be answered within 24-48 hours. During the inspection week there had been over 80 applications, and the log book recorded that some had not been answered within 48 hours. This undermined the objective of the system and compounded prisoners' negative perceptions.

2.182 OMU surgeries were held twice a week, with 26 slots that were regularly filled. The head of the OMU said that more staff outside the unit needed to be trained about its work so that they could deal with some of the prisoners' queries.

2.183 The lifers unit operated an open door policy. Prisoners said that they were permitted to go to the OMU with any problems, and a member of the team would speak with them. Lifers did not express any major concerns about the management of their sentence, and they were clear about their sentence planning targets and the reintegration services that were available.

Further recommendations

2.184 Caseloads should be fairly allocated across the offender management unit (OMU) teams.

2.185 The time of prison officers allocated to the OMU should be ring fenced.

2.186 Communication systems between the OMU, prisoners and staff should be monitored and improved. Management should devise a method to update prisoners with any changes to policies and procedures.

2.187 Staff should be trained on the function of the OMU.

Resettlement pathways

Reintegration planning

Education, training and employment

2.188 The working-out scheme should be reviewed to ensure that it provides a good quality resettlement opportunity to the maximum possible number of prisoners. (8.38)

Not achieved. We were told that the working out scheme had been reviewed, but this had not been documented. The previous inspection had highlighted some shortfalls, such as prisoner access to the job club at the weekend, the number of working out opportunities, and the

opportunities for shift work. The funding for the job club had been withdrawn earlier in 2008, but the education department was working with another provider to restart it. There were no prisoners working shifts, although three had employment that required them to leave the establishment at 5am, and the last prisoner returned from his job at 9pm. The head of interventions saw no reason why prisoners could not undertake shift work.
We repeat the recommendation.

Further recommendations

2.189 The job club should be reinstated.

2.190 Prisoners should have the opportunity to undertake shift work during their working out period.

Additional information

2.191 There were 39 prisoners in stage one resettlement (unpaid work) and 23 in stage two (paid work). A further 17 were on a waiting list – nine were employed in one of the workshops and eight had offers of paid positions. We asked for the figure for prisoners who met the criteria for working out, but this was not readily available and was supplied after the inspection had concluded. It recorded that 91 prisoners were at stage one, although this included prisoners who had applied for community service work but were not necessarily in unpaid work, and a further 85 were eligible for stage one but had not yet applied.

2.192 The criteria for applying for stage one were not clear, and the head of interventions had sent an email to the community service team outlining the criteria as of 1 October 2008. The criteria were not published as a formal notice to prisoners, as there was the possibility of more change. However, prisoners needed to know of any changes to the criteria as soon as they occurred.

Further recommendation

2.193 Prisoners should be made aware of the criteria for working out and be kept informed of any changes to these.

Drugs and alcohol

2.194 The prison should provide an acupuncture service to reduce stress for prisoners undergoing treatment for substance use. (8.54)

Not achieved. There were no alternative therapies for prisoners seen by the counselling, assessment, referral, advice and throughcare (CARAT) team, even though two CARAT workers were trained acupuncturists. This was because of the heavy workload – there were between 200 and 300 clients on the CARAT books.
We repeat the recommendation.

2.195 Additional administrative support should be given to the CARATs team to allow CARATs workers more time with prisoners. This should include a review of documentation required by the prison to be completed by CARATs staff. (8.55)

Not achieved. There had been no increase in administrative support to the CARAT team; a

part-time administrator worked 20 hours a week. CARAT workers dealt with excessive amounts of administrative work when they could have been working with prisoners.

Additional information

2.196 Despite the pressure of workload, CARAT staff provided support through relapse prevention, drug awareness and harm minimisation groups, as well as one-to-one work. The short duration programme had a target of 120 participants per year with a completion target of 78. Completion figures had improved substantially over the previous three months. Course content included aspects of reoffending behaviour and cognitive behavioural therapy.

2.197 The department was very busy, with prisoners coming and going throughout the day. A prisoner monitored who came in and out of the department, directing other prisoners to the appropriate room. The department was very small and congested, and the lack of rooms often compromised the delivery of an otherwise good service.

2.198 The CARAT department also had a shortage of IT equipment, with one computer for the administrator and two computers that were shared by the four CARAT workers. Additional administrators were needed to collate the weekly statistical information required for the prison, the CARAT provider and the national drug programme delivery unit.

Further recommendations

2.199 The counselling, assessment, referral, advice and throughcare (CARAT) department should have additional group rooms to facilitate the number of clients.

2.200 There should be additional computers and administrative support for the CARAT team.

Children and families of offenders

2.201 Subject to risk assessment, prisoners assessed as eligible and suitable for earned community visits should not have to be collected and returned by the same person. (3.71)

Achieved. Prisoners no longer had to be collected and returned by the same person.

2.202 Prisoners preparing for resettlement in the community should not be subject to a general restriction of a maximum of 20 listed numbers, with a charge for any change. (3.72)

Not achieved. Prisoners and staff managing PIN (personal identification number) telephone accounts reported that there had been no change to the previous policy.
We repeat the recommendation.

Attitudes, thinking and behaviour

2.203 The choice of offending behaviour programmes and the number of places available should meet the identified needs of the prisoner population. (8.30)

Partially achieved. There had been no offending behaviour programme needs analysis. The

short duration programme continued to be available (see paragraph 2.196), but no further accredited offending behaviour programmes had been delivered in the previous six months. The enhanced thinking skills (ETS) tutors were an area resource, and it had been agreed that prisoners who were eligible could be released on temporary licence to attend courses run by Sussex probation. Think First, aggression replacement therapy, cognitive skills booster and the integrated domestic violence programme were delivered at the external probation service office, and prisoners could be referred to these courses as part of their sentence planning. This resource was not restricted to prisoners from the local area. At the time of the inspection, eight prisoners were about to undertake the Think First group at Sussex probation service. In the absence of a needs analysis, it was not clear if the groups available met the needs of the population, if further accredited programmes were needed or if prisoners were released without having completed programmes.

We repeat the recommendation.

Section 3: Summary of recommendations

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

Recommendation — To the director general

Courts, escorts and transfers

3.1 The Prison Service should ensure that prisoners being transferred to Ford should be provided with information in advance, and should have the opportunity to notify family and legal representatives of their transfer. (2.9)

Recommendations — To the UK Border Agency

3.2 UKBA caseholders should respond promptly to inquiries from prisons concerning prisoners and detainees and should include contact details on all communications. (2.75)

3.3 When commenting on the governor's proposal to grant release on temporary licence within sentence planning, UKBA should contribute constructively to risk assessment by providing material reasons taking account of all relevant circumstances. (2.76)

Recommendations — To the area manager

3.4 The prison should have a bigger and better designed reception, suitable for the prison's throughput. (2.11)

3.5 There should be a refurbishment or rebuilding programme to ensure that the living accommodation remains in a decent condition. (2.27)

3.6 The prison should meet the recommendations of the environmental health authority on the kitchen. (2.163)

Recommendations — To the governor

First days in custody

3.7 New arrivals should not be kept waiting for long periods in cellular vehicles. (2.12)

3.8 Prisoners should be able to make a free telephone call, in private, when they arrive in a new prison. (2.13)

3.9 Prisoner orderlies' induction duties should not include gathering confidential information about new arrivals' special needs. (2.15)

Residential units

3.10 The establishment should once again approach the local council to install a pedestrian crossing to allow safe crossing of the road between the two sites. (2.16)

3.11 A regular deep cleaning programme should be reinstated as soon as possible. (2.18)

3.12 Floors should be regularly polished. (2.19)

3.13 The rooms in B-wing should only be used for single occupancy. (2.20)

3.14 Cleaning officers should ensure that unit cleaners do an effective job. (2.22)

3.15 A painting programme should be introduced to improve the internal appearance of prisoners' accommodation. (2.23)

3.16 Privacy hoods should be fitted to all payphones as soon as possible. (2.25)

Staff-prisoner relationships

3.17 Managers should work with staff and prisoners consultative groups to understand and change the negative perceptions held by prisoners about many staff. (2.28)

3.18 Managers should closely monitor and challenge any disrespectful behaviour by staff. (2.30)

Personal officers

3.19 An effective personal officer scheme should be developed and implemented. This should be complemented by a programme of staff training. (2.31)

Bullying and violence reduction

3.20 All staff should receive refresher anti-bullying training, and this should be recorded. (2.39)

3.21 The message on the anti-bullying telephone line should include details of the support available to victims of bullying. (2.41)

Diversity

3.22 A diversity manager should ensure that the role and functions of the diversity and race equality officer are adequately covered at all times. (2.51)

3.23 The designated disabled accommodation should have basic kitchen equipment, an association room, a stock of reading material and outside benches. (2.52)

3.24 Prisoners with long-term or permanent incapacity should not have television costs deducted from their basic allowance. (2.53)

3.25 There should be a disability impact assessment to improve access to facilities for prisoners with disabilities and enable them to be as independent as possible. (2.54)

Race equality

3.26 All staff should receive guidance to improve application of ethnic monitoring. (2.56)

3.27 All racist incident complaints should be promptly and fully investigated, and the log should be accurately completed. (2.57)

3.28 There should be effective cover for the diversity and race equality officer. (2.61)

3.29 Prisoner diversity representatives should have guidance on how to perform their role, and regular staff supervision. (2.62)

3.30 The diversity representatives' resource office should be open at the published times. (2.63)

Foreign national prisoners

3.31 There should be separate foreign national prisoner representatives with clear job descriptions and training for the role. (2.65)

3.32 Regular peer support meetings for foreign national prisoners should be resumed. (2.67)

3.33 Effort should be made to obtain independent immigration advice for the benefit of prisoners – for example, through the local law centre or a national advice agency. (2.70)

3.34 The foreign national prisoner strategy and resource pack should be updated, taking into account the assessed needs of the current population. (2.74)

Applications and complaints

3.35 All prison officers should be encouraged to use their discretion when dealing with minor applications, and should not require a written application form unless absolutely necessary. (2.77)

Legal rights

3.36 Legal problems raised by new arrivals should be logged and trends should be monitored. (2.80)

Substance use

3.37 The prison should make renewed efforts to limit illicit substance use, particularly by strengthening dynamic security, based on proactive staff engagement with prisoners. (2.82)

Health services

3.38 Therapeutic group work should be available to prisoners during the working day. (2.84)

3.39 There should be regular additional pharmacy support for administrative functions in the management and record keeping of pharmaceutical preparations. (2.89)

3.40 The clinical nurse manager should nominate a healthcare worker to provide health support for older prisoners. (2.107)

3.41 A nominated health worker should develop links with the disability officer to ensure the health needs of prisoners with disabilities are met. (2.108)

3.42 There should be additional dental sessions to reduce the waiting list for routine treatment. (2.109)

3.43 The dentist should record all dental treatment on the electronic medical information system. (2.110)

3.44 The PCT should assess the need for community mental health support to the prison, and formalise an agreement to ensure that support is available whenever necessary. (2.111)

Learning and skills and work activities

3.45 The range of workplaces should be appropriate to the resettlement role of the prison. (2.8)

3.46 The education contract should include the delivery of qualifications above level two. (2.114)

3.47 A wider range of accredited vocational qualifications should be introduced and developed. (2.116)

3.48 Prisoner pay should be increased. (2.119)

Physical education and health promotion

3.49 An appropriate programme of accredited sport and recreational qualifications should be developed. (2.120)

3.50 The gym should be adequately staffed at all times. (2.124)

Security and rules

3.51 Damaged perimeter lighting should be replaced and protected from further vandalism. (2.129)

3.52 There should be increased patrolling of residential areas at night. (2.134)

Discipline

3.53 Quality checking of adjudications should include the appropriateness of the use of disciplinary procedures for the nature and seriousness of the offence. (2.137)

3.54 Prisoners who plead not guilty should be given the opportunity to question witness evidence during an adjudication. (2.139)

3.55 The governor should quality-assure a percentage of completed monthly adjudication records. (2.140)

3.56 Monthly statistical data about adjudications should be collated and analysed. (2.141)

3.57 Initial segregation safety screen documents should be completed in full, including safety algorithms. (2.144)

3.58 Governors should not sign the initial segregation safety screen document before healthcare staff have completed the initial safety algorithm. (2.145)

Incentives and earned privileges

3.59 The privileges available on the different levels of the incentives and earned privileges (IEP) scheme should be revised, in consultation with prisoners, and publicised to encourage prisoners to gain enhanced status. (2.149)

Catering

3.60 More accredited training should be available to prisoners working in the kitchen. (2.151)

3.61 Staff supervising meals should ensure that the designated utensils are used to serve halal food to avoid cross-contamination. (2.160)

Strategic management of resettlement

3.62 There should be a resettlement policy that encompasses and leads all of the work done within and outside the prison. (2.3)

3.63 The resettlement strategy and policy document should:
– be based on an up-to-date needs analysis of the resettlement needs of the population;
– specifically address the resettlement needs of the various groups represented within the prisoner population;
– incorporate area resettlement objectives and targets, when these become available. (2.168)

3.64 The recording and analysis of resettlement data should be improved to enable good quality performance monitoring, and to inform management decisions. (2.171)

Offender management and planning

3.65 All prisoners should be subject to sentence or custody planning. (2.4)

3.66 Those prisoners who will not receive an OASys (offender assessment system) assessment should have their resettlement needs assessed, managed and reviewed. (2.172)

3.67 The reducing reoffending policy document should be distributed to all staff and fully implemented. (2.174)

3.68 Where appropriate, prisoners' family or friends should participate in sentence planning and in preparation for release. (2.175)

3.69 Life-sentenced prisoners should have some opportunity to cook for themselves. (2.178)

3.70 Caseloads should be fairly allocated across the offender management unit (OMU) teams. (2.184)

3.71 The time of prison officers allocated to the OMU should be ring fenced. (2.185)

3.72 Communication systems between the OMU, prisoners and staff should be monitored and improved. Management should devise a method to update prisoners with any changes to policies and procedures. (2.186)

3.73 Staff should be trained on the function of the OMU. (2.187)

Resettlement pathways

3.74 The working-out scheme should be reviewed to ensure that it provides a good quality resettlement opportunity to the maximum possible number of prisoners. (2.188)

3.75 The job club should be reinstated. (2.189)

3.76 Prisoners should have the opportunity to undertake shift work during their working out period. (2.190)

3.77 Prisoners should be made aware of the criteria for working out and be kept informed of any changes to these. (2.193)

3.78 The prison should provide an acupuncture service to reduce stress for prisoners undergoing treatment for substance use. (2.194)

3.79 The counselling, assessment, referral, advice and throughcare (CARAT) department should have additional group rooms to facilitate the number of clients. (2.199)

3.80 There should be additional computers and administrative support for the CARAT team. (2.200)

3.81 Prisoners preparing for resettlement in the community should not be subject to a general restriction of a maximum of 20 listed numbers, with a charge for any change. (2.202)

3.82 The choice of offending behaviour programmes and the number of places available should meet the identified needs of the prisoner population. (2.203)

Housekeeping points

3.83 The outer door to the multi-faith area should always be unlocked by staff at the start of the day. (2.126)

3.84 Prisoners who retain their own plates should be able to wash them hygienically with a suitable cleaning agent. (2.158)

3.85 Chairs in the dining hall should be regularly cleaned. (2.164)

3.86 Reducing reoffending policy meeting minutes should record the designation of attendees and absentee guests. (2.170)

Appendix I: Inspection team

Hindpal Singh Bhui	Team leader
Eileen Bye	Inspector
Vinnett Pearcy	Inspector
Lucy Young	Inspector
Bridget McEvilly	Healthcare inspector

Appendix II: Prison population profile

(i) Status	Number of prisoners	%
Sentenced	477	*89.2*
Civil prisoners	8	*1.5*
Detainees (single power status)	39	*7.3*
Detainees (dual power status)	11	*2*
Total	535	100

(ii) Sentence	Number of prisoners	%
Less than 6 months	31	*5.8*
6 months-less than 12 months	35	*6.5*
12 months-less than 2 years	55	*10.3*
2 years-less than 4 years	115	*21.5*
4 years-less than 10 years	231	*43*
10 years and over (not life)	34	*6.4*
Life	34	*6.4*
Total	535	*99.9*

(iii) Length of stay	Number of prisoners	%
Less than 1 month	3	*0.6*
1 month to 3 months	28	*5.2*
3 months to 6 months	35	*6.5*
6 months to 1 year	55	*10.3*
1 year to 2 years	115	*21.5*
2 years to 4 years	231	*43*
4 years or more	68	*12.7*
Total	535	99.8

(iv) Main offence	Number of prisoners	%
Violence against the person	105	*19.6*
Burglary	42	*7.9*
Robbery	40	*7.5*
Theft and handling	41	*7.7*
Fraud and forgery	39	*7.3*
Drugs offences	120	*22.4*
Other offences	135	*25.2*
Civil offences	8	*1.5*
Offence not recorded/holding warrant	5	*0.9*
Total	535	100

(v) Age	Number of prisoners	%
21 years to 29 years	168	*31.4*
30 years to 39 years	166	*31*
40 years to 49 years	114	*21.3*
50 years to 59 years	66	*12.3*
60 years to 69 years	19	*3.6*
70 plus years: *maximum age - 76*	2	*0.4*
Total	535	100

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	132	*24.7*
Between 50 and 100 miles of the prison	324	*60.5*
Over 100 miles from the prison	62	*11.6*
Overseas - *counted within over 100 miles*		
No fixed address	17	*3.2*
Total	535	100

(vii) Nationality	Number of prisoners	%
British	485	*90.65*
Foreign nationals	50	*9.35*
Total	535	100

(viii) Ethnicity	Number of prisoners	%
White:		
British	325	*60.7*
Irish	5	*0.9*
Other White	25	*4.8*
Mixed:		
White and Black Caribbean	4	*0.7*
White and Asian	1	*0.2*
Other Mixed	9	*1.7*
Asian or Asian British:		
Indian	15	*2.8*
Pakistani	11	*2*
Bangladeshi	2	*0.4*
Other Asian	28	*5.2*
Black or Black British:		
Caribbean	61	*11.4*
African	30	*5.6*
Other Black	15	*2.8*
Chinese or other ethnic group:		
Chinese	3	*0.5*
Other ethnic group	1	*0.2*
Total	535	99.9

(ix) Religion	Number of prisoners	%
Church of England	164	30.6
Roman Catholic	80	*15*
Other Christian denominations	14	*2.6*
Muslim	60	*11.2*
Sikh	5	*0.9*
Hindu	10	*1.9*
Buddhist	11	*2*
Jewish	15	*2.8*
Other	20	*3.8*
No religion	156	*29.2*
Total	535	100