Report on an unannounced short follow-up inspection of

HMP & YOI Moorland

6–8 October 2008

by HM Chief Inspector of Prisons

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1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

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Introduction

HMP & YOI Moorland is a large, complex and sprawling prison, holding over 1,000 prisoners in two sites: a closed training prison and an open resettlement prison at some distance from it. Both sites hold young adult, as well as adult, men, some of whom are deemed unsuitable for less secure category C environments. This is not an easy combination to manage, and this inspection found that the prison was not performing sufficiently well against two of our four key tests.

Moorland was a reasonably safe prison. Suicide and self-harm procedures were well managed, and there was a good violence reduction strategy, though some elements of implementation required improvement. The segregation unit was well run, but use of force was relatively high, and needed further analysis and attention.

By contrast, neither the physical environment nor staff–prisoner relationships were sufficiently good. Much of the closed site was shabby and dirty. Relationships between prisoners and staff were distant and distrustful, personal officer work was virtually non-existent, and there was over-reliance on formal applications and complaints.

Around one in five prisoners were from black and minority ethnic backgrounds, but race did not have a sufficiently high profile, and fewer staff than at the previous inspection had been trained in diversity and race equality. Other aspects of diversity were developing. Foreign nationals were well supported on the closed site, but not on the open site. Healthcare services were not matched to need, particularly in relation to mental health, and the regime in the in-patient unit was poor.

Activities were reasonably good. In theory, there was almost full employment, though in practice we found only half the available places filled on one day of the inspection. Vocational training had expanded, and was geared towards employability. The standard and range of educational provision was good. On the open site, around 100 prisoners were able to work outside the prison, in paid or voluntary work, though relatively few young adults were able to take advantage of this.

Given its role, it was particularly disappointing that resettlement work at Moorland had deteriorated since the previous inspection. There was no up-to-date or coherent strategy and no needs analysis: there appeared to be an assumption that Moorland's resettlement role was restricted to opportunities to work outside on the open site. Offender management was not sufficiently proactive, and there was a shortage of offending behaviour programmes. Resettlement pathways, on the closed site, were underdeveloped and under-resourced, though substance misuse services had improved.

Moorland was an early example of a closed training prison being clustered with an open prison. This is now becoming common practice. Moorland's experience, as evidenced at this inspection, is not encouraging. It had not proved possible either to tackle some of the underlying cultural issues, or to provide an effective resettlement strategy for the whole prison. Though the prison's new management was seeking to remedy these deficits, the nature of the site and the mixture of the population will continue to present a challenge.

Anne Owers
HM Chief Inspector of Prisons

April 2009

Fact page

Task of the establishment
Moorland closed: YOI and category C training prison
Moorland open: YOI and category D resettlement prison

Area organisation
Yorkshire & Humberside

Number held
Closed YOI: 322; Open YOI: 55
Closed adult: 449; Open adult: 180

Certified normal accommodation
Closed: 740; Open: 260

Operational capacity
Closed: 794; Open: 260

Last inspection
Full announced inspection of both sites: 12-16 December 2005

Brief history
HMP and YOI Moorland closed prison is a split site, housing adults and young adults, including restricted and E list status and life-sentenced prisoners. The adult category C includes a number of score 3 prisoners and prisoners who pose a risk in less secure category C prisons, usually prisoners who have been involved in incidents.

HMP and YOI Moorland open prison is also a split site, with a large proportion of its population comprising adult prisoners who work outside the establishment. A percentage of young adults work outside the establishment but most are serving short-term sentences.

Description of residential units
Closed site
House blocks 1 and 2: Convicted adult prisoners; house block 2: location of basic regime
House block 3: Convicted young adults
House block 4: Convicted young adults, basic regime
House block 5: Two wings; all enhanced adult prisoners

Open site
A Unit: 60 adult prisoners
B Unit: 60 adult prisoners
C Unit: 60 YOI prisoners, normally short-term sentence but 2% are outworkers
D Unit: 40 adult prisoners – outwork unit
E Unit: 40 adult prisoners – outwork unit

Section 1: Healthy prison assessment

Introduction

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

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

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed 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 At the previous inspection in 2005, we considered that the prison was performing reasonably well against this healthy prison test. Of 39 recommendations in this area, 15 had been achieved, eight partially achieved, 15 not achieved and one was no longer relevant. We have made 19 further recommendations.

HP5 The reception area in the closed site was dirty and unwelcoming and there continued to be delays for prisoners waiting to come into reception. The holding rooms were also dirty, and there were no notices displayed and nothing to keep prisoners occupied. The booking-in process could take up to five hours. Property was not dealt with on arrival, and there was a five-day backlog. Listeners were usually available in reception and had a dual role as orderlies. First night procedures had improved on the closed site and prisoners arriving on Monday to Thursday were unlocked on their first night. There had been improvements in reception and first night procedures on the open site, and newly received prisoners were given an initial assessment and a reception and first night pack containing induction information. On both sites, there was a good range of information in languages other than English, and staff were clearly confident in using, and had used, 'Big Word'.

HP6 The induction programme on the closed site offered a reasonable range of information but was over-long. It was rarely cancelled but the days were not full and prisoners were locked up when not attending induction activities. The programme was scheduled to last for two weeks, but some remained on induction for up to six weeks waiting for the anti-bullying course, which they had to complete before starting work. Induction on the open site was on a rolling programme but prisoners arriving on Thursday or Friday did not begin until Monday.

HP7 Closed-circuit television had been introduced on the walkway on the closed site. The Insiders on the closed site had taken on the role of violence reduction representatives, but had insufficient support in, and understanding of, their role. There was a single, up-to-date violence reduction strategy for both sites, which outlined the parts of the policy which applied to the open or closed site. The scheme was good and focused on behaviour change. The anti-bullying policy was in draft form. It outlined some of the differences on the open site, but not adequately. Allegations of bullying were dealt with on the open site, with six investigations in the year to date. Appropriately, from the paperwork we reviewed, none of these had resulted in anti-bullying measures being applied. On the closed site, 46 prisoners had been placed on anti-bullying measures since January 2008. There was insufficient victim support planning.

HP8 Suicide and self-harm was managed well across both sites. The number of open assessment, care in custody and teamwork (ACCT) documents was low, with nine across both sites at the time of the inspection. The documents examined showed a good level of engagement and involvement of families. A mobile Samaritans telephone had recently been introduced on the closed site, and its use was tracked and assessed against anti-bullying information. Listeners were available on both sites and the scheme was well known. The information about current Listeners was out of date on the open site

HP9 On the closed site, restriction in prisoner movement and the lack of ability to associate freely across the spurs made it seem like a more secure category of prison. The distant relationships between staff and prisoners on the closed site had implications for dynamic security. Staff clearly passed on security information and the number of security information reports submitted had increased since the previous inspection. The rules were over-restrictive, especially on the open site, and there were examples of collective punishments on the open site. The system for returning category D prisoners to category C had improved, with clear reasons given for decisions taken. Once recategorised, however, prisoners routinely had to wait three months before they could reapply for category D.

HP10 The segregation unit on the closed site was run well, with good interactions between staff and prisoners and efforts made to limit the time that prisoners stayed there. Around half of those held at the time of the inspection were scheduled for onward transfer. The regime remained underdeveloped and was under review.

HP11 The number of adjudications was similar to that at the previous inspection. Minor reports were used on both sites, as were incentives and earned privileges scheme warnings. Use of special cell accommodation had been limited to nine instances in the year to date. Use of force forms were filled in with relevant and varying detail. The level of use of force was high and required attention. There were insufficient management checks of completed documentation.

HP12 The introduction of the integrated drug treatment system (IDTS) had been effective and was becoming embedded. Mandatory drug testing took place at weekends as well as during the week.

HP13 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

HP14 At the previous inspection in 2005, we considered that the prison was not performing sufficiently well against this healthy prison test. Of 71 recommendations in this area, 29 had been achieved, 16 partially achieved and 26 not achieved. We have made 36 further recommendations.

HP15 The internal environment of the closed site was shabby, grimy and unwelcoming. The showers were in a particularly poor state of repair. Small cells intended for single occupancy continued to be shared. In some cases, sheets were used to partition the toilet area. There was a large amount of graffiti, and the painting programme was restricted and slow. Accommodation on the open site was better, although provision for the young adults was worse than for adults. Young adults were not able to have predictable and daily access to telephones owing to the rotating association. The grounds of both sites were in good order and rubbish collected effectively from communal areas.

HP16 There was little interaction between staff and prisoners. Prisoners' perceptions of staff–prisoner relationships were poor and they generally described most staff as unhelpful. The interaction with the young adults was better, but still reserved. Prisoners said that there were few members of staff that they could trust and go to for

support. Prisoners on the open site said that they were treated as if in an old-fashioned borstal.

HP17 The personal officer scheme did not function well on either site. The policy document showed a clear vision of the aspirations of the scheme, but this was not borne out in practice. Prisoners knew who their personal officers were on the closed site, but did not feel supported or encouraged. The quality of weekly wing file entries on both sites was generally poor. The work described as 'personal officer work' involved the member of staff doing whatever work was needed on that day for any prisoner, rather than for those on their caseload.

HP18 The incentives and earned privileges scheme had improved considerably since the previous inspection, and some innovative work was being done which concentrated on the reintegration of prisoners from the basic regime. The differentials between standard and enhanced on the closed site were not sufficient but were better on the open site. The scheme was used effectively on both sites.

HP19 Catering was reasonable but breakfast packs continued to be issued on the day before they were to be eaten. The range of goods available from the prison shop was limited, but was under review with the change of contract. Prisoners on the closed site were still required to hand in old goods while waiting for the delivery of new goods.

HP20 There was good screening for prisoners with a disability, and a prisoner carer was paid to look after another prisoner needing support. Reasonable adjustments had been made for prisoners with a disability and there were evacuation plans for those who needed them. A diversity awareness day had been run recently and there were plans to develop services for gay prisoners.

HP21 The number of racist incident report forms (RIRFs) in the year to date was low, with 17 on the closed site and two on the open. RIRFs were available among the general complaints forms but the separate boxes for their submission had fallen into disuse. Black and minority ethnic prisoners accounted for 22% of the population over both sites. The race equality officer did not have a sufficiently high profile on the open site. The role of the prisoner race relations representatives was underdeveloped. All prisoners received race relations training on induction, whereas the number of staff trained in race equality and diversity had dropped from 75% at the time of the previous inspection to 61%. All members of the senior management team had been trained in race relations.

HP22 On the closed site, there was a good policy document for foreign nationals, and bi-monthly meetings with the UK Border Agency. There was a good system to identify foreign nationals arriving at the closed site and to offer information and support. This system was not in place on the open site, and the six foreign nationals held there at the time of the inspection were isolated from support services.

HP23 The lack of engagement between staff and prisoners appeared to have led to an over-reliance on applications and complaints to try to resolve issues. Prisoners were not aware of the work carried out monthly to improve the quality and timeliness of replies to complaints, and to assess trends, and expressed a lack of faith in the system.

HP24 The legal services available were well advertised and formed part of prisoners' induction. There was a mismatch between the availability of staff and the needs of the prisoners.

HP25 The chaplaincy team was not sufficiently representative of the faiths or cultural diversity of the prison population. Statutory duties were carried out, but the department had a low profile in general.

HP26 A health needs assessment had been completed for two consecutive years using no local data, and there had been no staff skills needs analysis. Inpatient beds had been removed from the certified normal accommodation. Prisoners spent little time out of their rooms on the inpatient unit, and sometimes were not offered the opportunity to shower. The regime was impoverished and worse than at the previous inspection. Healthcare provision at the open site was worse than at the closed site and there was poor discharge planning there. Access to the GP on the closed site did not meet our expectations but was better at the open site. There was no formulised nurse triage. The management of controlled drugs was not in line with legislation. Primary mental health services had been reduced and there continued to be no day care services for prisoners.

HP27 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

HP28 At the previous inspection in 2005, we considered that the prison was performing reasonably well against this healthy prison test. Of 19 recommendations in this area, eight had been achieved, eight partially achieved, one not achieved and two were no longer relevant. We have made four further recommendations.

HP29 Delivery of accredited training in the workplace was progressing at a slow pace, but in some cases this training was ready to be implemented. Theoretically, 90% of the population on the closed site, and nearly 100% on the open site, were employed, but on one day of the inspection only 50% of available places were occupied. Open site opportunities depended on the number working in the community. At the time of the inspection, approximately 80 were working in the community, including eight young adults. Around 50% of these were in unpaid work and around 50% in paid employment.

HP30 The prison had expanded its vocational training provision on the closed site to meet the needs of both the skills market and prisoners. In addition, appropriate skills programmes had been introduced on the open site. Education and training was well managed, with good classroom management and active learning taking place in all classrooms and high standards of work achieved. The academic curriculum supported prisoners through to GCSE and A level qualifications, as well as Open University courses. Support for learning was good, with excellent resources. Accommodation for educational activities on the closed site was poor in many areas, but funding had been secured for refurbishment. Accommodation was much better on the open site.

HP31 Time out of cell caused concern because of the inequality of access between young adults and adults, and predictable changes to the advertised core day through the

twice-monthly occupational health hour and workshop meeting closures. There was evidence of regime slippage on the closed site. Association occurred as recorded and was rarely cancelled. This meant that access to showers and telephones had improved, but was still not daily for young adults. Prisoners on induction on house blocks 2 and 4 were locked up if the induction programme had a gap. Fifty-eight per cent of the young adults on house block 2 were locked up at 10.30am on one morning during the inspection.

HP32 Library resources on the closed site had improved owing to a recent increase in staffing, but access and staffing remained inadequate on the open site, where there was only evening or weekend access when the prisoner orderly was available.

HP33 The PE curriculum had improved across both sites, with a good range of appropriate qualifications. Access for prisoners had also improved.

HP34 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

HP35 At the previous inspection in 2005, we considered that the prison was performing reasonably well against this healthy prison test. Of 34 recommendations in this area, 12 had been achieved, 10 partially achieved and 12 not achieved. We have made two further recommendations.

HP36 The strategic management of resettlement was piecemeal. The strategy focused on the open site and working out. The resettlement policy committee meeting involved information sharing with all the agencies represented, but was not a strategic committee. The policy had last been reviewed in September 2007 but did not provide a strategic vision. The membership of the committee had been reviewed but the role it played did not meet prisoner needs. There was insufficient use of data and no needs analysis.

HP37 With regard to offender management and planning, sending prisons seemed to be serving Moorland better and there was no offender assessment system (OASys) backlog. There were 222 prisoners in scope for offender management. Those serving under 12 months were seen on induction and directed to agencies. Those who were serving over 12 months but who were not in scope received an OASys assessment with targets. This was then referred to the prisoner's personal officer, and the offender management unit had no involvement unless the prisoner failed to turn up for a planned intervention. Each offender supervisor had an average caseload of 20, and prioritised those in scope.

HP38 There was a shortage of offending behaviour programmes, as well as staff to run them. It was unlikely that the enhanced thinking skills annual target would be met. The open site had developed links with the Probation Service in the community, and prisoners could access courses in domestic violence or around driving offences if required. A victim awareness course was run by Manchester College and was accredited at OCN level.

HP39 An attempt had been made on the closed site to replicate the good work which had been carried out on the open site with regard to resettlement pathways, but the

resources were spread too thinly and relied too heavily on one person. Greater parity of access for prisoners was required and a broader perspective about what was available for prisoners across the country. Partnerships were in the process of being set up, rather than being well established. Particular emphasis was given to the accommodation; children and families; and employment, training and education pathways, but it was not clear why these had been prioritised above the others. A team of prisoner peer advisers was due to be recruited, but progress was slow. One trained housing adviser worked on the open site.

HP40 Resettlement provision under the education, training and employment pathway was limited and aimed at discharge rather than resettlement. Information, advice and guidance services for the open site were due to be increased, with additional staff recruited. The aims of the finance, benefits and debt pathway were limited to assessing needs and offering a discharge grant. There was a gap in the range of financial and debt management courses available.

HP41 Substance misuse support had improved. The action plans and performance measures were not integrated with the overall policy, but counselling, assessment, referral, advice and throughcare (CARAT) services were good. There was no intervention available for prisoners with alcohol-related problems.

HP42 Visits on the closed site had improved, although there were still delays for visitors. The Sure Start Play Bus came into the prison one day a week at each site and there were more staff in the visitors' centre on the closed site than at the previous inspection. The special and legal visits room on the closed site had been refurbished. Attempts had been made to improve the visitors' car park on the closed site, including the provision of bays for those with disabilities. Entry for visitors to the closed site took too long, and there had been no review of visits sessions, despite reported under-provision at the open site. Family days were only run for life-sentenced prisoners.

HP43 On the basis of this short follow-up inspection, we considered that the prison was 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) to the Governor

2.1 A coherent and distinct foreign nationals policy should be developed and implemented across the prison. (HP48)

Partially achieved. On the closed site, a distinct foreign nationals' policy/strategy document had been published and distributed throughout the establishment. It clearly set out protocols, procedures and entitlements for foreign nation prisoners, while describing the strategic direction of the prison and expected outcomes. It also contained educational material for staff concerning the cultural differences among groups of foreign national prisoners and how these might motivate their behaviour. Staff said that they were aware of the policy's content, and during the inspection we saw that they were clearly focused on supporting foreign national prisoners. However, although the policy was meant to cover both sites, there was little evidence that its content was known by staff on the open site, and its implementation was not being managed.
We repeat the recommendation for the open site.

2.2 Opportunities should be taken across the prison to accredit work skills to improve opportunities for employment. (HP49)

Partially achieved. The prison had identified areas of work that would have accredited qualifications available to prisoners in the near future, such as tailoring, waste recycling and contract work. Some of these qualifications had yet to be introduced.
We repeat the recommendation.

2.3 There should be more vocational employment-related training to meet resettlement needs at Moorland open. (HP50)

Partially achieved. Accredited vocational training had been expanded to include catering (up to National Vocational Qualification level two), gardening, industrial cleaning and information and communications technology. Information, advice and guidance for the open site were not fully embedded; additional staff had been recruited but were not in post at the time of the inspection. There were good links with Jobcentre Plus and SOVA.

2.4 The resettlement strategy should be re-written and based on an up to date needs analysis of the population. The distinct needs of the various sectors of the prison population should be identified and addressed. (HP51)

Not achieved. The resettlement policy had last been reviewed in September 2007 and covered the various resettlement pathways. However, the content was largely descriptive and did not fully reflect current practice in the prison. There had been no needs analysis and the policy did not address the specific needs of the different prisoner populations held at Moorland. The section of the policy relating to the open site concentrated heavily on the working out scheme, which, although a central aspect of the resettlement provision, only impacted on around a third of the open prison population at any time.
We repeat the recommendation.

2.5 A health needs and staff skills analysis should be conducted to identify and inform recruitment of sufficient staff with the appropriate skills and competencies. Emphasis on the recruitment of psychiatric and learning disability nurses should be a priority. (HP52)

Not achieved. There was a health needs assessment, which covered both sites. Healthcare managers told us that this document was renewed annually. However, the report for the current year was a duplicate of that of the previous one; the only section that contained different information related to escorts and bed watches. Local epidemiological data were not gathered for the health needs analysis, with national prevalence data being applied to local population data. There was no staff skills need analysis to inform recruitment planning or identify training and development needs. Mental health nurses within the primary care team carried out generic nursing duties.
We repeat the recommendation.

Other recommendations to the Governor

Arrival in custody

Courts, escorts and transfers

Moorland closed

2.6 Reception procedures at Moorland closed should be reviewed to minimise the delay to other prisoners on escorting vehicles. (1.9)

Not achieved. Prisoners were taken off escort vehicles one at a time, and initial reception procedures were completed before the next prisoner was brought off the vehicle. This led to delays for the escort staff and for prisoners waiting to come into reception.
We repeat the recommendation.

Moorland open

2.7 A clear protocol for transferring prisoners from Moorland open to Moorland closed should be established and made available to prisoners. (1.10)

Achieved. A clear protocol was in place and was published to prisoners. It included the reasons why a prisoner might be transferred and clearly stated that assessments to determine a prisoner's security category would be undertaken at regular intervals to ensure that any decision regarding recategorisation reflected the risks posed.

Additional information

Moorland closed

2.8 There were approximately 30 receptions a week into Moorland closed, which was similar to our findings at the previous inspection. Prisoners told us that escorting staff treated them well and none reported long journeys.

First days in custody

Moorland closed

2.9 Notices and information should be on display in the holding rooms at Moorland closed. There should be items available to help keep prisoners occupied while held there. (1.32)

Not achieved. The four holding rooms were dirty, bare and contained a lot of graffiti. They contained televisions, but these were not switched on while prisoners were being received. There was no information on display and no items available to help to keep prisoners occupied.
We repeat the recommendation.

2.10 Prisoners at Moorland closed should not be held in reception for excessive periods. (1.33)

Not achieved. Prisoners who were received just before the lunch hour were relocated to either the healthcare centre or residential units while reception was closed. However, nothing happened while in this alternative accommodation, and they were returned to reception when it reopened to complete the booking-in process, which could take up to five hours in total.
We repeat the recommendation.

2.11 All prisoners should be unlocked on their first evening at Moorland. (1.34)

Partially achieved. Prisoners arriving on Monday to Thursday were unlocked on their first night but this was not the case for those arriving on Friday, as there was no evening association.

2.12 The information channel on the in-cell television should be used to communicate key information to all newly arrived prisoners. (1.35)

Achieved. A comprehensive programme of information was broadcast on the information channel, which included a voice-over for those who were unable to read or were visually impaired.

Moorland open

2.13 Formal first night arrangements should be introduced for prisoners at Moorland open. (1.36)

Achieved. There were now formal and comprehensive first night procedures. Prisoners arriving in reception were seen promptly by staff, dealt with quickly and taken to residential units. They were seen by first night staff on the units and a basic assessment was carried out. Prisoners were not always seen by health services staff on reception, as there was not 24-hour cover.

2.14 The curriculum of the preparation for work course offered to all prisoners at Moorland open should be flexible to meet individual requirements. (1.37)

No longer relevant. The preparation for work course had ceased.

Both sites

2.15 All reception, first night and induction staff should be given guidance on how prisoners who cannot read or write, who are new to custody or who cannot speak English should be managed. (1.38)

Achieved. Guidance had been given to staff on both sites, and they demonstrated use of Big Word, audio tapes and written information in other languages, verbal and written presentations and use of other prisoners who could speak the same language as the prisoner requiring language assistance. Prisoners who were new to custody were identified in reception and first night officers and induction officers saw every new reception on their first night to offer additional support.

2.16 All information provided to prisoners in reception and on induction should be available in audio format and in languages other than English. (1.39)

Achieved. Audio tapes were available in 30 different languages. Written information had been produced in different languages and was issued when required.

2.17 All prisoners should be able to access the prison shop within 24 hours of arrival. (1.40)

Not achieved. All new receptions were given either a smokers' or non-smokers' pack in reception, the cost of which was recovered at 50 pence a week. Prisoners could also purchase additional packs if they had sufficient funds to pay in full. However, prisoners arriving from private prisons often had to wait up to two weeks for their accounts to be transferred and could therefore be disadvantaged by this system. Some prisoners waited 10 days before they received their first order from the shop.
We repeat the recommendation.

2.18 All assessments conducted on a prisoner at the reception stage should be done in private offering the prisoner ample opportunity to raise any concerns or fears he may have. (1.41)

Partially achieved. Initial assessments on the closed side were carried out in the open reception area in the sight and hearing of other prisoners and staff. Cell sharing risk assessments were carried out in a separate room, but prisoners may not always have been willing to impart personal information at this time, as various issues had already been covered in the initial assessment. On the open site, all assessments were carried out in private.
We repeat the recommendation for the closed site.

2.19 Prisoner Insiders should be used to provide information to newly arrived prisoners. (1.42)

Not achieved. On the closed site, Insiders reported that, although they had been in place for four months, they did not have a clear brief and did not see every new reception. There were no Insiders on the open site.
We repeat the recommendation.

2.20 All prisoners should be able to make a private telephone call on their first night. (1.43)

Partially achieved. Prisoners were not able to make a private telephone call on their first night on the closed site, as their telephone PIN numbers were not activated on the system.

However, staff attempted to make a call on their behalf to a nominated person. All prisoners on the open site were able to make a call.
We repeat the recommendation for the closed site.

2.21 Prisoners spending their first night at either site should be instantly identifiable to all staff. (1.44)

Achieved. On the closed site, all new receptions were identified using a yellow T card on the wing roll board. On the open site, all new receptions were identified in the movement logs, which formed the basis of the staff handovers.

Additional information

Moorland closed

2.22 The reception area at Moorland closed was adequate in size but was dirty and unwelcoming. We observed 12 prisoners arriving at 11.30am; they were located in the healthcare centre and house block 2 over lunch and returned to reception at 2.30pm, where they remained until 5.30pm. During their time in reception, they were seen by health services staff and the first night officer. Listeners were usually available in reception and had a dual role as orderlies. None of these prisoners had their property (including prescribed medications) processed, and staff reported that they had a backlog from the previous week. A prisoner arriving later in the afternoon was known to staff and presented as difficult to manage. He refused to walk into the reception area because of an injury or illness that apparently affected his leg and ability to walk. He was permitted to drag himself along the outside yard to the bottom of the reception steps, a distance of approximately 20 metres, before the duty governor intervened, and a wheelchair was brought for him. Escorting staff and reception staff (including two nurses) openly showed amusement at this and called us over to witness it.

2.23 The induction programme was a two-week rolling programme, followed by a four-day anti-bullying course. Prisoners who had been at Moorland in the previous six months were fast-tracked through induction. Prisoners told us that the induction process was too long, especially as it duplicated a lot of the information they had received at their previous establishment. Prisoners remained on induction for up to six weeks, as there was a waiting list for the anti-bullying course and they were not permitted to take up employment until this course had been completed. During this time, they spent long periods locked in their cells.

Further recommendations

2.24 Reception should be open to receive and administer prisoners during lunchtime.

2.25 The reception holding rooms should be regularly cleaned and refurbished, and graffiti removed.

2.26 Prisoners presenting with a disability should be offered and given assistance to move from escorting vehicles into reception.

2.27 Prisoners should be permitted to take up employment or education on completion of the two-week induction course.

2.28 The induction course should be flexible, to give prisoners information to meet their individual requirements.

Moorland open

2.29 The induction programme was a one-week rolling programme. However, staff told us that prisoners arriving on a Thursday or Friday did not generally start the programme until the following Monday, leading to delays in completing the course. Prisoners said that the induction course was too long and did not cover the information they needed in moving from closed to open conditions. A check of the documents given to prisoners confirmed that they were given information about systems and procedures, but no specific information about the differences they might expect to find in an open prison.

Further recommendations

2.30 Prisoners should start the induction programme on the next working day after their arrival.

2.31 The induction programme should include information highlighting the differences that prisoners might expect to find in open conditions.

Environment and relationships

Residential units

Moorland closed

2.32 Cells designed for single occupation should not be shared. While they are shared, effective lavatory screening should be provided. (2.21)

Not achieved. The cells designed for single occupation continued to be shared, despite being small and not appropriate for sharing. They were appropriately certified by the area manager to be occupied by two prisoners. Staff referred to these specific cells as 'small doubles'. There were 41 such cells across house blocks 1–4. A prisoner we spoke to who was in one of the cells on house block 2 described being accommodated in a small double cell as 'degrading', owing to the cramped conditions. Some of the small doubles had full-length curtains installed to screen the toilet, whereas others had bed sheets hung as a screen. We were told by staff that eventually all the toilets would be screened using curtains. On house block 4, where there were 15 small double cells, we were informed that some of the young adults tore down the toilet screening and used it for window coverings, and there were delays in replacing these. We repeat the recommendation.

2.33 Showers on units 1–4 at Moorland closed should be provided with screening. (2.22)

Not achieved. Several bids for funding had been submitted to make improvements around the establishment, but these had been rejected. Consequently, no progress had been made in the previous two years in relation to the screening of showers. We were told by the deputy head of residence that some funding had been secured recently and that improvements were planned for the shower units on the first floor of all the house blocks (12 showers in total). The showers not only lacked screening, but some of the units had peeling paint, tiles coming away from the

walls and floors that looked ingrained with dirt.
We repeat the recommendation.

Further recommendation

2.34 The tiling and paintwork in disrepair in the shower units across house blocks 1–4 should be repaired and, where appropriate, shower units refurbished.

Moorland open

2.35 Young adults at Moorland open should be subject to the same rules about accessing lavatories at night as adult prisoners. (2.23)

Achieved. Young adults we spoke to said that they were permitted to use the toilets at night without permission from night staff; this was confirmed by staff. Sanctions were imposed if young adults were found out of their cells with other prisoners, rather than using the toilets. Sanctions ranged from verbal warnings to a governor's report for those who persistently contravened the rules.

2.36 Showers at Moorland open should be provided with screening. (2.24)

Partially achieved. Showers on the outworkers' house blocks (D and E) had appropriately screened showers. The communal showers on the other units only had partitions between the showers and were not completely screened.
We repeat the recommendation.

Both sites

2.37 Cell furniture should be maintained and new or repaired items should be reinstated promptly. (2.25)

Partially achieved. A reasonable stock of cell furniture was stored on the house blocks at the closed site, including lockable cabinets and mattresses. We were told that any furniture which was damaged was taken to the workshop and repaired within a few days. However, cell furniture which had to be fixed in-cell was referred to the works department. This was a non-emergency matter and consequently was not prioritised, and it could therefore take a long time for such repairs to be carried out. Some of the cell furniture we observed was in reasonable condition, whereas other items looked worn and in need of replacing. Cells had lockable cabinets, although some of the locks had been damaged. On the open site, the lack of storage space meant that there was no supply of replacement cell furniture. Generally, the furniture was adequate and most cells had desks, lockers and shelves. We were told by staff that when items of furniture were damaged, replacements needed to be ordered and could take some time to arrive, although damage to furniture rarely occurred.
We repeat the recommendation.

2.38 All cells and rooms should be decorated to a satisfactory standard. (2.26)

Not achieved. On the closed site, there was a repainting programme on each of the house blocks, although the establishment mainly relied on cells being vacant in order to repaint them. Due to population pressures, this resulted in slow progress being made. Some of the cells were in a poor state of decoration and there was graffiti on some of the walls. The painting was

undertaken by prisoners who had completed the painting and decorating course. Prisoners were unable to paint their own cells, and each house block manager kept a record of the cells that had been painted. On house block 4, it was not only vacant cells that were painted; prisoners who were at work during the day were moved out while their cells were redecorated. Despite the efforts made, very few cells had been repainted. On the open site, the cells were in better condition, although the young adult house blocks had poor lighting in the corridors and the cells were in a poor state of redecoration. The environment on A and B house blocks appeared dull and dated.
We repeat the recommendation.

2.39 Cells should have notice boards. (2.27)

Partially achieved. On both sites, each cell had either a notice board or a section of the wall painted black, denoting where prisoners were permitted to place articles on the wall. We were told that the blacked out sections on the internal cell walls had been introduced because of the frequency with which notice boards needed to be replaced. Despite prisoners having a designated area on which to place articles, we found that many cells had pictures and articles plastered over large sections of the cell walls. This was generally accepted by staff, despite the fact that the impact of pictures being placed on cell walls rather than notice boards was evident in some cells, with paint being removed when pictures were taken down and remnants of posters and sticking tape.

Further recommendation

2.40 In order to maintain the overall fabric and presentation of cell walls, staff should ensure that prisoners display posters and personal articles only in the designated area.

2.41 The official offensive displays policy should be enforced across the prison. (2.28)

Achieved. There was no offensive display policy as such, but a notice about offensive materials was displayed on each of the house blocks, stipulating that no materials would be displayed showing racist slogans or wording, and outlining the types of picture that were deemed unacceptable. Prisoners were given written information during induction regarding what could be displayed. During the inspection, we did not see any material which contravened this rule.

2.42 All prisoners should have daily access to telephones. (3.82)

Not achieved. On the closed site, an additional telephone had been installed on each of the house blocks, and adult prisoners described few problems accessing the telephones. However, on the young offender units, association did not take place every evening (see section on time out of cell), and prisoners on these units did not have daily or predictable access to the telephones.
We repeat the recommendation.

2.43 Prisoners should be able to telephone their family and friends at times that can be arranged in advance and are likely to be convenient to the recipient of the call. If restrictions have to be placed on the time prisoners can access telephones, staff should provide supervision to ensure fair access. (3.83)

Not achieved. See recommendation 2.42.

Additional information

Moorland closed

2.44 The grounds were well maintained, although we observed litter directly outside the windows of some of the residential house blocks. Rubbish was collected effectively from communal areas. Walkways to the house blocks and departments were clean and well maintained.

Moorland open

2.45 The grounds were in good order and provided a pleasant and colourful environment. There was no litter and rubbish was collected efficiently.

Staff–prisoner relationships

Both sites

2.46 Management expectations about appropriate behaviour and use of language should be made known to staff and monitored. (2.34)

Achieved. The establishment had issued staff notices about appropriate behaviour. It was clear, from our observations and discussion with staff and prisoners, that staff were aware of the expected standard of behaviour. We observed one member of staff referring to the serving of meals as 'feeding', but he was promptly corrected by another member of staff and acknowledged that the use of the term was inappropriate.

2.47 Prisoners should participate in sentence planning boards and incentives and earned privileges reviews and be used as Insiders and employment and resettlement advisers. (2.35)

Partially achieved. Only life-sentenced and in-scope prisoners attended sentence planning boards (see section on offender management and planning). Prisoners could attend incentives and earned privileges reviews. At the time of the inspection, there were three Insiders and one resettlement adviser (see recommendation 2.285).

Additional information

Both sites

2.48 During the inspection, we held five prisoner groups across both sites. In each of the groups, prisoners were highly negative about staff–prisoner relationships at the two sites. Prisoners on the open site complained about staff swearing. Some prisoners were able to identify a member of staff that they could turn to if they needed help, but prisoners generally described most staff as unhelpful and perceived them to be distant, particularly if they were approached for assistance. Prisoners on the open site said that they were treated as if in an old-fashioned borstal. During a period of association, and throughout the inspection, we observed distant relationships and little meaningful interaction between staff and prisoners. This was compounded by the structure of the house blocks, with each of the spurs being gated. However, we found many staff congregated in offices and not interacting or engaging with

prisoners who were left on the house blocks. On the open site, prisoners said that they were not informed of rules or essential information and had to rely on other prisoners for information.

2.49 Staff on the prisoner development unit on house block 4 had a good knowledge of prisoners in their charge and demonstrated a caring approach to some challenging young adults who had been placed on the unit owing to their behaviour (see paragraph 2.71). Additionally, information contained in some of the wing history sheets, anti-bullying documents and assessment, care in custody and teamwork (ACCT) documents demonstrated that some staff showed sensitivity to vulnerable prisoners and worked hard to address inappropriate behaviour.

Personal officers

Both sites

2.50 The personal officer policy should contain a clearer description of what is required of a personal officer and be supported by appropriate training or written guidance to assist staff in undertaking the role. (2.41)

Achieved. A detailed policy document for both sites had been published and issued to personal officers. It described clearly what was expected of them and the importance of the role. It also gave practical guidance on how to deal with some of the complex problems that prisoners presented with, as well as a description of their general duties.

2.51 The personal officer scheme should be integrated with the sentence planning process. (2.42)

Not achieved. There was little evidence to show that effective links had been established between sentence management processes and personal officers. The personal officers we spoke to were, on the whole, unaware of the sentence planning targets set for the prisoners in their care, and entries in most wing files did not reflect proper engagement in terms of challenging or supporting prisoners to achieve their targets. Prisoners told us that they did not feel supported or encouraged (see additional information).
We repeat the recommendation.

2.52 The quality of wing history sheet entries should be improved and should reflect face-to-face contact with the prisoner. (2.43)

Not achieved. On the closed site, most wing files showed written entries from personal officers every week. However, there were examples, particularly on the adult units, where entries were less frequent. On the open site, entries were typically infrequent and in many cases did not appear at all. The quality of the entries on both sites was generally poor and did not reflect an understanding of the prisoner's personal circumstances or an identification of their individual needs. Many described single instances of poor behaviour, without regard to events surrounding the incident. Most did not give assurance that personal officers spent any meaningful time with their prisoners in order to build appropriate relationships based on guidance, support and mutual respect.
We repeat the recommendation.

Additional information

Both sites

2.53 Despite the publication of a comprehensive policy and guidance document, the personal officer scheme did not function effectively on either site. Even though all prisoners had been allocated an identified personal officer and knew who he or she was, those we spoke to said that they did not have a meaningful relationship with him or her, in terms of receiving help or guidance. Although most officers we spoke to said that they knew about the requirements of the scheme, they had not been allotted enough time to carry out all of their duties. As at the previous inspection, we were told that, due to staff shortages, prisoners were more likely to seek help from prison officers who were on duty to help them with problems as they arose, rather than waiting for their personal officer. Most prisoners we spoke to, on both sites, said that they were careful when seeking help from staff. They said that most officers were dismissive, unhelpful and uninterested in their problems (see section on staff–prisoner relationships).

2.54 Some time, described as 'personal officer work', was allotted to one officer on all residential units on the closed site every day. However, this involved dealing with general applications, such as personal telephone calls, home detention curfew reports and release on temporary licence contributions, and was not used to deal with his or her individual caseload. This period was often cancelled owing to staff shortages. No time was specifically allotted for personal officer work on the open site.

Further recommendation

2.55 Personal officers should be provided with enough time to deal appropriately with their casework.

Duty of care

Bullying and violence reduction

Moorland closed

2.56 Cameras should be installed in the walkway at Moorland closed. (3.12)

Achieved. Closed-circuit television cameras were installed in the walkways leading to each of the four house blocks. The screens were located in a private room along the operations corridor, where the orderly officers had a base. Although each of the four television screens was labelled with the number of the house block it was monitoring, it was not clear which corridor was being shown. However, we were told by a principal officer that they were in the process of labelling each of the screens in such a way that they would be aware of the exact location of what was being shown of the television screen. The cameras had been used for evidential purposes for adjudications, but no bullying incidents had been recorded, and staff considered that the cameras acted as a deterrent.

2.57 Prisoner violence reduction representatives should receive formal training before being appointed. (3.13)

No longer relevant. The violence reduction representatives had gradually been phased out, and some had been recruited as Insiders. The deputy safer custody coordinator and the head of residence were in the process of developing a role for Insiders in relation to violence reduction and providing support, advice and guidance to prisoners regarding anti-bullying, particularly victims of bullying. The Insiders had not received any formal training at the time of the inspection.

Moorland open

2.58 Prisoners suspected of bullying at Moorland open should not be immediately transferred back to closed conditions without being given a chance to change their behaviour. (3.14)

Achieved. The draft anti-bullying strategy we saw outlined that only prisoners who were placed on stage three (the most serious) anti-bullying measures would be transferred back to closed conditions. However, we were told by the safer custody coordinator that prisoners could be transferred back if they were on stage two anti-bullying measures. Nevertheless, no prisoners had been transferred back to open conditions in the year to date.

Further recommendation

2.59 The anti-bullying strategy should be consistently applied as written across both sites.

Both sites

2.60 Both sites should develop their own anti-bullying strategy or sub-strategies as the current practice is not entirely transferable. (3.15)

Not achieved. The anti-bullying strategy outlined few differences between the two sites regarding the management of bullying incidents. The document comprehensively outlined anti-bullying measures on the closed site, but did not outline how prisoners placed on stages one and two anti-bullying measures on the open site would be managed or how victims would be protected.
We repeat the recommendation.

2.61 Additional resources should be provided to ensure that prisoners are not waiting excessive periods to start the anti-bullying course. (3.16)

Not achieved. At the previous inspection, 19 prisoners had been waiting to start the anti-bullying course. At the time of the present inspection, there were 43 prisoners on the waiting list, with an expected waiting time in excess of two weeks. Prisoners were unable to start employment and had to remain on the induction unit until the course was completed (see section on first days in custody). Staff said that the long waiting list was due to the increase in new receptions; however, this number had not changed since the previous inspection. The education department ran the weekly course, and we were told that when the waiting list became long they delivered two courses simultaneously. On the open site, prisoners were informed of anti-bullying measures and the expected standards of behaviour as part of the induction course.

2.62 The violence reduction senior officer (VRSO) should be made aware of all information relevant to bullying. (3.17)

Achieved. We were told, and saw evidence, that suspected bullying incidents and actual incidents were referred to the safer custody coordinator. Additionally, intelligence from the security department was referred to the safer custody coordinator. On the open site, owing to the coordinator and his deputy being visible on the house blocks, any incidents were promptly referred to them, and they checked observation books on each of the house blocks.

2.63 The VRSO and shadow VRSO should meet regularly. (3.18)

Achieved. The safer custody coordinator and deputy coordinator on the closed site met regularly and provided each other with handover notes in relation to any investigations that had been undertaken and any outstanding work. Additionally, we were told by the deputy coordinator that there were plans for him to work alongside the coordinator instead of deputising in his absence. On the open site, an anti-bullying log was maintained, and the coordinator and his deputy had access to this. The safer custody coordinators from both sites were part of the safer custody meeting.

2.64 Interventions should be introduced for all prisoners identified as bullies. (3.19)

Not achieved. The establishment was in the process of devising programmes that would be suitable for identified bullies. On the young adult house block, we saw some individual interventions that had been devised for repeat bullies, and these were mainly delivered by the psychology department. The education department also ran a victim awareness course and a bullying and harassment course which prisoners could be referred to as part of their sentence plan. Persistent bullies were not routinely referred to these courses. There was no evidence that there were any formal links between the safer custody coordinator and the offender management unit.
We repeat the recommendation.

2.65 A reporting helpline number should be published for families and friends to report bullying. (3.20)

Not achieved. A telephone helpline had been installed, but there were some technical issues and it was not operational at the time of the inspection, and had not been advertised to prisoners or their families and friends.
We repeat the recommendation.

2.66 A victim support protocol should be developed to standardise the support provided to prisoners who have been bullied and should take account of the specific needs of both sites. (3.21)

Not achieved. The anti-bullying strategy contained ideas for devising a support plan, such as opening an ACCT document, closer supervision and involving family members. However, during the inspection there were no open victim support plans and the establishment was unable to provide us with any closed plans; this suggested that they were, at worst, not used at all or, at best, used inconsistently. The number of victims of bullying and the action taken were recorded at the safer custody meeting. A total of 24 victims had been identified in both July and August 2008; 12 had been placed on Rule 45 or 49 for their own protection, but it was not clear what had happened to the remaining victims. On one day during the inspection, we observed a young adult request a move to another house block, as he was being bullied. The member of staff he approached asked for the names of the alleged bullies and then allowed the prisoner to walk away in a distressed state. There was no consideration of whether the prisoner required any support and he was not informed what would happen to the alleged

bullies or how he would be supported during a potential investigation.
We repeat the recommendation.

Further recommendations

2.67 The use and quality of victim support plans should be monitored at the safer custody meetings.

2.68 All victims should be offered a victim support plan.

2.69 Staff should receive anti-bullying training. (3.22)

Not achieved. According to the training figures, there had been no anti-bullying training provided for staff.
We repeat the recommendation.

Additional information

Moorland closed

2.70 The safer custody coordinator and deputy coordinator managed the anti-bullying scheme and suicide prevention. The deputy coordinator was a senior officer and a residential manager when he was not undertaking his safer custody duties.

2.71 There were several ways of managing prisoners on anti-bullying measures at Moorland closed. House blocks 2 and 4 each had a landing, referred to as the prisoner development unit (PDU), where some bullies who had been placed on stages two and three anti-bullying measures were referred. Prisoners were required to remain on the PDU landing for a minimum of 21 days, and during that time they would undergo weekly behavioural assessments by staff. The quality of assessments on the young adult houseblock was satisfactory and some demonstrated in-depth work and interaction with prisoners to address their behaviour. Many of the prisoners on the PDU because of bullying were on the basic regime, and, as their behaviour improved, further privileges were attained until their behaviour was sufficiently good for them to be relocated to normal location and moved up from basic, depending on any issues pertaining to the victims of their bullying. Prisoners on this landing were treated according to issues identified in their individual assessments, and some prisoners could maintain their employment off the unit. When prisoners left the PDU, their subsequent behaviour was monitored.

2.72 The PDU also housed other prisoners who were on the basic regime, and staff told us that there were no issues about co-locating these prisoners on the same landing. At the time of the inspection, there were no prisoners on the PDU for suspected bullying. Despite the existence of the PDU, some bullies were managed in situ without being referred there. There were no clear criteria for referring a prisoner to the PDU or leaving him on normal location, and no protocol regarding the overall management of the PDU. At the time of the inspection, a protocol for the PDU was in the process of being written.

2.73 The establishment's anti-bullying database recorded that 46 prisoners had been placed on anti-bullying measures since January 2008 – 27 on stage one, six on stage two and 13 on stage three. The minutes of the safer custody meeting highlighted that 100 bullying incidents had been investigated between June and August 2008, but only 17 prisoners had been placed on anti-bullying measures during this period. The number of verbal bullying incidents was three

times higher than for physical bullying and bullying for canteen. This might have accounted for the low number of prisoners placed on anti-bullying measures, but this had not been discussed or investigated at the safer custody meetings. At the time of the inspection, there was only one prisoner on stage one of the anti-bullying measures.

2.74 There were five Insiders at the establishment. We met two of them, who had been Insiders for approximately four months. They described their roles as providing advice to new receptions but said that they were not always permitted to go to the reception area to meet new arrivals. They were unaware that they would have any involvement with promoting violence reduction at the establishment and said that they were unclear about their role, and that they had not received a job description. However, we were shown the compact that the Insiders were required to sign and it contained a job description. The deputy safer custody coordinator was planning to meet the Insiders to clarify their role.

Further recommendations

2.75 The policy for the prisoner development unit should clearly outline the management of alleged bullies on the unit, and referral to the unit should be consistently applied across the establishment.

2.76 The safer custody meeting should investigate the low number of prisoners placed on anti-bullying measures compared with the number of bullying investigations which have been undertaken.

2.77 Insiders who are used for violence reduction matters should receive formal training, and their role and responsibility should be made clear to them and to staff and prisoners across the establishment.

Moorland open

2.78 The safer custody coordinator was supported by a deputy coordinator, but at the time of the inspection the deputy coordinator was on long-term sickness absence. The coordinator was a senior officer and also a house block manager, and as part of his duties he went to each of the house blocks daily to check wing observation books and to discuss any concerns that staff or prisoners might have about bullying.

2.79 There had been six bullying investigations in the year to date and none had resulted in any anti-bullying measures being applied. The unit manager was expected initially to investigate the bullying allegation and interview the victim as well as the perpetrator, if appropriate. The information was then given to the safer custody coordinator to decide whether the remedial action taken by the unit manager had been appropriate and to determine what anti-bullying measure needed to be applied, if any.

2.80 The alleged bullying incidents mainly involved name calling. Such incidents were resolved by the unit manager or the coordinator facilitating a meeting between the prisoners or addressing the issues directly with the alleged perpetrator. One of the referrals had been made by a member of staff from the education department, who had observed persistent name calling by a prisoner and that the name calling was having an impact on the alleged victim. This had been resolved, and the perpetrator had apologised to for his behaviour. The overall management of these incidents was basic, although they were low-level incidents.

Self-harm and suicide

Moorland closed

2.81 A mental health in-reach nurse should routinely attend suicide prevention management team meetings. (3.38)

Achieved. The head of healthcare attended the monthly safer custody meetings and any issues regarding mental health in-reach services were fed back to appropriate staff. There was good liaison between staff and the mental health in-reach team. Where appropriate, they attended ACCT reviews and provided one-to-one support.

Moorland open

2.82 Prisoner access to Listeners at Moorland open should be at least as easy as for those at Moorland closed. (3.40)

Achieved. There were three Listeners at Moorland open: two on houseblock D and one on houseblock E. The safer custody coordinator was alerted when a trained Listener arrived from another establishment, so that a sufficient number of Listeners was maintained. The Listener employed in reception as an orderly explained the role of Listeners to newly arrived prisoners. The safer custody coordinator told us that prisoners could access a Listener throughout the day and night; the night orderly would be notified and the prisoner and Listener could either meet in the prisoner's cell or in the communal area. Photographs of Listeners were displayed throughout the prison, but some displays included Listeners who were no longer at the establishment.

Both sites

2.83 All prisoners should be able to speak to the Samaritans at all times. (3.41)

Achieved. On the open site, prisoners had access to the telephones after lock-up, although none of the telephones we saw displayed the Samaritans telephone numbers. At Moorland closed, Samaritan telephones had recently been installed and there was a portable Samaritans telephone on each of the house blocks that prisoners could use in their cells. Staff recorded all requests for the portable telephone. This information was checked by the safer custody coordinator and cross-referenced with the anti-bullying database and suicide prevention log, to identify any trends and monitor any previous victims of bullying or prisoners previously on open ACCT documents.

2.84 The programme for training in suicide and self-harm prevention should cover all staff that deal with prisoners, and include how to access/use ligature knives and use of inundation points. (3.42)

Partially achieved. According to the training records, 50% of staff had received ACCT foundation refresher training. Two members of staff had attended the ACCT 'training for trainers' course and were able to deliver in-house training. The minutes of the September 2008 safer custody meeting showed that just over 70 staff had not received ACCT awareness training; these were mainly operational support grade staff and the operations groups. Some of the operational support grades working on the night shift had not been trained, although further

training, including on access and use of anti-ligature knives, was being provided to address this.

Additional information

Moorland closed

2.85 We met 11 of the 13 Listeners at the closed site. A representative from the Samaritans met Listeners fortnightly, providing support and guidance. The Listeners also met the safer custody coordinator weekly to identify any issues that needed addressing. These meetings were not documented. Listeners presented feedback at the safer custody meetings and monitored the number of contacts with prisoners and their location; prisoners in the healthcare department had the most contact with Listeners, followed by those in reception.

2.86 The Listeners were positive about their role, but felt that some staff did not fully appreciate the importance of gaining access to prisoners who requested a Listener. A Listener on house block 3 said that it was particularly difficult to get access to young adults accommodated on house block 4. This had been highlighted at the safer custody meeting and was being investigated, particularly as this was also the induction unit for young adults, but there was no record of how or when staff would respond to this.

2.87 There had been no recorded requests for a Listener during the night in the year to date. Listeners' perceptions were that prisoners were told to wait until the morning, although the safer custody coordinator said that there were few requests for Listeners during the night and that they would be facilitated. During the night, the Listener and the prisoner had to meet in the Listener care suite in the healthcare department.

Both sites

2.88 The safer custody meetings were chaired by the head of residence and attended by the safer custody coordinators from both sites. The coordinators provided a written report for each meeting, outlining the numbers of ACCT documents opened and any trends identified. Although the Samaritans formed part of the membership, a representative had not attended the meeting between June and September 2008.

2.89 The quality of ACCT documents was discussed at the meeting and individual feedback was given to staff. The July 2008 meeting had highlighted that the closed ACCT documents that had been quality checked were poor. There were major concerns about one document, which only had one entry made in the ongoing record during the time that the document was open. In order to improve the quality, each ACCT document had inserts detailing the quality and standard that was expected, as well as the audit baseline. Managers felt that this supported staff who did not use the document regularly and we found this to be an appropriate response to the concerns about quality.

2.90 There were 31 ACCT assessors across both sites, from a variety of disciplines and departments. There had been 140 ACCT documents opened in the year to date, and during the inspection nine prisoners were on open ACCT documents across both sites. The general quality of recording and care maps in the documents we looked at was good. Case reviews were attended by relevant staff and extremely vulnerable cases were sensitively managed, with staff involving family members and facilitating telephone calls home. Staff we spoke to demonstrated a good knowledge of the prisoners placed on ACCT documents.

2.91 There had been two deaths in custody in the closed site since the previous inspection: a self-inflicted death in August 2007 and the most recent in August 2008, which was in the process of being investigated by the Prison and Probation Ombudsman (PPO). The first death involved a young adult who had been at the establishment for over a year. The PPO investigation had concluded that there had been no procedural failures or indications from the young adult that could have prevented the death, and that the prisoner had been adequately cared for. The PPO made one recommendation, for managers to undertake a 'hot debrief' following a death in custody, and also identified as good practice the electronic board located in the gate, which identified the number and location of prisoners on open ACCT documents.

Diversity

This area was not inspected at the previous inspection.

Additional information

Both sites

2.92 A good start had been made in developing the diversity agenda on both sites. An enthusiastic and committed race equality officer (REO) had introduced systems, including reception screening to identify and manage those with disabilities, and reasonable adjustments had been made for many prisoners. There were evacuation plans for all prisoners with a disability. One prisoner was paid to assist another prisoner who had lost his sight. A diversity awareness day and other activities had taken place and there were plans to improve services and provide additional support to gay prisoners on both sites. Management responsibility for diversity had recently been transferred from the REO.

Further recommendation

2.93 All aspects of diversity for prisoners should continue to be developed to provide a comprehensive service on both sites.

Race equality

Both sites

2.94 Programmes or guidance should be available to prison and probation staff to enable them to challenge racist offenders confidently and appropriately. (3.56)

Achieved. Guidance was provided in a notice to staff that was issued annually. New staff received appropriate training during their induction period.

2.95 All staff should be trained in cultural, racial and diversity issues. (3.57)

Not achieved. Sixty-one per cent of staff had attended training, compared with 75% at the time of the previous inspection. No staff had been trained in the previous 12 months. All members of the senior management team had been trained in race relations.
We repeat the recommendation.

2.96 Prisoners should receive a written response advising them of the outcome of any investigation into a racist incident complaint. (3.58)

Achieved. All prisoners received a comprehensive written response from investigations.

2.97 The race relations management team should investigate the reasons lying behind the poorer survey responses from black and minority ethnic prisoners referring to their experience of staff treatment, staff respect and victimisation. (3.59)

Achieved. Two measuring the quality of prisoner life (MQPL) surveys had been carried out since the previous inspection and had raised similar issues to those in the inspection survey. The race equality action team (REAT) was responding to the survey results through an action plan.

Additional information

Moorland closed

2.98 There were only three prisoner race relations representatives on the closed site; they delivered a presentation for those on induction and participated in REAT meetings, which were held quarterly. These meetings were detailed and focused on a race equality action plan and other relevant issues.

Moorland open

2.99 Provision of race equality services on the open site were not as well developed as on the closed site. An REO had been identified, but attempts to provide support groups for prisoners had not met with much success.

Further recommendation

2.100 Race equality services on the open site should be developed in line with those on the closed site, with additional close managerial support provided.

Both sites

2.101 The black and minority ethnic population across both sites was approximately 22%, and race equality services were well developed.

2.102 Nineteen racist incident report forms (RIRFs) had been received since April 2008, including two from the open site. They were investigated fully by the REO, although prisoners expressed little confidence in the system when complaining about staff. This was partly because of the REO stating in some investigations that he knew the member of staff well and knew that he or she would not act in the way stated by the complainant. This had been identified as an issue, and more recent investigations had been completed more appropriately. There was also confusion among prisoners as to how to submit RIRFs. Although they were available with other forms on the wings, the dedicated boxes had fallen out of use. The RIRFs were quality checked by a member of the senior management team and an Independent Monitoring Board member. Arrangements were underway for external scrutiny to be provided by a group of lay ministers from a Sheffield black church group, as they were felt to be more independent.

2.103 Community links were strong, particularly at the closed site, and developed at an appropriate level. A black and minority ethnic support group had been developed on the closed site and South Yorkshire Probation Service provided a black and minority ethnic adviser for 20 hours a week. This person, along with two other external facilitators, provided an eight-module support course, presented over three months, for black and minority ethnic prisoners. Doncaster Connexions provided a traveller support group.

Further recommendation

2.104 Boxes for submitting racist incident report forms (RIRFs) should be clearly marked.

2.105 External and independent scrutiny of RIRFs should be introduced and recommendations from this acted upon.

2.106 The internal monitoring of RIRFs by a member of the senior management team and an independent monitoring board member should continue.

Foreign national prisoners

Both sites

2.107 There should be a foreign nationals coordinator responsible for both sites who is conversant with the needs of foreign national prisoners. (3.65)

Partially achieved. The REO was responsible for the coordination of services for foreign national prisoners at the closed site. The role was understood, both by staff and prisoners, and governance arrangements were effective (see additional information). Arrangements on the open site were poor. A dedicated foreign nationals coordinator had not been appointed.

Further recommendation

2.108 There should be a distinct foreign nationals coordinator responsible for the open site conversant with the needs of foreign national prisoners and the local policy.

Additional information

Moorland closed

2.109 Arrangements for foreign national prisoners at the closed site were good. There were effective local systems to ensure that immediate needs were identified and addressed. Although there was not a distinct multidisciplinary foreign nationals committee, issues concerning foreign national prisoners were monitored at the monthly REAT meeting to ensure that prisoners' needs were brought up and that the policy was being implemented. Minutes of meetings showed that relevant issues were discussed and appropriate action taken as required.

2.110 During the inspection, there were 42 foreign national prisoners at the closed site. Foreign national prisoners and detainees were systematically identified at reception and during the induction process, and records were effectively kept and monitored by an administration officer and the REO. Language and legal needs were identified. Translation services (Big Word) were

used and lists kept of staff and prisoners who spoke languages other than English (see recommendation 2.15).

2.111 There were good contact arrangements between the prison and the immigration service. Immigration officers attended the closed site bi-monthly to give direct information to prisoners about the legality of their status as foreign national prisoners.

Moorland open

2.112 Arrangements on the open site were not sufficiently developed, and links between the REAT and the closed site were weak. There were six foreign national prisoners on the open site at the time of the inspection. Although most said that they felt that their day-to-day needs were generally being met, all complained that the prison had little understanding of the specific issues relating to their status and they were unsure about how to access help if they needed it.

Further recommendation

2.113 Systems should be introduced to ensure that the needs of foreign national prisoners are met on the open site and governance arrangements through the race equality action team should be improved.

Applications and complaints

Moorland closed

2.114 Staff answering complaints should always be identified. (3.93)

Achieved. We did not see any complaints for which the member of staff answering was not identifiable.

2.115 Analysis of complaints should be developed in order to improve responses to prisoners and inform relevant departments. (3.94)

Achieved. Work was carried out monthly to improve the quality and timeliness of replies to complaints, and to assess trends. The analysis was circulated to all relevant departments and action taken where necessary. Prisoners were not aware of this and expressed a lack of faith in the system.

Legal services

Moorland closed

2.116 Provision of legal services at Moorland closed should meet prisoners' needs and be monitored in relation to the demand and response time. (3.103)

Not achieved. The services available were well advertised and formed part of prisoners' induction. There was still a mismatch between the availability of staff and the needs of the prisoners. At the time of the inspection, there were nine outstanding applications on the closed site, the oldest of which dated back four months and the most recent of which was a month old.

Substance use

Moorland closed

2.117 The establishment should ensure that mandatory drug testing targets are consistently met at Moorland closed. (8.98)

Achieved. Mandatory drug test targets were consistently met.

Both sites

2.118 Mandatory and targeted drug testing should be undertaken at weekends as well as during the week. (6.20)

Achieved. The targets for weekend testing were 14% of tests on the open site and 10% of tests on the closed site. These targets were met.

2.119 A dedicated drug strategy manager should be appointed to coordinate the different strands of the strategy and to ensure its consistent implementation. (8.99)

Partially achieved. A governor grade held overall responsibility for the drug strategy. He was supported by a principal officer, who was responsible for the day-to-day management of the strategy, and a senior officer. All three were fairly new to their roles at the time of the inspection.

2.120 The establishment should develop an alcohol strategy and services based on the needs of its population, particularly those of young people. (8.100)

Partially achieved. An alcohol strategy had been developed. The psychology department had carried out a needs assessment in February 2008, but the information gathered in the survey had not been broken down to show the needs of young offenders and adults separately. We repeat the recommendation.

2.121 The drug strategy should contain detailed action plans, targets and performance measures. (8.101)

Partially achieved. Action plans relating to the different areas of the drug strategy contained detailed action points, targets and performance measures. However, these were not maintained as part of the main strategy document.

Further recommendation

2.122 Action plans relating to the drug strategy should be included in the main strategy document.

2.123 The establishment should have the appropriate resources, expertise, support and policies in place before accepting prisoners on methadone maintenance programmes. (8.102)

Achieved. There was an integrated drug treatment system (IDTS) team, including

appropriately trained nursing staff, supported by medical staff and a manager in the community. Policies were in place.

2.124 The voluntary drug testing (VDT) scheme should be reviewed and the role of the VDT unit clarified. The review should take the needs of young people into account. (8.108)

Not achieved. The drug strategy and testing did not distinguish between adult and young offenders in any way. The role of the VDT remained unclear, with no additional support offered to those located there. Sometimes prisoners not selected for the unit were located there when there was no space elsewhere.
We repeat the recommendation.

Health services

Moorland closed

2.125 The CARAT service should be relocated from healthcare and the current office space returned to healthcare. (4.84)

Achieved. Counselling, assessment, referral, advice and throughcare (CARAT) staff had been provided with alternative office accommodation in a prefabricated building.

2.126 Stock in the dispensary should be removed if it ceases to be a dispensing pharmacy. (4.85)

Not achieved. While the area was no longer used as a dispensing pharmacy, controlled drugs were still stored there. They were in a suitable locked cupboard but were out of date. The controlled drugs register showed that there should also have been 10 ampoules of pethidine but they could not be located. The use of stock medication was high, and exacerbated by medication being handed out on the house blocks in the morning, and in the healthcare suite later in the day. The labelling of medications supplied did not comply with legislation.

Further recommendations

2.127 The management and use of controlled drugs should be in line with current legislation and discrepancies reported to the accountable officer.

2.128 Stock should be audited to ensure its proper use; the use of patient-named medication is to be recommended.

2.129 The address of the supplying pharmacy should be included on any labelled medication.

2.130 All the beds in healthcare should be removed from the certified normal accommodation. (4.86)

Achieved. The beds were not included on the certified normal accommodation and admission to them was by assessment of clinical need. The Partnership Board was considering a proposal to close the inpatient beds on the Moorland closed site, but this had yet to be agreed by all the parties involved.

2.131 Prisoners should not be located in healthcare without medical reason. (4.87)

Achieved. All the prisoners located in the healthcare suite at the time of the inspection were there for clinical reasons. Staff told us that on a few occasions former patients had remained there while waiting to return to normal location, but this had only been for a short time.

2.132 The crisis suite should not be located in healthcare and the management of it should not be a healthcare responsibility. (4.88)

Partially achieved. The crisis suite was still located in the healthcare department. There were no records of it being used. Health services staff told us that it was not used as a crisis suite or as other accommodation, although the seating area was sometimes used for ACCT reviews.
We repeat the recommendation.

2.133 Healthcare rooms should not be used by other departments for meetings, education or course work to the detriment of in-patients. (4.89)

Achieved. Healthcare rooms were not used by other departments for meetings or other purposes.

2.134 Healthcare staff should not be supervising prisoners undergoing education in the department. (4.90)

Achieved. Discipline officers were responsible for supervising prisoners attending education in the department. Nurses told us that they never undertook this task.

2.135 Healthcare staff should ensure prescription and administration charts are completed properly. Where medication has not been given, it should say why. (4.91)

Not achieved. We found prescription charts that were incomplete. For example, data regarding allergies were missing and not all charts had the prisoner's name and number recorded. We also found some charts for prisoners undergoing a detoxification programme that were not annotated to indicate this, so contraindicated medications had been prescribed. Some prisoners had more than one prescription chart.
We repeat the recommendation.

2.136 The practice of doctors doing daily rounds in the segregation unit should be stopped. (4.92)

Achieved. GPs visited the segregation unit three times a week and nurses visited daily.

2.137 The in-patient regime should be reviewed to ensure patients are out of their rooms as much as possible within the core day and staff should be more proactive in engaging with prisoners. (4.93)

Not achieved. We observed prisoners spending little time out of their rooms on the inpatient unit. We were told by staff on the unit and healthcare managers that this was because of the level of staffing on the unit. There were two officers on the unit first thing in the morning, until one officer moved to the primary care department. One nurse was on the unit all day. On one day of the inspection, the inpatient nurse was also responsible for administering medication in the primary care centre and spent some time screening new prisoners arriving in the prison reception. While she was undertaking these tasks, there was only one officer on the inpatient unit. An additional nurse was usually based on the inpatient unit in the evenings, after the

primary care centre had closed. There was no regular schedule of activity for prisoners on the inpatient unit, and on one day of the inspection, prisoners had not been offered showers; nursing staff told us that this was not unusual. We did not observe any education sessions on the inpatient unit, and nurses and discipline officers were unable to tell us when these had last taken place. The inpatient association room was austere, with hard chairs and tables. Prisoners appeared to have limited opportunity to interact with staff or each other. The regime for inpatients was poor. Risk assessments increased staffing levels to a three-person unlock for those seen as high risk but were not used in reverse to let patients out when the risk was minimal.
We repeat the recommendation.

Further recommendations

2.138 Inpatients should have access to the same range of activities, including daily showers, as other prisoners.

2.139 The inpatient association room should be redecorated and comfortable seating provided.

Moorland open

2.140 There should be a defibrillator in the healthcare centre. (4.95)

Achieved. There was a defibrillator in the treatment room of the healthcare department. There was documented evidence to show that it was checked weekly, but the records did not indicate that expiry dates were checked. Checks carried out the day before the inspection had not identified that the gel pads were out of date.

Further recommendation

2.141 Checks of the resuscitation equipment should include ensuring that all equipment is fit for use.

2.142 Agency nurses should not work in isolation. (4.96)

Achieved. We were informed by healthcare managers and nursing staff on the open site that agency staff were no longer sent to work on this site.

2.143 Prisoners should be provided with written information about healthcare services. (4.97)

Partially achieved. On arrival at the establishment, all prisoners were seen by a nurse and a health screen was completed. They were given a leaflet, but it was badly photocopied, of poor quality and contained some inaccurate information. Prisoners told us that they were not given information about how to order repeat prescriptions.
We repeat the recommendation.

2.144 A range of frequently used medications should be provided in one-day supplies to avoid the need for secondary dispensing. (4.98)

Achieved. Patients prescribed daily medication were supplied in suitably labelled one-day packs. However, risk assessments were not suitably documented or adhered to. We came

across patients with risk assessments for seven-day supplies who were being issued daily packs.

Further recommendation

2.145 In-possession risk assessments should be undertaken for all patients; the risk assessments of each drug and patient should be documented, and any the reasons for the determination recorded and adhered to.

Both sites

2.146 Nurses should follow Nursing & Midwifery Council guidelines for the administration of medications. This includes ensuring that prescription only medications are legally prescribed for the patient prior to administration. (4.99)

Not achieved. No evidence was seen on the open site of nurses administering medications without a legal prescription. However, on the closed site we found evidence of nurses administering prescription-only medications before a legal prescription existed.
We repeat the recommendation for the closed site.

2.147 The drugs and therapeutics committee should develop patient group directions for a range of medications, including vaccinations. (4.100)

Not achieved. There were no patient group directions in use on either site.
We repeat the recommendation.

2.148 Meningitis C vaccines should be offered to prisoners under the age of 24 years. (4.101)

Not achieved. Although Moorland held young offenders under the age of 24 years, they were not offered a meningitis C vaccination or questioned as to whether they had already received it.
We repeat the recommendation.

2.149 A primary care mental health needs assessment should be conducted to ensure that:

- the requirement for primary mental health support is identified
- the staffing levels/skills required to establish and maintain the service are in place
- care pathways and protocols are introduced
- registered mental health nurses are employed exclusively to provide mental health care
- effective joint working with the mental health in-reach team is established and maintained. (4.102)

Not achieved. We were unable to obtain a specific mental health needs assessment. There were two registered mental health nurses (RMNs) within the primary care team, but they worked as generic nurses and did not carry out any specific role that used their mental health

skills and competencies. There were no care pathways or protocols. Working arrangements with the in-reach team were informal.

Further recommendations

2.150 A primary care mental health needs assessment should be carried out. This should determine the level of need for primary mental health support and the staffing levels and skill mix required to establish and maintain the service.

2.151 Care pathways and protocols should be introduced.

2.152 Registered mental health nurses should provide mental health care and not be used as generic nurses.

2.153 Effective joint working with the mental health in-reach team should be established and maintained.

2.154 Funding should be established to implement a clinical information technology system. (4.103)

Partially achieved. The hardware for an electronic clinical information system (SystmOne) had been installed, and training for its use was planned for later in the month of the inspection, before the system went live.

2.155 All clinical policies and protocols should be evidence-based, signed, dated and regularly reviewed. (4.104)

Partially achieved. Serco Health had been commissioned to provide health services on both sites since 1 June 2008. It had inherited clinical policies and protocols that were out of date. We saw evidence that the nurse managers were in the process of updating all the policies and protocols to ensure that they were evidence based, but they had yet to be provided to staff.
We repeat the recommendation.

2.156 Additional and appropriately qualified administrative assistance should be identified for both sites. (4.105)

Partially achieved. There was one full-time administrative post based at the closed site. The post holder was relatively new and was attempting to develop systems and processes to manage some of the administrative tasks. She was also supposed to cover the open site, but in reality did not have enough time to devote there, so nursing staff carried out all the limited administrative tasks there.
We repeat the recommendation.

2.157 Discipline support should be identified for both sites to escort and supervise prisoners attending and waiting for healthcare treatment. (4.106)

Achieved. On the closed site, a discipline officer was allocated to the primary care centre each day to escort and supervise prisoners attending for healthcare appointments and treatment. We observed appropriate supervision of prisoners in the area. At medication times, wing officers were seen to be supervising prisoners waiting to receive medication or speak to the nursing staff. Prisoners from the open site were given a licence to leave the prison and were taken by minibus to attend appointments on the closed site.

2.158 The healthcare manager should be removed from the orderly officer rota. (4.107)

Achieved. Prison hospital officers no longer worked in the healthcare department; the healthcare managers were nursing staff.

2.159 Monthly team meetings should include all healthcare staff and be obligatory. (4.108)

Achieved. The minutes showed that the monthly healthcare team meetings were well attended by nursing and administrative staff. However, there was no representation from the wider multidisciplinary team, such as the GP.

Further recommendation

2.160 Monthly healthcare team meetings should include members of the wider multidisciplinary team, as well as nurses and administrative staff.

2.161 Clinical supervision should be identified, and protected time allocated to facilitate it. (4.109)

Partially achieved. Serco Health had developed a process for clinical supervision, which included identifying clinical supervisors across the four prisons in the area to which they provided health services. They were in the process of allocating supervisors to supervisees.
We repeat the recommendation.

2.162 Doctors should be qualified general practitioners. (4.110)

Achieved. All doctors providing primary care services were qualified GPs, and confirmation of their registration was available in the healthcare department.

2.163 A programme of change management should be identified to assist staff to manage change within their area of concern. (4.111)

Not achieved. Since the previous inspection, there had been at least two changes in the health services provider. Serco Health managers had a programme and action plan in place to implement changes. However, some staff we spoke to appeared disgruntled and one member of staff resigned during the inspection.
We repeat the recommendation.

2.164 Triage algorithms should be used to ensure consistency of nursing assessment. (4.112)

Not achieved. There were no triage algorithms in use to ensure consistency of care and advice provided. This was of particular concern on the open site, where the nurse was a lone worker.
We repeat the recommendation.

2.165 A pharmacist should visit the prison regularly to review medication and audit faxes with prescriptions. (4.113)

Partially achieved. The pharmacist worked at Moorland open and closed sites, and at the neighbouring HMP Lindholme and Lindholme Immigration Removal Centre. It was estimated that he spent approximately one day a week at the Moorland closed site and visited the open

site occasionally. During his visits, he reviewed medications, audited deliveries against prescriptions and occasionally undertook medication reviews with individual patients.

2.166 Up to date reference sources should be available and out-of-date ones removed. The BNF for children is the most appropriate reference source for medication supplies to adolescents. (4.114)

Not achieved. We were unable to find an up-to-date British National Formulary (BNF). Some copies were over five years out of date, although there was one that was only six months old at the open site.
We repeat the recommendation.

2.167 Nurses should not be used to escort prisoners from Moorland open to attend dental appointments. (4.115)

Achieved. The dentist held one session a fortnight for prisoners from the open site (see recommendation 2.157).

2.168 The doctors should consult with the mental health in-reach team and pharmacy staff when prescribing anti-psychotic drugs. (4.116)

Partially achieved. The GPs and the mental health in-reach team met at the medicines and therapeutics committee, but the psychiatrist did not attend. This resulted in the mental health in-reach team being consulted before the prescribing of anti-psychotic drugs. There appeared to be high use of benzodiazepines and strong antidepressants.

Further recommendation

2.169 The medicines and therapeutics committee should undertake audits of the usage of medications.

2.170 The healthcare manager should have input to the provision of the pharmacy service and the service level agreement between the primary care trust and the provider. (4.117)

Achieved. There was a Service Level Agreement between the service provider, the primary care trust (PCT) and the prison, and this was adhered to. However, prisoners had no regular contact with a pharmacist.

Further recommendation

2.171 The Service Level Agreement should be reviewed to ensure that patients in prison receive a similar service to that in the community, with prisoner access to a pharmacist for advice.

2.172 If methadone maintenance is to be introduced, the prison should ensure that proper provision is in place for the supply, storage and security of the drug. (4.118)

Achieved. There were suitable storage facilities for methadone and other controlled medications. Methadone was given using a computerised administration and record-keeping system.

2.173 Patient group directions should be introduced where possible. (4.119)

Not achieved. There were no patient group directions in use on either site (see recommendation 2.147).

2.174 There should be input to the drugs and therapeutics committee from the pharmacy supplier. (4.120)

Achieved. The pharmacist chaired the medicines management sub-committee for the four establishments he visited. The medicines and therapeutics committee met quarterly and was attended by health services, the PCT and pharmacy provider staff, as well as the prescribers and representatives of the mental health in-reach team.

2.175 A dental therapist should be employed to undertake simple treatment and health promotion. (4.121)

Not achieved. All dental care was delivered by the dentist and dental nurse. Dental triage was not used, and the waiting list was long, with prisoners waiting approximately 10 weeks to see the dentist, who attended two full days each week.
We repeat the recommendation.

Additional information

Closed site

2.176 The treatment room in house block 1 was used by the IDTS team and primary health services staff at the same time, with two IDTS staff working on one side of the room and a primary care nurse on the other. There was insufficient space for the three nurses to work safely and effectively, and prisoners would try to speak to nurses from both teams at the same time, rather than queue up for a second time if they needed to see both primary care and IDTS nurses.

Both sites

2.177 Health services were commissioned by the Doncaster PCT. It had recently reviewed the commissioning arrangements for primary care services to the three prisons in the area and awarded Serco Health the contract for all of them, including both of the HMP Moorland sites. It was clear that there had been little investment or improvements in health services since the previous inspection, and Serco Health had therefore inherited a poor service. This was further hampered by the fact that several other contracts were in existence for allied health professionals, such as the dentist and optician, who also provided primary care services.

2.178 The provision of health services was clearly weighted in favour of the closed site. The open site was covered by primary care nurses (registered general nurses or RMNs) from the closed site; two of them were allocated to the site for two weeks every seven weeks and one nurse was on duty on the site each day. There appeared to be little induction to the work, other than shadowing a colleague, with 'custom and practice' being repeated rather than being challenged. Not all the nurses had the necessary skills to provide a comprehensive service. For example, prisoners requiring blood tests had to wait until the nurse working on the open site was competent in taking blood samples; this had the potential to delay care. Managers rarely visited the open site and there was no ownership of the department. Systems and processes were not in place and services had not been developed. Not all the services

available on the closed site were replicated at the open site. For example, prisoners requiring a genito-urinary medicine appointment had to travel to the local hospital from the open site, even though there was a nurse-led clinic on the closed site. The prisoner orderly for the open site healthcare department was under-utilised and did not have a job description. Prisoners were not able to attend local primary care services, such as dentists and opticians, in the community.

2.179 At the time of the inspection, there were no nurse-led clinics on either site for patients with life-long conditions.

2.180 There appeared to be a lack of integrated working between health services staff and discipline staff. For example, prisoners arriving at the closed site from another establishment did not reliably have access to their medication. Health services staff told us that if prisoners had prescribed in-possession medication from another establishment in their property, they could continue to take it and therefore it was not immediately prescribed. However, health services staff were not aware that prisoners did not always have access to their property on their first night or, indeed, their first few days in the prison (see section on first days in custody).

2.181 The waiting time for a GP appointment on the closed site was 10 days. Unless nursing staff identified someone who needed to be seen sooner, prisoners who made an application to see the doctor were added to the waiting list by the administrator. The wait was much shorter on the open site; some prisoners we spoke to on this site had seen the GP on the same day that they had requested it.

2.182 We could find no evidence of an infection control audit being undertaken. We found prison towels for use in clinical areas. The sink in the open site treatment room was dirty and the flooring in the dental surgery was damaged in places. The dentist said that it had been deep cleaned, but it appeared grubby, particularly around the edges of the room where the flooring met the walls and units.

2.183 The mental health in-reach team was employed by Rotherham, Doncaster and South Humber Mental Health Foundation NHS Trust (RDASH). There were two full-time mental health nurses, but the mental health support worker whose inclusion in the mental health in-reach team we had cited as good practice at the previous inspection was no longer in post. The team was part of a larger prison in-reach team that also covered HMP Doncaster and HMP Lindholme. They took referrals from a variety of sources, and allocated patients between them each day. There were approximately 30 patients known to them at the time of the inspection, four of whom were located at the open site. The RDASH team from HMP Lindholme provided continuity of care for any prisoner who transferred from Lindholme to Moorland. No group work or day services were provided. The RMNs were able to refer patients to counsellors from MIND, or the GP. They had a good working relationship with RMNs in the IDTS team. Records were poor, so we were not able to ascertain how many prisoners, if any, were waiting for transfer to NHS secure beds.

Further recommendations

2.184 There should be dedicated staff at the open site, with the seniority, skills, knowledge and competencies to develop a comprehensive nurse-led service to meet the needs of the prison population.

2.185 Those prisoners from Moorland open who are able to access primary care services in the community should be encouraged to do so and be assisted, if necessary, as part of their resettlement programme.

2.186 The role of the prisoner orderly on the open site should be reviewed.

2.187 Prisoners should have access to their prescribed medication on the day of their arrival at Moorland closed.

2.188 The treatment room on house block 1 should not be used by IDTS and primary health services nurses at the same time.

2.189 Prisoners with life-long conditions should have access to clinics run by appropriately skilled staff.

2.190 Patients should be able to access GP appointments in a timely manner.

2.191 An infection control audit of both healthcare suites should be carried out and any deficiencies addressed as a matter of urgency.

2.192 New flooring should be provided in the dental surgery.

Activities

Learning and skills and work activities

Moorland closed

2.193 The accommodation for literacy and numeracy courses at Moorland closed should be improved, as should the accommodation and classroom facilities for painting and decorating and electrical installation courses. (5.24)

Partially achieved. Some workshop and classroom accommodation remained poor. However, funding had been secured for improvements in accommodation in education rooms and workshops through capital bids (approximately £150,000). Electrical installation courses were no longer offered. On the open site, accommodation was good and information and communications technology well resourced.

2.194 The library should be given more priority to ensure that sessions are not cancelled and prisoners received adequate visits. (5.25)

Partially achieved. On the closed site, a well published timetable ensured that prisoners could access the library during the day, on some evenings and on Saturdays. Sessions were infrequently cancelled, but as prison library officers were required to be present at all times, opening hours were dependent on the availability of prison staff. A second librarian had recently been recruited. On the open site, the library was under-resourced by Doncaster Library Services. It was staffed by prisoner orderlies and was open during the day, and in evenings and weekends when these orderlies were available. Some prisoners had poor access to the library.
We repeat the recommendation.

2.195 Prisoners should be given more time in a session to browse through the books and use the library for study. (5.26)

Achieved. At the closed site, prisoners were given a minimum of 20 minutes for each session. Some groups, such as those on open learning programmes and on house block education, could access the library for much longer periods. On the open site, library timing allowed adequate time for browsing and research.

Both sites

2.196 There should be a wider range of vocational training courses to ensure that the needs of prisoners are met. (5.27)

Partially achieved. At the closed site, additional vocational training opportunities had been introduced recently in brickwork, gardening and horticulture, and others were planned. The provision of information, advice and guidance was moving forward at a rapid pace.
We repeat the recommendation.

2.197 There should be more effective quality assurance arrangements to ensure the quality of learning and skills is monitored and targets set for continuous improvement. (5.28)

Achieved. A member of staff had been appointed to coordinate and support National Vocational Qualifications (NVQs) and the assessment and internal verification processes, both for offender learning and skills service (OLASS) and for other funded provision across both sites. The work included regular meetings for standardisation and assessor and verifier staff development. This worked well and quality files were in place in all areas, with central coordination of external verifier visits.

2.198 A mobile library system should be set up. (5.29)

No longer relevant. Prisoners in all areas had regular access to the main library.

2.199 A selection of educational DVDs and music CDs should be offered. (5.30)

Achieved. On the closed site, the library had significantly improved its stock of music CDs and educational DVDs. On the open site, a small range of music CDs was available for prisoners to access.

2.200 Library orderlies should be enrolled on a qualification. (5.31)

Not achieved. On both sites, the peer partner course had been identified as the most appropriate courses for library orderlies who were involved in supporting prisoners through the Toe by Toe programme. Orderlies had yet to enrol on the courses.

2.201 The range of vocational training programmes should be increased to meet the needs of the population and identified skill shortages. (5.47)

Partially achieved. See recommendations 2.3 and 2.196.

Additional information

Both sites

2.202 Education and training were well managed, with good classroom management and active learning taking place in all classrooms. Prisoners produced high standards of work, particularly

in brickwork and painting and decorating. The academic curriculum supported prisoners through to GCSE qualifications and A level and Open University courses. Support for learning was good, with excellent resources.

2.203 On average, there were employment opportunities for about 90% of prisoners on the closed site and nearly 100% on the open site. However, on one day during the inspection, only 50% of available work places were occupied, with the exception of education classes. The open site relied on between 80 and 100 prisoners working outside the prison. At the time of the inspection, 83 prisoners, including eight young adults, were working out. There was an equal split between those on unpaid community work and those in paid employment.

Physical education and health promotion

Both sites

2.204 Wing times to attend the gym should be on rotation to ensure equality. (5.55)

Achieved. On the closed site, published timetables ensured that gym was provided on a rotational basis, especially in the evenings, to ensure equality of access. On the open site, PE was flexible during the day, evening and weekends to meet the needs of prisoners inside the prison and those working out.

2.205 More vocational accredited courses should be available for prisoners. (5.56)

Achieved. On the closed site, the number of gym courses had been increased to offer courses in gym instruction, cycle fusion, first aid, rugby, NVQ level one sport and recreation, healthy living, basketball, Community Sport Leader Award, diet and nutrition, and Football Association (FA) treatment of injuries level two. On the open site, there were courses in FA treatment of injuries, first aid and the NVQ gym instructors award. Good work took place with local special needs schools, and some outward-bound courses were available.

2.206 Data about recruitment, achievements and leavers should be better collected. (5.57)

Achieved. On both sites, data on recruitment and achievement were kept and used to inform improvements.

2.207 Courses should be quality monitored and quality improvement initiatives introduced. (5.58)

Achieved. On both sites, quality improvement processes were included in the development of the role of the NVQ coordinator (see recommendation 2.197) and quality files were in place and monitored well.

Faith and religious activity

Both sites

2.208 All prisoners should be able to practice their religion fully. (5.68)

Not achieved. Not all prisoners had access to corporate worship or to a chaplain of their faith. There were no Buddhist or Sikh chaplains available to conduct meditation sessions or

services, and the Muslim chaplain could only attend each site once every two weeks to conduct prayers.
We repeat the recommendation.

2.209 The chaplaincy team should be resourced to be able to provide the necessary religious services and to contribute to prisoners' overall care, support and resettlement. (5.69)

Not achieved. Christian and Muslim prisoners had good access to corporate worship. The coordinating chaplain told us that the small chaplaincy team was struggling to cope with the workload provided by 1,000 prisoners across the two prison sites. He said that most of the chaplaincy team's time was spent seeing newly arrived prisoners, dealing with prisoners' applications and supporting those identified as being at risk from self-harm, and there was some evidence to support this. Members of the chaplaincy team had made little contribution to the prison's resettlement strategy, they were not routinely involved in the sentence planning process, and their input into prisoner group work was confined to one Christian-based faith group and one Muslim teaching group per site each week.

Further recommendation

2.210 The work of the chaplaincy should be properly resourced to ensure that it can carry out the full range of duties.

Additional information

2.211 The chaplaincy team, responsible for both the open and closed sites, consisted of: an Anglican coordinating chaplain, a full-time Ecumenical chaplain, a part-time Salvation Army volunteer and a part-time Muslim chaplain. A Roman Catholic priest attended each site once a week to conduct mass. We were told that a full-time Roman Catholic lay chaplain had been appointed, but was not in post during the inspection. As at the previous inspection, there were no visiting ministers and no religious volunteers, and links with local faith communities had not been properly developed.

2.212 Statutory duties were normally carried out by one of the full-time chaplains across both sites. There was a duty chaplain available on both sites every day, and prisoners we spoke to said that they could get access to a chaplain if they needed to.

2.213 The timings of religious services were well advertised, and there were effective systems to allow easy access. Prisoners at the closed site applied to attend services on their residential units the day before, but could also be added to lists on the day of the service through requests to residential officers. Some prisoners on the open site were able to attend services in the community.

Time out of cell

Both sites

2.214 A full hour of exercise should be provided on both sites for those who wish to participate. (5.79)

Partially achieved. Exercise was scheduled to take place for 30 minutes on Monday to Friday

and for an hour on Saturday and Sunday.
We repeat the recommendation.

2.215 Published daily routines should be placed on each wing, alongside any rota system that is being used for association. (5.80)

Achieved. A schedule of prisoners' out-of-cell activity had been published (core day) and was found displayed in all residential house blocks, workshops and education areas. Copies had been issued to some prisoners. It set out the list of activities, including daily association, exercise, movement to off-unit activities, meal times and domestic periods, offered to prisoners from 7.45am to 8.15pm, designating the amount of time that they could spend out of their cells each day.

2.216 Out of cell activities should be improved, particularly for young adults. (5.81)

Partially achieved. Out-of-cell activities had not changed significantly. Although unemployment figures were low, association and exercise continued to be restricted.
We repeat the recommendation.

Additional information

2.217 The prison reported that the average amount of time that prisoners spent out of their cells was 9.6 hours at the closed site. This was, on the whole, consistent with the number of hours generated by the core day, based on all prisoners being unlocked as scheduled, although the means by which this figure was calculated were not clear. While there had been improvements in the amount of time that adult prisoners could spend out of their cells, and periods of association were appropriately scheduled and rarely cancelled, there were inconsistencies in the delivery of the published core day and inequities in the amount of time that some prisoners could spend unlocked.

2.218 There was clear evidence of slippage in the delivery of the published core day at the closed site. A random roll check undertaken during the inspection revealed about 30% of prisoners locked in their cell during the late morning, despite low unemployment rates (see section on education and work). Many of those locked up were described as not required for activity or having returned early from other sessions, such as group work and induction sessions. Fifty-eight per cent of the young adults on house block 4 were locked in their cells with nothing meaningful to do in the middle of the core day.

2.219 During the inspection, we also found that regular and predictable regime changes, resulting from the introduction of a monthly staff occupational health hour and workshop meetings for staff, took place during the scheduled core day. This meant that prisoners were unlocked late from cells at least twice a month. We could find no records to indicate that this was being recorded or monitored.

2.220 Prisoners on the adult house blocks received association on four evenings a week, but young adults on house blocks 3 and 4 received two evening association sessions. Despite this, regime monitoring figures showed that most young adults on house blocks 3 and 4 were being credited with 2.25 hours association on four evenings each week.

2.221 The core day at the open site provided about 16 hours of activity, including association and exercise. This was consistently delivered across the site.

Further recommendations

2.222 Young adults should be allowed the same amount of association time as adult prisoners.

2.223 The prison core day should be consistently delivered as published.

2.224 Monitoring figures should accurately reflect the amount of time that prisoners spend unlocked from their cells.

2.225 All prisoners should receive 10 hours out of cell each day.

Good order

Security and rules

Moorland closed

2.226 Security information should be scrutinised in more detail and cross-referenced with a range of other events at Moorland closed to improve intelligence and allow security resources to be targeted more successfully. (6.17)

Partially achieved. More cross-referencing was carried out, but there were still gaps. A member of staff with a deputy had been trained as an intelligence analyst but still relied predominantly on security information report (SIR) information for analysis rather than tapping into other sources of information, such as those available through the violence reduction officer.

Further recommendation

2.227 Security information should be cross-referenced with other information, such as safer custody data, to ensure the best targeting of action.

2.228 The practise of transferring out segregated prisoners should cease, except in the most extreme circumstances. Prisoners placed on good order or discipline should be case-managed by segregation unit managers to enable return to normal location. (6.18)

Partially achieved. The approach towards difficult prisoners had become much more robust, and the policy was now to keep them rather than transfer them out. This had yet fully to translate into practice. The reviews we observed were not always predicated on returning prisoners to normal location.
We repeat the recommendation.

2.229 Long-term prisoners serving over four years should, as part of their sentence planning process, have the possibility of progressive moves examined. This should be based not only on security categorisation but also on other factors such as closeness to home and education possibilities. (6.19)

Not achieved. Progressive moves for long-term prisoners serving over four years were not automatically scheduled.

Discipline

Moorland closed

2.230 Managers should record in detail the reasons behind their authorisation of the use of special accommodation, including why less intrusive measures are not appropriate. (6.40)

Not achieved. The use of special accommodation paperwork was still inadequate. Managers recorded the reasons why the accommodation was used, but did not explain why alternative methods were not appropriate. Records of overnight use of the special cell, in particular, were poor.
We repeat the recommendation.

2.231 There should be managerial scrutiny of each incident involving force or the special cell to ensure that actions are appropriate and justified and that lessons are learned. (6.41)

Partially achieved. There was some good oversight of use of force incidents, but this was not consistent. Paperwork was not readily accessible and some incidents had yet to have all the paperwork completed. There were no examples of overall analysis.

Further recommendation

2.232 Use of force paperwork should be collated speedily and scrutinised to ensure that procedures have been carried out correctly and determine whether any lessons can be learnt.

2.233 Trends in the use of force and use of the special cell should be monitored over time so that strategies can be introduced to identify high-risk activities, areas and times, and to reduce these types of interventions. (6.42)

Not achieved. There was no evidence of overall analysis.
We repeat the recommendation.

2.234 Information about the occupancy of the segregation unit should be developed and monitored over time to assist managers in reducing time spent in the unit. (6.43)

Not achieved. There was no evidence of overall analysis.
We repeat the recommendation.

2.235 Some appropriate activity and support structures should be provided for prisoners who spend longer periods in the segregation unit. (6.44)

Not achieved. The regime was under review, but access to activity remained as at our previous inspection.

Moorland open

2.236 The use of Moorland closed segregation unit for prisoners from Moorland open should be subject to a formal procedure that includes consideration of the security classification and a system for close monitoring of the effects of these decisions. (6.45)

Achieved. Prisoners from Moorland open were only allocated to the segregation unit of the closed site if assessed on arrival as needing this. A system for recategorisation at the open site had been introduced and the majority of transfers were to normal location.

Both sites

2.237 The number of adjudications for prisoners and young adults on both sites should be reduced by ensuring that minor infringements are dealt with using alternative responses. (6.46)

Partially achieved. Minor reports and incentives and earned privileges (IEP) scheme warnings were used, but the level of adjudications remained similar to that observed at our previous inspection.

Additional information

Both sites

2.238 We had concerns that the distant relationships between staff and prisoners weakened dynamic security. However, staff clearly submitted security information; the use of SIRs was reasonably good and the number had increased since the previous inspection. Staff provided a regular flow of information to the security department and this was acted on.

2.239 Generally, the closed site did not feel like a category C establishment. Prisoner movement and the inability to associate freely across the spurs made it seem like a more secure category of prison. There were two prisoners on three-person unlock.

2.240 The rules felt over-restrictive, especially on the open site. Examples of this were prisoners not being allowed to shower until everyone had returned to the wing and restrictions on prisoners wearing their own clothes. There were examples of collective punishments at the open site, such as not allowing all cleaners to go to the gym if one had not completed his work.

2.241 The system for returning category D prisoners from the open site to category C conditions had improved, with clear reasons given for decisions taken. Once recategorised, however, prisoners routinely had to wait three months before they could reapply for category D.

2.242 The use of force was well managed on a case-by-case basis. The use of force forms were filled in with relevant and varying detail. Several cases were still waiting for all the documentation to be collated, notably the F213s (the form used to report injuries to prisoners), some dating back several months. Use of force was relatively high, with 173 incidents recorded for the first nine months of 2008. The use of special cell accommodation had been limited to nine instances in the year to date. The documentation was not sufficiently detailed.

2.243 The closed site segregation unit was run well. The relationship between staff and prisoners was good and active efforts were made to limit the time that people stayed there. The plan for around half of those held at the time of the inspection was for onward transfer. The regime remained underdeveloped and was under review.

Further recommendations

2.244 There should be no collective punishments. Individuals failing to complete work or breaching rules should be dealt with through the appropriate mechanisms.

2.245 Prisoners who are segregated for any length of time should have risk-assessed access to core activities.

2.246 The high level of the use of force should be investigated and strategies developed to reduce it.

Incentives and earned privileges

Moorland closed

2.247 Prisoners at Moorland closed should be given the opportunity to attend their incentives and earned privileges review boards. (6.57)

Achieved. All prisoners were given the opportunity to attend review boards. They were notified of the dates and times of boards in writing and given the option of submitting written representations if they did not wish to attend in person.

Both sites

2.248 Links between the incentives and earned privileges and resettlement (sentence planning) policies should be strengthened. (6.58)

Partially achieved. Links had not improved significantly since the previous inspection. The offender management unit (OMU) could refer prisoners who failed to make progress in achieving their sentence planning targets to the IEP review board, but this had happened in only two cases between January and September 2008.
We repeat the recommendation.

2.249 Differential regime review boards should specifically consider compliance with sentence planning targets when deciding to promote or demote prisoners within the incentives and earned privileges scheme. (6.59)

Partially achieved. Although due consideration was given to compliance with sentence planning targets when information was presented to the review board, referrals were mostly based on patterns of the prisoner's custodial behaviour and were not measured against his progress toward achieving sentence planning targets (see recommendation 2.248).

2.250 The possible correlation between high levels of adjudications and low use of basic level should be investigated to ensure that the incentives and earned privileges scheme is being used appropriately to manage poor behaviour. (6.60)

Achieved. The IEP scheme had been reviewed since the previous inspection. Although there

had been little change in the number of formal adjudications since 2005, the IEP scheme appeared to be being used rigorously in terms of the correlation of the number of recurrent formal disciplinary charges and the number of prisoners on the basic regime for patterns of poor behaviour.

2.251 The differential regime review board should have greater oversight of the progress of all prisoners to demonstrate fair and consistent application of the incentives and earned privileges scheme. (6.61)

Achieved. Governance arrangements had improved since the previous inspection. Two principal officers ensured that boards were consistent with the stated policy and that prisoners were being referred appropriately according to observed patterns of their behaviour.

2.252 Prisoners should not be deprived of access to showers and telephones as part of the basic regime. (6.62)

Not achieved. There had been some improvement, in that access had increased from twice to four days a week, but prisoners on the basic regime did not have daily access to showers and telephones.

Further recommendation

2.253 Prisoners on the basic regime should have access to showers and telephones every day.

2.254 The basic regime should provide prisoners with sufficient opportunity and support, including structured interventions when appropriate, for them to demonstrate improvement in their behaviour. (6.63)

Achieved. Arrangements for the management of prisoners on the basic regime on the closed site had improved. Young adults were located on a separate landing on house block 4, and adults on a separate landing on house block 2. Prisoners on the basic regime could retain their work or education activity following an assessment of risk. The basic regime consisted of three levels. Prisoners had to get to level three of the programme before returning to ordinary location. Progression through the scheme was dependent on gaining target points, earned through good behaviour. At the end of each week, the prisoner's overall behaviour was reviewed and his progress was measured against the number of points he had accumulated during the week. Reviews were consistently conducted and attended by a principal officer, a member of education staff, the prisoner and a unit officer who knew the prisoner. Following the review, behaviour targets for the following week were set through consultation with the prisoner and recorded in individual care plans. The average time that prisoners remained on basic was about three weeks. Relationships between staff and prisoners on basic units were good. Officers encouraged positive behaviour and supported prisoners in achieving their targets.

Additional information

Both sites

2.255 An IEP policy document had been published, and was advertised on all of the residential units on both sites. It set out in clear and simple language how the system worked, how prisoners could progress through the levels and the expected standards of behaviour. Copies of the

document were available to prisoners during their induction programme, and were found in the residential house blocks. All prisoners had signed compacts. The document described three incentive levels: basic, standard and enhanced. Newly arriving prisoners were generally placed on the standard level, unless arriving from another prison where they had been on the enhanced level, in which case they were allowed to retain their previous status.

2.256 A facilities list determining what privileges prisoners at each level could have was published. Although the range of privileges was adequate for the standard and basic levels at the closed site, there was insufficient difference between the standard and enhanced levels to encourage more responsible behaviour.

Further recommendation

2.257 There should be sufficient difference between the levels of the incentives and earned privileges scheme to encourage responsible behaviour.

Services

Catering

Moorland closed

2.258 Breakfast packs should be issued on the morning they are to be eaten. (7.8)

Not achieved. Prison managers had rejected this recommendation on the basis that it would interfere with the morning regime and that existing arrangements allowed prisoners to choose when they ate their breakfast meal. Breakfast packs continued to be issued on the day before they were to be eaten.
We repeat the recommendation.

Additional information

2.259 Prisoners on the open site still ate all of their meals in the communal dining hall. We received some complaints from prisoners on both sites concerning the quality and choice of the menu, but they also acknowledged recent improvements following the appointment of a new catering manager. The cold lunches that had proved unpopular at our previous inspection had been supplemented by hot options.

Prison shop

Both sites

2.260 When ordering goods, prisoners should not have to surrender old goods until the new ones are received. (7.16)

Not achieved. Prisoners on the closed site were still required to hand in old goods while waiting for the delivery of new goods. There was a proposal to change this as part of the new prison shop contract.
We repeat the recommendation.

Additional information

2.261 The contract for the prison shop was due to be transferred to a new supplier, and limited information on the new service was available. The number of items available was limited (just over 200) compared with other category C or D prisons. Consultation with prisoners took place through the prisoner committee meetings, and shop provision was a standing item on the agenda.

Resettlement

Strategic management of resettlement

Both sites

2.262 Attendance at the resettlement committee should be improved to incorporate all relevant departments. (8.7)

Partially achieved. Membership of the resettlement policy committee had been reviewed and was described in the resettlement policy. It focused mainly on resettlement staff and representatives from community and voluntary sector organisations, and operated more as a resettlement team meeting than a strategic committee. There had been no meeting between May and September 2008.
We repeat the recommendation.

2.263 The resettlement committee should take a more strategic focus on resettlement and an action plan should be devised to plan the developmental work of the function. (8.8)

Not achieved. The resettlement policy was weak (see recommendation 2.4) and there was no associated action plan. The collection and use of data to inform strategic planning and performance management were poor and limited mainly to demonstrating achievement against key performance targets. The resettlement policy committee was not routinely chaired by the head of risk and offender management or her deputy, and we found little staff awareness of what the prison was aiming to achieve in the area of resettlement.
We repeat the recommendation.

2.264 The work to link all assessments of individual prisoners together to contribute to the completion of the OASys document should be completed. (8.9)

Partially achieved. Managers responsible for the offender assessment system (OASys) assessors were not aware of the flow chart system that had been in place at the previous inspection and to which this recommendation referred. However, staff interviewing prisoners during their induction sent copies of any assessments to the OASys department and the assessors chased up any missing information before completing the assessment.

Offender management and planning

Moorland closed

2.265 Life-sentenced prisoners should be encouraged to invite family members or a friend to review boards. (8.41)

Partially achieved. It had been decided not to include family members in review boards, but they were given the opportunity to make written representations.
We repeat the recommendation.

2.266 The management of risk and public protection issues should be incorporated into the decisions about prisoners at all levels rather than being seen as the work of a small number of specialist staff. (8.73)

Achieved. The public protection function was part of the OMU, which was responsible for several key processes involving decisions about prisoners, so risk information was readily available and consistently used. The sharing of appropriate information with other staff, including residential officers, had improved. Notifications were routinely circulated and a coloured dot system in the main residential offices quickly allowed staff to identify prisoners subject to various public protection measures. The staff we spoke to appeared knowledgeable about the issues and sensitive in the handling of information. An email was circulated to all staff before the monthly public protection meeting, inviting them to raise any concerns about individual prisoners, and a number of appropriate referrals had been made to the meeting.

2.267 There should be a comprehensive central public protection register of prisoners, which includes all aspects of risk and public protection measures, and this should be available to all staff. (8.74)

Partially achieved. The OMU held details of all prisoners on the various risk registers, but this was not available to all staff. Restrictions applying to individual prisoners were highlighted on the local inmate database system, to which all staff had access, and notifications were sent out to relevant departments (see recommendation 2.266).

2.268 The public protection coordinator should be allocated sufficient time to develop strategy as well as managing individual prisoners' risk management. (8.75)

Achieved. The full-time public protection coordinator was part of the OMU and had dedicated administrative support. Some aspects of the management of individual prisoners were shared by OMU staff. The coordinator was on leave during the inspection, but other unit staff were able to talk knowledgeably about the work and to produce relevant information for us. There was a detailed public protection policy and risk management meetings were held regularly.

Both sites

2.269 All prisoners should have their needs assessed and relevant targets set within 12 weeks of arrival. (8.24)

Achieved. There were three main systems for ensuring that prisoners' resettlement needs were assessed in a timely fashion. Prisoners serving less than 12 months were dealt with by a generic assessment panel, which was chaired by the resettlement manager. Issues raised

during induction were identified and targets set, usually in the area of preparation for release. Prisoners serving more than 12 months underwent an OASys assessment. It was more common than at the previous inspection that prisoners arrived at Moorland with these assessments already completed. Life-sentenced prisoners continued to be managed by trained lifer staff, who were responsible for ensuring that the necessary assessments and planning meetings took place within the required timescales.

2.270 All assessors should be made aware of all offending behaviour programmes available in the service and other training opportunities available outside Moorland. (8.25)

Achieved. A national directory of programmes and courses provided in all prisons was available on the shared computer drive and could be accessed easily.

2.271 All residential staff should receive awareness training on OASys. (8.26)

Partially achieved. There had been no formal awareness training and there was no evidence that the briefing package that had been developed at the time of our previous inspection had been used. Notices to staff had been issued concerning OASys and developments in the OMU, but these lacked sufficient detail to assist officers operating as personal officers.
We repeat the recommendation.

Additional information

Both sites

2.272 At the closed site, the multidisciplinary OMU was well established and training was in progress to enable the administrative officers to deal with all aspects of the unit's workload, rather than have specialist responsibilities. Once this had happened, the OMU staff would be divided into four self-contained teams, each responsible for groups of prisoners allocated alphabetically; the target date for this change was January 2009. There was a smaller, but separate OMU at the open site which was managed by the same principal officer and governor. The two groups of OMU staff did not meet to discuss issues or develop practice.

2.273 Eleven staff were identified and trained as offender supervisors, although at the time of the inspection one was on sickness absence and there was one vacancy. Offender supervisors managed a workload of 222 prisoners identified as in scope under the offender management model. This included 92 prisoners serving indeterminate sentences for public protection (IPP). Four of the offender supervisors were lifer trained and they also managed the 47 young adult prisoners who were serving life sentences. This brought the team's active workload to 269, or 35% of the total population. Full sentence planning boards were held for all these prisoners; these were normally chaired by the external offender manager and included the prisoner.

2.274 Prisoners serving over 12 months, but who were not in scope, had their OASys assessments completed by a member of the OMU, and OMU managers chaired a sentence planning board, which did not routinely include the prisoner. Once the sentence plan targets had been agreed, oversight of the plan became the responsibility of the prisoner's personal officer. As the personal officer scheme did not operate effectively (see section on personal officers), at least a third of prisoners had no identified person they could work with to ensure that targets were prioritised, monitored and achieved. OMU staff were involved in enforcing any failures to comply with sentence plans, and these were dealt with under the IEP scheme.

2.275 The additional induction programme for life-sentenced prisoners that we commended as good practice at the previous inspection was still in place, and a similar programme had been developed for IPP prisoners. In our group meetings, IPP prisoners spoke positively about this programme.

Resettlement pathways

Moorland closed

2.276 CARAT service workers should contribute to sentence planning at Moorland closed. (8.97)

Achieved. Counselling, assessment, referral, advice and throughcare (CARAT) workers sat on panels, if requested by either the panel or the prisoner, and shared information with the OMU. They obtained the consent of the prisoner before sharing information with others. There was a good relationship between the CARAT manager and the OMU principal officer.

2.277 The standard and safety of the visitors' car park at Moorland closed should be improved. (3.78)

Achieved. Attention had been paid to the security and maintenance of the visitors' car park and there were now designated parking bays for those with disabilities. Visitors' centre staff and visitors we spoke to had few complaints about the area, which was better presented than at the time of the previous inspection.

2.278 The entry and search area for visitors at Moorland closed should be redesigned to provide adequate space and privacy. (3.79)

Not achieved. There had been no additional funding for modifications, so the entry and search arrangements remained the same as at the previous inspection. There was a separate room for private and sensitive searching, but the majority of social and official visitors were still searched in the open area in full view of other visitors and the main staff entrance.
We repeat the recommendation.

2.279 Prisoners and their professional visitors should be able to conduct meetings and interviews in private. (3.80)

Achieved. The special visits room had been upgraded and now contained seven individual interview booths, as well as two small meeting rooms. All rooms could be booked by legal and official visitors, and prison resettlement staff also held interviews and sentence planning boards in this area.

2.280 The level of staffing in the visitors' centre should be sufficient to meet demand. (3.81)

Achieved. There had been a slight increase in the number of hours allocated to visitors' centre staff, and a member of operational support grade staff attended the centre to assist with the booking in of visitors. Demand remained high, but staff told us that the workload was generally manageable.

2.281 The number of enhanced thinking skills courses at Moorland closed should be increased and a local target for waiting time should be established. (8.51)

Not achieved. Additional funding had not been secured, so the number of courses remained the same. There was no target for waiting times, but the number of prisoners waiting to be assessed for suitability for the enhanced thinking skills (ETS) course had fallen from 300 in 2005 to 120 at the time of the inspection. Significant staff shortages over an extended period had impacted on the delivery of the programme, and psychology staff told us that the annual target of 72 ETS completions was unlikely to be achieved.

Further recommendation

2.282 The provision of offending behaviour programmes should be reviewed to ensure that all prisoners assessed as needing a programme are able to complete it during their sentence.

2.283 There should be provision for alcohol awareness offending behaviour programmes. (8.52)

Not achieved. There were alcohol awareness sessions, but no alcohol offending behaviour programmes. Those with alcohol-related problems could only access CARAT services if there was also a drug issue.
We repeat the recommendation.

Moorland open

2.284 Healthcare should be involved in the resettlement of prisoners; this should include providing prisoners with information on how to access primary care services on release and support in accessing the services if required. (4.94)

Not achieved. Health services staff were not actively involved in the preparation of prisoners for release. The nurse saw all prisoners leaving the open site – whether to attend court, for home leave or for release – one or two days beforehand and completed a pro-forma that included whether the prisoner needed any medications to be dispensed. Prisoners were also weighed, although there was no obvious reason for this. Prisoners were not given information about how to access health or social services on release or advice on how to register with a GP.
We repeat the recommendation.

Both sites

2.285 Suitably skilled and trained prisoners should be used to assist in the provision of housing and other resettlement advice. (8.65)

Partially achieved. One trained housing adviser worked on the open site, but there had been no success in developing such provision on the closed site. Some staff told us that it was because no suitable prisoners could be identified, which seemed unlikely. As a condition of a new contract with Shelter, the prison's main housing advice provider, a team of prisoner peer advisers was to be recruited, trained and used to provide information and assistance to other prisoners. This was not yet in place, and the provision of other resettlement advice was poorly developed.
We repeat the recommendation.

2.286 In light of prisoners' work schedules, especially on Moorland open, the provision of CARAT service evening sessions should be explored. (8.103)

Achieved. CARAT staff provided one evening session each week on the open site.

2.287 The CARAT service should be resourced to offer a range of group work modules to meet the need of adults and young people across the two sites. (8.104)

Partially achieved. CARAT staff worked alongside nurses to offer a variety of courses from the IDTS resource pack. However, no group work modules were available on the open site.
We repeat the recommendation.

2.288 The establishment should provide adequate accommodation for the CARAT team as well as more administrative and IT support. (8.105)

Achieved. The majority of the CARAT team were located in a prefabricated building, with the remainder being in office space on house block 1. There was adequate administration and information technology support for the team.

2.289 The establishment should provide adequate access to a dedicated counselling service. (8.106)

Not achieved. There was no dedicated counselling service.
We repeat the recommendation.

2.290 The potential need for additional or extended visits sessions on both sites should be reviewed at least annually to ensure that all prisoners who wish to are able to receive visits. (3.84)

Not achieved. There was no evidence that any such review had taken place, and the provision of visits on both sites had not changed since the previous inspection. Prisoners on the open site complained to us about aspects of the visits arrangements, including the lack of visit sessions during the week. Psychology staff had undertaken a visitors' survey in November 2007 and had received 70 responses from visitors to the closed site and 24 from the open site. The questionnaire concentrated on visitors' perceptions of the visits experience and did not include specific questions about the timing and availability of visit sessions.
We repeat the recommendation.

2.291 Structured aftercare support should be provided to prisoners completing the P-ASRO programme, and a peer support scheme should be developed. (8.107)

Partially achieved. At the review interview conducted four weeks after completion of the prison addressing substance-related offending (P-ASRO) programme, any further needs were identified and, if considered appropriate, prisoners were referred back to the CARAT team, with clear aims and objectives to achieve. There was no routine ongoing support for those completing the programme and no peer support scheme.
We repeat the recommendation.

Additional information

Moorland closed

2.292 Some courses, such as dependency awareness and victim awareness, were provided by the OLASS contractor (Manchester College). These were not classed as offending behaviour programmes and were at Open College Network level and not accredited.

2.293 The multidisciplinary programmes team delivered the ETS and controlling anger and learning to manage it (CALM) courses to the required standards and had achieved ratings of over 95% in recent quality audits. However, a high turnover of staff and difficulties in recruiting and training new tutors meant that it was hard to plan effectively and there was no certainty as to when courses would run. At the end of August 2008, 35 prisoners had completed ETS (against the annual target of 72) and eight had completed CALM (against the target of 24).

2.294 All referrals for the programmes came through the OMU as part of the prisoner's sentence plan. Prisoners were not assessed for suitability for ETS in advance, but were interviewed once they had been listed as having a place on the next programme. This made it difficult to determine how many prisoners who met the criteria were waiting to complete the programme and whether they were likely to achieve this before being released. The programme running at the time of the inspection was specifically for prisoners serving indeterminate sentences for public protection (IPP).

Moorland open

2.295 Prisoners were able to attend a range of offending behaviour courses run by the Probation Service in the community, and prisoners could access courses in domestic violence or around driving offences if required. There were good structures and processes in place for working out. Staff visited community placements and employers to determine health and safety policies and the quality of work offered. Prisoners were suitably risk assessed and supported, and were often accompanied to interviews by prison staff. However, staffing levels were low and staff were often responsible for their own administration work, resulting in a reduction in the number of prisoners able to work out and sometimes long waiting lists for placements. In addition, we found confusion and some contradictory views as to whether the working out scheme was operating at its full capacity or could be extended. From different groups of staff and managers, inspectors were told that:

- All eligible and suitable prisoners were already on the working out scheme, and, given the nature of the open prison population, it was difficult to achieve the maximum number of 100.
- The number on the working out scheme was lower than necessary, and prisoners sometimes had to wait for long periods to get on the scheme because staffing levels were inadequate and staff were responsible for their own administration.
- A certain number of suitable and trusted prisoners were required to undertake key jobs within the prison and this prevented some from accessing the working out scheme.

Both sites

2.296 Although the resettlement policy stated that 'No one pathway is more important than another', the resettlement manager told us that she had concentrated primarily on accommodation; education, training and employment; and children and families. Managers acknowledged that the mental and physical health, and finance, benefit and debt pathways had received little attention. Much of the development and provision of pathway work relied on single members of staff, which was concerning, especially given the absence of a robust strategic lead or framework (see section on strategic management of resettlement).

2.297 The resettlement manager, who had previously worked solely on the open site, had now introduced a range of voluntary and community agency work to the closed site, similar to that on the open site. This had proved successful, especially in respect of the accommodation and education, training and employment pathways. She, and a range of agency staff, now worked on both sites, ensuring a greater equality of access and opportunity to prisoners. The resource was stretched in trying to meet the needs of this wider population.

2.298 Work under the education, training and employment pathway was underdeveloped and poorly resourced on both sites (see recommendation 2.3). The Gateway to Release course was no longer run on the open site. Prisoners could access aspects of resettlement through work with partner organisations, although these arrangements were uncoordinated and depended on numbers available to attend.

2.299 According to the resettlement policy, the prison aimed to provide advice on benefits and general financial management by (i) using the OASys plan to record financial needs and plan interventions and (ii) giving every eligible offender a discharge grant on release. This was inadequate. Prisoners' financial issues were highlighted during initial assessment processes, but there was no suitable specialist advice and guidance. Finance and budgeting courses were only available through a business studies course and were not discrete programmes. Prisoners were helped to set up benefit claims before release, but few of the prisoners we spoke to were aware of where to go for help with finance or benefit problems. There was no provision for assisting prisoners to set up bank accounts in preparation for release.

2.300 Relationship and parenting courses were available only as part of the generic skills for life course, and family days were available only for life-sentenced prisoners.

2.301 Since the previous inspection, arrangements had been made for the Sure Start Play Bus to be available on one day a week at each site. This provided children under five and their carers with somewhere to go while waiting for the visit. There were plans to extend the role of the Play Bus in providing information and support to prisoners' families.

2.302 On the closed site, visitors could book a visit through a telephone booking line or in person at the visitors' centre. On the Tuesday of the inspection, visitors were able to book a visit for Thursday and staff told us that they were normally able to accommodate requests for visits within a week. Visitors to the open site did not need to book.

2.303 Most visitors to the closed site arrived in good time for the visits session, but the various entry and search procedures and the distances between different areas resulted in delays in reaching the main visits hall and starting the visit. On the afternoon we observed visits, only a third of the visitors were in the visits hall by the published 2pm start time, and the last arrived after 2.30pm. Managers felt that this was acceptable, as it still allowed for a visit beyond the statutory minimum time of 30 minutes, and the action plan in response to the previous

inspection also gave this as the reason for not extending the number of sessions (see recommendation 2.290). There had also been some slippage in the last allowed entry time; staff told us that, previously, visitors could arrive up to 3.15pm and still be allowed into the visits hall, but that the cut-off time had now been reduced to 3pm. We were given no explanation for this.

2.304 The closed site continued to rely on volunteers from the Women's Royal Voluntary Service to run the tea bars in the visitors' centre and main visits hall. There were no alternative or cover arrangements for times when volunteers were not available. The provision of refreshments had been highlighted as an issue by visitors in the annual survey and by prisoners in the prisoner consultative committee. We observed good interaction between visits staff and prisoners and their families.

Further recommendations

2.305 Prisoners should be assisted in opening a bank account.

2.306 Relationship and parenting courses should be available as stand-alone modules.

2.307 The provision of children and/or family days should be extended.

2.308 Entry and search procedures should be improved to ensure that visitors do not experience unnecessary delays and have the opportunity to spend the maximum possible time on the visit.

2.309 Visitors should always be able to purchase hot drinks and other refreshments while at the visitors' centre and during the visit.

Section 3: Summary of recommendations

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

Main recommendation (from the previous report)

3.1 A coherent and distinct foreign nationals policy should be developed and implemented across the prison. (2.1)

3.2 Opportunities should be taken across the prison to accredit work skills to improve opportunities for employment. (2.2)

3.3 The resettlement strategy should be re-written and based on an up to date needs analysis of the population. The distinct needs of the various sectors of the prison population should be identified and addressed. (2.4)

3.4 A health needs and staff skills analysis should be conducted to identify and inform recruitment of sufficient staff with the appropriate skills and competencies. Emphasis on the recruitment of psychiatric and learning disability nurses should be a priority. (2.5)

Recommendations to the Governor

Courts, escorts and transfers

Moorland closed

3.5 Reception procedures at Moorland closed should be reviewed to minimise the delay to other prisoners on escorting vehicles. (2.6)

First days in custody

Moorland closed

3.6 Notices and information should be on display in the holding rooms at Moorland closed. There should be items available to help keep prisoners occupied while held there. (2.9)

3.7 Prisoners at Moorland closed should not be held in reception for excessive periods. (2.10)

3.8 All assessments conducted on a prisoner at the reception stage should be done in private offering the prisoner ample opportunity to raise any concerns or fears he may have. (2.18)

3.9 All prisoners should be able to make a private telephone call on their first night. (2.20)

3.10 Reception should be open to receive and administer prisoners during lunchtime. (2.24)

3.11 The reception holding rooms should be regularly cleaned and refurbished, and graffiti removed. (2.25)

3.12 Prisoners presenting with a disability should be offered and given assistance to move from escorting vehicles into reception. (2.26)

3.13 Prisoners should be permitted to take up employment or education on completion of the two-week induction course. (2.27)

3.14 The induction course should be flexible, to give prisoners information to meet their individual requirements. (2.28)

Moorland open

3.15 Prisoners should start the induction programme on the next working day after their arrival. (2.30)

3.16 The induction programme should include information highlighting the differences that prisoners might expect to find in open conditions. (2.31)

Both sites

3.17 All prisoners should be able to access the prison shop within 24 hours of arrival. (2.17)

3.18 Prisoner Insiders should be used to provide information to newly arrived prisoners. (2.19)

Residential units

Moorland closed

3.19 Cells designed for single occupation should not be shared. While they are shared, effective lavatory screening should be provided. (2.32)

3.20 Showers on units 1–4 at Moorland closed should be provided with screening. (2.33)

3.21 The tiling and paintwork in disrepair in the shower units across house blocks 1–4 should be repaired and, where appropriate, shower units refurbished. (2.34)

Moorland open

3.22 Showers at Moorland open should be provided with screening. (2.36)

Both sites

3.23 Cell furniture should be maintained and new or repaired items should be reinstated promptly. (2.37)

3.24 All cells and rooms should be decorated to a satisfactory standard. (2.38)

3.25 In order to maintain the overall fabric and presentation of cell walls, staff should ensure that prisoners display posters and personal articles only in the designated area. (2.40)

3.26 All prisoners should have daily access to telephones. (2.42)

Personal officers

Both sites

3.27 The personal officer scheme should be integrated with the sentence planning process. (2.51)

3.28 The quality of wing history sheet entries should be improved and should reflect face-to-face contact with the prisoner. (2.52)

3.29 Personal officers should be provided with enough time to deal appropriately with their casework. (2.55)

Bullying and violence reduction

Moorland closed

3.30 The policy for the prisoner development unit should clearly outline the management of alleged bullies on the unit, and referral to the unit should be consistently applied across the establishment. (2.75)

3.31 The safer custody meeting should investigate the low number of prisoners placed on anti-bullying measures compared with the number of bullying investigations which have been undertaken. (2.76)

3.32 Insiders who are used for violence reduction matters should receive formal training, and their role and responsibility should be made clear to them and to staff and prisoners across the establishment. (2.77)

Moorland open

3.33 The anti-bullying strategy should be consistently applied as written across both sites. (2.59)

Both sites

3.34 Both sites should develop their own anti-bullying strategy or sub-strategies as the current practice is not entirely transferable. (2.60)

3.35 Interventions should be introduced for all prisoners identified as bullies. (2.64)

3.36 A reporting helpline number should be published for families and friends to report bullying. (2.65)

3.37 A victim support protocol should be developed to standardise the support provided to prisoners who have been bullied and should take account of the specific needs of both sites. (2.66)

3.38 The use and quality of victim support plans should be monitored at the safer custody meetings. (2.67)

3.39 All victims should be offered a victim support plan. (2.68)

3.40 Staff should receive anti-bullying training. (2.69)

Diversity

Both sites

3.41 All aspects of diversity for prisoners should continue to be developed to provide a comprehensive service on both sites. (2.93)

Race equality

Moorland open

3.42 Race equality services on the open site should be developed in line with those on the closed site, with additional close managerial support provided. (2.100)

Both sites

3.43 All staff should be trained in cultural, racial and diversity issues. (2.95)

3.44 Boxes for submitting racist incident report forms (RIRFs) should be clearly marked. (2.104)

3.45 External and independent scrutiny of RIRFs should be introduced and recommendations from this acted upon. (2.105)

3.46 The internal monitoring of RIRFs by a member of the senior management team and an independent monitoring board member should continue. (2.106)

Foreign national prisoners

Moorland open

3.47 Systems should be introduced to ensure that the needs of foreign national prisoners are met on the open site and governance arrangements through the race equality action team should be improved. (2.113)

Both sites

3.48 There should be a distinct foreign nationals coordinator responsible for the open site conversant with the needs of foreign national prisoners and the local policy. (2.108)

Substance use

Both sites

3.49 The establishment should develop an alcohol strategy and services based on the needs of its population, particularly those of young people. (2.120)

3.50 Action plans relating to the drug strategy should be included in the main strategy document. (2.122)

3.51 The voluntary drug testing (VDT) scheme should be reviewed and the role of the VDT unit clarified. The review should take the needs of young people into account. (2.124)

Health services

Moorland closed

3.52 The management and use of controlled drugs should be in line with current legislation and discrepancies reported to the accountable officer. (2.127)

3.53 Stock should be audited to ensure its proper use; the use of patient-named medication is to be recommended. (2.128)

3.54 The address of the supplying pharmacy should be included on any labelled medication. (2.129)

3.55 The crisis suite should not be located in healthcare and the management of it should not be a healthcare responsibility. (2.132)

3.56 Healthcare staff should ensure prescription and administration charts are completed properly. Where medication has not been given, it should say why. (2.135)

3.57 The in-patient regime should be reviewed to ensure patients are out of their rooms as much as possible within the core day and staff should be more proactive in engaging with prisoners. (2.137)

3.58 Inpatients should have access to the same range of activities, including daily showers, as other prisoners. (2.138)

3.59 The inpatient association room should be redecorated and comfortable seating provided. (2.139)

3.60 Nurses should follow Nursing & Midwifery Council guidelines for the administration of medications. This includes ensuring that prescription only medications are legally prescribed for the patient prior to administration. (2.146)

Moorland open

3.61 Checks of the resuscitation equipment should include ensuring that all equipment is fit for use. (2.141)

3.62 Prisoners should be provided with written information about healthcare services. (2.143)

3.63 In-possession risk assessments should be undertaken for all patients; the risk assessments of each drug and patient should be documented, and any the reasons for the determination recorded and adhered to. (2.145)

Both sites

3.64 The drugs and therapeutics committee should develop patient group directions for a range of medications, including vaccinations. (2.147)

3.65 Meningitis C vaccines should be offered to prisoners under the age of 24 years. (2.148)

3.66 A primary care mental health needs assessment should be carried out. This should determine the level of need for primary mental health support and the staffing levels and skill mix required to establish and maintain the service. (2.150)

3.67 Care pathways and protocols should be introduced. (2.151)

3.68 Registered mental health nurses should provide mental health care and not be used as generic nurses. (2.152)

3.69 Effective joint working with the mental health in-reach team should be established and maintained. (2.153)

3.70 All clinical policies and protocols should be evidence-based, signed, dated and regularly reviewed. (2.155)

3.71 Additional and appropriately qualified administrative assistance should be identified for both sites. (2.156)

3.72 Monthly healthcare team meetings should include members of the wider multidisciplinary team, as well as nurses and administrative staff. (2.160)

3.73 Clinical supervision should be identified, and protected time allocated to facilitate it. (2.161)

3.74 A programme of change management should be identified to assist staff to manage change within their area of concern. (2.163)

3.75 Triage algorithms should be used to ensure consistency of nursing assessment. (2.164)

3.76 Up to date reference sources should be available and out-of-date ones removed. The BNF for children is the most appropriate reference source for medication supplies to adolescents. (2.166)

3.77 The medicines and therapeutics committee should undertake audits of the usage of medications. (2.169)

3.78 The Service Level Agreement should be reviewed to ensure that patients in prison receive a similar service to that in the community, with prisoner access to a pharmacist for advice. (2.171)

3.79 A dental therapist should be employed to undertake simple treatment and health promotion. (2.175)

3.80 There should be dedicated staff at the open site, with the seniority, skills, knowledge and competencies to develop a comprehensive nurse-led service to meet the needs of the prison population. (2.184)

3.81 Those prisoners from Moorland open who are able to access primary care services in the community should be encouraged to do so and be assisted, if necessary, as part of their resettlement programme. (2.185)

3.82 The role of the prisoner orderly on the open site should be reviewed. (2.186)

3.83 Prisoners should have access to their prescribed medication on the day of their arrival at Moorland closed. (2.187)

3.84 The treatment room on house block 1 should not be used by IDTS and primary health services nurses at the same time. (2.188)

3.85 Prisoners with life-long conditions should have access to clinics run by appropriately skilled staff. (2.189)

3.86 Patients should be able to access GP appointments in a timely manner. (2.190)

3.87 An infection control audit of both healthcare suites should be carried out and any deficiencies addressed as a matter of urgency. (2.191)

3.88 New flooring should be provided in the dental surgery. (2.192)

Learning and skills and work activities

Moorland closed

3.89 The library should be given more priority to ensure that sessions are not cancelled and prisoners received adequate visits. (2.194)

Both sites

3.90 There should be a wider range of vocational training courses to ensure that the needs of prisoners are met. (2.196)

Faith and religious activity

Both sites

3.91 All prisoners should be able to practice their religion fully. (2.208)

3.92 The work of the chaplaincy should be properly resourced to ensure that it can carry out the full range of duties. (2.210)

Time out of cell

Both sites

3.93 A full hour of exercise should be provided on both sites for those who wish to participate. (2.214)

3.94 Out of cell activities should be improved, particularly for young adults. (2.216)

3.95 Young adults should be allowed the same amount of association time as adult prisoners. (2.222)

3.96 The prison core day should be consistently delivered as published. (2.223)

3.97 Monitoring figures should accurately reflect the amount of time that prisoners spend unlocked from their cells. (2.224)

3.98 All prisoners should receive 10 hours out of cell each day. (2.225)

Security and rules

Moorland closed

3.99 Security information should be cross-referenced with other information, such as safer custody data, to ensure the best targeting of action. (2.227)

3.100 The practise of transferring out segregated prisoners should cease, except in the most extreme circumstances. Prisoners placed on good order or discipline should be case-managed by segregation unit managers to enable return to normal location. (2.228)

Discipline

Moorland closed

3.101 Managers should record in detail the reasons behind their authorisation of the use of special accommodation, including why less intrusive measures are not appropriate. (2.230)

3.102 Use of force paperwork should be collated speedily and scrutinised to ensure that procedures have been carried out correctly and determine whether any lessons can be learnt. (2.232)

3.103 Trends in the use of force and use of the special cell should be monitored over time so that strategies can be introduced to identify high-risk activities, areas and times, and to reduce these types of interventions. (2.233)

3.104 Information about the occupancy of the segregation unit should be developed and monitored over time to assist managers in reducing time spent in the unit. (2.234)

Both sites

3.105 There should be no collective punishments. Individuals failing to complete work or breaching rules should be dealt with through the appropriate mechanisms. (2.244)

3.106 Prisoners who are segregated for any length of time should have risk-assessed access to core activities. (2.245)

3.107 The high level of the use of force should be investigated and strategies developed to reduce it. (2.246)

Incentives and earned privileges

Both sites

3.108 Links between the incentives and earned privileges and resettlement (sentence planning) policies should be strengthened. (2.248)

3.109 Prisoners on the basic regime should have access to showers and telephones every day. (2.253)

3.110 There should be sufficient difference between the levels of the incentives and earned privileges scheme to encourage responsible behaviour. (2.257)

Catering

Moorland closed

3.111 Breakfast packs should be issued on the morning they are to be eaten. (2.258)

Prison shop

Both sites

3.112 When ordering goods, prisoners should not have to surrender old goods until the new ones are received. (2.260)

Strategic management of resettlement

Both sites

3.113 Attendance at the resettlement committee should be improved to incorporate all relevant departments. (2.262)

3.114 The resettlement committee should take a more strategic focus on resettlement and an action plan should be devised to plan the developmental work of the function. (2.263)

Offender management and planning

Moorland closed

3.115 Life-sentenced prisoners should be encouraged to invite family members or a friend to review boards. (2.265)

Both sites

3.116 All residential staff should receive awareness training on OASys. (2.271)

Resettlement pathways

Moorland closed

3.117 The entry and search area for visitors at Moorland closed should be redesigned to provide adequate space and privacy. (2.278)

3.118 The provision of offending behaviour programmes should be reviewed to ensure that all prisoners assessed as needing a programme are able to complete it during their sentence. (2.282)

3.119 There should be provision for alcohol awareness offending behaviour programmes. (2.283)

Moorland open

3.120 Healthcare should be involved in the resettlement of prisoners; this should include providing prisoners with information on how to access primary care services on release and support in accessing the services if required. (2.284)

Both sites

3.121 Suitably skilled and trained prisoners should be used to assist in the provision of housing and other resettlement advice. (2.285)

3.122 The CARAT service should be resourced to offer a range of group work modules to meet the need of adults and young people across the two sites. (2.287)

3.123 The establishment should provide adequate access to a dedicated counselling service. (2.289)

3.124 The potential need for additional or extended visits sessions on both sites should be reviewed at least annually to ensure that all prisoners who wish to are able to receive visits. (2.290)

3.125 Structured aftercare support should be provided to prisoners completing the P-ASRO programme, and a peer support scheme should be developed. (2.291)

3.126 Prisoners should be assisted in opening a bank account. (2.305)

3.127 Relationship and parenting courses should be available as stand-alone modules. (2.306)

3.128 The provision of children and/or family days should be extended. (2.307)

3.129 Entry and search procedures should be improved to ensure that visitors do not experience unnecessary delays and have the opportunity to spend the maximum possible time on the visit. (2.308)

3.130 Visitors should always be able to purchase hot drinks and other refreshments while at the visitors' centre and during the visit. (2.309)

Appendix I: Inspection team

Sara Snell	Team leader
Karen Dillon	Inspector
Gail Hunt	Inspector
Vinnett Pearcy	Inspector
Gordon Riach	Inspector
Elizabeth Tysoe	Health services inspector
Mandy Whittingham	Health services inspector
Susan Melvin	Pharmacy inspector
Bob Cowdrey	Ofsted inspector

Appendix II: Prison population profile

Moorland closed[1]

(i) Status	Number	%
Sentenced	732	*95*
Detainees (single power status)	34	*4*
Detainees (dual power status)	5	*1*
Total	771	100

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	16	*2*
6 months to less than 12 months	27	*3*
12 months to less than 2 years	76	*10*
2 years to less than 4 years	123	*16*
4 years to less than 10 years	290	*38*
10 years and over (not life)	14	*2*
Life	133	*17*
Information not available	92	*12*
Total	771	100

(iii) Length of stay	Sentenced prisoners	
	Number	%
Less than 1 month	130	*17*
1 month to 3 months	166	*21*
3 months to 6 months	188	*24*
6 months to 1 year	172	*23*
1 year to 2 years	87	*11*
2 years to 4 years	28	*4*
4 years or more	0	*0*
Total	771	100

[1] These are printed as received

(iv) Main offence	Number	%
Violence against the person	242	*32*
Sexual offences	2	*0*
Burglary	108	*14*
Robbery	170	*22*
Theft and handling	21	*3*
Fraud and forgery	6	*1*
Drugs offences	110	*14*
Other offences	102	*13*
Civil offences	1	*0*
Offence not recorded/ holding warrant	9	*1*
Total	771	100

(v) Age	Number	%
18 years to 20 years	290	*38*
21 years to 29 years	295	*39*
30 years to 39 years	122	*16*
40 years to 49 years	50	*6*
50 years to 59 years	9	*1*
60 years to 69 years	5	*0*
Please state maximum age	66	
Total	771	100

(vi) Nationality	Number	%
British	729	*94.5*
Foreign nationals	42	*5.5*
Total	771	*100*

(vii) Ethnicity	Number of prisoners	%
White:		
British	594	*77*
Irish	4	*0.5*
Other White	16	*2*
Mixed:		

White and Black Caribbean	22	*3*
White and Black African	2	*0.3*
White and Asian	3	*0.4*
Other Mixed	10	*1*
Asian or Asian British:		
Indian	5	*0.6*
Pakistani	26	*3.5*
Bangladeshi	3	*0.4*
Other Asian	20	*3*
Black or Black British:		
Caribbean	29	*4*
African	8	*1*
Other Black	24	*3*
Chinese or other ethnic group:		
Chinese	1	*0.1*
Other ethnic group	1	*0.1*
Total	768	*99.9*

(viii) Religion	Number	%
Baptist	173	*22*
Church of England	114	*15*
Roman Catholic	7	*1*
Other Christian denominations	89	*12*
Muslim	Information not available	
Sikh	3	*0.5*
Buddhist	7	*1*
Jewish	0	
Other	17	*2*
No religion	361	*47*
Total	771	*100.5*

Moorland open

(i) Status	Number	%
Sentenced	252	*100*
Detainees (single power status)	0	
Detainees (dual power status)	0	
Total	252	100

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	16	*6.4*
6 months to less than 12 months	12	*4.7*
12 months to less than 2 years	26	*10.3*
2 years to less than 4 years	49	*19.4*
4 years to less than 10 years	119	*47.2*
10 years and over (not life)	28	*11.2*
Life	2	*0.8*
Total	252	100

(iii) Length of stay	Sentenced prisoners	
	Number	%
Information not available		
Total		

(iv) Main offence	Number	%
Information not available		
Total		

(v) Age	Number	%
21 years to 29 years	58	*23*
30 years to 39 years	54	*21.4*
40 years to 49 years	48	*19*
50 years to 59 years	14	*5.6*
60 years to 69 years	2	*0.8*

Information not available	76	*30.2*
Total	252	100

(vi) Home address	Number	%
Within 50 miles of the prison	146	*58*
Between 50 and 100 miles of the prison	40	*15.8*
Over 100 miles from the prison	60	*23.8*
Overseas	1	*0.4*
No fixed address	5	*2*
Total	252	100

(vii) Nationality	Number	%
British	246	*97.6*
Foreign nationals	6	*2.4*
Total	252	100

(viii) Ethnicity	Number of prisoners	%
White:		
British	208	*82.4*
Irish	2	*0.8*
Other White	4	*1.6*
Mixed:		
White and Black Caribbean	2	*0.8*
Other Mixed	1	*0.4*
Asian or Asian British:		
Indian	9	*3.6*
Pakistani	7	*2.8*
Bangladeshi	0	*0*
Other Asian	6	*2.4*
Black or Black British:		
Caribbean	7	*2.8*
African	0	*0*
Other Black	3	*1.2*
Chinese or other ethnic group:		
Chinese	2	*0.8*

Other ethnic group	1	*0.4*
Total	252	100

(ix) Religion	Number	%
Baptist	1	*0.4*
Church of England	73	*28.4*
Roman Catholic	33	*13.2*
Other Christian denominations	5	*2*
Muslim	19	*7.6*
Sikh	3	*1.2*
Buddhist	4	*1.6*
Jewish	3	*1.2*
Other	3	*1.2*
No religion	108	*43.2*
Total	252	100