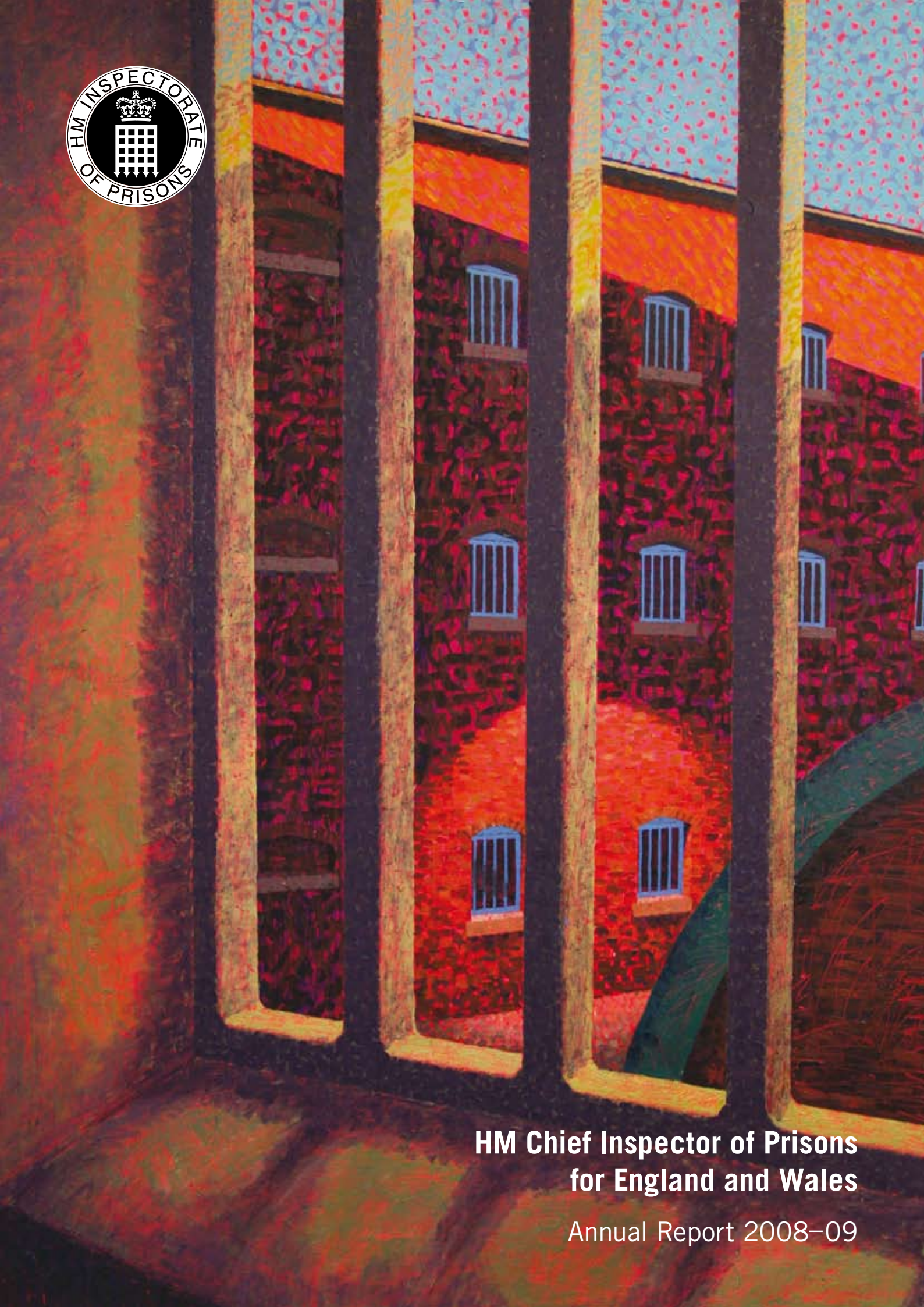

HM Chief Inspector of Prisons for England and Wales

Annual Report 2008–09

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Statement of purpose

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

Value statements

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

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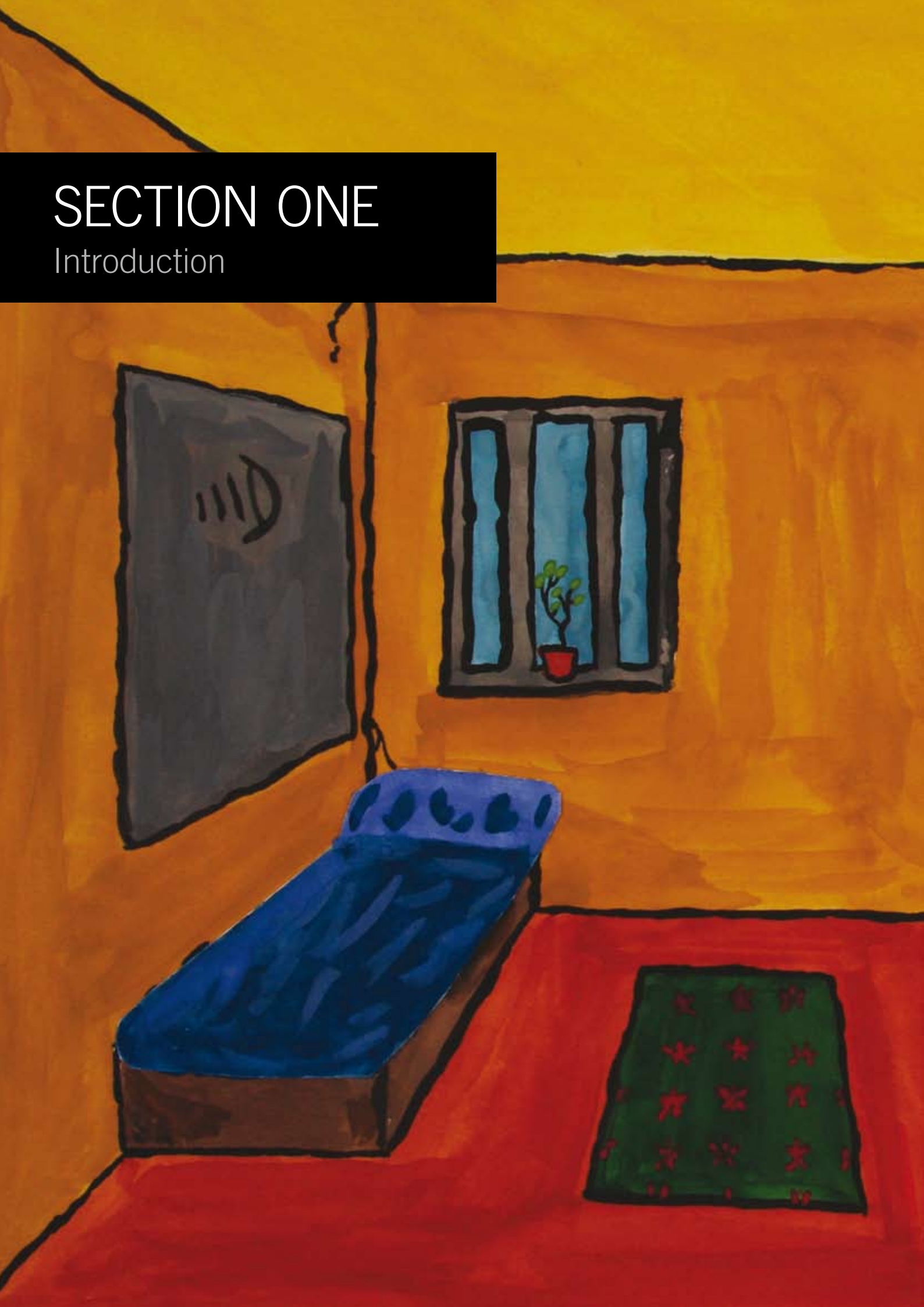
Introduction



Dame Anne Owers
Chief Inspector of Prisons

This is my eighth and last annual report as Chief Inspector of Prisons. It has been the Inspectorate's busiest year, with 103 reports and publications designed to improve treatment and conditions in a range of custodial environments.

2009 saw the expansion and reinforcement of the Inspectorate's role as an independent guarantor of best practice and human rights in places of custody. The UK's National Preventive Mechanism (NPM) was established under the Optional Protocol to the UN Convention against Torture and Inhuman and Degrading Treatment. The NPM consists of 18 existing bodies throughout the UK, which are independent and have the right regularly to inspect all places of detention. It is coordinated by this Inspectorate and reports to the UN treaty body.

This has resulted in increased cooperation with other independent monitors and inspectorates both at national and international level. It has also led to an expansion of our own inspectorial work – a regular programme of joint inspection, with HM Inspectorate of Constabulary, of police custody, and a firming up of our role in inspecting military detention.

Though our workload and range of activity has increased, our effectiveness has not diminished. Last year alone, we were able to establish that over 2,800 inspection recommendations had been achieved, wholly or partially, in prisons and places of immigration detention.

The independent findings of the Inspectorate are rightly taken very seriously. The downside of this was, however, apparent in the decision of some managers at Wandsworth and Pentonville to swap difficult prisoners for the duration of their respective inspections. This was both unacceptable and pointless – indeed it overshadowed the undoubted progress made in both prisons. By making the welfare of prisoners subordinate to the desire to impress inspectors, it fundamentally misunderstood, and indeed undermined, the purpose and methodology of inspection. One consequence is that we have asked for, and been promised, additional resources to carry out more unannounced inspections in future.

There are some positive features in the prison system that we report on this year, compared to the one I first reported on in 2002. In prisons, 72% of our assessments were positive – though this was significantly lower in closed male prisons. That is nevertheless an impressive record, in a prison system which is struggling with the

twin pressures of increased population and decreasing resources. It reflects the hard work of many prison governors and staff and the operational strength of the system.

The sections on health and education show the impact of considerable investment of professional resources, in terms of the quality and relevance of what is provided. This has been assisted by joint inspection activity – we have worked closely with education and health inspectorates throughout the UK. Yet that investment, and our inspection, has also exposed the scale of the need: for mental health services and for a sufficient quantity of skills-based activity. Primary mental health services in particular remain stretched, and fewer than two-thirds of so-called training prisons were assessed as providing sufficient purposeful activity.

The number and rate of self-inflicted deaths in prison has declined, from 95 in 2002 (133 per 100,000 prisoners) to 60 in each of the last two years (73 per 100,000). Increased support and proper detoxification in the early days of custody, when prisoners are at their most vulnerable, have contributed to this. But this should not disguise the inherent vulnerability of many of those in prison, particularly those who are new – half the suicides in 2009 were unsentenced prisoners, only 16% of the prison population. In spite of better procedures for managing those at risk, and investigating why deaths occur, prisons still struggle to deal with the underlying causes of suicide and self-harm. This is most evident in women's prisons, where, though suicide rates have dropped significantly, self-harm remains both prevalent and shocking, and is in many cases contained rather than addressed. Less obvious, but equally troubling, are the links between violence, self-harm and mental illness in men's prisons – where violence reduction strategies are in general under-developed and inadequately implemented.

The focus on decency, over the last decade or so, has changed the culture in prisons and the expectations of staff. Pockets of disrespect or even abuse remain, but they are exceptions. However, moving on from preventing abuse to promoting positive engagement has proved more difficult. Effective personal officer schemes remain a considerable rarity – we found only one this year. As the diversity section shows, the reported experience of prisoners from minority groups – by ethnicity, religion, nationality or disability – remains noticeably poorer than others'.

Resettlement, which I described as 'essentially an add-on' in 2002, is now seen as a core part of prisons' function. Jointly run, and jointly inspected, offender management is designed to provide end-to-end case management through custody and the community – though so far only for a minority of prisoners and with varied degrees of engagement and expertise. The seven 'resettlement pathways' define the actual and practical support necessary for reintegration. Some are relatively well developed, and it is welcome to see a greater focus on the hitherto neglected area of children and families – though there is much more to be done. Yet coherent custody planning for the majority of short-term and remanded prisoners, often serial reoffenders, has if anything declined, with the emphasis on providing offender management for the minority. The new 'layered' approach aims to redress this, but in the context of reduced and restricted resources in the system as a whole.

The experience of minority groups within the prison population – women, children and young adults – remains mixed. For the first time since 2001, the population of under-18s in the prison system has dropped below 2,000 – by the end of 2009, it showed a 21% decrease from a year ago. In prisons themselves, the establishment of the small units for girls, and the excellent Keppel Unit for some of the most disturbed boys, shows what can be done. By contrast, there remain problems of safety, control and under-activity within the large male establishments, exacerbated by poor design and limited funding for education and training.

There has been a considerable and welcome drive, led at Ministerial level, to make significant reductions in the women's prison population and invest resources outside prison, as recommended in the Corston report. As yet, the impact is relatively small: the women's prison population fell slightly, by 3%, during 2009, but remains over 4,000 – 15% higher than when I became Chief Inspector, and more than twice as high as in 1995. Within the prison system, the re-roling of women's prisons to hold men has resulted in more complex establishments, with many women further from home and family, and there is still a significant number for whom prison is an entirely inappropriate and unnecessary setting.

By contrast, there has been no discernable progress for young adults in prison. The relevant section of this report concludes, in almost identical terms to those I used in 2002: 'This is still a neglected and under-resourced age-group. The high rate of reoffending among young adult men is unlikely to reduce without significant changes in approach, funding and focus.'

In general, the prison system, in spite of the progress it has made, remains caught between the irresistible force of an increasing population and the immovable object of actual and threatened budget cuts. The consequences of overcrowding and population pressure have been themes running through all my annual reports. There are 28% more men in prison than when I became Chief Inspector, and one in 15 of them are serving indeterminate sentences for public protection, without the resources to support them and provide the interventions they need. That sentence is, and will remain, a significant driver of the prison population.

Population pressure affects the whole system – stretching resources and managerial energy, keeping in use buildings that ought to be condemned, doubling up prisoners in cramped cells, and leading to unnecessary and destabilising prisoner moves. All of this compromises successful rehabilitation. This year, in spite of a new population high of 84,700, a building programme has more or less kept pace with population growth, and more is planned. But this raises its own problems. Despite the welcome decision not to build the huge 2,500-bed Titan prisons, existing and planned prisons are bigger and more complex than ever. Some are run in 'clusters'; others, particularly training prisons, have virtually doubled in size.

As the population expands, resources are under increased threat. The cuts already announced for next year come on top of

already sliced budgets, with the possibility of even more cuts later. The hidden and incremental pressures this produces should not be underestimated, even though they are at present being contained. As I said last year, there are two risks: of increased instability in inherently fragile environments, and of reducing prisons' capacity to rehabilitate those they hold.

The new benchmarking process for key regime activities is at least honest – clarifying what can actually be delivered within limited resources. But it is also an exercise in regression to the mean. Prisons doing excellent work are being told to aim for the bronze standard; prisons with full employment are told that this will not be affordable; innovative work, outside formal and mandated interventions, is under threat. All the images in this report are from the outstanding artistic work done by prisoners and showcased in the 2009 Koestler exhibition at London's South Bank. There cannot be a clearer example of how art, drama and other 'soft' skills can unlock talent and grow the self-esteem that is essential if men and women are to be able to change the narrative of their lives – and how important it is to preserve this.

But investment in prisons alone cannot achieve this. In my first annual report, I said: 'It is vitally important that energies and resources are not wholly diverted into crisis management, building more of the same – more spaces in existing prisons, or large new prisons. Prison can do little for those held for short periods. It needs to be one of a range of viable alternatives available to the courts…' That is just as true today as it was then. It was powerfully reiterated in the recent report of the all-party Justice Committee, which described the current system and prison-building proposals as unsustainable and recommended justice reinvestment – 'shifting resources away from incarceration towards rehabilitation and prevention'.

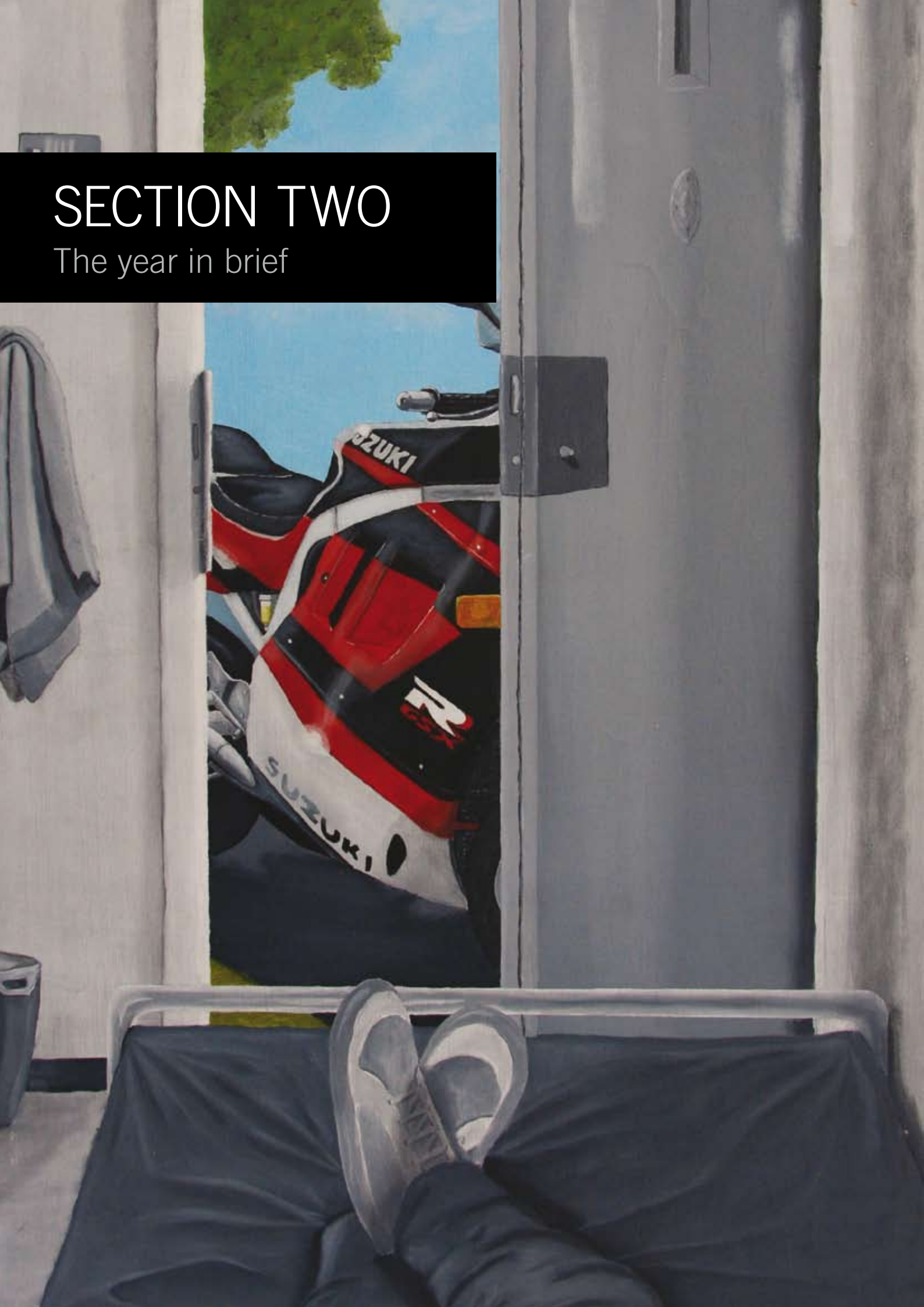
Prisons are our largest area of work, but our broader custodial remit casts light on other forms of detention. Independent inspection forces organisations to look again at some of their accepted practices and norms. Early immigration detention inspections revealed some hidden problems and issues. There have as a result been some changes – for example, increased activities and better welfare provision in immigration removal centres, and the positive approach taken by G4S, the main company running short-term holding facilities. There are, however, some worrying signs that progress has stalled, or even reversed. In contrast to prisons, there were fewer positive inspection assessments of removal centres than there were last year. There was also evidence of reversion to a prison environment and approach, and detainees' perceptions of relationships with staff have deteriorated over time. This is not the case in all removal centres, but should be of concern to the UK Border Agency (UKBA), as the detainee population is set to increase. It is particularly concerning that all new removal centres are being built to prison-like specifications.

Most recently, inspections of police custody have focused on this important area. They have in general confirmed that detainees were properly treated and their legal rights

respected. But they have also revealed some underlying problems which require local or national attention – such as healthcare, the retention of forensic samples, the specialist care of juveniles and women, the physical state of some custody suites and the monitoring of use of force and complaints. This has been a challenge to services and managers, but we have been encouraged by the positive response of forces and police authorities to our concerns. We have had a similarly positive response from those responsible for military detention in the UK, since we began inspecting the Military Corrective and Training Centre in 2004. That is why independent custodial inspection, based on regular but unpredictable visits, is fundamentally important, and is now an international as well as a domestic requirement.

Inspection has had a demonstrable effect on the operation of custodial facilities in all kinds of environments, and on the outcomes for prisoners and detainees. That has been possible because of the specialised nature of the Inspectorate's role, the expertise and commitment of its staff, and its human rights focus, methodology and values.

Those values are set out on the opening page of this report. They define the Inspectorate's work and the reasons why it has been, and must continue to be, a necessary part of ensuring decent and effective prisons and places of detention.



SECTION TWO

The year in brief

Summary

During the reporting year (September 2008 to August 2009) we inspected a total of 93 custodial establishments:

- 36 adult male prisons, 6 adult female prisons, 8 male young adult and 10 juvenile establishments and units in England and Wales
- 6 immigration removal centres (IRCs) and 15 short-term holding facilities (STHFs) and escorts
- 1 prison in Northern Ireland and 1 in Guernsey
- the military corrective and training centre
- 9 police custody suites (jointly with HM Inspectorate of Constabulary).

93
custodial establishments inspected

103
reports and publications produced

12
joint inspections and reports

Of the 62 prison inspections, 34 were announced, as were three of the six IRC inspections and all of the STHF inspections.

All inspections were carried out jointly with Ofsted in England, Estyn in Wales or the Education and Training Inspectorate in Northern Ireland; all full inspections were carried out with the Care Quality Commission (or its equivalent in other jurisdictions), the Dental Services Division of the NHS Business Services Authority, and the Royal Pharmaceutical Society. In addition, we and HM Inspectorate of Probation carried out offender management inspections in the course of prison inspections in 12 prisons.

This joint approach minimises the impact on inspected organisations, as well as allowing us to obtain a full picture of a custodial establishment, in which education, healthcare and offender management should be integral parts.

In addition, we participated in:

- an HM Inspectorate of Probation led follow-up thematic inspection of indeterminate sentences for public protection
- an HM Inspectorate of Probation led inspection of mentally disordered offenders in the community
- a thematic inspection led by HM Inspectorate of Court Administration (HMICA) of information exchange and security of data
- a thematic report into juvenile gangs (jointly with HM Inspectorate of Probation and HM Inspectorate of Constabulary)
- the comprehensive area assessments undertaken by the Audit Commission.

We worked on thematic reviews on:
- Muslim prisoners
- women in prison

and developed criteria for the inspection of police custody.

We published 103 reports on:
- 65 prisons and young offender institutions in England and Wales
- 1 prison in Northern Ireland
- 1 prison in Guernsey
- 6 IRCs, 11 STHFs and 2 escorts
- 6 police custody suites
- the military corrective and training centre
- indeterminate sentences for public protection
- the characteristics of prisons performing well
- disabled prisoners
- detainee escorts and removals
- women and race
- children and young people in prison
- alcohol services for prisoners.

We also published:
- revised *Expectations* on diversity
- revised Juvenile *Expectations*
- police custody *Expectations*.

We produced:
- surveys of children and young people in 14 juvenile establishments.

We contributed to joint inspection reports on:
- 5 offender management regional inspections
- prolific and priority offenders
- commissioning healthcare.

This year, we also formally took on responsibility for coordinating the UK's National Preventive Mechanism (NPM), required under the UN Optional Protocol for the Prevention of Torture and Inhuman and Degrading Treatment. The NPM is made up of 18 organisations in the four different nations of the UK, covering all forms of detention.

The prison year

Full inspection reports on prisons in England and Wales made 4,513 recommendations for improvement. Ninety-six per cent of recommendations were accepted, wholly or in principle, by the National Offender Management Service (see Appendix three).

Unannounced follow-up inspections found that overall 67% (2,398) of recommendations had been achieved or partially achieved (see Appendix four). This is the same proportion as last year. This year, training prisons had the fewest recommendations achieved, with 37% unachieved, and this may reflect the fact that they are finding it increasingly difficult to provide enough activity for their increased populations. Open prisons and women's prisons did much better, achieving virtually three-quarters of recommendations.

96%
of prison recommendations were accepted

67%
(2,398) of prison recommendations had been implemented wholly or partially

As in previous years, there were differences between establishments of the same type. The two training prisons on the Isle of Wight, Parkhurst and Camp Hill, each failed to achieve 56% of recommendations, reflecting a 'learned helplessness' that we recorded there. By contrast, two other trainers had fewer than 25% of recommendations unachieved. Similarly, in young adult prisons, Rochester had failed to achieve 47% of recommendations, compared with fewer than 25% at Thorn Cross and Swinfen Hall. In all functional categories, it was clear that prisons that were already good found it easier to improve.

Our reports assess each establishment against four healthy prison tests – safety, respect, purposeful activity and resettlement – to determine whether it is performing well or reasonably well (positive assessments) or not sufficiently well or poorly (negative assessments).

72%
of prison assessments were positive; open prisons did much better than male and young adult closed prisons

As last year, 72% of assessments, across all functional types of prison, were positive. This is encouraging, but there were significant differentials between prison types. Closed young adult prisons only achieved 63% of positive assessments, and male training and male local prisons only achieved 67%, compared with 100% in resettlement prisons and the small units for young women.

Positive safety assessments continued to rise overall, to 72%, and this held up in male local and training prisons, unlike last year. However, it was of some concern that fewer than half of male juvenile establishments, and just over half of closed women's prisons, were performing well or reasonably well against this test. Two training prisons, Haverigg and Parkhurst, and one juvenile establishment, Cookham Wood, were assessed as poor.

Positive assessments on respect overall remained virtually the same as last year, at 69%. Here, however, results were poorer in male local and training prisons (56% and 64% respectively) and in women's closed prisons (57%).

Overall, 71% of prisons were assessed positively on activity, but this concealed huge variations. All women's prisons, all open, resettlement and dispersal prisons and all but one of the juvenile establishments were performing well or reasonably well. Fewer than two-thirds of training prisons had positive assessments, in spite of their role, though this was an improvement on last year. Four were performing well, and two poorly. Local prisons performed worse than those inspected last year, with only a third (three prisons out of nine) having a positive assessment. Young adult establishments also did worse than those inspected last year, with only two of the six closed prisons inspected performing well or sufficiently well – even though this is a population much in need of activity and training.

Resettlement assessments remained predominantly positive, at 75% and, as last year, the proportion was even higher in local prisons. The performance of training prisons was by some distance the weakest of any prison type, with just over a half doing well or reasonably well against this key indicator. Given the number of prisoners released every year from these prisons, this is of some concern. By contrast, all but one of the nine local prisons inspected had a positive assessment in this area. Women's prisons did much better than those inspected last year, with all but one performing positively on resettlement. It was disappointing that one open prison, Ford, was not performing sufficiently well in this, its core area of work.

Just over a third of male adult closed prisons inspected this year were assessed positively against all four tests, an improvement on the quarter that achieved this last year. However, four had no positive assessments at all, and a further three had only one out of four. Only two of the seven women's closed prisons, and only one of the six closed young adult establishments, were assessed positively across all tests. Open and resettlement prisons did much better, with six of the seven performing positively across all tests. The two small units for girls were both assessed positively in all areas, compared to fewer than half of the male juvenile establishments.

Prisons assessed positively against all four healthy prison tests:

- 13 out of 36 male adult closed prisons
- 2 out of 7 closed women's prisons
- 1 out of 6 closed young adult prisons
- 3 out of 7 male juvenile establishments
- 2 out of 2 female juvenile establishments
- 6 out of 7 open/resettlement prisons.

Though the overall trend remained upwards, there were still too few prisons that managed to achieve the highest assessment – that they were performing well against any of the four tests. Of 188 assessments in adult and young adult closed prisons, only 15 (8%) considered that a prison was doing well against any one of the four tests. There was only one such assessment in each of male local, young adult and women's prisons. By contrast, in open and resettlement prisons, 16 out of the 28 assessments were 'well', and one, Askham Grange, achieved this against each of the four tests. Grendon, one of the two therapeutic communities inspected, also had two assessments of 'well'.

The immigration detention year

Full inspection reports on immigration removal centres and short-term holding facilities made 308 recommendations for improvement. Ninety-five per cent of those recommendations were accepted, wholly or in principle, by the UK Border Agency (see Appendix three).

Unannounced follow-up inspections found that 66% of recommendations had been achieved, wholly or partially, the same proportion as last year. This varied, however, between centres, with Dungavel achieving 72% against 54% at Dover. We have also begun returning to short-term holding facilities to assess progress against recommendations, and there too we found 65% of recommendations achieved wholly or in part. Improvements were particularly noticeable in the Glasgow holding centres.

95%
of immigration detention recommendations were accepted in 2008–09

65%
(311) of immigration detention recommendations had been implemented wholly or partly

Immigration removal centres are also assessed against four healthy establishment tests of safety, respect, purposeful activity, and preparation for release or removal. They too are given positive assessments (performing well or reasonably well) or negative assessments (performing not sufficiently well or poorly) against each test.

Only 63% of assessments were positive, compared with 68% last year. Only one centre, Dungavel, was assessed positively against all four tests. It was also the only immigration removal centre to be assessed as performing well – the highest assessment – against any of the tests.

63%
of immigration removal centre assessments were positive

Three of the six centres were not judged to be sufficiently safe. However, two-thirds were performing reasonably well on respect.

Assessments of activity had improved considerably, with all but one centre (Campsfield House) performing reasonably well in this area. This reflects a welcome recognition that activity is important, in order to enhance security and reduce anxiety and depression – particularly as a significant proportion of the population will stay for months, not days.

Preparation for release or removal was, however, less good than last year, with half the centres inspected not performing sufficiently well in this important area.

We do not assess short-term holding facilities as such. We did, however, commend G4S, who run all but two of the centres inspected, for the positive approach they have taken to meeting our expectations. By contrast, the two non-G4S centres were much less impressive.

The police custody year

This was the first full year of the regular, funded inspections of police custody jointly carried out by this Inspectorate and HM Inspectorate of Constabulary. We do not yet produce assessments of each area inspected – strategy, treatment and conditions, individual rights and healthcare – nor have we yet carried out any follow-up inspections.

Some themes are, however, developing as the inspection methodology becomes more embedded. It is encouraging that it is very rare to find that the provisions of the Police and Criminal Evidence Act are not properly adhered to, or that suspects are not treated respectfully by staff. However, concerns have arisen about the consistent standard of healthcare provision, the arrangements for juveniles (particularly 17-year-olds for whom no specific provision is made), the governance of use of force and complaints, and the physical state of some facilities.

Inspections have shown that custody is not a key strategic objective in all police forces. Where this is the case, and there is high level interest and effective governance, there are fewer concerns. It is already clear that inspection is focusing attention, in all forces, on the safe and humane treatment of those in police custody.

Other inspection activity

Prisons inspections in Northern Ireland are carried out under the statutory authority of, and in partnership with, the Criminal Justice Inspectorate of Northern Ireland. This year, Maghaberry prison was inspected. This was an extremely disappointing unannounced follow-up inspection. The prison was not performing well or reasonably well in any area, and was assessed as performing poorly in two of the four tests: safety and activity. This was one of the two worst overall assessments in the 62 prisons inspected this year. Fifty-four per cent of recommendations from the previous inspection had not been achieved, including seven of the 11 main recommendations.

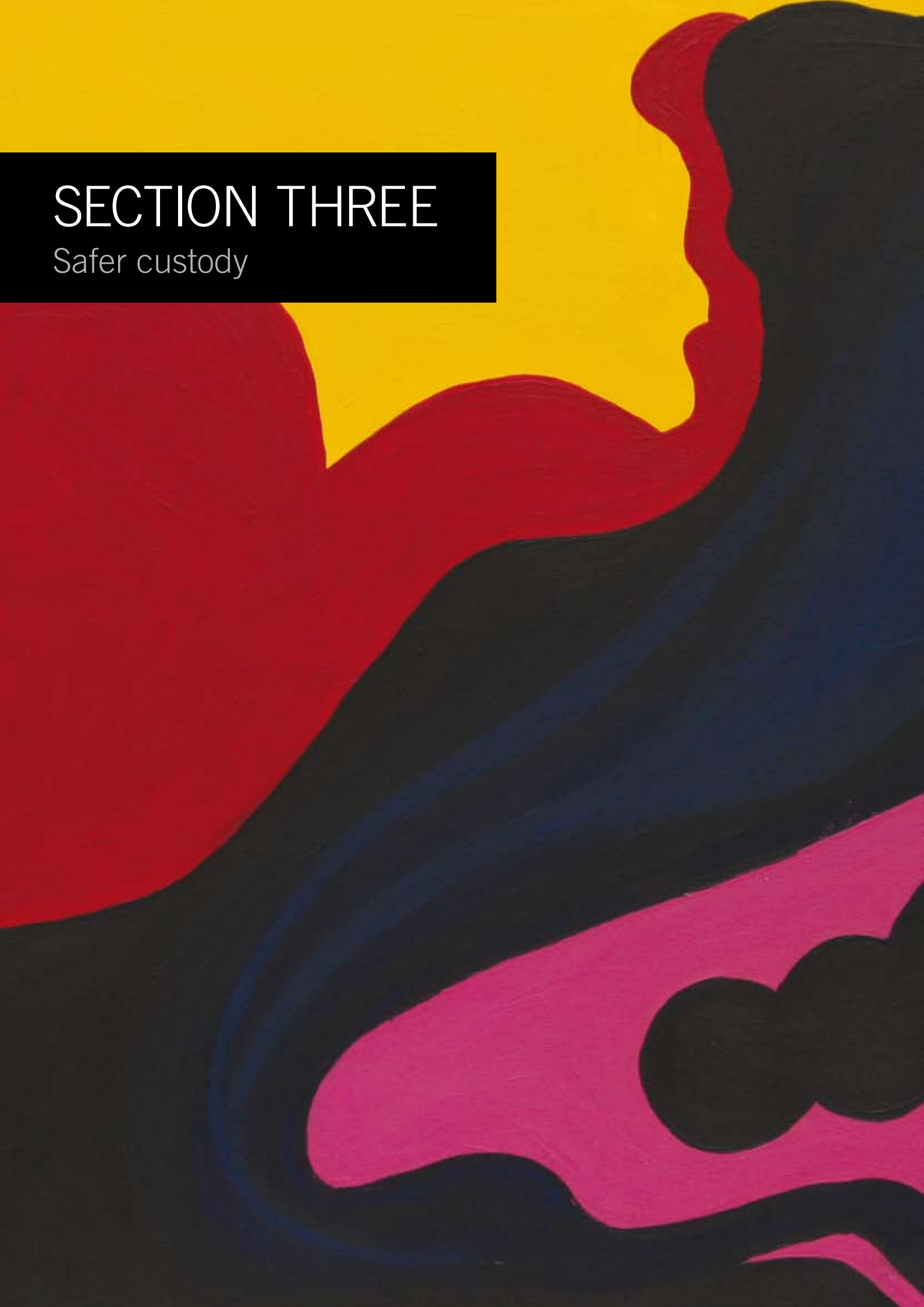
Safety was a particular concern, with weaknesses in violence reduction and suicide prevention procedures, and poor support for those withdrawing from drugs or alcohol. There was little supportive and active engagement from staff and weaknesses in diversity work, complaints procedures and healthcare. Education, training and work provision was described as wholly inadequate. Despite some good reintegration services, resettlement needs, particularly in relation to offending behaviour and addiction, were not met. The Chief Inspectors described this situation as one which could not be permitted to continue and called for stronger governance and accountability arrangements and improved working practices.

This year, we also carried out an unannounced follow-up inspection of the prison on Guernsey. It was assessed as performing reasonably well in three of the four healthy prison areas. This represented progress in a number of areas since the last inspection, helped by a reduced population. Safety and security had improved, and the prison was less overcrowded. Some good joint resettlement work was being carried out. However, provision and facilities for women and children were inadequate and there was too little purposeful activity. The Inspectorate once again called for separate and more appropriate accommodation for women and children and a better range of work and accredited training.

Finally, we carried out our third independent inspection of the Military Corrective and Training Centre at Colchester. The centre was found to be performing reasonably well in safety, respect and activity, but we found that the resettlement work had not kept pace with the needs of young men and women leaving the centre or the armed services. Pressures on the Provost Marshal's staff, often redeployed overseas, had reduced the centre's ability to make hoped-for progress in all areas. However, we commended the approach and drive of senior staff and the commitment of the custodial staff. We recommended increased resources for the Provost Marshal's staff and the development of a range of resettlement and reintegration services.

SECTION THREE

Safer custody



Violence reduction

Prisoners' perceptions of safety in our surveys varied considerably, even among establishments of the same functional type. Unsurprisingly, it was highest in open prisons and lowest in dispersals. But the range of perceptions in all other functional types was wide.

Table 1 – Have you ever felt unsafe in this prison?

Prison type	Highest %	Lowest %	Overall %
Local prisons	56	21	45
Cat C training prisons	48	18	34
Young adult prisons	45	32	35
Cat B training prisons	50	33	42
Dispersal prisons	66	55	59
Female closed	59	33	48
Open	11	9	10

In category B training prisons, perceptions of safety were closely allied to effective management and staff supervision. This was absent at Parkhurst, where we described bullying and violence as 'endemic'; whereas procedures and relationships were strong at Swaleside.

In all prisons, the links between good staff-prisoner relationships and perceptions of safety were strong. The women's prison where the largest proportion (59%) of women said they had felt unsafe also had the largest proportion (29%) who said they had been victimised by staff. Conversely, in the male category C prison where the lowest percentage (18%) of prisoners had felt unsafe, 86% said staff treated them with respect.

In the category C estate, a great deal depended on size and the availability of drugs. Kennet, a newly-opened 337-bed prison on Merseyside, was performing well on safety, whereas at its near neighbour, Risley, with nearly 1,000 prisoners, twice as many said they had felt unsafe.

At Haverigg, both the design of the old billeted accommodation and the ready availability of drugs made for an extremely unsafe environment, where over a third of prisoners said they had been bullied. Drug availability also impacted on safety at Brixton and Wellingborough.

> Staff themselves chose to walk around in pairs on two units. Nearly half of survey respondents said they had felt unsafe. Many other survey findings on prisoner–prisoner intimidation and the availability of drugs were much worse than at comparator prisons. Haverigg

> Prisoners described Kennet as a safe prison. There was thorough interrogation of all available indicators at the monthly violence reduction meeting and investigation reports were produced for all incidents and unexplained injuries.

Prisoners from minority groups were more likely to feel unsafe. Our thematic review of prisoners with disabilities showed that half had felt unsafe at some time, compared to a third of those without a disability.

Similarly, a higher proportion of black and minority ethnic, Muslim and foreign national prisoners said they had felt unsafe.

Some prisons had well-attended meetings to oversee the delivery of violence reduction strategies, usually under the umbrella of a wider safer custody forum. Some devoted sufficient, and even increased, resources to this work, though very often inspections found that it was not sufficiently embedded, particularly in the work of residential staff on the wings. Some strategies were out of date or did not reflect the current population, and in other prisons staff were routinely cross-deployed or did not have a clear job description. Poor staff-prisoner relationships and inadequate supervision could compound the problem.

Bullying and violence appeared endemic. A startling 75% of vulnerable prisoners reported feeling unsafe. The quality of violence reduction and anti-bullying arrangements was poor and there was poor supervision of prisoners on the wings. Parkhurst

Data collection and analysis of bullying and violence was good in some prisons: for example, Parc, which monitored the nationality and geographical origin of prisoners involved in fights in order to review procedures and develop strategies. More often, though, we found gaps in data analysis – for example, unexplained injuries and security information not being routinely captured or scrutinised – or else that no action was taken on the basis of analysis of data.

We frequently commented on the limited or non-existent training for staff in local violence reduction procedures. This was a key factor undermining effective implementation. It was all too common to find, as at Wellingborough, that there was a well-developed strategy and a large number of referrals, but that staff were untrained and did not understand the strategy. Wymott's own survey reported that only 20% of staff understood the procedures. By contrast, at Wealstun, we found that staff had to complete electronic anti-bullying training, and at Ford there was an easily understood booklet summarising the strategy and procedures.

The comprehensive violence reduction strategy was readily available. In order to promote it and the overall commitment to violence reduction, staff were required to complete electronic anti-bullying training. Wealstun

Action to tackle bullying was often inhibited by this lack of understanding and training. We found many examples of perfunctory, unsophisticated or weak investigations. Bullying was in some cases under-reported, and not effectively dealt with – even for example in Send women's prison, where three previous deaths had been associated with bullying. Monitoring arrangements were usually poor, with little evidence of detailed knowledge of prisoners subject to formal procedures, and weak management checks.

The availability of structured interventions to tackle bullying or antisocial behaviour also varied, though a few prisons had developed innovative procedures for conflict resolution or restorative justice. These could be effective, though they needed to be carefully managed – in one case we found untrained prisoners working without any staff involvement or even knowledge.

Suicide and self-harm

Conflict resolution by trained officers was used to deal with low level disputes between prisoners. Swinfen Hall

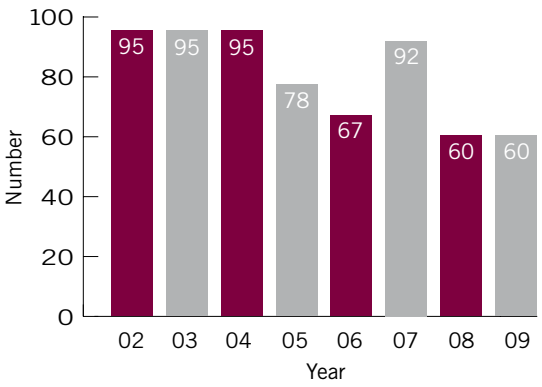
Prisoner representatives had been involved in mediating between prisoners, but had no formal training or support, and on many occasions staff were not involved or informed that they were carrying out mediation. Camp Hill

In a few prisons, there were support services for victims: such as a reintegration programme, counselling or therapeutic day care support. In many, however, there was little or no victim support, even when the strategy required this. In some cases, the only action taken was to relocate the perpetrator to another wing, or the victim to the segregation unit. At Haverigg, for example, the segregation unit was so full of prisoners there for their own protection that it could not be used for punishment. Some prisons had invented units to try to manage the large number of prisoners feeling unsafe or seeking transfer, without any clear definition of the role, operation and management of such locations.

Overall, though there have been some improvements in the understanding of violence reduction and anti-bullying work, many of the weaknesses identified in last year's, and previous years', reports still remain. There is, as yet, little evidence of a holistic approach to ensuring safety in prisons that are increasingly large and volatile, and where regimes and staffing may be reduced because of resource constraints.

This year, last year's downward trend in self-inflicted deaths was maintained. There were 64 deaths in the inspectorate reporting year, as compared with 68 last year, and in the calendar year 2009, there were 60, the same as in 2008, a decline of a third since 2007. As a proportion of the prison population, the rate has dropped from 133 per 100,000 in 2002 to 72 per 100,000 last year.

Graph 1: Self inflicted deaths by calendar year 2002-09



As in previous years, around two-thirds of self-inflicted deaths took place in local prisons, though one in four were in training prisons. A disproportionate number were unsentenced: though only 16% of the population, they accounted for half the deaths. A high proportion of deaths continue to take place in the early days in a new prison. One in three occurred within the first seven days of being in the current prison – an indication of the additional vulnerability at this stage – and 42% occurred within the first 28 days. Foreign national prisoners this year were under-represented in self-inflicted deaths, but life-sentenced prisoners remained over-represented.

In 2009:

50%
of self-inflicted deaths were unsentenced prisoners

32%
had been in their current prison for less than 7 days

42%
had been in their current prison for less than 28 days

Most local prisons were not monitoring near-fatal incidents in order to learn lessons. Where assessment, care in custody and teamwork (ACCT) procedures worked well, there were quality interactions based on strong multi-disciplinary working. However, in many prisons, there was still insufficient evidence of good and multi-disciplinary case management, and too often we found care plans which had vague targets or where action depended on the prisoner. The lack of a consistent case manager also meant that in some cases links were not made between assessments and reviews, or care maps were not updated.

There were poor or minimal interactions with prisoners, poor observations by staff and reviews which did not cover all issues of concern. Some care maps had 'keep safe' recorded as an action with no detail of how or by whom the prisoner was to be kept safe. Hull

One of the factors contributing to a decrease in self-inflicted deaths has been the improved procedures when prisoners enter prison: specifically, first night support and effective detoxification processes. There is evidence that both are improving, though we still found prisons with ineffective support for prisoners in the early days (see substance use section), and the figures above show the vital importance of support at this crucial period.

Some prisoners at risk of self-harm were held in inappropriate conditions, such as segregation units, with insufficient management checks. The use of strip clothing and cells was sometimes not recorded and in one prison, force was used to put men in strip clothing. It was also disturbing that we continued to find those on suicide and self-harm monitoring being placed on the basic regime, without consideration of its effect on their care arrangements.

In local prisons, it was often difficult to retain sufficient Listeners: there were only two to serve the 1,200 men in Wormwood Scrubs. In some other prisons, access to Listeners at night was difficult or impossible.

Procedures were better developed in most training prisons. In two category B training prisons, there had been increased levels of self-harm, and in one, where recorded self-harm had doubled, this was associated specifically with the larger number of prisoners serving indeterminate sentences for public protection (IPPs). It was of concern that the two privately-run category B prisons had no Listener schemes, and in one only a third of prisoners said they were given information on their first day about help or support available.

The general quality of recording and care maps was good. Case reviews were attended by relevant staff and extremely vulnerable cases were sensitively managed, with staff involving family members. Moorland

Self-harm was in general lower in male category C prisons, and in some the quality of care was good. There were two notable exceptions: Risley and Camp Hill. In the former, staff relationships with prisoners were poor and there was over-use of segregation; in the latter, only half the staff had been trained and the standard of documentation was mainly poor.

Most women's prisons were alert to the need to learn from near-fatal incidents and from death in custody investigations, though this was not universal. The main problem in women's prisons was how to effectively manage the most needy women, given the large number of women on ACCT procedures. Reviews were rarely multi-disciplinary, or care plans sufficiently individualised. Eastwood Park had good management and review arrangements, compared with those at Styal (see women's section).

Self-harm remained high in women's closed prisons, especially local prisons. As in previous years, 47% of recorded self-harm incidents involved women, though they were only 5% of the population. Many incidents reflect prolific self-harm by the same women. Three women's local prisons each reported over 1,700 incidents over the year, though there are unexplained variations between prisons, which may represent different ways of recording rather than different patterns of self-harm. Holloway, with a reported 2,256 self-harm incidents, reported over 331 incidents in its worst month – averaging over ten a day.

No incidents of self-harm were, however, reported in the only women's open prison inspected, Askham Grange. This is, at least in part, a reflection of the relaxed environment, with small numbers, ample activity and supportive staff relationships.

Inspections of high security prisons found no evidence of the 'merry-go-round' whereby the management of difficult and self-harming prisoners consisted mainly of transferring them between segregation units. However, we did find over-use of gated cells and under-use of interaction with prisoners at risk in Whitemoor, which had experienced a number of deaths.

Responses to young adults at risk varied considerably. We found poor relationships and ineffective management checks at Lancaster Farms, and an over-use of segregation in other establishments. However, some had developed very good systems of support, with multi-disciplinary input. Thorn Cross open prison had developed a peer mentors' scheme in cooperation with the NSPCC and Childline.

The peer mentor scheme had been devised by Childline and the NSPCC. In total 75 prisoners had been trained, and received follow-up training in listening skills from the Samaritans. Thorn Cross

Segregation and use of force

As is now common, 20 of the segregation units we inspected had been redesignated 'care and reintegration', or 'care and separation' units. However, as last year, the majority of these units offered little more than traditional segregation: with no underpinning policies or protocols outlining the purpose of the unit and how this would be achieved. Prisoners and staff routinely referred to them as segregation units. Routine strip searching continued to be used for those entering segregation – indeed, in one prison, we found that 90% were squat-searched.

A concern this year was the number of establishments holding prisoners in separate cells or units outside formal segregation units. In such cases, the guidance and governance provided in PSO 1700 are not applied and there are no clear protocols for the use of this accommodation.

We welcome the recent revision of PSO 1700, which places more emphasis on care planning, as we found that many units offered little of this. The exceptions were Wormwood Scrubs, where we found good facilities, staff-prisoner relationships and engagement, and Dorchester, Kennet and Featherstone, where we also found care planning and target setting.

Entries in personal files showed that levels of engagement were high. Individual care plans were drawn up, behaviour improvement targets were set and reviewed, and prisoners were moved back to ordinary location quickly. Dorchester

In most male adult and young adult prisons, reviews of prisoners in segregation remained perfunctory: with little emphasis on reintegration to a normal residential unit or meaningful target setting to challenge and address poor behaviour. Sometimes prisoners were not routinely present at their reviews.

Although our own observations and the comments of prisoners confirmed that relationships with staff were generally positive, segregation unit wing files recorded little more than observational or functional records of interactions and engagement.

There was a noticeable lack of specialist training for staff to manage some of the most challenging prisoners, with the exception of Kennet and Wormwood Scrubs where staff had received a full range of training.

In the great majority of cases, we found little more than a basic regime for segregated prisoners and worryingly there were more units where prisoners did not have daily access to washing facilities and telephones. In two prisons, prisoners received their meals at their cell doors. Accommodation was sometimes poor and inadequate.

Communal corridors were ingrained with dirt, despite attempts to keep them clean, walls were damaged, and there was no natural light. Cells were dirty and poorly maintained with graffiti on many walls. In-cell toilets needed deep cleaning. Haverigg

In women's prisons, it remained evident that segregation and the use of force were inadequate ways of dealing with challenging and often self-harming women (see sections on women and suicide and self-harm).

On the whole, we found that adjudications were well conducted. However, in a significant number of reports on male adult prisons this year, we noted insufficient enquiry into disciplinary offences.

Additionally, issues raised by prisoners during adjudications relating to safer custody (bullying and feelings of safety) and substance use were not always followed up. In one establishment, we found that minor offences were routinely referred to the district judge for added days.

In young adult establishments, the number of adjudications was in general high, and, as we have frequently commented, the proceedings and documentation were not age-appropriate.

In one establishment, we found the use of unofficial punishments – field runs for young men who had misbehaved.

Use of force had increased or was high in nine of the male adult establishments we visited. Five were category C training prisons which did not have formal use of force committees and did not routinely and effectively monitor or analyse use of force. In 14 establishments, use of force had reduced or was low – even though some were high security or category B training prisons. The majority had good systems for monitoring and analysing use of force. Six establishments recorded the use of de-escalation techniques, but this is still a very small percentage of those inspected.

> De-escalation had been used to good effect during particularly difficult situations and managers encouraged this. De-escalation training had recently been introduced into control and restraint refresher training. There were good monitoring arrangements with links to violence reduction. Wormwood Scrubs

Over half the prisons inspected did not record planned interventions or review those they did record. In many prisons, documentation was incomplete or poorly completed and there were few quality assurance and formal monitoring systems. This made it impossible for managers to identify discrepancies, such as the high use of ratchet handcuffs in 60% of control and restraint incidents, or the routine use of personal protective equipment.

Special accommodation usage was generally low, but documentation was sometimes poor, with no record of authorisation, or little evidence that prisoners were removed at the earliest opportunity. The condition of special accommodation was generally poor.

In three women's prisons, we found that use of force had increased or was high. One was Styal, where over a third of instances concerned young women; another was Holloway, where the majority of usages were on women who were mentally disturbed and in healthcare (see women's section). In many prisons, force was used to remove ligatures or prevent self-harm. As in male prisons, there was generally a lack of sophisticated monitoring and analysis of use of force or video recording of planned uses.

All but one young offender establishment had recorded either an increase in or high levels of use of force – similar to last year's findings. A major concern was the number of fractures or suspected fractures recorded at Castington following use of force (see also young adult and juvenile sections). As elsewhere, there was a lack of monitoring and analysis. Some planned interventions were video recorded, and use of de-escalation was variable.

SECTION FOUR
Health

Healthcare

Management and commissioning

During the year, we have continued to work closely with the Care Quality Commission (CQC), the successor to the Healthcare Commission. The CQC inspects commissioning arrangements, and we inspect the delivery of services. We also work in conjunction with the other healthcare professional and regulatory bodies in England, Wales and Northern Ireland.

In the main, Primary Care Trusts (PCTs) commission prison healthcare services through NHS-employed staff. However, in some cases, services are commissioned from prison-employed staff or indeed private companies. This can have implications for professional isolation, or access to training opportunities. Most healthcare managers are now clinicians, usually nurses; we found that where this was not the case, they were supported by senior nurses.

Inspections found that an increasing number of GPs were coming into prisons from local surgeries, and treating patients as they would in the community. A few prisons, however, still relied on GPs working exclusively in the prison, or on locum services.

The physical environment for delivering healthcare had improved in some prisons, with much-needed refurbishment. At other prisons, the environment remained poor: sometimes cramped or with insufficient confidentiality.

More prisons have electronic systems for the management of clinical information, though there is as yet no national software system – which is much-needed. This has helped to gather information for health needs assessments and also to maintain registers of prisoners with lifelong conditions. Not all systems were, however, reliable: regular failures on the Isle of Wight were attributed to trees and bird droppings getting in the way. Not all healthcare staff were using these systems, which meant that they did not always provide a comprehensive record of care. If both paper and electronic records were in use, staff treating patients did not always have access to both during consultations. Some prisons were overcoming this by summarising paper information on to the electronic record.

> The nurse typed the patient's information into the electronic record, while the GP wrote on the hard copy of the notes. The information from the GP had not been included in the electronic record, and there was no cross-reference to additional information in the hard copy. Leicester

Healthcare application processes continued to be a concern in many prisons and often lacked confidentiality or were ineffective. Some prisons still used a general applications box or required prisoners to make applications to wing staff. Inefficient application processes resulted in delays in securing appointments, with prisoners in some establishments having to wait up to two weeks, or missing appointments because they did not receive sufficient notification. In some prisons, prisoners attending appointments had to wait for long periods, sometimes all day; while in others they were swiftly returned to their cells in groups.

In some cases, prisoners could only make complaints through the prison complaints system, which was not appropriate and did not provide sufficient patient confidentiality. Some prisons used both prison and PCT systems, which could cause confusion:

in one prison, managers believed that the PCT system was used, whereas prisoners only knew about the prison's complaints system.

Care and treatment

Prisoners' first experience of healthcare, at reception, is important, both to ensure that needs are identified and to establish good links with healthcare staff. Inspections found some deficiencies: in a number of cases, the environment was poor, or lacked privacy. More importantly, prisoners who arrived late did not always have an initial healthcare screen before they were locked up on their first night. Nor did all prisons ensure that there was a secondary health screen within 72 hours of arrival, as required. Even where screening did take place, we were not always confident that identified needs were reliably followed up.

> The first part of the first night health assessment included recording blood pressure and discussion of any requirement for urine testing for substance use or pregnancy. It was carried out by a member of healthcare staff talking to the woman in a toilet.
> New Hall

At the other end, discharge planning was variable, and some prisoners left with little preparation. Most prisons provided initial medication for those with ongoing prescriptions, but some did not provide help or advice on accessing healthcare in the community. There were some examples of good discharge planning – for example, at Wakefield where a probation officer worked with the healthcare team.

We continued to find problems with the sharing of health-related information. This meant either that important information was not shared with other staff, or that it was shared without appropriate safeguards for handling the information. Some healthcare staff asked prisoners to sign an agreement for the sharing of clinical information, and a few – such as Foston Hall and Hull – had suitable protocols in place.

Most prisons offered support for prisoners with lifelong conditions, but the care provided was variable. In some cases, it was provided by specialist nurses from the community or appropriately trained nurses from the primary care team. However, some prisons had no formalised support, or no appropriately trained staff.

As with last year, our inspections found that healthcare beds were often part of prisons' certified normal accommodation. This should not be the case – admission to in-patient care should only be on assessment of clinical need.

In some prisons, the in-patient regime was good, with patients being unlocked for most of the day and having access to a range of purposeful activity. However, in other prisons, time out of cell was minimal and patients complained they had nothing to do. In one prison, patients were locked up for almost 19 hours a day.

In-patients were able to do some in-cell work assembling plastic parts, but those we spoke to found it meaningless and prisoners said work was infrequent. We did not see any prisoners doing in-cell work and all were locked up. Gartree

In-patients were out of their cells and engaging well with staff and other patients. The excellent therapeutic activity included sessions delivered by the education staff, art and creative writing. There was an in-patient exercise area for physical activity, such as basketball. Lancaster Farms

Prisoners in several establishments struggled to attend hospital appointments within the NHS target of 18 weeks. Often, appointments were cancelled and rescheduled, sometimes more than once: in one prison, we found that one in five appointments had been cancelled, some at least twice. Some prisons failed to monitor cancellations and re-bookings, making it impossible to identify whether prisoners were being seen within the target waiting time. On the other hand, some establishments were performing well in this area. In one prison, none of the 183 out-patient appointments in a six-month period had been cancelled.

Last year, we published a thematic review of mental health in prisons, and this was followed by Lord Bradley's review, published in April 2009. The Bradley report followed up many of the themes of our thematic.It stressed the importance of early intervention, beginning at the police station.It recommended a national programme board, bringing together all relevant departments, supported by a national advisory group and implementation team. This would oversee the development of a national model of criminal justice mental health teams, with core minimum standards, which would ensure early identification and assessment of a range of mental disorders and disabilities, improve information sharing and provide continuity of care.

As yet, this has not led to major changes in mental healthcare in prisons. We continue to have particular concerns about the lack of primary mental health services, and of daycare provision for those less able to cope on the wings – though there is some better support from child and adolescent mental health services (CAMHS).

Mental health in-reach was a good service but underused; most prisoners with a mental disorder had a primary mental health need. Primary mental health provision was poor and there had been no mental health awareness training for staff in the last two years. Northallerton

If a young person had a disorder giving rise to challenging behaviour or a learning disability, CAMHS provided links and support to the discipline staff, with a care plan highlighting the types of behaviour they should expect and how best to interact with the young people at times of difficulty. Wetherby

Mental health in-reach teams continued to support prisoners with severe and enduring mental health problems. Their work was sometimes well coordinated with that of the primary mental health team, if it existed, though there could sometimes be tension between the two. In some establishments, mental health in-reach teams filled the gap where no primary mental health nurses were available, but they were often under-resourced, with staff carrying a heavy

caseload. This had an impact on the service: in one prison, the team was unable to use the care programme approach due to staff shortages, and in many prisons there was very little mental health awareness training for residential staff. In some prisons, however, there were extremely good links, both within and outside the prison, and a well-resourced service that offered a range of therapies.

The transfer of prisoners to NHS facilities had improved, but was sometimes still beset by delays. In one prison, for example, eight prisoners were awaiting transfer to secure NHS mental health beds. One had been waiting for 22 months. In another, rapid tranquillisation had been used six times in the previous six months for prisoners awaiting transfer.

Pharmacy

In most prisons, pharmacy services continued to be 'supply only', so that very few prisoners were able to seek the advice of a pharmacist. Electronic prescribing was not always used, and in some instances we found unsafe systems with several different prescription methods in use.

In spite of repeated recommendations, we still found evidence of secondary dispensing, which is both risky and in contravention of professional standards. This year, we instituted separate inspections of the storage of controlled drugs, in line with the 2007 regulations, and these findings were relayed directly to the accountable officer. Some deficiencies in storage were found.

Dental services

Relationships between the Inspectorate and NHS Dental Services have become closer: in one case, joint work with the Counter Fraud and Security Management Service led to the arrest of a prison dentist on fraud charges.

The standard of facilities and treatment appears to be improving. Both at local and national level, there was more awareness of prison dentistry, and guidelines had been produced for prison dentists. Surgeries were in general fit for purpose, though in some cases deficiencies in equipment were identified. Cross infection control was also in general satisfactory, with more washers/disinfectors in place.

The full range of NHS treatments was generally available, though there were still a few prisons that offered only emergency treatment to those on remand or in the last six months of sentence. There were still unacceptably long waiting times in some prisons, with some so long that prisoners would leave without having had treatment.

> The waiting list was up to five months, and a full course of routine treatment could take up to two years to complete. Hull

Healthcare provision in immigration detention and in police custody is dealt with in the relevant sections of this report. In general, the improvements and greater consistency of care and governance that we have recorded in prisons is not replicated in the other custodial settings we inspect, where services are usually not yet commissioned through PCTs.

Substance use

Strategic approaches to substance use varied considerably. Ninety-one per cent of prisons inspected had a substance use strategy, but only three-quarters of them properly included alcohol, fewer than two-thirds were informed by a meaningful needs analysis, and just over a third had action plans to implement the strategy.

The paucity of services for alcohol, particularly alcohol-only users, continued, and the serious issues this raises are chronicled in our short thematic report, published this year. Though there were some exceptions, mainly in Yorkshire and Humberside, inspections continued to find that CARAT services in most prisons were not funded to work with primary alcohol users.

We found that 77% of prisons had adequate drug interventions, but only 44% had alcohol interventions (usually Alcoholics Anonymous). Yet our surveys recorded that 30% of young adults, 29% of women and 25% of men in local prisons said that they had arrived in prison with an alcohol problem. There were some new initiatives, such as the 'addressing alcohol-related offending' programme awaiting accreditation, but they were rare. Even where alcohol awareness programmes were offered by the education department, there was usually little communication with CARAT workers, or ongoing support.

A high proportion of women reported alcohol problems on arrival: 48% at Eastwood Park, 47% at New Hall and 38% at Styal. Only at Holloway did the CARAT service include ongoing support for alcohol problems.
Alcohol services in prisons: an unmet need

Last year saw the further roll-out of the integrated drug treatment system (IDTS). In April 2009, funding to implement IDTS was extended to all adult prisons in England. This led to continued improvement in the treatment of opiate-dependent prisoners, but the gap between prisons with established IDTS provision and those at the preparation stage was apparent. Prisons without stabilisation units could not ensure safe detoxification.

In women's prisons, there was similarly a mixed picture, with Eastwood Park providing an integrated and flexible service, while provision at New Hall was limited and staff were inexperienced.

Structured psychosocial support was available at local IDTS prisons, with some examples of good joint work between health and substance use services. This was much less evident in pre-IDTS prisons.

After the first night, prisoners moved to the stabilisation unit. They felt well supported and there was a high level of engagement between staff and prisoners, with a full range of group work and support groups. Dorchester

The effects of IDTS roll-out to training prisons were also evident. At Featherstone, for example, this coincided with a steep drop in positive mandatory drug tests (MDTs). One problematic consequence of the slow roll-out, and the limited provision, in training prisons was a log-jam of prisoners in IDTS local prisons, unable to transfer to trainers because of non-existent or capped maintenance provision.

> Treatment could only begin once substance-dependent prisoners were admitted to the stabilisation unit, but it was often full. Several prisoners had received only symptomatic relief for some days, which was unacceptable and dangerous. Wormwood Scrubs

The roll-out of IDTS programmes has had unexpected and unplanned for consequences. More and more prisoners are entering and being maintained on methadone programmes and therefore the numbers available for drug treatment programmes, which are abstinence-based, have dwindled. We have found programmes struggling to attain targets, and frustration and concern among both prisoners and staff. There is, however, a pilot of P–ASRO (prison – addressing substance related offending) with a proportion of methadone maintained prisoners.

The short duration programme was running in around a third of adult prisons inspected, and is extremely useful in prisons with short-stay populations. The high intensity FOCUS programme was running in the dispersal prisons we inspected and prisoners were very positive about its effects. Therapeutic communities for substance users at Garth and Wymott were also functioning well.

We found some good examples of care planning and care coordination, for example at Dorchester, Wellingborough and Everthorpe. However, some young offender institutions were doing less well, and New Hall, without IDTS, lacked support systems. Encouragingly, in 96% of establishments inspected, prisoners were involved in care planning and reviews.

In the absence of clinical management guidelines for children and young people, treatment in the juvenile estate remained variable. Brinsford, for example, offered flexible and individualised treatment; while opiate-dependent young people at Castington had to rely only on detoxification using dihydrocodeine.

Dual diagnosis services for the many drug and alcohol users with mental health problems remained patchy. Three women's prisons – Eastwood Park, New Hall and Holloway – had impressive services. Two others – Styal and Downview – had no dual diagnosis expertise available, even though at the latter an estimated 80% of clients on the mental health in-reach team's caseload fell into this category. Similarly, some male local prisons had dual diagnosis practitioners, but some, such as Wormwood Scrubs, did not.

Supply reduction

Inspections found considerable variation in the implementation of supply reduction strategies in prisons. Some were operating effective systems, with reduced MDT rates. Others, though, were clearly struggling: at Brixton and Haverigg, with high positive MDT rates, the availability of drugs was clearly linked to perceptions of a lack of safety. In some prisons, random MDT test targets did not appear to be an accurate indication of prevalence, and there were considerable weaknesses in carrying out target tests and following up suspicion tests, many of which were abandoned as out of time. Since April 2009, buprenorphine (Subutex) has been included in reported MDT figures and, particularly in the north-east, this has considerably inflated positive tests, sometimes doubling them.

The monthly 5% testing target had been missed in 2007/8. Frequent testing programmes were not completed regularly. Forty-two per cent of survey respondents said it was easy to get illegal drugs.
Brixton

Prisons will always struggle physically to prevent drugs entering prisons, while demand remains high. It was therefore noticeable that at Grendon, the only prison that is wholly a therapeutic community, MDT rates were zero. We noted that prisoners themselves actively contributed to supply reduction measures as they valued a safe and drug-free environment. Similarly, at Askham Grange women's open prison, drug use was low, in a positive environment where women themselves wanted to remain drug free.

Children and young people continue to be subject to MDT; a national review of this practice has not yet been published. This usually involves the routine strip-searching of young people, and produces little by way of results. In two establishments there had been no positive tests in the last six months, and in two others only one.

Voluntary drug testing was in place in all establishments except some young offender institutions, but in over a third of prisons the procedures were unsatisfactory or ineffective. There remained confusion between compliance and voluntary testing, some prisons insisted on strip-searching before voluntary testing, and in one prison the programme had broken down to the point that prisoners described it as 'a joke'. Eight out of ten prisoners tested refused to supply a sample. Other establishments, however, were operating good systems which allowed prisoners to remain drug free.

Resettlement links

Nine out of ten prisons had good links with community drug intervention programmes (DIPs). This often involved DIP workers attending the establishments to meet prisoners approaching release, and in some cases, particularly in Yorkshire and Humberside, it included a 'gate pick-up' scheme to assist newly-released prisoners to avoid drug use. Links with DIPs were of course easier for prisoners being released close to home, and in some prisons we found differential treatment between those living locally and those further afield.

SECTION FIVE

Diversity

Strategy

The proposed new equality and diversity legal framework will clarify and strengthen prisons' responsibilities in this area. Resources to deliver this are stretched at both national and local level. The national Race Equality Action Team has been converted into a Race and Equalities Action Group.

At the level of individual prisons we are often finding over-stretched race and disability liaison officers. The creative and committed work we see in some prisons is rarely communicated to others, with the result that most inspections recorded weaknesses in diversity work, which could expose NOMS to challenge under existing as well as future equality legislation.

Few prisons had wider diversity strategies, and, where they did exist, most focused solely on staff. Where there was an integrated strategic approach, this provided benefits.

At national level, the requirement to carry out impact assessments before implementing proposed changes was ignored when a new system for managing foreign national prisoners was introduced and when Cookham Wood women's prison was re-roled.

Apart from race, there was also little diversity monitoring. Even in prisons with a proactive approach to supporting diversity, there were no systems in place to monitor the impact of the regime on other minority groups or to manage incidents of discrimination.

Provision for prisoners who were gay or bisexual was generally poor in male prisons – with Hull and Wakefield being notable exceptions. In our surveys, over a quarter of women prisoners defined themselves as gay or bisexual, but we still found no policies or provision in two out of four local prisons inspected. Gender-specific issues for women are dealt with in the women's section.

Disability and older prisoners

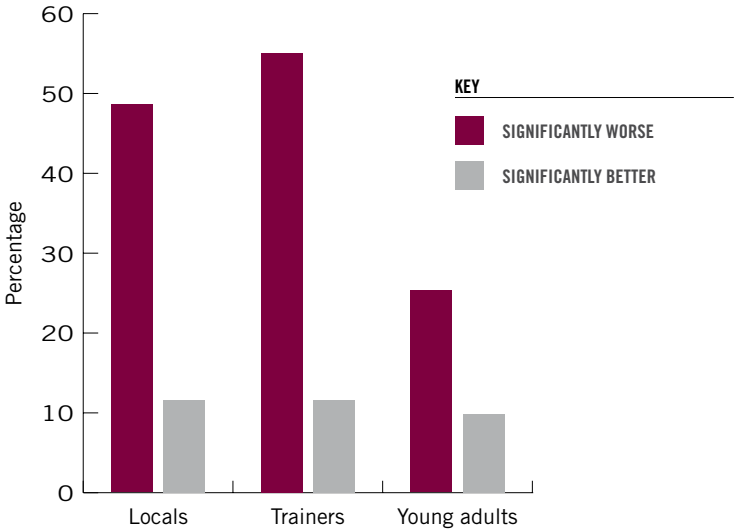
Survey responses from prisoners with disabilities remained consistently more negative than those of other prisoners (see Appendix six). Prisoners with disabilities reported worse experiences in response to 130 out of 190 questions, though they were often more positive about healthcare. This indicates that disability is still seen largely as a healthcare issue.

Over half of prisoners with a disability said that they had felt unsafe at some point, and around a third said that they had been victimised, both by staff and other prisoners. Young adults with disabilities were more likely than other young prisoners to say that force had been used against them.

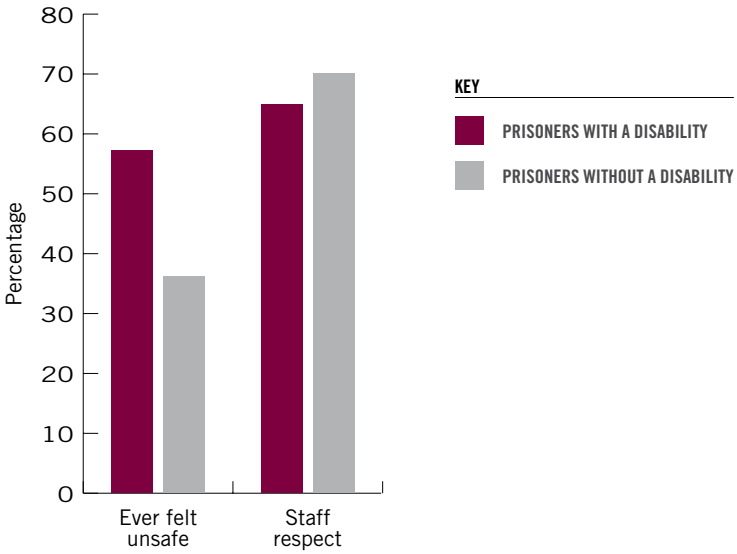
Most prisons had some procedures for identifying disabilities at reception. However, the weakness of these processes is evident from the fact that, in our surveys, a much higher proportion of respondents self-reported a disability than the proportion known to the prison. In our short thematic report on disability we noted that overall, prisons recorded only 5% of prisoners with a disability, whereas our surveys showed 15%. Some establishments still failed to record learning disabilities. Few prisons had the capacity to follow up assessments, but where this was done, it had considerable impact.

In the thematic report, 40% of disability liaison officers surveyed said that they did not have time to discharge their responsibilities. In a seminar organised after the report's publication, it was evident that there were no mechanisms for identifying and circulating good practice.

Graph 2: Survey responses of those who consider themselves to have a disability compared to those who do not



Graph 3: Disability – safety and respect



Race

> Staff lack training and support, there is over-reliance on healthcare, and examples of innovation, such as trained peer supporter schemes, are not replicated across the system. Prisons have a long way to travel to ensure that they can fulfil their positive equality duty.
> Disabled prisoners: A short thematic review on the care and support of prisoners with a disability, 2009

Facilities and adaptations for prisoners with disabilities varied considerably. A few prisons had no adapted cells, and some did not have enough. By contrast, Dovegate had both sufficient cells and a service level agreement with the local primary care trust to identify needs and make reasonable adjustments. Parkhurst, however, had lamentably failed to make any adequate provision.

Often, inspections found that prisoners with mobility difficulties suffered considerable disadvantage because of the refusal of prison staff to push wheelchairs without training. It is unacceptable that this has not been resolved. A few prisons had developed buddy schemes to provide peer support, though this was rarely formalised or accredited.

There is clearly considerable overlap between age and disability, though there are also issues for non-disabled older prisoners. Not all prisons had policies that reflected the specific needs of older men and women, and we still found instances of retired prisoners being locked up for long periods. However, there were also examples of good facilities and provision.

The role of race equality officer (REO) remains pivotal in tackling race issues in prisons. In most cases, REOs had senior management support, with the Governor sometimes leading the race equality action team. However, we came across prisons where this was not the case, and others where this did not translate into positive engagement by residential staff.

Most REOs had little back-up, and some doubled up as diversity managers. In practice, they often focused mainly on racial incident report investigations. Where there were 'deputies' on residential areas, their role and dedicated support time were often unclear. There were some worrying signs that the already stretched resources in this area might be reduced still further in the quest for more budget cuts.

Staff training was also variable. In the best case, 82% of staff at Hull had been trained in a range of diversity issues. More typically, the figure was less than 50%, and in a number of recent inspections all such training had been put on hold while staff were trained in the new computer system.

On the whole, the investigation of racist incidents was prompt and thorough, and there were fewer examples of staff using the system inappropriately to complain that prisoners had accused them of racism. There was evidence of good information-sharing between departments. Mediation to resolve incidents, and interventions for those exhibiting racist behaviour, remained rare. External scrutiny of racist incident investigations was often perfunctory and appeared to be mainly to meet audit requirements. By contrast, prisons in the Yorkshire area had a scrutiny panel of external representatives and prison managers.

A quarterly scrutiny panel for racist incident complaints was attended by a representative of Humberside Diversity Panel, two prisoner representatives and the REO. Incidents were anonymised and reviewed. A detailed log was kept to show emerging trends. Everthorpe

All prisons had prisoner race equality representatives, who attended REAT meetings, and some had invested time in developing their role. At Wakefield, a prisoner representative acted as co-chair, but this was exceptional. At other prisons we found that they lacked support and guidance and were not sure how to deal with queries.

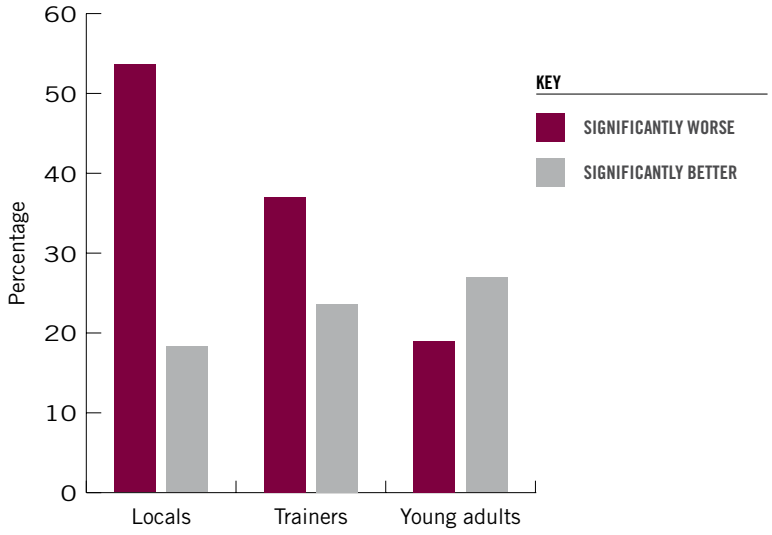
The perceptions of black and minority ethnic prisoners in our surveys remained more negative than those of white prisoners in key areas. Overall, as last year, black and minority ethnic prisoners responded more negatively to 52% of questions, and more positively only to 23%. The discrepancy was slightly less pronounced in women's and training prisons. Black and minority ethnic prisoners were more likely to feel unsafe, to have problems on arrival, to report more difficulties with daily life and requisites, and to report poorer relationships with staff. On the other hand, they were less likely to report drug and alcohol problems and more likely to participate in, and find helpful, education and vocational training. Perceptions of safety and of staff relationships were particularly bad in dispersal prisons.

The overall survey results can be broken down further by ethnicity. They show that, in relation to five main ethnic groups (white; white Irish and other; black; Asian; mixed heritage), black prisoners were most likely to report difficulties in relationships with staff, and Asian prisoners were most likely to have concerns about safety: though their responses on relationships with staff were nearly as negative as those of black prisoners.

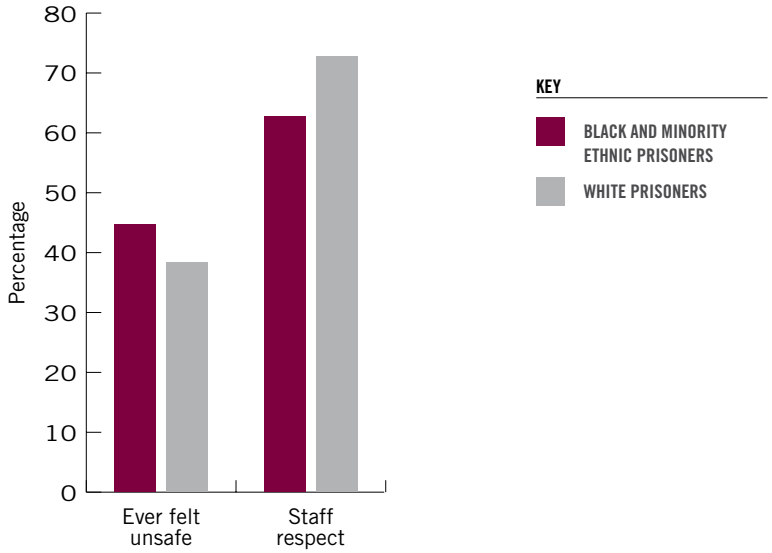
This year, the high level of negative responses from white Irish/other respondents was very noticeable. Those negative responses did not focus principally on safety and respect, but on support and understanding in the early days of custody and contact with families and friends. Some in this group are foreign nationals, others are Gypsies and Travellers, whose specific needs are often overlooked. Interestingly, black prisoners were most likely, and white Irish/other prisoners least likely, to say that they had done something in prison that would make them less likely to offend.

Sometimes, negative responses from minority ethnic prisoners were reflected in poor processes and management. But sometimes they appeared to be the consequence of a lack of cultural awareness by residential staff, particularly in rural areas which held prisoners from major cities. Most prisons had made some efforts to promote diversity, though this often consisted of a single event, such as black history month. It rarely informed all policies and activities.

Graph 4: Black and minority ethnic survey responses compared to those of white prisoners



Graph 5: Ethnicity comparison – safety and respect



Religion

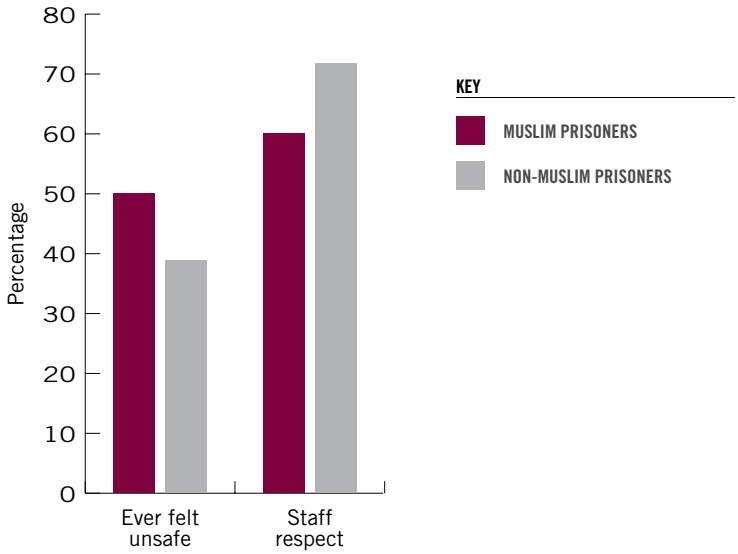
Perceptions of Muslim prisoners, both overall and in individual prisons, remained noticeably more negative than those of non-Muslim prisoners. In almost identical proportions to last year, Muslim prisoners responded more negatively than non-Muslim prisoners to 55% of the questions in the survey. This included most responses on support during early days in custody, access to basic amenities, respect, safety, healthcare and resettlement services. More positive responses related to respect for religion, use of and access to drugs and alcohol, involvement in education and training, and the belief that something had happened in prison that made offending less likely.

While it is welcome that the work of imams had been strengthened, and the faith needs of Muslims were in general well-met, we continued to find residential staff who were unsure how to engage with Muslims as prisoners, rather than as potential extremists. Only in one prison, Coldingley, did we find that managers had attempted to get underneath the concerns of Muslim prisoners by meeting them regularly.

We found no prisons that were monitoring access to the regime or outcomes for prisoners by religion. There was therefore no hard evidence either to disprove Muslim prisoners' perceptions, or to indicate to staff and managers the areas where there were reasons for concern.

Graph 6: Muslim prisoner survey reponses compared to those of non-Muslim prisoners

Graph 7: Religion – safety and respect



Foreign nationals

Foreign nationals comprised 40% of the population in two prisons inspected this year (Brixton and Holloway), and were between 10% and 20% of the population in 23 others. Foreign nationals were disproportionately represented in the six–12 month sentenced population (possibly as a consequence of imprisonment for passport offences).

During the year, a foreign national 'rationalisation' programme was put into place, through a service level agreement between NOMS and the UK Border Agency (UKBA). This was done without any prior consultation, announcement or indeed equality impact assessment. It envisaged foreign nationals in the adult male estate being held in fewer prisons, designated as 'hubs' or 'spokes'. The former would have permanent UKBA staff and the latter would have regular visits from them. The service level agreement aimed to facilitate deportation, removal or early release and to reduce the number of foreign nationals held in the prison estate. Apart from UKBA services, it was silent on the support, services or regimes that foreign nationals might expect. Moreover, foreign nationals were to be moved to hubs and spokes irrespective of whether they were liable for deportation, or whether they had families and friends close by.

In contrast to the rapid development and implementation of the 'rationalisation' programme, there is still no national strategy for the care and treatment of foreign nationals held in prison, in spite of their evident needs.

Some prisons had well-developed local systems and services, and we noted some improvements. We particularly commended the case tracking system developed by the foreign nationals liaison team at Risley. In others, however, services remained underdeveloped or had even deteriorated. For example, there were still no clear policies or strategies in Downview, even though it was supposed to have a specialist function for foreign national women. In other prisons, we found policies, even comprehensive ones, which were poorly implemented.

There was a multi-disciplinary foreign nationals committee with monthly, well-attended meetings. Foreign national prisoners' needs were systematically identified on induction and records were effectively kept and monitored. Swaleside

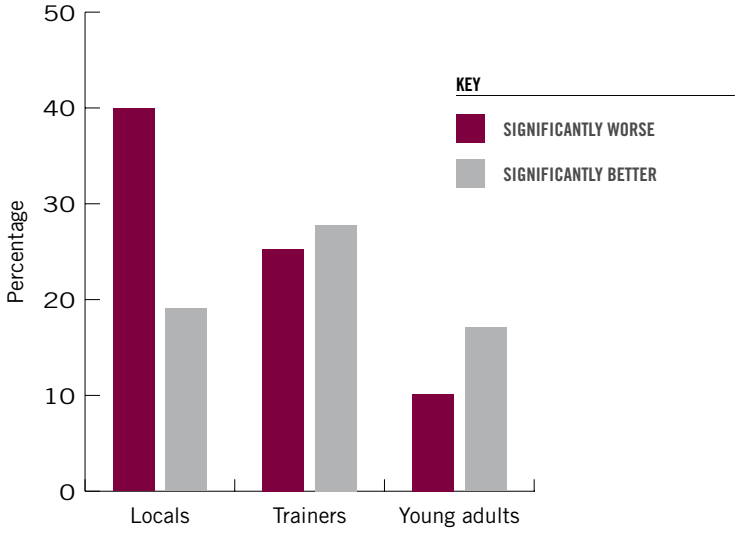
Despite Downview being a designated foreign national centre, a draft policy had only recently been drawn up. There was no management committee. The liaison officer was frequently deployed elsewhere.

Very little training was available for staff, though in one prison, Blundeston, the foreign nationals coordinator had developed a comprehensive training package for wing staff and foreign national representatives. We did not come across any systematic monitoring or needs analysis, even where this had been recommended at the last inspection. Some prisons, even those with a large number of foreign national prisoners, had no foreign nationals coordinator, or one with no dedicated time. We frequently found work that depended on one committed and unsupported individual.

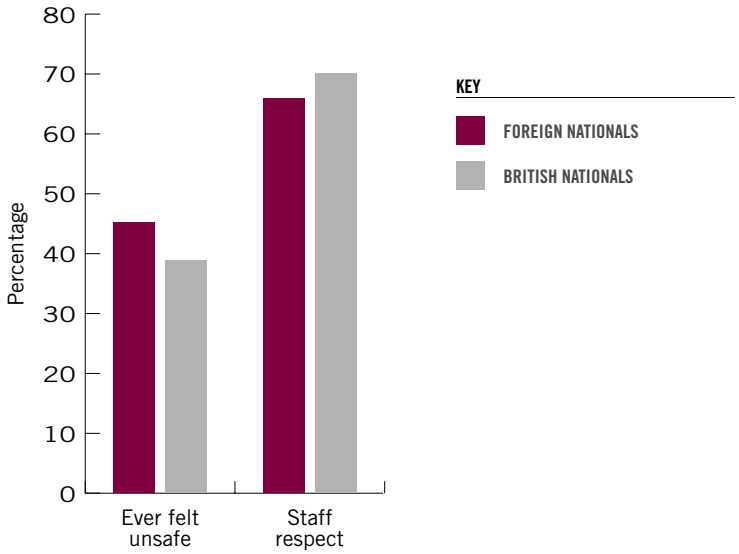
Foreign nationals reported more negatively than British nationals in response to 46% of survey questions, compared to 32% last year. They also reported more positively to fewer questions: 21% as against 37%. They were more likely to feel unsafe. In one category C prison, 20% of foreign nationals, compared to 8% of British prisoners, felt unsafe at the time of the inspection; at a women's prison, 92% of foreign nationals had felt unsafe at some time. They were also less likely to feel that they could approach staff for help, or that they were respected by staff, and in some prisons the gap was wide. Yet at Swaleside, where there were good systems and support services, 91% of foreign nationals said that they were treated with respect, higher than the percentage of British prisoners. Considerably fewer foreign nationals said that they went on association more than five times a week, and this appears to point to a degree of isolation or fear.

Interpretation services continued to be poor, except in healthcare and occasionally in reception. At two prisons, holding 60 and 100 foreign nationals respectively, telephone interpretation had not been used at all in the six months before the inspection. Prisoners themselves were often used as interpreters, even for confidential matters. It was far from clear that foreign nationals, in most prisons, knew what was going on, or that staff were able to recognise where there were problems. Translated material was also in short supply in a large number of establishments.

Graph 8: Foreign national survey responses compared to those of British nationals



Graph 9: Nationality – safety and respect

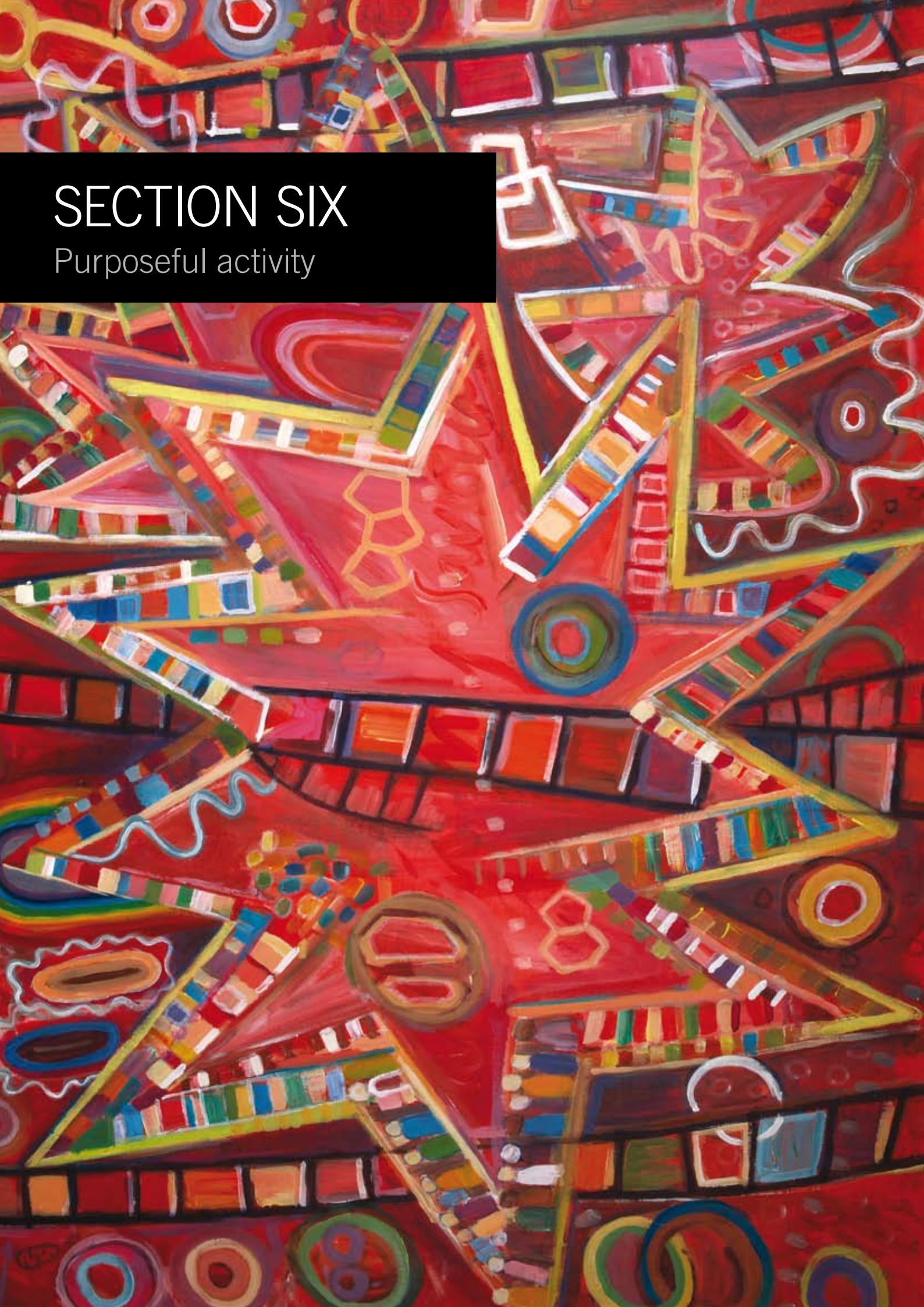


Immigration remained a major problem. Foreign nationals reported greater difficulties in communicating with solicitors, and in most cases it was difficult to find solicitors specialising in immigration matters. Many prisons had no links with independent advice agencies.

UKBA's engagement with prisons remained uneven. Some prisons had built good contacts with the local office, but in others, particularly young offender institutions, links had weakened or were non-existent. There were still considerable frustrations arising from slow progress on immigration cases, and the issuing of authority to detain forms just before the end of sentence. We continued to find detainees held under immigration powers after the expiry of sentence, though this varied considerably among prisons: a quarter of those in Dorchester were sentence expired, compared to 6% at Peterborough.

Foreign nationals in surveys reported worse access to phones and visits than British nationals. In most establishments, free phone calls were only available to foreign nationals who had received no visits in the previous month. In several, free phone calls were only available on application, in English.

There still appeared to be problems in relation to moves to category D establishments: in one case such a move was refused to a prisoner who had in fact been confirmed as being a British national. Foreign nationals were also less likely to say that they knew where to get help with practical resettlement issues, even in areas where they were more likely to expect to experience problems.



SECTION SIX

Purposeful activity

Learning, skills and work

The inspection of learning, skills and work is conducted jointly with Ofsted (in England), Estyn (in Wales) and the Education and Training Inspectorate in Northern Ireland.

The improvement in the quality of provision noted in the previous annual report has continued. Ofsted's latest annual report on education in England noted that only two prisons (6% of the total) were judged to be inadequate, compared with 24% in the previous year. For the first time one adult prison was assessed as outstanding.

However, though quality continued to improve, the quantity of, and the access to, educational and vocational training remained problematic. The most common finding was that there was simply too little activity to engage the number of prisoners held. Only 59% of the adult male closed prisons inspected were assessed as performing well or reasonably well in activity, and only four out of 34 were assessed as performing well.

Table 2 – Purposeful activity

	Performing well/ reasonably well	Performing not sufficiently well/ poorly
Dispersals	3	0
Locals	3	6
Trainers	14	8
Open/resettlement	5	0
Young adults	3	4
Male juvenile	6	1
Female juvenile	2	0
Women	8	0

Achievement in employability training was high for those prisoners who completed courses, but some were unable to do so because of transfer to other prisons or release. There was too little provision of modular courses so that skills gained in short periods could be accredited, as well as a lack of management information systems to record achievements when prisoners moved prisons.

Workshops should provide opportunities for prisoners to gain accreditation for their experience and learning but the work offered was sometimes found to be mundane and did not develop employability skills. However, the integration of key skills had become more widespread and physical education was generally good.

The large number of foreign national prisoners has increased the demand for teaching of English for speakers of other languages (ESOL). The provision of literacy, numeracy and ESOL had improved with more specialist tutors and improved integration into other activities, but there was still weak ESOL provision in many prisons.

Local prisons face particularly challenging circumstances, always overcrowded and holding a transient population. Out of nine inspected, six were assessed as not performing sufficiently well on activity. The main problems were a lack of places and the absence of a strategic approach to the provision of education and training.

In the absence of any workshops, there was no vocational skills training, and the work that was available – for about half the population at any one time – was low-skilled and menial. Brixton

The variation among training prisons is extremely concerning. Four of the 22 inspected were performing well, including the adjacent category B and C prisons at Garth and Wymott. But eight were not performing sufficiently well, of which two were assessed as poor. Those that were performing well not only had high levels of participation in education and training but adopted a strategic approach to provision, seeing training and learning as central to their establishment. By contrast, those that under-performed were poorly managed and often failed to fill the training spaces available.

The amount and range of activity at Garth was outstanding. Almost all prisoners could engage in education or work, much of it providing high quality skills and training related to employability.

All three dispersal prisons we reported on this year were performing reasonably well, despite a lack of resources in some establishments. They had responded to the needs of their population – often high risk young men serving long sentences – by trying to provide sufficient relevant activity to create milestones during sentence, as well as employability on release.

Fewer than half the young adult establishments inspected this year were performing sufficiently well in activities, and only one, the only open prison, was performing well. Young men aged between 18 and 21 years need access to activities, not only for their own development and to contribute to reducing reoffending among this high risk group, but also as an important part of dynamic security to reduce levels of violence and bullying. Too many young adult establishments, however, had high levels of unemployment and poor quality work placements which did not provide vocational qualifications. Provision of education was often of insufficient quality to stretch young men to achieve their potential, and one establishment was graded inadequate by Ofsted.

Learning and skills was graded as inadequate. There was an insufficient range of education or vocational training to meet the needs of the population. Work was low level and nearly a quarter of prisoners were unemployed. Aylesbury YOI

There was a noticeable difference between men's and women's prisons. All of the seven women's closed prisons were performing reasonably well in activity. Less surprisingly, three of the four open prisons, including one women's open prison, were performing well in activity.

Library facilities were generally adequate but in many cases had not developed beyond providing a range of reading material and reference books. More creative libraries offered access to online resources, book clubs, DVD borrowing and facilities for prisoners to record stories for their children.

Access to libraries for disabled prisoners was problematic in some prisons and restricted opening times meant the use of libraries was often not optimised.

PE provision in many prisons was good and varied, with provision for older and disabled prisoners being developed on many sites. In some local prisons, however, this was not the case and there was poor access for those in work or education. Some prisons needed to refurbish activity and changing areas, increase the provision of accredited learning and expand opportunities for outdoor exercise. The importance of physical activity to young adults was not always recognised and in some young adult establishments there was insufficient access to the gym.

Recreational and accredited PE were well managed to maximise participation. Sixty-five per cent of the prison's population participated in PE at least twice a week. Blundeston

PE facilities were good, and there was a well-resourced remedial centre. Despite good access to the gym, only about 35% of prisoners used it, and there was insufficient promotion of the facilities. Success rates on courses were high. Wymott

The last few years have seen an increased focus on, and investment in, education and training in prisons. This has led to a noticeable increase in the quality and relevance of what is provided. However, there is still insufficient work and training to meet the need. Budget cuts have already affected prisoners' access to time out of cell, and next year are likely to bite on activity levels, particularly in those prisons that have succeeded in providing almost full employment.

Time out of cell

In spite of recent changes, the calculation of time out of cell by the prisons inspected was not accurate or credible in most cases, and even where there was an accurate average, this disguised the diversity of experience in most prisons. In some prisons, the figure calculated could not possibly reflect the experience of any prisoner, as it was impossible for it to be achieved even by a prisoner with maximum access to work and association.

The prison reported an unvarying average of 10 hours out of cell each weekday and had done so for some time. This was not possible to achieve even for a prisoner fully employed and the figure took no account of the numbers locked up without activity of whom there were a number. Gartree

A good system had been developed to monitor activities. Every day, during both the morning and afternoon, the numbers of prisoners on each wing and in each workshop and education class were recorded. Included in this figure was the number of prisoners locked in their cells for any reason. From this an accurate figure for time out of cell was produced. Whitemoor

Whitemoor, by contrast, had produced accurate and credible figures, by recording actual participation in activity and the number of prisoners locked in cell. This information provided a management tool to monitor and improve prisoners' experience of imprisonment.

Since the last annual report, the new core day has been applied in all prisons except women's prisons, which were given a year's grace. As a consequence, there is no formal activity between Friday lunchtime and Monday morning. This restricts the time available for purposeful activity and also reduces the amount of time out of cell between Friday evening and Monday morning.

Responses from prisoner surveys this year have begun to reflect these changes. Survey results from this year's inspections compared unfavourably with last year's responses in all establishments except dispersal prisons. In all other male prisons, fewer prisoners reported going to the gym at least twice a week. In local prisons and young adult establishments fewer than 10% of respondents reported spending more than ten hours a day out of their cells, and there were drops in all functional types, particularly training prisons. Fewer prisoners than last year in local and young adult male prisons said that they went on association at least five times a week: in local prisons this had dropped from 57% to 49% and in young adult prisons from 44% to 37%.

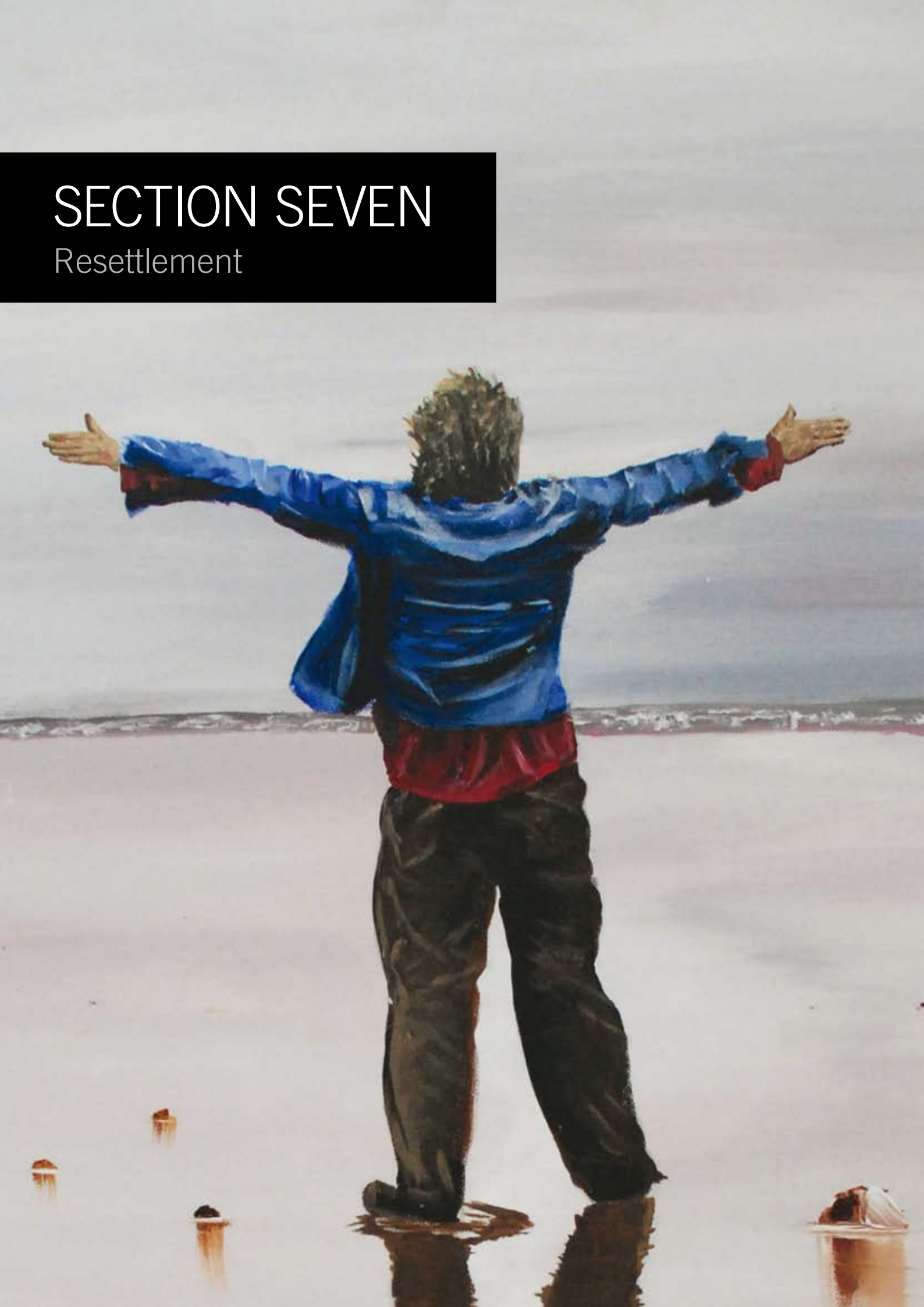
Table 3 – Time out of cell and association

	2007–08		2008–09	
	Local	Young adult	Local	Young adult
Spend 10+ hours a day out of cell	8	9	7	6
Have association 5+ times on weekdays	57	44	49	37

The number reporting that they went outside for exercise three or more times a week in local and training prisons had also dropped. In the dispersal estate, however, there were improvements in access to exercise and time out of cell.

SECTION SEVEN

Resettlement



Strategy and offender management

Most establishments had resettlement policies, but in general they were descriptive of what the prison could provide, rather than being based on an analysis of prisoners' needs. Some relied on local area strategies; high security prisons used a needs analysis for the whole high security estate.

As a consequence, there were gaps in provision: particularly where, as was frequent, the population had changed significantly. For example, some prisons had experienced an influx of prisoners sentenced to indeterminate sentences for public protection; some category B training prisons were holding significant numbers of category C prisoners whom they would be releasing; women's prisons were performing a multiplicity of roles. Those establishments that had done a needs analysis were much better placed to plan.

Most prisons had regular resettlement committee meetings, but they tended to lack strategic focus. Voluntary and community organisations were engaged in providing services along some of the resettlement pathways, though there was sometimes insufficient coordination, or opportunity for involvement at a strategic level.

Last year saw the conclusion of a joint inspection cycle with HM Inspectorate of Probation, examining offender management in prisons by region. In future, HM Inspectorate of Probation staff will join individual prison inspections to assist in inspecting offender management work, based on a shared methodology, including the inspection of case files. This is a welcome development, which will provide a more comprehensive assessment of offender management, alongside other evidence, such as the experience of prisoners reflected in surveys and groups.

This year, we found that offender management units had generally been able to consolidate practice in supervising prisoners under phases 2 and 3 of the offender management model. With some exceptions, however, there was little face-to-face contact with offender managers at sentence planning meetings, and few prisons were able to use video conferencing for this purpose. Sentence planning was therefore mainly driven by offender supervisors, with approval from offender managers and some contact via telephone conferencing. Sentence planning boards were of variable quality and use.

Offender management boards were late by up to eight months and staff said most delays were due to offender managers being unable to attend and boards were not held in their absence. Styal

There is still frequent redeployment of uniformed staff from offender management units to cover other duties, which delayed work and reduced the time spent with prisoners. Few prisons had provided offender supervisors with additional training and development, such as motivational interviewing or risk of harm training. There were, however, notable exceptions, and one prison provided mental health awareness training. Some prisons offered offender management to all sentenced prisoners, whether or not they were in scope, but there was no guarantee of support on release.

Though offender management arrangements have in general been developing well, we have concerns about these processes in the future. The specification, benchmarking and costing exercise now under way is an attempt to extend the scope of offender management within a shrinking resource base. There is considerable concern that this may reduce the quality of the best work. Indeed, some prisons have been told in terms that they should aim for the bronze, rather than the gold, standard; and the risk of staff redeployment will be even greater as other areas of prison regimes and work become increasingly stretched.

All prisoners were managed under the offender management model. Offender supervisors maintained detailed electronic records of contact, with most files showing some update every month. Garth

In many prisons we found that the focus on (and funding for) offender management had stifled the development of custody planning for short-term and remanded prisoners. Before the arrival of offender management, some prisons, and particularly local prisons, had begun to develop a custody planning model for such prisoners, the majority of their population. We found that this had not progressed beyond, at best, collecting relevant information about needs on arrival and organising a pre-release board shortly before release. In some cases, the information that was gathered was not routinely passed on to any service providers; in no prison did we find that it formed the basis of an active engagement with the prisoner to assist in meeting needs before and on release.

In some cases, this task was supposedly performed by personal officers. However, we did not find any instances of this being actually done. Indeed the engagement of residential staff in sentence planning in general, including motivating prisoners to engage with the process, remained a weakness.

Custody plan targets were rudimentary and ineffectual, such as 'comply with the regime'. Some prisoners had no custody plans. There was little evidence that personal officers used the targets in their contact with prisoners. Leicester

An initial assessment was carried out in 15 minutes through hatches in cell doors. This afforded no confidentiality and could not be relied on for accuracy. There was no system to ensure that referrals were picked up, and no pre-release boards. Wormwood Scrubs

Public protection arrangements appeared to be well managed, and a new public protection manual has clarified prisons' role in this. Nevertheless, we found several establishments which had not provided child safeguarding training for staff, for instance for visits staff who have contact with children.

The rise in the number of indeterminate-sentenced prisoners, and particularly those serving indeterminate sentences for public protection (IPP), continues. By November 2008, one in 15 prisoners were serving IPP sentences – a 19% increase in a single year. Though the number of newly-sentenced IPP prisoners has decreased, due to changes in legislation, very few, even those on short tariffs, have been released: indeed over a third of IPP prisoners are beyond tariff. This is partly because of the difficulty in accessing offending behaviour programmes, especially given population pressure. It is also due to parole delays, and a considerable risk aversion on the part of the Parole Board, in authorising both moves to open conditions and release.

The necessary focus on IPP prisoners has led to a reduction in work with and resources for life-sentenced prisoners. Short-tariff IPP prisoners were prioritised for offending behaviour courses, and the needs of lifers in general appeared to have a lower profile in many training prisons. There were fewer dedicated lifer staff, and there is still no national mechanism for ensuring their progression to stage 1 prisons and onwards.

Resettlement pathways

Awareness of resettlement services varied across different prisons. At local prisons and, perhaps surprisingly, at category C training prisons fewer than one in five prisoners said they had been helped by staff to prepare for release. This rose to one in four at women's prisons and nearly half of those in open prisons – though that figure is itself surprisingly low, given their role.

Almost all establishments had some form of specialist housing advice. In most prisons, very few prisoners were recorded as being released to no fixed abode; however, to some extent this was disguised by the use of end of custody licence, where prisoners could get early release by claiming a place to live, without further checks needing to be done. At Holloway, this undermined drug treatment work, as women in mid-treatment left to go to unsuitable premises. It remained the case that, in our surveys, half of those leaving local prisons and only slightly fewer leaving women's prisons thought they would have difficulty in finding accommodation on release.

Some prisons had done good work to identify and try to meet specialist needs, or to help prisoners be good tenants. Prisoners from Wales could rely on the guarantee of accommodation provided by the Welsh Assembly. There was some evidence that the new public service agreement (PSA) that required local authorities to assist in reducing reoffending had made some English local authorities take a more positive role in offering housing. Sometimes, as in Holloway, this was associated with an enhanced resettlement package that involved the drug intervention team.

> Women from eight boroughs had an enhanced local authority resettlement package, including more involvement by the drug intervention team, priority for housing, additional mental health services and support for those at risk of domestic violence.
> Holloway

Some prisons, however, still failed to respond to need. One in five prisoners at Camp Hill were released to no fixed abode, and housing officers received over 600 applications for support. This was partly due to the fact that 60% of prisoners were more than 50 miles from home; but it was equally evident that the prison was doing little proactive work to mitigate this.

Finance, benefit and debt remained one of the weakest resettlement pathways, often focusing on little more than closing down tenancies and ensuring that benefits were discontinued. Education departments sometimes provided budgeting courses, but debt advice, which had previously been provided through Citizens Advice, had reduced in many prisons. At an increasing number of prisons, prisoners were able to open bank accounts before release. However, inexplicably, this applied to only one of the four open prisons we inspected. We found one prison, Leicester, which provided debt advice to families.

Only those establishments that had conducted a needs analysis could be sure that provision of offending behaviour programmes matched need. Only around two-thirds of prisoners in training prisons said that they were able to complete some or all of their sentence plan targets at their current prison. Throughout the prison estate, there were gaps in courses linked

to violence, including domestic violence, and alcohol-related offending. Some non-accredited courses were available (such as victim awareness, often run by the chaplaincy team), but their efficacy was not always evaluated. At Parc, however, the programmes team also monitored non-accredited programmes.

Even where needs were identified, they could not always be met. There were significant waiting lists for enhanced thinking skills (ETS) and in particular CALM. Some prisoners were discharged without having completed courses, and others, particularly sex offenders and indeterminate-sentenced prisoners, spent long periods waiting for a progressive transfer to undertake courses.

There continued to be a lack of interventions and strategic guidance about working with prisoners who refused to engage in programmes, sometimes because they were maintaining innocence. Some prisons used programme graduates to try to motivate and encourage others.

The availability of pre-release courses was variable, as was the provision of information, advice and guidance. Some prisons had developed good links with local employers and provided through the gate support for prisoners released locally – but this was harder for category C training prisons, whose prisoners often came from some distance. Four out of the six category C prisons inspected this year had not developed active links. As in previous years, there was very little use of release on temporary licence for resettlement purposes.

Two of the open prisons inspected, Hollesley Bay and Spring Hill, had very good working out schemes, and managed to place 70% and 40% respectively of their prisoners into education, training or employment on release. This was, however, less well developed at the two other open prisons, Moorland and Ford.

Children and families

There have been some improvements in support for prisoners' family ties and it is likely that the children and families resettlement pathway has stimulated and focused interest in this area.

There was a greater awareness in women's prisons of the need to ask about care for dependants, but little awareness in men's prisons that men may have similar concerns. A relatively high proportion of prisoners in closed prisons reported difficulties with sending or receiving mail – averaging around 40%. Access to phones could also be a problem, with a third of those in male local prisons reporting difficulties. Seven prison reports recorded that there were insufficient phones. Only one prison, Askham Grange, allowed incoming phone calls, though some prisons allowed incoming emails.

Problems in booking visits persisted in too many establishments. Five years ago, we noted that these difficulties existed in 12 prisons: this year, it was 16. There were, however, more opportunities to book in person and four prisons allowed email booking. In 26 reports, we criticised the frequent late starts to visits – sometimes beginning 45 minutes late. This applied to all of the six women's prisons inspected. Both late starts and booking difficulties are problems that we have continually reported over many years. They seriously inhibit family contact and need addressing at national level.

Evening visits remained rare, though they are much-needed and much-appreciated. At Kennet, we saw some extremely good and proactive practice, where staff followed up visitors who had failed to arrive in order to reassure prisoners.

There were more visits centres, the best of which were run by voluntary organisations. We noted some excellent and supportive facilities; however, prison-run visits centres were much less impressive.

> All visitors had to arrive in the outside waiting room 30 minutes before visits started and any arriving late forfeited the visit. We saw one mother with two young children turned away because the waiting room was closed. Swansea

> Staff telephoned visitors who had not arrived to see if all was well and communicated this to prisoners. Barnardo's provided family support to prisoners assessed as needing this on induction and had recently begun 'through the gate' family work. Kennet

Two prisons provided a free bus service, but at others poor transport links and parking problems were real barriers to families' access. At one prison, an elderly woman visitor with mobility difficulties had spent £160 on a round trip. With expanding prison populations, space in many visits rooms was under pressure.

Half of all prisoners surveyed had children under 18, and this rose to 57% of women over 21. The children and families pathway itself was beginning to develop, and we saw examples of some excellent family support services, for example at Styal and Askham Grange. There were also more children and family days: in 40 prisons, as opposed to only 27 last year. Some, however, were restricted to enhanced prisoners, or to prisoners attending parenting groups. This fails to appreciate the importance of family

and child contact for all prisoners and families. More recently, we have learnt with concern that family days in some prisons (including women's prisons) may be among the victims of the budget cuts.

In around 25 prisons, we noted that there were relationship or parenting courses, including counselling sessions and an 'after adoption' group. At Parc, we were particularly impressed by the programme that allowed fathers to help children with homework and gain an OCN qualification in 'helping your child'. Nineteen prisons were running Storybook Dads or Mums, eight more than we reported in 2008.

There was an even more impressive rise in the number of prisons employing family support workers. We found only seven such workers in 2008, but 18 this year: five in women's prisons and four in YOIs. The family support work at Askham Grange was particularly impressive. By contrast, there was nothing at Holloway, in spite of the evident distress of mothers separated from children, and the recommendations made by the Inspectorate ever since 2002.

At Parc, fathers could help children with homework and gain an OCN qualification in 'helping your child'.

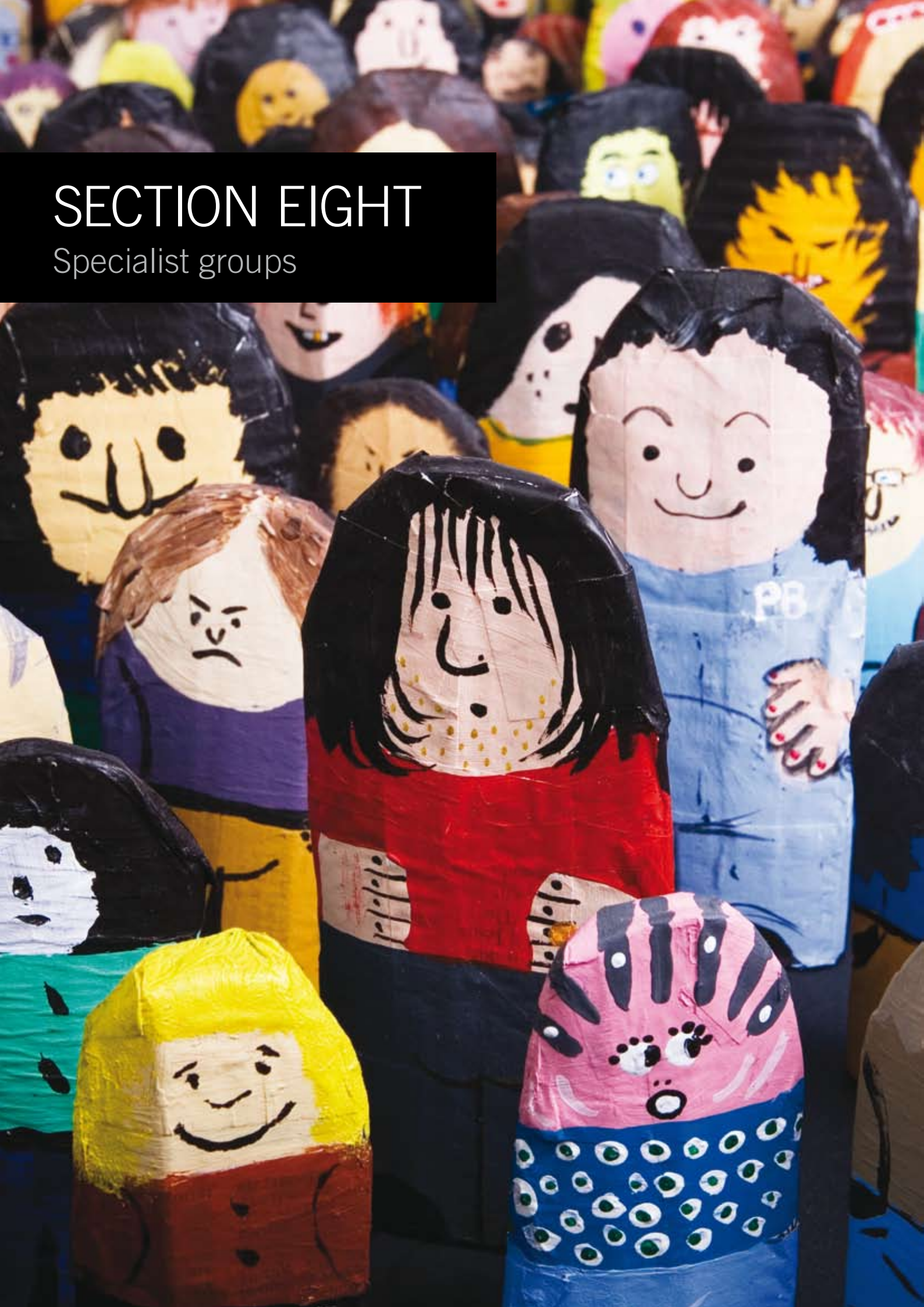
Lack of contact with children, partners, parents and siblings had been identified by Holloway in a needs analysis but there was no specific strategy to address it.

In 10 prisons, families were able to attend sentence planning or course reviews. Two women's prisons had accommodation where selected women were able to spend time privately with children.

Distance from home remains a major impediment to family ties. This was particularly noticeable in women's prisons and YOIs, where the need may be greatest. At Eastwood Park, one in five women were more than 100 miles from home. Nearly half the young men at Stoke Heath, and over 60% of those at Huntercombe, were more than 50 miles away. Prisoners in remote locations had fewer visits: only one in 10 at Camp Hill on the Isle of Wight had had a visit within their first week, compared to one in two at Wormwood Scrubs.

SECTION EIGHT

Specialist groups



Women

During the annual report year we published inspection reports on eight women's prisons, more than half the women's estate.

The women's prison population decreased slightly during the annual report period, to around 4,300 in August 2009, a 2.5% decrease since the same time in 2008. It has remained at around that level since then. While this is a welcome development, assisted by the cross-departmental group set up following the Corston report, there is still no clear strategy for the women's prison estate. The women and young people's group at headquarters provides policy advice and operational support to women's prisons, including the delivery of gender-specific training for staff.

The introduction of new guidance for women's prisons, including gender specific standards, was a welcome response to the gender equality duty under the Equality Act 2006. Routine strip-searching of women entering prison has ceased, but otherwise there was relatively little operational impact. Yet another women's prison, Cookham Wood, re-roled to take young men rather than women, without any prior impact assessment of its effect on women. At Peterborough, the only prison holding both women and men, we still found that there was insufficient focus on the distinct and different needs of a diverse female population.

The reduction in the number of women's prisons has resulted in women and young women being held further from home. It also means that women's prisons have a multiplicity of roles, unplanned for and usually inadequately resourced. Many women's prisons deal with a much more complex and demanding population than any men's prisons, holding juveniles, young adults, mothers and babies and women serving life sentences. A high proportion of women in local prisons are addicted to drugs and/or alcohol, and many are seriously self-harming and mentally ill.

Askham Grange, however, provided a model of good and focused work with women. The open prison near York is the only adult prison we have judged to be performing well against each of our healthy prison tests of safety, respect, purposeful activity and resettlement – and the only prison assessed by Ofsted as having outstanding education provision. It was described as a centre of excellence: the result of clear leadership and management of a small establishment, focused on meeting the individual resettlement needs of the women. However, shortly after the inspection, Askham Grange's management was amalgamated with New Hall, a very difficult women's local prison almost 40 miles away. The consequences of this, for both prisons, have yet to be seen.

Eastwood Park covered a wide geographical area and over 70 courts, following the change of function of Brockhill and Bullwood Hall, and this caused significant problems. One in five adult women and over a third of young adults were over 100 miles from home.

Askham Grange provided a holistic and individualised approach to managing the transition from custody back to the community. This is a credit to its staff and managers. It is also a message to the prison system about the kind of establishment and approach that most benefit prisoners, particularly women prisoners.

During the year we inspected all but one of the mother and baby units. All provided decent conditions and all but one had good care planning for mothers and babies. However, some lacked proper support plans for mothers separated from their babies at birth or shortly afterwards. The standard of training for staff varied. While the units aim to promote parental responsibility, few allowed women to prepare and cook meals for themselves and their babies. Most were able to involve families but more needed to be done to help co-parents fulfil their responsibilities.

Most units were still managed by uniformed prison staff. However well-motivated and caring they were, this created a prison ethos, and managers lacked sufficient training and focus on children and parenting. By contrast, at Styal, the unit was run by trained staff from Action for Children (formerly NCH). This provided the best and most constructive environment we have seen in such a facility, and should be a model for other units.

Three of the five women's local prisons inspected were performing reasonably well on safety, with noticeable improvements at Peterborough and Eastwood Park. Holloway and Styal, however, continued to cause concern. At Holloway, a significant number of women continued to feel unsafe and at risk of bullying, partly as a consequence of the unsuitable design of the building, which was hard to supervise safely. Styal struggled to deal with the extreme vulnerability of some of its women. Staff in its 'therapeutic unit' (previously the segregation unit) lacked sufficient resources or training to deal with women with serious mental health problems, often exhibited in prolific self-harming, which in turn led to a high level of use of force.

Eastwood Park, however, had created a genuinely multi-disciplinary and supportive environment for such women. Nevertheless, all women's local prisons were dealing with women whose complex and acute mental health needs meant that prison was a wholly inappropriate environment for them.

> Force was used on the high dependency unit to place women in protective clothing routinely and against their will. It resembled a segregation unit and officers did not have sufficient training or support to deal with the complex problems and behaviour. Styal

> K wing was used to house particularly difficult or self-harming women. It was not a segregation unit under another name, and provided a supportive environment, with multidisciplinary input and interventions. Eastwood Park

The short follow-up inspection of Send training prison found a serious deterioration in a prison which had previously been a very safe and settled environment. There was no violence reduction strategy and in spite of two self-inflicted deaths, support for women at risk was not sufficiently robust.

Detoxification processes for newly arrived women had improved, but the scale of need is huge. At Holloway 70% of new arrivals were dependent on drugs or alcohol and at New Hall 80% of new arrivals were admitted to the substance misuse unit.

Most of the women's prisons inspected had reasonably good staff-prisoner relationships, with marked improvements at Styal and Holloway. But at New Hall and Peterborough relationships were more problematic. At

New Hall too many staff appeared cynical and dismissive of women prisoners, including those with mental health issues. At Peterborough there was relatively little interaction between fairly inexperienced and sparse staff and women prisoners. Personal officer work remained underdeveloped in nearly all women's prisons.

Race equality was generally an improved and positive picture but support for foreign national women, a significant proportion of women prisoners, is still not well developed at many prisons (see foreign nationals section).

Across the whole estate, there is little evidence of a strategic approach to meeting the needs of women with disabilities. Neither of the women's open prisons can accept women with severe mobility problems. Attention to the needs of older women prisoners was also an underdeveloped area. New Hall and Styal had formed groups for lesbian and bisexual women just before their inspections, but otherwise there was little recognition of sexuality in diversity policies.

As in the prison estate generally, health services, though improved, struggled to meet need. Few prisons, except for Holloway, had access to much-needed counselling and daycare services, and in-patient units were full of women with mental health problems and with little therapeutic regime.

All the women's prisons inspected were performing at least reasonably well on purposeful activity. Establishments were able to provide a reasonable amount of time out of cell, though not at weekends. Most prisons were not able to meet the full range of women's needs, though in general education provision was good. At most prisons, there was insufficient opportunity to gain vocational qualifications.

All but one of the women's prisons we inspected were performing at least reasonably well in resettlement, an improvement on last year's inspections. The exception was Peterborough, which had taken on the role of a first stage lifer prison and had also accepted sentenced young women under 21, without proper planning of how their needs would be met.

However, none of the prisons had fully effective custody planning systems for women on remand or serving less than 12 months, even though they were the majority in local prisons. Early release on end of custody licence meant that some women were released midway through drug treatment to unsuitable addresses.

> Provision for short-term prisoners, lifers and young adult women was underdeveloped, and there was still no short-term custody planning. Peterborough

> In the absence of a needs analysis or a formal system of custody planning for all women, it was not clear that services matched need. Holloway

Sentence planning for those serving over 12 months varied, as did relationships with outside offender managers (see resettlement section). Some reintegration services were good, for example the drop-in service at Styal was well used, but others, such as accommodation support at Peterborough and New Hall, were under-resourced.

Without either a central strategic steer or effective local needs analyses, it is impossible to know whether there are sufficient and appropriate interventions for women. Inspections found gaps in most prisons: for first stage lifers and young adults, women with lower educational levels, or those with alcohol problems (see substance use section). The short duration drug programme is helpful but has not been adapted sufficiently to cover areas of particular concern to women, such as the care and welfare of their children. A lack of central strategic direction also meant that the therapeutic community at Send had not been effectively utilised.

Most women in prison have children, many are primary carers, and most are at a considerable distance from home. Only one prison inspected had an incoming call facility to mitigate the continuing problem of very expensive outgoing phone calls. Only three prisons had appointed qualified family support workers, despite the obvious need in all women's prisons. There is beginning to be some recognition of the needs of those separated from children through adoption. Two prisons – Downview and Askham Grange – had developed accommodation to allow women to spend some private time with their children and help rebuild relationships.

Young adults

During this year we inspected 10 establishments holding young adults: six dedicated young adult training prisons, two local prisons holding adults and young adults on mixed landings, and two training prisons holding adults and young adults in separate units.

In general, relationships with staff were distant, and staff had low expectations of prisoners and limited engagement with them. In surveys, fewer young adults than adults (61% compared to 71%) said that staff treated them well. However, there were exceptions, such as Dorchester and Rochester.

Conditions and regimes for young adults held in adult establishments remained unsatisfactory. In Hull, where they were one in 10 of the population, they were located with adults, without any special measures, supervision, or consideration of their specific needs. Young adults were less positive about safety and respect than adult prisoners: a third felt unsafe, only half felt well-treated by staff and nearly half said they had been threatened by other prisoners.

The violence reduction strategy did not adequately show how the varying population would be safeguarded. This was particularly concerning as young adults were located across the residential units. Hull

At Dorchester, however, young adults were held together, relationships with staff were good, and staff were aware of their needs and of age-related issues. They were not over-represented in use of force or adjudications for assaults. However, there were no specific formal policies and they suffered from the restrictive regimes often found in local prisons. There was little purposeful activity and many were spending too much time locked in their cells with nothing meaningful to do.

Similarly, in adult training prisons, strategies for young adults were underdeveloped, despite evidence that this group of prisoners was proving problematic. Young adults were disproportionately involved in use of force incidents, reflecting a high number of assaults and fights. Equally, time out of cell was inadequate, and in general worse than that of adult prisoners, with evidence of regime slippage.

Young adults received only two evening association sessions, while adults had four. Fifty-eight per cent of the young adults on one house block were locked in their cells with nothing meaningful to do in the middle of the core day. Moorland

Even in dedicated sites, there were problems. Though 68% of all healthy prison assessments were positive, two young offender institutions were not performing sufficiently well on safety, and four out of the six closed prisons were not performing well enough on activity. This included two allegedly training prisons. In three of the six, we found no evidence that staff had the training or support needed to recognise and deal with age-motivated behaviour. At Thorn Cross, the only open establishment holding only young adults, the quality of education and training had improved, with a greater focus on employability and resettlement.

Resettlement services had improved somewhat, and six out of the seven dedicated young adult establishments were

assessed as performing reasonably well on resettlement. However, as elsewhere, there was little formal management of short-term or remanded young adults.

Use of force levels remained high with dramatic increases at some establishments. At Aylesbury, incidents involving the use of force had increased by about 60% since the last inspection. Although there had been some improvement in the recording of incidents, there were still too many examples where the use of force was not properly authorised or de-escalation techniques adequately employed. Monitoring of trends was underdeveloped, governance was sometimes poor, and links between use of force coordinators and violence reduction committees were not always consistent.

Forty-four per cent of uses of force in the previous three months had involved young adults and only 9% had involved adults. Parc

As in adult prisons, violence reduction strategies were often ineffective. All prisons had a published violence reduction policy, to reduce bullying and the number of violent incidents, but staff and prisoners were not always clear about how they operated. Many were not based on an analysis of the specific patterns of violence in the prison nor did they fully consider the age of the population. Allegations of bullying were not always treated consistently or investigated promptly. We found a significant under-reporting of incidents, partly due to young men's reluctance to do so.

Overall, this is still a neglected and under-resourced age-group. Busy and overcrowded local prisons struggle to deal with their specific needs, and even specialist young offender institutions lack the resources, support and training to do so. The high rate of reoffending among young adult men is unlikely to reduce without significant changes in approach, funding and focus.

Children and young people

The number of children and young people held in prisons decreased significantly during the year: by the end of August 2009 there were 2,079 under-18s in prison, a 17% drop from the same time the previous year. This is a very welcome development.

However, the number of those serving longer sentences is steadily increasing: there were 415 young men given sentences other than detention and training orders during the same period. The Youth Justice Board (YJB) commissioned research into their needs in 2007, but very few recommendations of the published report have yet been implemented.

Distance from home remained a major problem for many young people. This was even more pronounced in some establishments. Following the re-role of Cookham Wood, all young women held at Eastwood Park were more than 100 miles from home: though there was a beneficial effect for some young men from the south-east. The sudden re-role late in 2009 of Brinsford, before alternative accommodation is available in the Midlands, is likely to have a detrimental effect for young men.

In our surveys, only a third of young people said that it was easy for their families to visit, and 29% of young women and 16% of young men said they had never received visits. Some establishments had appointed family links workers to seek to mitigate the effects of distance from home.

During the year, we inspected eight establishments holding children and young people. We also published the annual summary of young people's responses to surveys in all juvenile establishments during 2008–09, commissioned and funded by the YJB. In addition, we issued a revised edition of *Expectations*: our criteria for inspection of establishments holding 15–18-year-olds.

The revised *Expectations* incorporate learning from inspections and Inspectorate reviews since 2005, as well as changes in law, policy and procedure. They look for outcomes that reflect best practice in the care and treatment of young people held in young offender institutions, and which are deliverable even in those settings.

Inspections and survey analysis during the year showed that this has been achieved in some establishments, but in others there is still a failure to understand or implement management processes that recognise the difference between children and young people and adults, or that properly manage risk.

It is welcome that 30 of the 36 healthy prison assessments of the nine establishments inspected showed establishments performing at least reasonably well. It is less encouraging that four of the six lower assessments related to safety, and that two of the lower assessments were for the same establishment – the re-roled Cookham Wood.

Table 4 – Assessments: male units

	No. of establishments	Performing well/ reasonably well	Performing not sufficiently well/poorly
Safety	7	3	4
Respect	7	6	1
Purposeful activity	7	6	1
Resettlement	7	7	0

Table 5 – Assessments: female units

	No. of establishments	Performing well/ reasonably well	Performing not sufficiently well/poorly
Safety	2	2	0
Respect	2	2	0
Purposeful activity	2	2	0
Resettlement	2	2	0

Across the estate, surveys showed that more than one in four young people had felt unsafe at some time. Though this is significantly lower than five years ago, it is troubling that it has not declined further. The significant improvements in perceptions of safety among young women, following the opening of the small units, was maintained. Among establishments holding young men, perceptions of safety had improved in eight, and decreased in five. Those most likely to feel unsafe were in larger, split sites rather than smaller dedicated units.

Safeguarding procedures remained fractured at most establishments. Vulnerability assessments were generally not good enough and none of the establishments inspected had a clear strategy or coordinated system of care planning to identify, assess and meet the needs of the most vulnerable or challenging young people. Even where good multi-disciplinary work was being done, there were often too many different and confusing care plans and uncoordinated planning systems.

Apart from Huntercombe, child protection practice and the necessary relationships with local safeguarding children boards, were not sufficiently well-developed. Only two establishments had ensured that all staff were CRB cleared, and in only one, Brinsford, had all relevant staff had the short specialised JASP training for working with adolescents. Arrangements to take part in specialist training with the local authority had lapsed in all but one establishment. Some establishments, but not all, had good involvement and oversight of allegations against staff by the local authority designated officer.

Assessment and care planning was complex and no staff had been appropriately trained. There were too many uncoordinated systems: a vulnerable young person with behaviour problems could have been subjected to seven or more different care plans.
Wetherby

The involvement of social workers in juvenile establishments is crucial and extremely beneficial, especially as surveys showed that a quarter of young men and half of young women had been in care at some point. Yet the prospect of reliable and consistent funding for these posts appears to be further away than ever. Funding had been provided by the YJB, on a temporary basis. Last year, children's services directors were asked to agree on a formula for funding these posts for 2009–10 and the longer term. They failed to agree and there has been no central funding of these posts since April 2009. As a consequence, less than half of the 25 social work posts were filled by the end of 2009.

Behaviour management, and the balance between care and control, remains a live issue. The independent review of restraint, set up following the deaths of two young people during or following restraint, made 58 recommendations. Among them were that all units should ensure that use of restraint is placed within an overall behaviour management strategy and that every establishment should publish and report against a restraint reduction strategy. The YJB has circulated guidance to all establishments on producing restraint minimisation strategies by March 2010, and we will be inspecting these next year.

None of the male establishments inspected had a comprehensive and fully implemented behaviour management policy, and there was little use of mediation or restorative justice. However, the Josephine Butler female unit was operating such a policy, and the number of adjudications had decreased. Stoke Heath was the only male establishment delivering a programme of pro-social modelling.

New ways to confront bullying had been introduced, including mediation. An innovative approach to training young women and staff had raised awareness of the many facets of bullying. Josephine Butler Unit

At Castington, we found, and surveys showed, that the use of restraint was high; moreover, it had resulted in four confirmed or suspected fractures among children and young people. There had been no external independent review. Only in two of the eight establishments was use of force adequately monitored by the safeguarding committee.

All segregation units in the male estate have been rebadged as 'care and separation', 'reorientation' or 'intensive supervision' units. However, they continued to operate as traditional segregation units, with the emphasis on separation rather than care.

The small units for young women have, however, allowed a more positive and child-centred approach to young women in some important aspects. Routine strip-searching no longer takes place on arrival and elsewhere risk assessed strip searching is becoming common practice. By contrast, all young men continue to be strip-searched on arrival and as part of other routine procedures. At Ashfield, young men were routinely strip-searched not only on arrival but as part of full cell searches, which happened every other month. We have still found strip-searching under restraint, even for those at risk of self-harm, in both male and female units.

There had been some improvements to the condition of residential units in some establishments. However, the fundamental problem, in most places holding young men, was the size and design of establishments and units. At Cookham Wood, an inappropriate design was exacerbated by a poorly-planned re-role with inexpert and insufficiently supported staff.

> The living units were poorly designed, creating a claustrophobic environment unsuitable for boisterous young people. The long, narrow corridors between cells and the stairwells linking the landings were hotspots for fights. Cookham Wood

Reported relationships with staff in our surveys were marginally less good than in the previous year: though inspections found good relationships in the two young women's units and at four of the six male establishments. The role of personal officers remained underdeveloped everywhere.

As in the adult estate, aspects of diversity, particularly disability and sexual orientation, are underdeveloped, though some establishments had made a start. There was progress in the management of race, though the survey showed that black and minority ethnic young people continued to report poorer relationships with staff than white young people. Only a quarter thought staff would take them seriously if they mentioned being victimised.

All young women had plenty of time out of cell, but this was adequate in only half of the young men's establishments inspected. There was still a wide gap in the availability of exercise for young men: in half the 14 establishments surveyed, 15% or fewer young men said that they could exercise daily, and this was as low as 3% at Werrington. By contrast, at four establishments, over 70% of young men could have daily exercise.

Education and training continued to show improvement this year, and the provision – both in terms of quality and quantity – was assessed as at least satisfactory, and often good. In our surveys, over 80% of young men and 98% of young women reported being in education, and just over half said that they were learning a skill or trade. The achievement of qualifications and accredited skills had also improved: at three establishments over 90% of young people left with at least one qualification.

The range of courses, especially vocational courses, varied considerably between establishments. With a few exceptions there was too little attention given to the specific needs of young people who were under school-leaving age and who might be returning to mainstream education upon release. Most establishments had started to improve the opportunities for accreditation for those young people on shorter sentences and the more able.

Attendance at education was generally satisfactory and most establishments had made progress in monitoring and recording the reasons for absence. However, punctuality was variable and in some establishments young people were withdrawn from lessons to attend appointments with other agencies.

Relationships between teachers and residential staff were in general good. Learning support assistants, most of whom were professionally qualified, made valuable

contributions. Behaviour had continued to improve in most, but not all establishments. Returning young people to the residential units due to poor behaviour was increasingly seen as a last resort. There were some good examples of the effective use of 'time out' facilities.

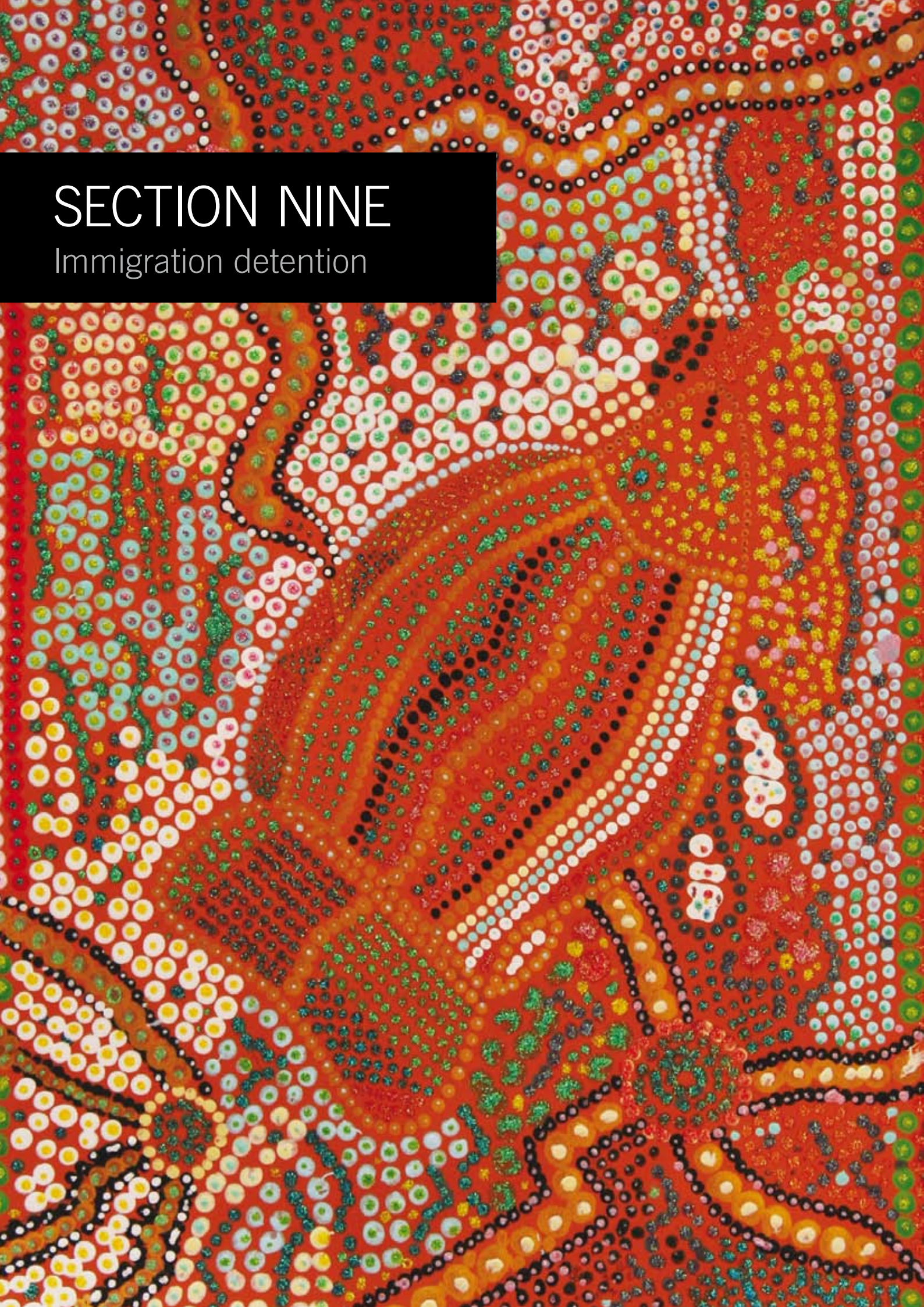
The quality and quantity of activity was very good. There was a broad education curriculum with specialist support for those with attention deficit and hyperactive disorder. More vocational courses had been introduced. Ashfield

In spite of this generally improving picture, we have serious concerns about the likely impact of changes to the funding arrangements. The YJB funds only three hours of education each day, based on a cost per child. Establishments are meant to top this up with daily additional activity. The challenge for establishments will be to ensure a coordinated approach, and a full and purposeful day, to meet the educational and personal and social development needs of all children and young people. Around half of the sentenced young people that we surveyed said that they thought they had not done anything in prison that would stop them reoffending – even though nine out of 10 wanted to stop.

As last year, few establishments had carried out a comprehensive needs analysis to inform the development of resettlement services. The training planning process and reintegration planning was well managed in all but one of the establishments inspected but the quality of individual training plans for young people was variable, and in general target setting was weak. The quality and quantity of the services provided by Connexions were extremely variable.

SECTION NINE

Immigration detention



Immigration removal centres

Statistics published this year show that during the first six months of 2009, nearly 14,000 men, women and children entered immigration detention: equivalent to 28,000 a year. Of those, 470 were children: equivalent to nearly 1,000 a year. Almost half of the children entering detention were under five years of age.

Snapshots of the population, taken at the end of each quarter, show a rise in those held in detention at any one time to 2,745 at June 2009. Of those, 35 were children. Detention is not predominantly a short-term phenomenon: in the last two quarterly snapshots, there were more adult detainees who had spent over four months in detention than those who had been detained for less than 14 days; and between 8% and 9% of adults had been detained for over a year. Ten children, about a third of the total in each quarter, had been detained for over 29 days.

This year, we have found continuing pressure on the immigration removal centre (IRC) estate, and an increasingly prison-like feel to IRCs themselves. There is still a large proportion of ex-prisoners in the estate, which is placing a strain on IRCs and appears to have led to less focus on the distinctness of the detainee population.

Detainees in Colnbrook found lengthy detention in the centre's noisy and tense, prison-like environment very stressful – its cellular design, similar to a category B prison, has been followed in the newest IRC, Brook House, and is apparently to be replicated in any new IRCs. Two of the IRCs inspected had been prisons. Lindholme continued to struggle to maintain an identity separate from the neighbouring prison, with which it shared some of its staff, and disappointingly at Dover there were signs of some reversion to the previous prison mentality.

> It was disappointing that there had been slippage in a number of areas and that the regime and approach was tending to revert to that of a prison.
> Dover

In some IRCs we noted fewer reports of frequent and lengthy journeys around the detention estate, but we still found some detainees arriving disorientated and distressed after exhausting journeys. Movements regularly took place overnight, increasing stress: for example, in Oakington most arrived during the late shift, and over half of these arrived after midnight.

Though it remained the case that most assessments of IRCs were positive, the proportion of positive assessments had decreased since last year – from 68% to 63% – and only one establishment was assessed as performing well against any of our four tests of a healthy custodial environment. Worryingly, three centres were not performing sufficiently well in relation to safety. Detainee surveys showed little change in responses since last year to some key questions relating to safety. Though infrequent in most centres, use of force had risen in some, and some inappropriate use of separation was noted in all but one establishment.

We noted improvements or reasonably good practice in most IRCs in relation to the management of the most vulnerable detainees. Lindholme and Colnbrook were notable exceptions. At Colnbrook, we noted some inappropriate separation of vulnerable detainees and excessive use of demeaning anti-ligature clothing. We were particularly concerned about our findings at Lindholme, where in response to two recent serious night time incidents staff responded slowly and demonstrated some dangerously complacent practice.

The continued detention of a small number of women in the first night centre that doubled as a short-term holding facility in Colnbrook placed them in a wholly inappropriate environment. For a short time a man was accidentally allocated to the same room as a woman. Detainees were locked up for 23 hours a day, with little access to information or a regime, and less than a third of detainees surveyed said that they felt safe on their first night there. The other end of the spectrum was Dungavel, where improvements had been made to the women's accommodation and women reported that their needs were well met.

Dungavel continues to be an extremely respectful place, where good relationships between staff and detainees underpin a generally safe environment, with a wide range of activities.

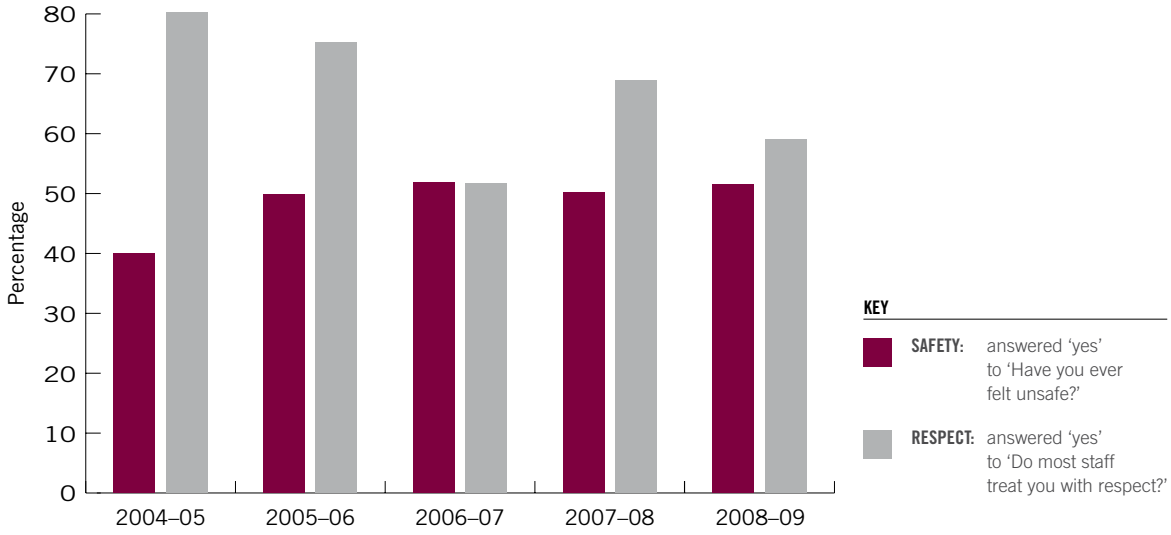
We found little improvement at Colnbrook since our last visit. It holds women in a wholly inappropriate facility and the vulnerable persons unit was not fit for purpose.

Dungavel House was the only inspected IRC to hold children. We found that the physical conditions and facilities for children had improved, but independent welfare checks did not take place within seven days and there was a lack of continuity in child protection. However, detention of children is in itself a cause for concern. The UK Border Agency (UKBA) is still unable to provide figures showing the cumulative length of detention for children held in different places, and anything other than a snapshot of the number and length of stay at the end of each quarter.

In spite of the fact that the UK has now agreed to remove its immigration reservation to the International Convention on the Rights of the Child, there is little evidence that decisions to detain or to maintain detention fully take account of the needs and welfare of children. Nor do some detention standards: there is for example no specific guidance on the circumstances in which force can be used, or the methods that can be deployed, on infants and children.

Staff-detainee relationships were reasonably positive across the centres inspected, though there were signs of deterioration under pressure. In surveys this year, overall only 59% of detainees said that most staff treated them with respect, lower than the 69% last year, and the 80% in 2005. Dungavel was the only establishment performing well against our test on respect, and two centres were not performing sufficiently well. Relationships at Oakington had shown the most significant deterioration: in 2004, 94% of detainees said that staff treated them with respect, but by 2008 this had decreased to 60%.

Graph 10: Reporting periods between 2004–09



Although detainees generally lived in harmony with each other, systems for managing diversity were underdeveloped in most centres and did not provide assurance that adequate systemic safeguards were in place. Diversity management meetings tended to take place irregularly and to have little strategic oversight, and there was little evidence of effective monitoring, use of management information or formal consultation arrangements with detainees. Those who did not speak good English were disadvantaged, especially Chinese detainees. In Campsfield House, Chinese people reported poorer experiences of relationships with staff than English speakers.

Detainees with disabilities reported worse experiences in our surveys in a number of areas, notably safety and healthcare. Sixty-five per cent of detainees with disabilities said they felt unsafe compared to 41% of others. They were far more likely to report health problems and only a quarter thought that healthcare was good compared to 36% of other detainees.

Healthcare provision in the centres inspected was variable. In only one Prison Service run centre was healthcare commissioned by the primary care trust (PCT) and overseen by the Healthcare Commission (now the Care Quality Commission). In others, links with the local PCT were variable, and we found little evidence of clinical governance or adequate assessments of health needs. Mental health provision was unable to meet need in most centres inspected.

Ineffective communication with and from UKBA was still a cause of much distress for detainees, with monthly reviews, though more timely, still being largely formulaic and repetitive. In safety interviews, uncertainty and insecurity about immigration cases remained detainees' greatest cause of concern. Onsite immigration teams tended to be diligent in responding to detainees' queries. However, they had little ability to progress casework and insufficient experience or seniority to respond to complex cases. Responses to rule 35 letters (alleging unfitness to detain because of previous

torture) remained variable; not all received a response and not all responses addressed the issue of fitness to detain. Some that related to serious allegations appeared to receive scant consideration.

Legal advice remained in short supply in all centres. Legal Services Commission funded surgeries were in place in most centres, but were unable to meet the need for detailed and sometimes urgent representation. There were particular problems in Dungavel, due to detainee movements between the English and Scottish legal systems.

The ability to have mobile phones had improved communication with the outside world. However, Prison Service run centres still refused to allow detainees access to email and the internet, the best and cheapest way for detainees to stay in touch with families abroad and the situation in their home countries.

Activities for detainees had improved, with five of the six centres now performing reasonably well in this area. The main improvement was that paid work was now available in all centres. Both the distraction and the ability to earn money were appreciated by detainees. The number of workplaces had increased, but so had the IRC population, and there was still much scope for improvement. Even at the best centres, there was work for only about a third of the population.

There is a considerable need for welfare support to deal with the practical problems associated with sometimes unexpected detention and to prepare detainees for release or removal. However, provision was inadequate in three of the six centres inspected. Where welfare support was properly established, it was greatly appreciated. There was little evidence of support and care planning for those facing removal.

Escorts

This year, we published a short thematic report on escorted removals. This found a number of weaknesses in the systems for monitoring, investigating and complaining about incidents where force had been used or where abuse was alleged. Detainees were not informed of how to complain, and escort staff themselves did not know what they would do if a complaint was made. The Detainee Escorting and Population Management Unit contract monitors did not have a clear role in the oversight of escorts.

Most observed escort staff were professional and respectful, but there was some bad practice, which increased tension, showed little concern for the wellbeing of the detainee, and sometimes frustrated removal. Reasons for the use of force were not always clear and medical examinations were not routinely carried out afterwards.

In a separate inspection of escorts at Dungavel, we found that most detainees had few concerns about the behaviour of escort staff or the condition of escort vans, but little effort was made to communicate with those who spoke little English. A number of detainees did not know they were coming to Dungavel, with implications for contact with families and legal advisers. This lack of information added unnecessarily to the stress of detention.

This review found that there were considerable gaps and weaknesses in the systems for monitoring, investigating and complaining about incidents where force had been used.
Detainee, Escorts and Removals

Short-term holding facilities

Short-term holding facilties (STHFs) varied considerably. Some, such as London City Airport, were inadequate, though others had been refurbished to an appropriate standard.

The most positive aspect of STHF inspections was the emphasis placed by G4S (who ran all but two of the STHFs) on good communication between staff and detainees and the encouragement of managers to adopt a welfare-based approach. Detainees reported positive relationships with staff in most STHFs, and in most facilities staff displayed a thoughtful and flexible approach, trying to minimise the stressful effects of detention. This was not the case, however, in the two facilities inspected which were not run by G4S. At Harwich, we found that interaction between staff and detainees was largely functional, with little communication taking place once the reception process was over, and no use of interpretation services. At the STHF facility at Colnbrook, we found little attempt to engage with detainees and almost no evidence of interaction with staff.

There is no comprehensive mechanism for monitoring the number of children detained in STHFs, their ages and how long they have been held for. Most facilities held children on a regular basis, but not all had separate rooms for women and families, and staff were often unaware of child protection responsibilities or policies, though we noted some individual good practice. All UKBA staff were receiving some child protection training, but G4S staff had received only minimal initial training and no refresher training.

There was little use of force in any facility, but where it did happen, the documentation was not always properly completed and did not therefore provide sufficient assurance that sufficient safeguards were in place. At Portsmouth, staff said force (arm locks or handcuffs) had been used on detainees, but it was not recorded or monitored, and no medical examinations had been conducted.

Information about the complaints procedure was not routinely provided or clearly displayed and staff sometimes did not understand the process themselves. Complaints forms usually had to be requested from staff, and in some holding rooms the complaints had to be handed back to staff (at whom the complaint may have been directed).

Staff training and understanding of anti-bullying and suicide and self-harm interventions, and operating policies, were adequate in most STHFs. Staff did not routinely carry ligature knives, though they usually knew where to get one. However, at Harwich, where detainees spent more time out of the sight of staff, staff did not carry ligature knives nor were able to locate them when asked.

Custodial staff of the contractor, G4S, were alert to the needs and vulnerabilities of detainees. Immigration staff lacked training in self-harm and there appeared to be no effective feedback.
Reliance House

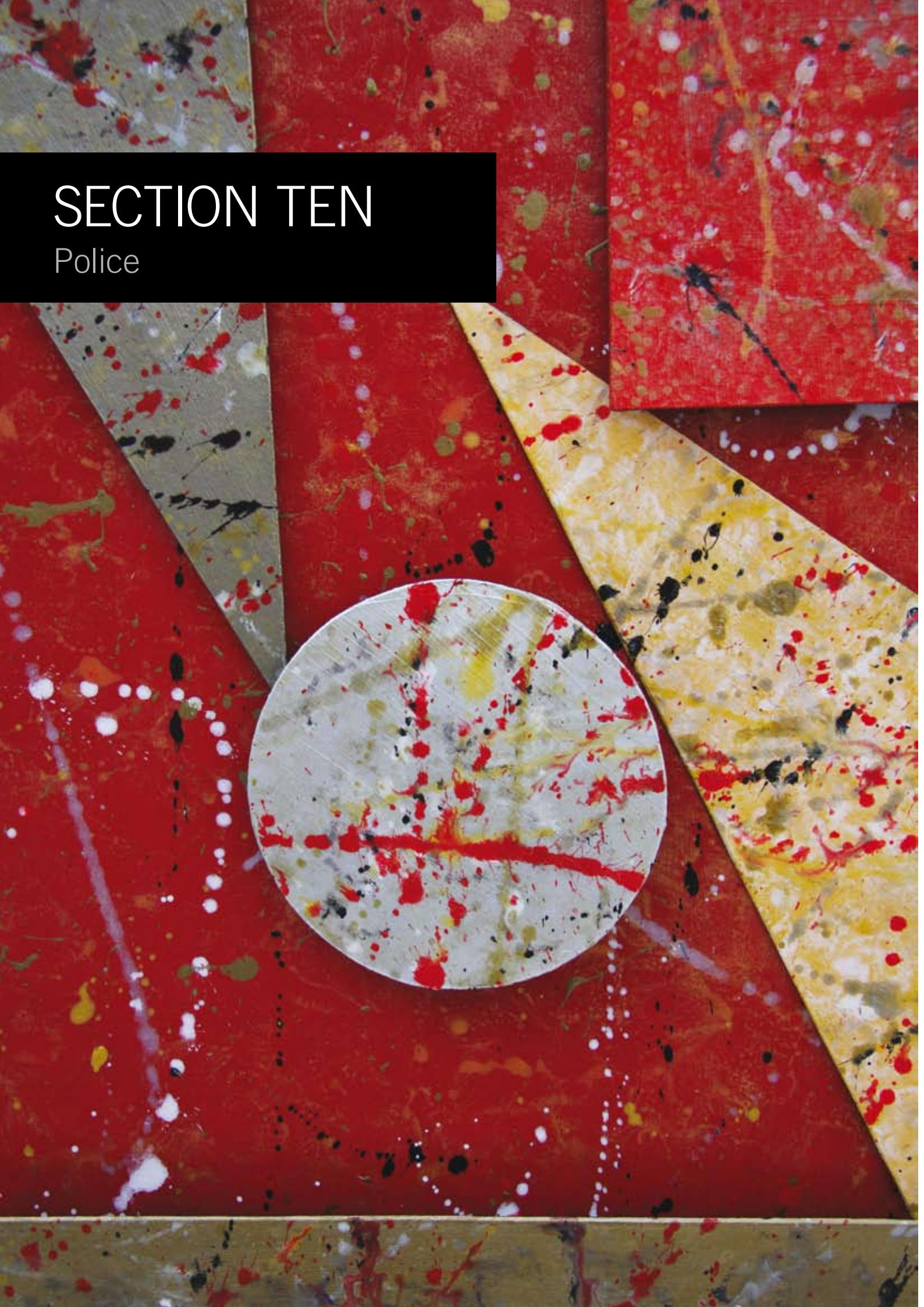
Men and women were not adequately separated, and there were few activities. Incidents of self-harm were rare, but there were some serious deficiencies in suicide prevention procedures.
Harwich International Port

There was little information about legal provision in any facility. Most had phone numbers for national advisory services, but these were often of little use for short-term detention. Only a few STHFs had translated Office of the Immigration Services Commissioner (OISC) information. Access to phones was usually adequate, but most centres did not actively offer detainees free calls, and there was no access to the internet.

Hot food, adequate for short stays, was now available in most holding facilities and a range of hot and cold drinks was usually offered on arrival and available on request thereafter.

All reports found that there were insufficient activities to alleviate boredom. Apart from at Harwich, no detainees had access to the open air, regardless of length of detention. Even at Harwich, access was dependent on which member of staff was on duty and the environment provided lacked decency.

Detainees usually had little opportunity to recover their property. Although some facilities allowed property to be delivered, this was dependent on staff collecting it from visitors, as only one centre allowed social visits. There was some good practice: at Sheffield, family and friends were able to bring property and cash to the front desk. Some facilities ensured that detainees who did not have appropriate clothing or bags were offered suitable alternatives. Detainees being removed or deported were given some information, but this was rarely sufficient.



SECTION TEN

Police

Police custody inspections

This was the first full year of the regular programme of joint inspections of police custody suites, together with HM Inspectorate of Constabulary. During the year, we carried out nine inspections, and published six inspection reports, into police custody suites in Gloucestershire, Durham, West Yorkshire and Cambridgeshire and two Metropolitan Police Service boroughs, Islington and Hillingdon.

These inspections examine all aspects of the treatment of detainees, including, but not confined to, those matters provided for under the Police and Criminal Evidence Act (PACE) and current guidance to forces. They look at strategy, treatment and conditions, individual rights and healthcare. In the course of the year, we have refined the detailed criteria for inspection, referenced to human rights standards and instruments, and the revised criteria were published at the start of 2010.

Inspections have brought to light some good practice in individual forces and custody suites, but they have also raised some general and systemic concerns.

At a strategic level, it was evident that some forces lacked effective attention to custodial issues, and where that was the case this led to inconsistency, as well as a failure to recognise safe custody as a key task. This was evident, for example, in Cambridgeshire, where little progress had been made in rectifying problems identified by the force's own internal audit of custody and the National Police Improvement Agency (NPIA) peer review. Without a centralised policy framework or custody model, basic command unit (BCU) commanders retained considerable autonomy and policies did not inform and drive local practice. By contrast, where there was a clear strategic focus and commitment to custody at chief officer level, sound policy frameworks underpinned safer detention. In Gloucestershire, for example, the Chief Constable had taken a personal interest, the police authority was fully engaged, and work was underpinned by a clear strategy.

We were disappointed at the lack of effective strategic attention to custodial issues in Cambridgeshire, evidenced by little meaningful progress in rectifying problems identified by internal audit and the NPIA.

We were impressed that the Chief Constable of Gloucestershire had taken a personal interest in custodial matters and the Police Authority was fully engaged. As a result, there had been significant attention to this area.

An emerging concern was the lack of governance and monitoring of uses of force on detainees in custody. Such events should be recorded on individual custody records. However, there is no central record kept in custody suites or forces that would allow managers to know, monitor and analyse the extent, type or circumstances of its use. Also, while there is national guidance on the use of Tasers or incapacitants more generally, there is no specific guidance for their use in custodial environments, which can rarely if ever be either necessary or proportionate.

In half of the forces inspected there were mechanisms for learning from adverse incidents, via newsletters, intranet sites or (in West Yorkshire) themed supportive visits, which we identified as thorough, searching and best practice which could be replicated elsewhere.

Complaints should be another source of management learning. However, in the majority

of cases, detainees were not told how they could make a complaint about their care and treatment, and were not enabled to do so. In general, complaints were not taken from detainees while they were in custody, and they were instead told to make a complaint to the duty inspector or at the front desk. In one force, some staff actively discouraged detainees from making complaints, and in another a detainee was not able to make a complaint about an alleged assault. There was no central monitoring, in any of the forces inspected, of the number or types of complaints made in custody, nor was there a specific formal system for dealing with racist incidents in custody, or a local register of such incidents.

In most forces, we found that custody staff were respectful in their daily interactions with detainees. However, we had concerns, in all inspections, about the absence of policies and practices that directly acknowledged the differential impact of detention on particular groups – women, children and young people, those with disabilities, and immigration detainees.

In relation to women, only in one custody suite were detainees routinely asked about dependency issues and obligations. Elsewhere detainees were expected to raise any issues about dependants themselves. One woman, whose babysitting arrangements expired within half an hour, was detained for five hours worrying about her children. In most of the force areas inspected however, staff said if detainees raised issues about dependants themselves they would facilitate arrangements for their care.

Many showers, with only stable doors, offered little privacy for female detainees, and were sometimes in areas where there were male detainees. On the positive side, women in Bradford who might otherwise have faced a custodial sentence were directed to one of the four national Together Women projects, which provided help and support in the community.

We had particular concerns about children and young people, on two grounds. First, under PACE they are only recognised as juveniles, and in need of special safeguards, up to the age of 17. This conflicts with every other international and national provision, where the relevant age is 18, and clearly is an issue that requires national attention. Second, even for those recognised as juveniles, there were few specific policies and, in general, no specific training for staff on working with children or child protection. Though particular cells were designated for their use, they were in most cases identical to adult cells. Although juveniles were not usually interviewed without an appropriate adult present, such services were often under-resourced or inaccessible outside normal office hours. This could lead to long stays in custody: in one force, juveniles arriving after 7pm were routinely held overnight, and in another, although it had been planned to bring a 14-year-old girl into custody, no advance arrangements had been made for an appropriate adult to be present, so that she was not detained for longer than necessary.

Frequent disagreements between social services and mental health services over responsibilities for providing appropriate adults led to people spending longer than necessary in custody.

Few custody suites had appropriate facilities for detainees with disabilities, and the weakness of appropriate adult services also affected those with learning disabilities.

Immigration detainees could be detained for longer – up to seven days. The UK Border Agency (UKBA) was sometimes slow in responding to such detention: in one case, a man was held for six days before being moved to an immigration removal centre. It was sometimes difficult to find appropriate legal advice, and most custody suites did not allow family visits, even for those detained longer, so the impact of custody was compounded. Nor was there enough to do: showers and exercise were usually only available on request and there was little reading material in languages other than English. Some of these issues need to be addressed by the UKBA, the commissioning authority.

In all suites, there was a keen awareness of the risks of self-harm, injury or other threats to the safety and wellbeing of detainees. However, as we reported last year, this often led to risk aversion, without any assessment of individual risk, which compromised the dignity and respectful treatment of individuals. In one custody suite, we saw a detainee denied his spectacles, even though there was no evidence of a risk of self-harm; at another, a young woman's strapped top was cut off her in a public area, as a potential ligature threat (though ironically she retained her bra).

Some aspects of safer custody were also absent: all the suites inspected had booking-in desks that, while meeting national Home Office design guidelines, offered little privacy, inhibiting the disclosure of sensitive or personal information. Others relied too heavily on CCTV and life signs monitoring, rather than personal contact, though we did find some evidence of risk assessments in custody records. In some suites, anti-ligature knives had been issued but were not routinely worn by all staff.

All cells had call bell systems but their purpose was not always explained to detainees. In some suites, we found unsafe practices: staff had muted call bells, and in one this was done immediately the bell sounded, and staff then took up to 20 minutes to respond.

The vast majority of detainees were held in single cells, mitigating the risk of harm to others. There were few examples of formal cell sharing policies, but one custody suite in Cambridgeshire did have such a policy, which included a detailed risk assessment.

The standard of accommodation was variable, even within individual forces or basic command units. Some of this variation was due to the age and design standards at the time of original construction. However, even in some of the more modern buildings, standards of maintenance had been allowed to deteriorate – evidence that there was not sufficient central or structured monitoring of all facilities. Some suites, for example in Gloucestershire, were generally clean, free from ligature points and with little evidence of graffiti.

In one force, custody staff made a weekly check of all cells and logged any necessary repairs. Cells had been taken out of commission pending repair.

In another force, many cells were not fit for purpose, particularly the older ones, which were dark, dingy, smelly and covered in graffiti. One had a large swastika on the wall, which had been there for many months.

In some other forces, however, cells were cold, shabby, poorly ventilated, or with very

little natural light. Cells in one custody suite were considered unfit for purpose. We found observation panels in one suite that were difficult to access, while in another there were two cells with glass doors opposite each other, offering no privacy.

Provision of basic necessities and hygiene items across forces was variable. All provided mattresses, but some did not provide pillows; others provided blankets only on request and subject to a risk assessment. In all but one case, toilet paper was only provided on request and detainees were not always told of its availability. Toilets in all but one custody suite lacked privacy, and many had only external flushing and hand-washing facilities. In two forces, cells assigned to juveniles had no internal sanitation. Showers in all suites were only available on request, but this was not always explained to detainees. Some showers were not sufficiently private for women to use.

In the two Metropolitan police boroughs, fresh meals were available for detainees during the daytime. Elsewhere and at night, microwaveable food was provided, sometimes only on request, and if staff were not 'too busy': we found detainees in two forces who had not eaten for over 18 hours.

Although most suites outside London had exercise yards, activities and exercise were limited. Even where there were outside exercise areas, this was not routinely offered, and in all but one suite there were very limited supplies of reading materials, available only on request.

Detention was properly authorised and appeared appropriate. It sometimes lasted longer than was necessary due to delays in finding specialist support such as appropriate adults. Both solicitors and police reported delays and inflexibility caused by Crown Prosecution Service charging arrangements; early court cut-off times could also result in detainees spending longer in custody than was necessary. At one police station, those arrested on court warrants for breach of bail were not listed to appear within the next 24 hours. In some suites, such as Uxbridge in Hillingdon, custody sergeants were active in expediting bail.

In all the forces inspected, detainees were informed that they could have someone concerned for their welfare informed of their whereabouts. In some cases, they were able to speak directly to a relative or friend, but the phone was often in the main custody area and offered little privacy, though in one suite detainees were allowed to take calls in their cell. Good use was made of telephone interpreting services and face-to-face interpreters were used to communicate with detainees who spoke little or no English.

In Durham, a pre-release risk management plan had recently been introduced for the most vulnerable detainees. We saw one woman being helped to find alternative accommodation, and referrals to social services were made.

There was no formal pre-release planning in most of the force areas inspected. There were inconsistent practices in relation to pre-release risk assessments. Detainees spoke of having to make their own way home in the early hours of the morning. Yet in some forces, staff did conduct checks and make arrangements for vulnerable detainees, women and children to be escorted home or taken by taxi. In one suite in Durham there were pre-release risk assessments.

All detainees were offered free legal representation and were not interviewed if they were under the influence of alcohol or drugs. They were granted eight hours' continuous break from interviewing in a 24-hour period, they could consult a copy of the PACE Code of Practice C, and their legal representatives could obtain a copy of their custody record on request.

As widely reported, mechanisms for ensuring the storage and continuity of forensic evidence were unreliable or poor in most custody suites inspected. In general, the rooms where samples were taken were not forensically clean, and there was no clear accountability or audit of the storage or swift transmission of samples. On many occasions, inspectors found old DNA and other samples, in packed fridges or next to food. This raised the possibility of cross-contamination or of failure to record important evidential samples on the national database.

As we reported last year, inspections have revealed significant concerns about the consistency and governance of healthcare services in police custody. Inspections recorded two models of healthcare delivery: direct contracting of forensic medical examiners (FMEs) by the police force, and services that were contracted out to private healthcare providers. We found examples of good and unsatisfactory provision in both models.

In directly-contracted health services, we did not find that there was any clinical governance, or assurance that staff were appropriately trained for the task. Clinical record-keeping tended to be inconsistent or poor. In contracted-out services, we rarely found that the contract was effectively monitored by the force: for example, there was no record of waiting times or length of time spent with a detainee. In all suites inspected, we could not be sure that all those who needed it were referred for healthcare examination or support, and in four out of the six force areas we had concerns about the length of time between a referral and the arrival of the doctor or nurse. We frequently recorded problems with safe and effective medicines management, and in three of the forces inspected we found FME rooms that failed to meet basic clinical standards.

Mental health provision was a particular concern. There was no assurance that FMEs were approved under section 12 of the Mental Health Act, even where custody suites could be and were used as places of safety under the Act. We also found examples of poor protocols with mental health support services and secure facilities, and ineffective use of diversion schemes. The best arrangements that we found were where mental health support was provided by specialist mental health teams, such as the local prison in-reach team at Islington or the community mental health team in Gloucestershire – though even here there could be delays at the weekend and out of hours.

In general, access to substance misuse services was good, though arrangements for those with drug problems were in general much better developed than those for people with alcohol-only problems.

Overall, our inspections have highlighted consistently good compliance with the requirements of PACE and improving attention to this important area of policing by senior managers. The treatment and conditions of those in custody, however, and the attention to their needs, vary widely and these are issues that senior managers will need to consider.

APPENDICES

Inspections undertaken – 1 September 2008 to 31 August 2009

ESTABLISHMENT	TYPE OF INSPECTION	INSPECTION DATES
Kennet	Full announced	1–5 September 08
Styal	Full announced	1–5 September 08
Lancaster Farms (young adults)	Full unannounced	8–12 September 08
Coldingley	Short follow-up	8–10 September 08
Durham police cells	Announced	22–23 September 08
Leeds Waterside Court non-residential STHF	Unannounced follow-up	22–23 September 08
Askham Grange	Full announced	29 September – 3 October 08
Dovegate Category B	Full announced	29 September – 3 October 08
Dungavel IRC & escorts	Short follow-up	30 September – 2 October 08
Moorland (open and closed)	Short follow-up	6–8 October 08
Eastwood Park	Full announced	13–17 October 08
Stoke Heath (children and young people)	Full announced	13–17 October 08
Wymott	Full announced	20–24 October 08
Featherstone	Full announced	20–24 October 08
West Yorkshire police cells	Announced	27–29 October 08
Ford	Short follow-up	27–29 October 08
Kingston	Short follow-up	3–5 November 08
MCTC	Full announced	3–7 November 08
London City Airport non-residential STHF	Unannounced full	6 November 08
Hull	Full announced	10–14 November 08
New Hall	Full announced	10–14 November 08
Colnbrook IRC, Colnbrook residential STHF & escorts	Full announced	17–21 November 08
Northallerton	Short follow-up	18–20 November 08
Cambridge police cells	Announced	24–26 November 08
Wealstun (open and closed)	Full announced	1–5 December 08
Wakefield	Full announced	1–5 December 08
Parkhurst	Full follow-up	8–12 December 08
Huntercombe	Short follow-up	9–12 December 08
Heathrow escorts	Unannounced	9–11 December 08
John Lennon Airport non-residential STHF	Unannounced follow-up	15 December 08
Glasgow Festival Court non-residential STHF	Unannounced follow-up	6 January 09
Glasgow Airport non-residential STHF	Unannounced follow-up	7 January 09
Everthorpe	Full announced	12–16 January 09
Dover IRC	Short follow-up	19–21 January 09
Maghaberry	Full follow-up	19–23 January 09
Castington (young adults & children and young people)	Full announced	19–23 January 09
Hertfordshire police cells	Announced	26–28 January 09
Haverigg	Full announced	2–6 February 09
Cookham Wood	Post opening	2–9 February 09
Sheffield non-residential STHF	Unannounced full	4 February 09
Camp Hill	Full follow-up	9–13 February 09
Hollesley Bay	Full announced	9–13 February 09
Rochester	Short follow-up	16–18 February 09
Lindholme IRC	Full announced	16–20 February 09
Bedford	Full announced	2–6 March 09
Grendon	Full announced	2–6 March 09

Inspections undertaken – 1 September 2008 to 31 August 2009 (continued)

ESTABLISHMENT	TYPE OF INSPECTION	INSPECTION DATES
Hindley	Pre-opening	3–5 March 09
Aylesbury	Full announced	9–13 March 09
Kirklevington Grange	Short follow-up	9–12 March 09
Holme House	Short follow-up	16–18 March 09
Guernsey	Short follow-up	17–19 March 09
Garth	Full announced	30 March – 3 April 09
Dorchester	Full announced	30 March – 3 April 09
Wayland	Short follow-up	6–10 April 09
Portsmouth Continental Ferry Port non-residential STHF	Unannounced follow-up	6–7 April 09
Low Newton	Short follow-up	20–23 April 09
Wetherby (Keppel Unit)	Post opening	20–24 April 09
Haslar IRC & escorts	Full announced	20–24 April 09
Belmarsh	Full follow-up	27 April – 1 May 09
Elmley	Short follow-up	28–30 April 09
Pentonville	Full announced	11–15 May 09
High Down	Short follow-up	11–13 May 09
North Sea Camp	Full announced	11–15 May 09
Enfield police cells	Announced	18–19 May 09
Eastwood Park	Short follow-up	1–3 June 09
Wandsworth	Full announced	1–5 June 09
Reading	Full announced	1–5 June 09
Electric House non-residential STHF	Unannounced full	6–7 June 09
Lunar House non-residential STHF	Unannounced full	7 June 09
Acklington	Full follow-up	8–12 June 09
Lambeth police cells	Announced	15–17 June 09
Stafford	Short follow-up	15–18 June 09
Parc (children and young people)	Full announced	15–19 June 09
Latchmere House	Short follow-up	29 June – 1 July 09
Werrington	Full announced	29 June – 3 July 09
Rye Hill	Full follow-up	6–10 July 09
Portland	Full announced	6–10 July 09
Ealing police cells	Announced	6–10 July 09
East Sutton Park	Short follow-up	13–15 July 09
Tinsley House IRC	Short follow-up	13–15 July 09
New Hall	Short follow-up	27–29 July 09
Manchester	Full announced	27–31 July 09
Tower Hamlets police cells	Unannounced	27–31 July 09
Chelmsford	Full follow-up	3–7 August 09
Port of Dover residential STHF	Unannounced full	3–7 August 09
Dover asylum screening centre	Unannounced follow-up	3–5 August 09
Stanstead Airport non-residential STHF	Unannounced follow-up	10–11 August 09
Preston	Full announced	10–14 August 09
Deerbolt	Short follow-up	17–19 August 09
Gatwick North and South non-residential STHFs and escorts	Unannounced full	17–21 August 09
Leicestershire police cells	Announced	24–28 August 09

Inspection reports published – 1 September 2008 to 31 August 2009

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Lowdham Grange	Short follow-up	2 September 08
Swansea	Short follow-up	3 September 08
Blantyre House	Short follow-up	9 September 08
Preston	Short follow-up	10 September 08
Holloway	Full follow-up	16 September 08
Swaleside	Full announced	23 September 08
Foston Hall (Toscana Unit)	Full announced	25 September 08
Swinfen Hall	Short follow-up	30 September 08
Risley	Full follow-up	8 October 08
Whitemoor	Full follow-up	10 October 08
Brixton	Full announced	21 October 08
Harwich International Port residential STHF	Unannounced follow-up	28 October 08
Reliance House non-residential STHF	Unannounced follow-up	28 October 08
Sandford House non-residential STHF	Unannounced follow-up	28 October 08
Gartree	Short follow-up	30 October 08
Erlestoke	Full announced	31 October 08
Downview	Full announced	4 November 08
Downview (Josephine Butler Unit)	Short follow-up	4 November 08
Shepton Mallet	Short follow-up	5 November 08
Islington police custody suites	Announced	12 November 08
Wormwood Scrubs	Full unannounced	18 November 08
Stocken	Short follow-up	25 November 08
Campsfield House IRC	Full follow-up	2 December 08
Campsfield House escorts		2 December 08
Dovegate Therapeutic Community	Full announced	9 December 08
Hillingdon police custody suites	Announced	11 December 08
Oakington IRC	Full announced	12 December 08
Leicester	Full announced	19 December 08
Peterborough (men)	Short follow-up	9 January 09
Peterborough (women)	Short follow-up	9 January 09
Long Lartin	Full announced	13 January 09
Thorn Cross	Short follow-up	20 January 09
Send	Short follow-up	27 January 09
Birmingham International Airport non-residential STHF	Unannounced follow-up	30 January 09
Blundeston	Short follow-up	3 February 09
Gloucestershire police custody suites	Announced	10 February 09
Wetherby	Full announced	11 February 09
Brinsford (children and young people)	Full announced	19 February 09
Leeds Waterside Court non-residential STHF	Unannounced follow-up	20 February 09
Dungavel IRC	Short follow-up	24 February 09
Styal	Full announced	26 February 09
Lancaster Farms	Full unannounced	27 February 09
Spring Hill	Full announced	3 March 09
Coldingley	Short follow-up	18 March 09
Wellingborough	Full announced	24 March 09

Inspection reports published – 1 September 2007 to 31 August 2008 (continued)

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Askham Grange	Full announced	27 March 09
Ashfield	Short follow-up	1 April 09
Parc (adults & young adults)	Full follow-up	2 April 09
Dovegate Category B	Full announced	7 April 09
Kennet	Full announced	15 April 09
Featherstone	Full announced	20 April 09
Kingston	Short follow-up	22 April 09
Military Corrective Training Centre	Full announced	22 April 09
Durham police custody suites	Announced	28 April 09
London City Airport non-residential STHF	Unannounced full	1 May 09
John Lennon Airport non-residential STHF	Short follow-up	1 May 09
Wymott	Full announced	5 May 09
Ford	Short follow-up	7 May 09
Stoke Heath (children and young people)	Full announced	12 May 09
Northallerton	Short follow-up	13 May 09
Dungavel IRC escorts	Unannounced	15 May 09
Glasgow Airport non-residential STHF	Unannounced follow-up	15 May 09
Glasgow Festival Court non-residential STHF	Unannounced follow-up	15 May 09
Wealstun (open and closed)	Full announced	19 May 09
Parkhurst	Full follow-up	20 May 09
New Hall	Full announced	28 May 09
Wakefield	Full announced	29 May 09
Colnbrook IRC & Colnbrook residential STHF	Full announced	2 June 09
Eastwood Park	Full announced	3 June 09
Hull	Full announced	9 June 09
Haverigg	Full announced	10 June 09
Huntercombe	Short follow-up	16 June 09
Everthorpe	Full announced	18 June 09
Hollesley Bay	Full announced	19 June 09
Castington (young adults & children and young people)	Full announced	23 June 09
West Yorkshire police custody suites	Announced	1 July 09
Rochester	Short follow-up	2 July 09
Moorland (open and closed)	Short follow-up	3 July 09
Sheffield non-residential STHF	Unannounced full	3 July 09
Dover IRC	Short follow-up	7 July 09
Maghaberry	Full follow-up	21 July 09
Camp Hill	Full follow-up	30 July 09
Cambridge police cells	Announced	4 August 09
Cookham Wood	Post-opening	5 August 09
Kirklevington Grange	Short follow-up	11 August 09
Aylesbury	Full announced	14 August 09
Grendon	Full announced	18 August 09
Guernsey	Short follow-up	19 August 09
Hindley	Pre-opening	20 August 09
Lindholme IRC	Full announced	25 August 09
Portsmouth Continental Ferry Port non-residential STHF	Unannounced follow-up	25 August 09
Garth	Full announced	26 August 09
Dorchester	Full announced	28 August 09

YOI summaries of questionnaires and interviews

TITLE	DATE PUBLISHED
Lancaster Farms	1 October 08
Stoke Heath	10 October 08
Eastwood Park, Mary Carpenter Unit	16 October 08
New Hall, Rivendell Unit	13 November 08
Cookham Wood	18 November 08
Warren Hill & Carlford Unit	25 November 08
Huntercombe	9 December 08
Castington	29 January 09
Wetherby	1 May 09
Eastwood Park, Mary Carpenter Unit	12 June 09
Ashfield	26 June 09
Parc	26 June 09
Werrington	20 July 09
New Hall, Rivendell Unit	23 July 09

Other publications

TITLE	DATE PUBLISHED
Prisoners under escort	19 September 08
London prisons offender management inspection	23 September 08
The indeterminate sentence for public protection (thematic review)	15 October 08
Welsh prisons offender management inspection	9 December 08
Annual report 2007–08	29 January 09
The prison characteristics that predict prisons being assessed as performing 'well' (thematic review)	29 January 09
West Midlands prisons offender management inspection	3 February 09
Commissioning healthcare in prisons	12 February 09
Disabled prisoners (thematic review)	17 March 09
Race relations in prisons: responding to adult women from black and minority ethnic backgrounds (thematic review)	31 March 09
Children and young people in custody 2006–08	27 April 09
Yorkshire and Humberside offender management inspection	5 May 09
Business plan 2009–10	8 May 09
Expectations – updated diversity section	29 June 09
North East offender management inspection	14 July 09
Prolific and other priority offenders	16 July 09
Expectations for children and young people	29 July 09
Detainee escorts and removals (thematic review)	13 August 09

Recommendations accepted

PRISONS				
ESTABLISHMENT	RECOMMENDATIONS	ACCEPTED	PARTIALLY ACCEPTED	REJECTED
LOCAL PRISONS				
Brixton	168	132	18	18
Leicester	176	161	10	5
Wormwood Scrubs	165	146	9	10
Total	**509**	**439 (86%)**	**37 (7%)**	**33 (6%)**
HIGH SECURE PRISONS				
Long Lartin	144	119	24	1
Wakefield	200	171	20	9
Total	**344**	**290 (84%)**	**44 (13%)**	**10 (3%)**
TRAINER PRISONS				
Dovegate Cat B	187	181	0	6
Dovegate Therapeutic Community	149	131	2	16
Erlestoke	183	173	7	3
Everthorpe	-	-	-	-
Featherstone	149	146	2	1
Garth	-	-	-	-
Grendon	119	100	7	12
Haverigg	199	172	20	7
Kennet	141	126	8	7
Swaleside	118	115	2	1
Wealstun	188	168	18	2
Wellingborough	203	176	17	10
Wymott	140	130	5	5
Total	**1,776**	**1,618 (91%)**	**88 (5%)**	**70 (4%)**
OPEN PRISONS				
Hollesley Bay	99	87	9	3
Spring Hill	119	109	10	0
Total	**218**	**196 (90%)**	**19 (9%)**	**3 (1%)**
SPLIT SITES (LOCAL AND TRAINER)				
Hull	200	166	21	13
Total	**200**	**166 (83%)**	**21 (11%)**	**13 (7%)**
SPLIT SITES (LOCAL AND YOUNG ADULTS)				
Dorchester	-	-	-	-
Lancaster Farms	171	145	15	11
Total	**171**	**145 (85%)**	**15 (9%)**	**11 (6%)**
SPLIT SITES (JUVENILES AND YOUNG ADULTS)				
Castington	-	-	-	-
Total	**-**	**-**	**-**	**-**
YOUNG ADULT ESTABLISHMENTS				
Aylesbury	-	-	-	-
Total	**-**	**-**	**-**	**-**

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Recommendations accepted (continued)

PRISONS				
ESTABLISHMENT	RECOMMENDATIONS	ACCEPTED	PARTIALLY ACCEPTED	REJECTED
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS				
Brinsford	212	195	10	7
Foston Hall – Toscana Unit	91	81	7	3
Stoke Heath	144	120	16	8
Wetherby	169	156	8	5
Total	**616**	**552 (90%)**	**41 (7%)**	**23 (4%)**
WOMEN'S PRISONS				
Askham Grange	91	77	8	6
Downview	164	154	8	2
Eastwood Park	-	-	-	-
New Hall	221	201	11	9
Styal	203	175	21	7
Total	**679**	**607 (89%)**	**48 (7%)**	**24 (4%)**
PRISON TOTAL	4,513	4,013 (89%)	313 (7%)	187 (4%)

IMMIGRATION REMOVAL CENTRES (IRCs) and SHORT-TERM HOLDING FACILITIES (STHFs)				
ESTABLISHMENT	RECOMMENDATIONS	ACCEPTED	PARTIALLY ACCEPTED	REJECTED
IMMIGRATION REMOVAL CENTRES				
Colnbrook	125	122	0	3
Lindholme	-	-	-	-
Oakington	111	94	8	9
Total	**236**	**216 (92%)**	**8 (3%)**	**12 (5%)**
SHORT TERM HOLDING FACILITIES				
Harwich International Port Residential	42	38	3	1
London City Airport	30	23	4	3
Total	**72**	**61 (85%)**	**7 (10%)**	**4 (6%)**
IMMIGRATION TOTAL	308	277 (90%)	15 (5%)	16 (5%)

KEY TO TABLE: Hyphen (-) indicates that outstanding action plans were not returned within the deadline

Outcome of recommendations assessed in follow-up inspection reports published 2008–09

PRISONS				
ESTABLISHMENT	**RECOMMENDATIONS**	**ACHIEVED**	**PARTIALLY ACHIEVED**	**NOT ACHIEVED**
LOCAL PRISONS				
Peterborough	218	81	69	68
Preston	89	46	29	14
Swansea	144	42	43	59
Parc	155	62	44	49
Total	**606 (100%)**	**231 (38%)**	185 (31%)	**190 (31%)**
HIGH SECURE PRISONS				
Whitemoor	138	63	26	49
Total	**138 (100%)**	**63 (46%)**	**26 (19%)**	**49 (36%)**
TRAINER PRISONS				
Blundestone	127	62	28	37
Camp Hill	154	40	27	87
Coldingley	90	43	22	25
Gartree	143	47	36	60
Kingston	92	39	24	29
Lowdham Grange	109	50	32	27
Parkhurst	115	28	24	63
Risley	163	60	39	64
Shepton Mallet	104	63	18	23
Stocken	110	41	31	38
Moorlands	161	65	43	53
Total	**1,368 (100%)**	**538 (39%)**	**324 (24%)**	**506 (37%)**
OPEN PRISONS				
Ford	100	52	23	25
Total	**100 (100%)**	**52 (52%)**	**23 (23%)**	**25 (25%)**
RESETTLEMENT PRISONS				
Blantyre House	37	20	5	12
Kirklevington Grange	56	23	11	22
Total	**93 (100%)**	**43 (46%)**	**16 (17%)**	**34 (37%)**
YOUNG ADULT ESTABLISHMENTS				
Northallerton	111	50	29	32
Rochester	93	31	18	44
Swinfen Hall	105	61	18	26
Thorn Cross	83	46	21	16
Total	**392 (100%)**	**188 (48%)**	**86 (22%)**	**118 (30%)**
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS				
Ashfield	122	64	26	32
Downview – Josephine Butler Unit (Girls)	74	43	14	17
Huntercombe	169	80	30	59
Total	**365 (100%)**	**187 (51%)**	**70 (19%)**	**108 (30%)**
WOMEN'S PRISONS				
Holloway	136	65	38	33
Peterborough	226	91	75	60
Send	109	34	34	41
Total	**471 (100%)**	**190 (40%)**	**147 (31%)**	**134 (28%)**

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Outcome of recommendations assessed in follow-up inspection reports published 2008–09 (continued)

PRISONS				
ESTABLISHMENT	RECOMMENDATIONS	ACHIEVED	PARTIALLY ACHIEVED	NOT ACHIEVED
EXTRA-JURISDICTION				
Guernsey	151	61	31	59
Maghaberry	155	44	28	83
Total	**306 (100%)**	**105 (34%)**	**59 (19%)**	**142 (46%)**
PRISON TOTAL	3,839 (100%)	1,597 (42%)	936 (24%)	1,306 (34%)

IMMIGRATION REMOVAL CENTRES (IRCs) and SHORT-TERM HOLDING FACILITIES (STHFs)				
ESTABLISHMENT	RECOMMENDATIONS	ACHIEVED	PARTIALLY ACHIEVED	NOT ACHIEVED
IMMIGRATION REMOVAL CENTRES				
Campsfield House	82	35	23	24
Dover	82	26	18	38
Dungavel	69	36	14	19
Total	**233 (100%)**	**97 (42%)**	**55 (24%)**	**81 (35%)**
SHORT TERM HOLDING FACILITIES				
Reliance House	23	7	9	7
Sandford House	24	5	9	10
Birmingham International Airport	32	13	9	10
Waterside Court	37	9	11	17
John Lennon Airport	24	7	7	10
Glasgow Airport	37	20	9	8
Glasgow Festival Court	36	16	11	9
Portsmouth Continental Ferry Port	31	6	11	14
Total	**244 (100%)**	**83 (34%)**	**76 (31%)**	**85 (35%)**
IMMIGRATION TOTAL	477 (100%)	180 (38%)	131 (27%)	166 (35%)

Healthy prison and establishment assessments

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
LOCAL PRISONS					
Brixton	FA	2	2	2	2
Dorchester	FA	4	3	3	3
Hull	FA	3	3	3	3
Leicester	FA	3	2	2	3
Peterborough	SFU	3	2	3	3
Preston	SFU	3	3	2	3
Swansea	SFU	3	3	2	3
Wormwood Scrubs	FU	2	3	2	3
HIGH SECURE PRISONS					
Long Lartin	FA	3	3	3	3
Wakefield	FA	3	3	3	2
Whitemoor	FFU	2	2	3	3
TRAINER PRISONS					
Blundeston	SFU	3	3	4	3
Camp Hill	FFU	2	2	2	2
Coldingley	SFU	4	3	3	3
Dovegate Cat B	FA	3	3	3	2
Erlestoke	FA	2	2	4	3
Everthorpe	FA	3	3	3	3
Featherstone	FA	3	3	3	4
Garth	FA	3	4	4	3
Gartree	SFU	2	3	2	2
Haverigg	FA	1	2	2	2
Kennet	FA	4	3	2	2
Kingston	SFU	4	3	3	3
Lowdham Grange	SFU	3	3	3	2
Parkhurst	FFU	1	1	1	2
Risley	FFU	2	2	2	3
Shepton Mallet	SFU	4	3	3	3
Stocken	SFU	3	2	3	2
Swaleside	FA	4	3	2	3
Wealstun	FA	3	3	3	4
Wellingborough	FA	3	2	1	1
Wymott	FA	3	3	4	3
THERAPEUTIC COMMUNITY PRISONS					
Dovegate TC	FA	3	3	3	2
Grendon	FA	4	4	3	3
OPEN PRISONS					
Ford	SFU	3	2	3	2
Hollesley Bay	FA	4	3	4	3
Spring Hill	FA	4	3	4	3
RESETTLEMENT PRISONS					
Blantyre House	SFU	4	4	4	3
Kirklevington Grange	SFU	4	3	3	4

Healthy prison and establishment assessments (continued)

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
SPLIT SITE TRAINER AND OPEN PRISON					
Moorland	SFU	3	2	3	2
SPLIT SITE LOCAL AND YOUNG ADULT PRISON					
Parc	FFU	3	2	2	3
YOUNG ADULT ESTABLISHMENTS					
Aylesbury	FA	3	3	2	3
Castington	FA	2	3	3	4
Lancaster Farms	FA	2	2	2	2
Northallerton	SFU	3	2	2	3
Rochester	SFU	3	3	2	3
Swinfen Hall	SFU	3	3	3	3
Thorn Cross	SFU	4	4	4	3
CHILDREN AND YOUNG PEOPLE'S ESTABLISHMENTS					
Ashfield	SFU	3	3	4	3
Brinsford	FA	2	3	2	3
Castington	FA	2	3	4	4
Cookham Wood	FA (Post opening)	1	2	3	3
Downview - Josephine Butler Unit (Girls)	SFU	3	3	4	3
Foston Hall - Toscana Unit (Girls)	FA	3	4	3	4
Huntercombe	SFU	2	3	3	3
Stoke Heath	FA	3	3	3	3
Wetherby	FA	3	3	3	3
WOMEN'S PRISONS					
Askham Grange	FA	4	4	4	4
Downview	FA	3	3	3	3
Eastwood Park	FA	3	3	3	3
Holloway	FFU	2	2	3	3
New Hall	FA	3	2	3	3
Peterborough	SFU	3	2	3	2
Send	SFU	2	3	3	3
Styal	FA	2	4	3	3
EXTRA-JURISDICTION					
Guernsey	SFU	3	3	2	3
Maghaberry	FFU	1	2	1	2
MILITARY CORRECTION AND TRAINING CENTRE					
Colchester	FA	3	3	3	2
IMMIGRATION REMOVAL CENTRES					
Campsfield House	FFU	3	3	2	3
Colnbrook	FA	2	2	3	3
Dover	SFU	3	3	3	2
Dungavel	SFU	3	4	3	3
Lindholme	FA	2	3	3	2
Oakington	FA	2	2	3	2

KEY TO TABLE: **Numeric: 1** – Performing poorly, **2** – Not performing sufficiently well, **3** – Performing reasonably well, **4** – Performing well
Type of inspection: **FFU** – Full follow-up, **SFU** – Short follow-up, **FA** – Full announced, **FU** – Full unannounced

2008–09 survey responses: ethnicity / religion / disability

		Black and minority ethnic prisoners	White prisoners	Muslim prisoners	Non-Muslim prisoners	Consider themselves to have a disability	Do not consider themselves to have a disability
	Number of completed questionnaires returned	1,037	2,890	422	3,435	559	3,170
		%	%	%	%	%	%
1d	Was the attention paid to your health needs good/very good?	27	32	27	31	27	31
3	Were you treated well/very well by the escort staff?	61	65	54	65	58	65
4a	Did you know where you were going when you left court or when transferred from another prison?	72	82	69	81	71	82
1	In the first 24 hours, did staff ask you if you needed help/support with the following:						
1e	Problems contacting family?	51	49	44	50	45	50
1h	Problems of feeling depressed/suicidal?	41	52	42	51	50	50
1i	Health problems?	60	59	58	60	56	60
2	When you first arrived:						
2a	Did you have any problems?	73	64	73	65	80	63
3a	Were you seen by a member of health services in reception?	84	84	83	84	82	85
3b	When you were searched in reception, was this carried out in a respectful way?	67	77	61	77	67	77
4	Were you treated well/very well in reception?	60	68	56	67	60	67
7	Within the first 24 hours did you meet any of the following people:						
7b	Someone from health services?	69	74	66	74	73	74
9	Did you feel safe on your first night here?	70	78	63	78	63	79
10	Have you been on an induction course?	86	85	87	85	81	87
1	In terms of your legal rights, is it easy/very easy to:						
1a	Communicate with your solicitor or legal representative?	43	50	44	49	43	49
3	For the wing/unit you are currently on:						
3a	Are you normally offered enough clean, suitable clothes for the week?	50	57	47	56	57	55
3b	Are you normally able to have a shower every day?	84	90	80	90	87	89
3e	Is your cell call bell normally answered within five minutes?	39	37	36	38	36	38
4	Is the food in this prison good/very good?	24	31	22	30	29	29
5	Does the shop/canteen sell a wide enough range of goods to meet your needs?	37	51	35	49	44	48
6a	Is it easy/very easy to get a complaints form?	78	85	74	84	79	84
6b	Is it easy/very easy to get an application form?	84	89	82	89	82	89
9	Have you made a complaint?	56	51	57	51	56	51
13a	Do you feel your religious beliefs are respected?	56	53	61	53	53	54
13b	Are you able to speak to a religious leader of your faith in private if you want to?	63	55	73	56	54	58
14	Are you able to speak to a Listener at any time, if you want to?	48	59	48	57	58	56
15a	Is there a member of staff, in this prison, that you can turn to for help if you have a problem?	68	75	61	75	68	74
15b	Do most staff, in this prison, treat you with respect?	64	72	60	71	65	70
1	Have you ever felt unsafe in this prison?	45	38	50	38	57	36
2	Do you feel unsafe in this prison at the moment?	21	16	24	16	29	15
4	Have you been victimised by another prisoner?	25	24	25	24	37	21
5	Since you have been here, has another prisoner:						
5d	Victimised you because of your race or ethnic origin?	10	2	10	3	5	4
5i	Victimised you because you have a disability?	1	3	1	3	12	1
5j	Victimised you because of your religion/religious beliefs?	6	2	9	2	5	3
6	Have you been victimised by a member of staff?	32	23	38	24	33	25

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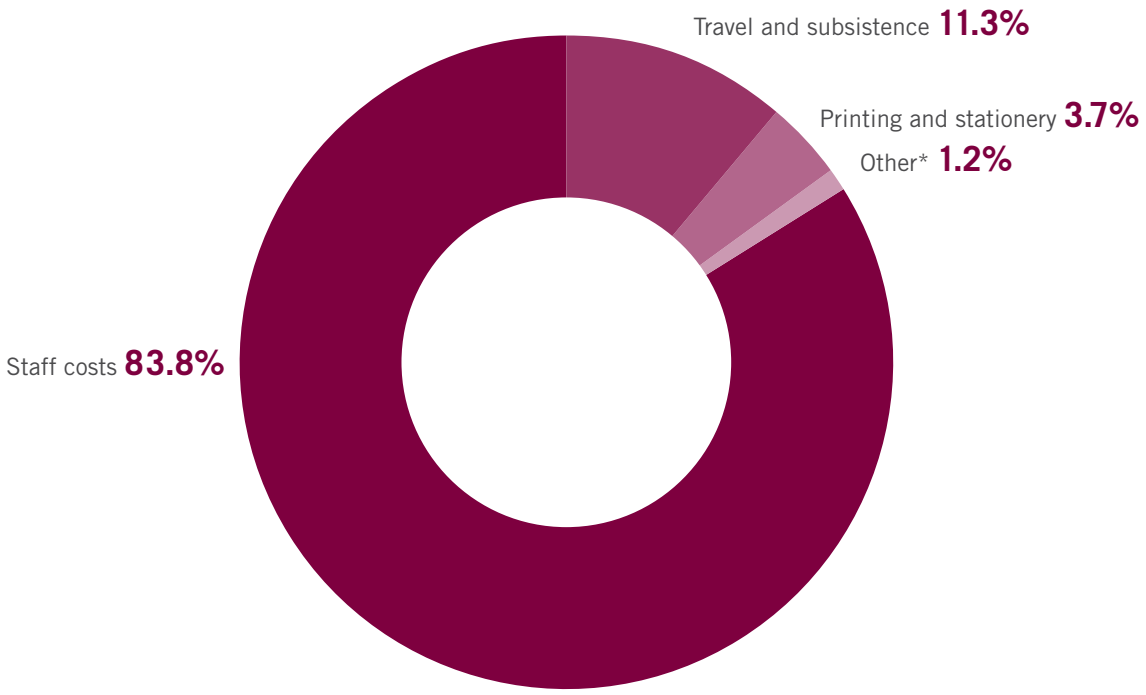
2008–09 survey responses: ethnicity / religion / disability (continued)

		Black and minority ethnic prisoners	White prisoners	Muslim prisoners	Non-Muslim prisoners	Consider themselves to have a disability	Do not consider themselves to have a disability
	Number of completed questionnaires returned	1,037	2,890	422	3,435	559	3,170
		%	%	%	%	%	%
7	Since you have been here, has a member of staff:						
7d	Victimised you because of your race or ethnic origin?	15	2	20	3	6	5
7h	Victimised you because you have a disability?	2	3	1	2	12	1
7i	Victimised you because of your religion/religious beliefs?	9	2	17	2	5	4
9	Have you ever felt threatened or intimidated by another prisoner/group of prisoners in here?	25	28	24	28	42	25
10	Have you ever felt threatened or intimidated by a member of staff in here?	29	21	34	22	32	22
11	Is it easy/very easy to get illegal drugs in this prison?	27	38	26	36	35	34
1a	Is it easy/very easy to see the doctor?	36	39	33	39	40	37
1b	Is it easy/very easy to see the nurse?	61	63	59	63	66	61
2	Are you able to see a pharmacist?	48	49	44	50	44	50
5	Are you currently taking medication?	37	48	39	46	72	40
7	Do you feel you have any emotional well being/mental health issues?	22	30	26	29	52	24
1	Are you currently involved in any of the following activities:						
1a	A prison job?	55	64	53	63	52	63
1b	Vocational or skills training?	22	17	22	17	14	19
1c	Education (including basic skills)?	47	30	50	32	33	34
1d	Offending behaviour programmes?	18	17	21	17	12	18
3	Do you go to the library at least once a week?	42	43	41	43	39	44
4	On average, do you go to the gym at least twice a week?	60	46	57	49	31	54
5	On average, do you go outside for exercise three or more times a week?	41	45	41	45	35	47
6	On average, do you spend ten or more hours out of your cell on a weekday?	10	14	9	14	10	14
7	On average, do you go on association more than five times each week?	59	70	62	68	64	69
8	Do staff normally speak to you most of the time/all of the time during association?	19	22	19	21	21	21
1	Do you have a personal officer?	62	71	65	69	70	69
9	Have you had any problems with sending or receiving mail?	43	40	49	39	44	40
10	Have you had any problems getting access to the telephones?	27	22	31	23	26	22
11	Did you have a visit in the first week that you were here?	29	29	29	29	23	30

KEY TO TABLE

- Significantly better than the comparator
- Significantly worse than the comparator
- There is no significant difference

Expenditure for April 2008 to March 2009



* Includes: information technology and telecommunications, translators, meetings and refreshments, recruitment, conferences, training and development.

PURPOSE	EXPENDITURE (£)
Staff costs	3,060,495
Travel and subsistence	412,534
Printing and stationery	135,831
Information technology and telecommunications	12,546
Translators	12,497
Meetings and refreshments	4,413
Recruitment	8,490
Conferences	3,287
Training and development	2,463
Total	3,652,556

Inspectorate staff

	Anne Owers	Chief Inspector
	Nigel Newcomen	Deputy Chief Inspector
	Barbara Buchanan	Senior Personal Secretary to the Chief Inspector
	Michelle Reid	Personal Secretary to the Deputy Chief Inspector
A TEAM (adult males)	Sara Snell	Team Leader
	Vinnett Pearcy	Inspector
	Karen Dillon	Inspector
	Andrew Rooke	Inspector
O TEAM (women)	Michael Loughlin	Team Leader
	Joss Crosbie	Inspector
	Paul Fenning	Inspector
	Hayley Folland	Inspector
	Martin Owens	Inspector
N TEAM (young adults)	Martin Lomas	Team Leader
	Keith McInnis	Inspector
	Marie Orrell	Inspector
	Andrea Walker	Inspector
	Stephen Moffatt	Inspector (part time)
	Gordon Riach	Inspector (part time)
J TEAM (juveniles)	Fay Deadman	Team Leader
	Ian Macfadyen	Inspector
	Ian Thomson	Inspector
I TEAM (immigration detention)	Hindpal Singh Bhui	Team Leader
	Lucy Young	Inspector
	Martin Kettle	Inspector
P TEAM (police custody suites)	Sean Sullivan	Team Leader
	Anita Saigal	Inspector
HEALTH SERVICES TEAM	Elizabeth Tysoe	Head of Health Services Inspection
	Mandy Whittingham	Deputy Head of Health Services Inspection
	Michael Bowen	Health Inspector (part time)
	Bridget McEvilly	Health Inspector (part time)
	Nicola Rabjohns	Health Inspector (part time)
	Sigrid Engelen	Drugs and Alcohol Inspector (part time)
	Paul Roberts	Drugs and Alcohol Inspector (part time)
RESEARCH, DEVELOPMENT AND THEMATICS	Louise Falshaw	Head of Research, Development and Thematics
	Samantha Booth	Senior Researcher
	Laura Nettleingham	Senior Researcher
	Sherelle Parke	Researcher
	Catherine Nichols	Researcher
	Michael Skidmore	Researcher
	Adam Altoft	Researcher
	Hayley Cripps	Researcher
	Amy Summerfield	Researcher
	Lucy Trussler	Research Trainee
	Amy Pearson	Research Trainee

(continued on next page)

Inspectorate staff (continued)

ADMINISTRATION	**Angela Johnson**	**Head of Administration**
	Tamsin Williamson	**Publications Manager**
	Stephen Seago	**Senior Administration Officer**
	Francette Montgry	**Administration Officer**
EDITORS	**Brenda Kirsch**	
	Adrienne Penfield	
	Emily Wood	
	Anne Fragniere	
STAFF WHO LEFT DURING THE REPORTING PERIOD	**Jonathan French**	
	Gail Hunt	
	Susan Fenwick	
	Gemma Kelly	
	Julia Fossi	
	Deborah Tye	
	Rachel Murray	
	Eileen Bye	
	Margot Nelson-Owen	

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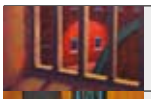
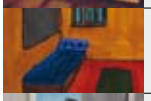
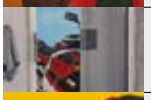
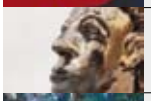
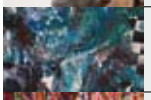
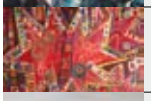
	***Christmas morning*** (oil on canvas)	HMP Preston	cover picture
	***Room with a view 2*** (watercolour)	HMP Lewes	page 4
	***The out*** (acrylic on canvas)	HMP Whatton	page 10
	***Heart and soul*** (acrylic on canvas)	HMP Styal	page 18
	***Thank you miss*** (sculpture)	Hydebank Wood YOC	page 26
	***Tapestry of elements*** (collage)	HMP Styal	page 34
	***Universe #2*** (acrylic on paper)	HMP Grendon	page 44
	***One off*** (oil on canvas)	Maghaberry Prison	page 50
	***All walks of life*** (recycling)	HMP Peterborough	page 58
	***Aboriginal fish*** (acrylic on paper)	Harmondsworth IRC	page 70
	***Starry plateau*** (mixed media)	Maghaberry Prison	page 78

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