HM Chief Inspector of Prisons for England and Wales

Annual Report 2013–14

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

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One small but important part of the 'total experience of imprisonment' is the arts activities available in prisons. These are, however, increasingly under pressure and too often seen as an expendable extra whose benefit is hard to 'measure'. The arts are a lifeline from despair for some prisoners, a gateway to improvement for others and an antidote to both tedium and tension for many. We have illustrated the report this year with examples of art projects in prisons to underline our view of their continued value and to pay tribute to the staff, volunteers and prisoners who make their provision possible.

Cover image:
'Light at the End of the Tunnel', HMP Everthorpe, winner of a Shearman Bowen Platinum Award for Painting in the 2014 Koestler Awards. The Koestler Trust is the UK's best-known prison arts charity and has been awarding, exhibiting and selling artworks by offenders, detainees and secure patients for over 50 years. The Koestler Awards receive over 8,000 entries a year – inspiring offenders to take part in the arts, work for achievement and transform their lives. www.koestlertrust.org.uk

WHO WE ARE AND WHAT WE DO

Our 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.

Our values

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

Our approach

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

Expectations for inspections of prisons and immigration detention facilities are based on four tests of a healthy establishment.[1] For prisons, the four tests are:

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

The tests for immigration detention facilities are similar but also take into account the specific circumstances applying to detainees and the fact that they have not been charged with a criminal offence or detained through normal judicial processes. The other forms of detention we inspect are also based on variants of these tests, as we describe in the relevant section of the report. For inspections of prisons and immigration detention facilities, we make an assessment of outcomes for prisoners or detainees against each test. These range from good to poor as follows:

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

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

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

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

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

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

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

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

Until 31 March 2013, each adult prison and immigration detention centre received a full main inspection at least every five years and a follow-up inspection to review progress against recommendations in the intervening period. Inspections were either 'announced' or 'unannounced'. Follow-up inspections were 'full' or 'short', according to our assessment of risk. Establishments holding children and young people received a main inspection on a three-year cycle. From 1 April 2013, all inspections have been unannounced (other than in exceptional circumstances) and most inspections have followed up recommendations made at the previous inspection. This report includes some inspections from our 2012–13 programme that were published in 2013–14.

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

OPCAT and the National Preventive Mechanism

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

1

Introduction
by the Chief Inspector of Prisons

In 1999, HM Inspectorate of Prisons published its seminal thematic report 'Suicide is Everyone's Concern'.[2] In his preface to the report, the Chief Inspector at the time, David, now Lord, Ramsbotham explained that the review was undertaken at the request of Ministers who were concerned that the number of suicides in prisons had risen from 68 in 1997–98 to 83 in 1998–99. The report set out the concept of a 'healthy prison', now internationally recognised and central to the Inspectorate's work to this day, and included a call that everyone concerned with prisons, from top to bottom, should accept accountability for reducing the number of suicides:

> "Central to my recommendations is the need for a ringing declaration from the Home Secretary, through the Director-General, to everyone in the Prison Service, that suicide and self-harm can and will be reduced, and that accountability for delivering that reduction begins at the top and goes right down to the bottom. If this needs resources these must be made available, but personal commitment does not cost money."

Ramsbotham concluded that 'The total experience of imprisonment affects suicidal behaviour',[3] and reflected this in four tests of a 'healthy prison'.[4] He announced they would form the basis of all future inspections and these tests remain very similar to those we use in prisons today:

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

We use adapted versions of the tests for different types of custody and in some cases the standards or language we use also reflects the requirements of partner inspectorates – but essentially the basic principles remain the same. Each test is underpinned by 'Expectations' or inspection standards, all linked to international human rights standards and norms.

In the years since we first introduced these tests we have learnt more about how they connect with each other. For example, it is not just that treating any detainee as an individual, keeping them busy and giving them hope for the future is essential to keeping them safe, important though that is; it is also that detainees are unlikely to engage positively in activity if they do not feel safe and will not have been prepared adequately for release if their treatment in detention has left them institutionalised.

2 *Her Majesty's Inspectorate of Prisons for England and Wales, Suicide is Everyone's Concern: A Thematic Review by HM Chief Inspector of Prisons for England and Wales*, May 1999, www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/07/suicide-is-everyones-concern-1999-rps.pdf
3 Ibid, p.57
4 Ibid, p.60

In my first annual report for 2010–11, I said I wanted to:

> "set a baseline for the work of the Inspectorate itself and the state of the institutions it inspects. I hope this will provide a useful point of comparison as the work of the Inspectorate develops over the next few years and the government's reforms take effect."[5]

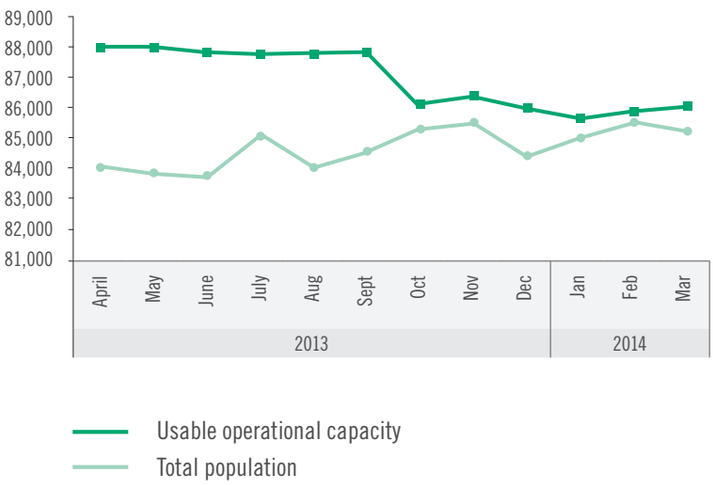
This year, as every year since, my report uses the framework of the healthy prison tests to assess progress.

Prisons

There is no doubt that the pressures on prisons were very significant in 2013–14. The National Offender Management Service (NOMS) as a whole delivered further savings of £274 million which represented 7% of its resource budget. This included a reduction of 4% (£84 million) in public sector prison running costs, mainly as a result of benchmarking and competition processes, and £88 million as a result of the closure of older prisons and their planned replacement with cheaper places elsewhere. Benchmarking was applied first in adult male prisons. Four prisons closed by January 2014 and others changed their role during the year. Prison costs will reduce by £2,200 per place by the end of 2015–16.[6] In the short-term at least, the planned staffing reductions these changes involved resulted in a significant loss of more experienced staff as old prisons closed; new prisons with inexperienced staff, such as Oakwood and Thameside, struggled. This was exacerbated by significant, long-lasting but unplanned vacancies, particularly in London and the South East of England. The staffing reductions followed closely on the heels of the 'Fair and Sustainable' programme that changed the role of front-line managers and supervisors, reduced their number and sometimes allocated them to individuals who were unfamiliar or unhappy with their new responsibilities. Whether or not the resources that will remain once these reductions have been completed will be adequate, there is no doubt that the process of making the changes involved has been distracting and challenging for prison managers throughout 2013–14.

At the end of April 2013, the total prison population stood at 84,083 which was 96% of the usable operational capacity of 87,930. On 28 March 2014 the total population had unexpectedly increased above projections to 85,252 which was 99% of the usable operational capacity of 85,972.[7] These population pressures had become particularly intense from the autumn of 2013 onwards, as shown in Figure 1. The population is not spread evenly and this led to significant overcrowding in many prisons. Overcrowding is not simply an issue of prisoners being doubled-up in cells designed for one but means that the purposeful activities, rehabilitation programmes and other services and facilities are insufficient for the size of the population.

Figure 1: Prison population and usable capacity[8]



5 *HM Chief Inspector of Prisons for England and Wales Annual Report 2010–11*, London, The Stationery Office, 2011
6 *National Offender Management Service Annual Report and Accounts 2013–14*, HMSO, 2014
7 *Prisons and Probations Statistics, Population Bulletin* – Weekly 26 April 2013 and Population Bulletin – Weekly 28 March 2014, Ministry of Justice
8 *Prisons and Probations Statistics, Weekly Population Bulletins* – final week each month April 2013 to March 2014, Ministry of Justice

At the same time, prisons have also been required to deliver a significant new policy agenda.

- From April 2015 the Transforming Rehabilitation programme is intended to ensure most prisoners serving short sentences and most of those in the final months of a longer sentence are held in 'resettlement prisons' in or connected to the area in which they will settle, with commissioned 'through-the-gate' resettlement services organised by new Community Rehabilitation Companies.
- Changes to the incentives and earned privileges (IEP) scheme have made it harder for prisoners to earn privileges.
- Following some disastrous failures, procedures for granting release on temporary licence (ROTL) to aid prisoners' rehabilitation, usually as they near the end of their sentence, have been tightened.

Under each healthy prison test we assess outcomes for prisoners as being 'good', 'reasonably good', 'not sufficiently good' or 'poor' and the percentage of establishments we assessed as 'good' or 'reasonably good' since 2005–06 is shown in Figure 2 below.

This report summarises findings from individual inspection reports published in 2013–14, most of which took place in 2013. However, as the final column of Figure 2 shows, inspections that took place in the remainder of 2013–14 but with reports published in 2014–15 revealed a sharp decline in outcomes. Care has to be taken comparing one year with another, and with part years, as different establishments are inspected each year, but these findings are undoubtedly a cause for great concern.

The safety outcomes we reported on in 2013–14 declined significantly from the previous year. Safety outcomes were worst in adult male local prisons and not good enough in a third of all the prisons inspected. We too often found weaknesses in basic safety processes. Critical risk assessments for new prisoners, at their most vulnerable time in custody, had gaps. Too many prisoners in crisis were held in segregation in poor conditions and without the exceptional circumstances required to justify this. Some prisons were insufficiently focused on tackling violence. The increased availability in prisons of 'new psychoactive substances', often known as 'legal highs', was a source of debt and associated bullying and a threat to health.

Figure 2: Percentage of prisons and young offender institutions assessed as 'good' or 'reasonably good' in full inspections 2005–06 to 2014–15[9]

	Published reports (%)									
	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	Inspected Nov 2013 – Mar 2014 Published 2014–15
Safety	75	57	69	72	78	84	82	80	69	42
Respect	65	63	69	69	76	74	73	73	67	58
Purposeful activity	48	53	65	71	68	69	73	50	61	42
Resettlement	68	62	75	75	76	71	84	64	75	53

9 For inspection outcomes in published reports see http://www.justiceinspectorates.gov.uk/hmiprisons/inspections/

The declining safety outcomes we identified were consistent with the safety data NOMS itself produced. Of most concern, the number of self-inflicted deaths[10] rose by 69% from 52 in 2012–13 to 88 in 2013–14, the highest figure in 10 years.[11] As Figure 3 shows, the number of self-inflicted deaths was particularly high in the last half of 2013–14.[12]

What pushes an individual in despair over the edge will be different in every case. However, as reports from the Prisons and Probation Ombudsman and coroners make clear, bullying is a factor in many cases.[13] Two important indicators of the level of bullying in prisons are assaults and 'incidents at height'.

The overall level of assaults in prison increased in 2013–14 and the increase was particularly high in adult male prisons. The number of assaults involving adult male prisoners increased by 14% on the year before and was the highest for any year for which we have data.[14] Adult male prisons are becoming more violent every year; that trend accelerated in 2013–14 and included a dramatic 38% rise in the number of serious assaults.

The number of incidents at height in adult male prisons increased dramatically in the year. This should be regarded as a major concern.[15] There are many reasons for this but we find they often involve prisoners clambering onto the netting or railings attached to wing landings in the hope they will be taken to segregation and then 'shipped out' of the prison to somewhere they feel safer, where the conditions appear better or where they will be closer to home. Some appear to be protests about the IEP scheme.

Figure 3: Apparent self-inflicted deaths by quarter, England and Wales 2013–14

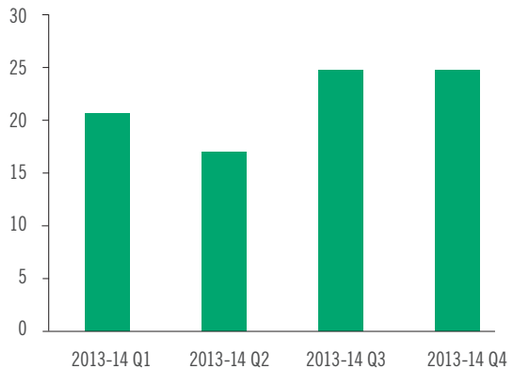
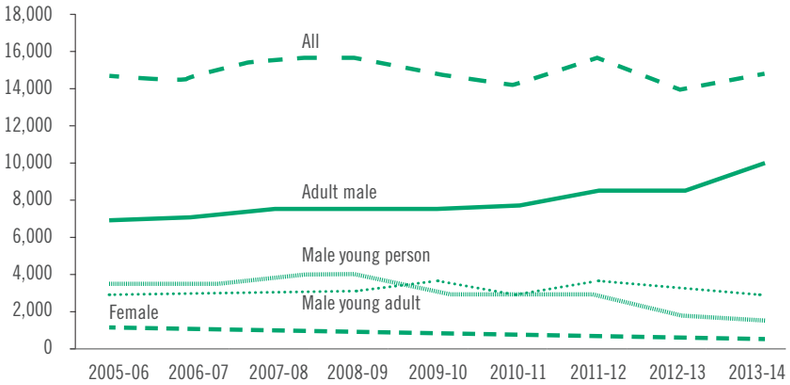


Figure 4: Assault incidents by gender and age group, April 2005 to March 2014

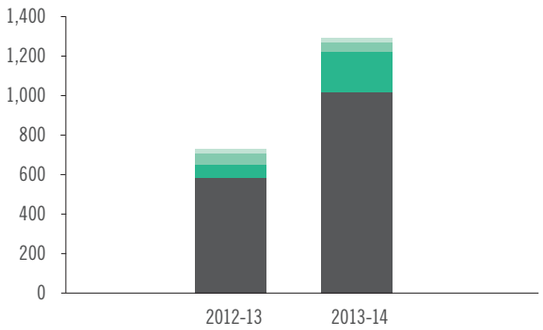


Number of assault incidents

Year	Adult male	Male young adult	Male young person	Female	All
2005–06	7,148	2,969	3,566	1,149	14,832
2006–07	7,184	2,920	3,569	1,107	14,780
2007–08	7,597	3,179	3,849	1,019	15,644
2008–09	7,647	3,296	3,984	848	15,775
2009–10	7,564	3,535	3,182	635	14,916
2010–11	7,840	3,030	2,915	688	14,473
2011–12	8,616	3,469	2,803	689	15,577
2012–13	8,667	3,017	1,889	510	14,083
2013–14	9,867	3,052	1,572	542	15,033

10 Self-inflicted deaths are any death of a person who has apparently taken his or her own life irrespective of intent. This not only includes suicides but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide.
11 Safety in Custody Statistics for England and Wales: Update to March 2014, MOJ www.gov.uk/government/statistics/safety-in-custody-statistics-quarterly-update-to-march-2014
12 Safety in Custody Statistics for England and Wales: Update to March 2014, Summary tables, op.cit.
13 See for example PPO Learning Lessons Bulletin Fatal incident investigations issue 6, July 2014.
14 NOMS unpublished data but see also Safety in Custody Statistics op.cit.
15 NOMS unpublished data.

Figure 5: Incidents at height by age and gender 2012–13 and 2013–14



Incidents at height by age and gender 2012–13 and 2013–14			Key
Female	6	19	
Male young person (under 18 years)	25	49	
Male young adult (18-20 years)	110	206	
Adult male (21 years and over)	591	1,007	

Increases in self-inflicted deaths, self-harm and violence cannot be attributed to a single cause. They reflect some deep-seated trends and affect prisons in both the public and private sectors. Nevertheless, in my view, it is impossible to avoid the conclusion that the conjunction of resource, population and policy pressures, particularly in the second half of 2013–14 and particularly in adult male prisons, was a very significant factor in the rapid deterioration in safety and other outcomes we found as the year progressed and that were reflected in NOMS' own safety data. The rise in the number of self-inflicted deaths was the most unacceptable feature of this. It is important that the bald statistics do not disguise the dreadful nature of each incident and the distress caused to the prisoner's family, other prisoners and staff. It is a terrible toll. 'The total experience of imprisonment affects suicidal behaviour' is a valid conclusion today, just as it was when the Inspectorate first addressed the issue back in 1999. Then, as now, it requires acknowledgement, action and accountability for doing so from top to bottom.

This deterioration in outcomes continued well into 2014–15 but by the summer of 2014 there were some signs that warnings had been heeded and remedial action had begun to take effect. Population pressures eased slightly as additional accommodation came on stream. Support for safer custody work was strengthened from the centre and staff were sent on detached duty to help those prisons most under pressure. Recruitment was speeded up and some former staff were invited to return on short-term contracts. A number of prisons were temporarily placed on restricted regimes which focused the available staff on providing consistent and safe time for association and domestic duties, but restricted the time available for purposeful activities and rehabilitation. Our monitoring appeared to show some reduction in the number of self-inflicted deaths and there was some slight improvement in inspection findings. At the time of writing, it was too early to say whether these improvements would be sustained.

The overcrowding described above contributed to a decline in respect outcomes in adult male prisons. After a period of improvement, overcrowding worsened as the year progressed. Two-thirds of the prisons we reported on during the year as a whole were overcrowded. At its worst, overcrowding meant two prisoners sharing a six foot by 10 foot cell designed for one, with bunks along one wall, a table and chair for one, some shelves, a small TV, an unscreened toilet at the foot of the bunks, little ventilation and a sheet as a makeshift curtain. A few prisoners might spend 23 hours a day in such a cell – 20 hours was relatively common in a local prison. Prisoners would eat most of their meals in their cell. The food budget was reduced from £2.20 per prisoner per day in 2012 to £1.96 a day in 2013.

In many prisons, strong relationships between staff and prisoners mitigated the worst effects of overcrowding and helped make prisons safer than they would have otherwise been. Our inspection of HMP Pentonville for instance, found it beset with staff shortages, an appalling physical environment and a very needy population

with high levels of substance misuse and mental health problems. I described some impressive staff and governors at Pentonville as working 'heroically' against the odds. It was a fair description and one that could be applied to other staff in other prisons too. Good relations are not just a matter of being friendly but also require staff to act as role models and challenge poor behaviour, and in some cases inexperienced staff failed to do this.

On 31 March 2014, there were 7,172 prisoners aged 50–59 and 3,577 aged 60 and over, an 8% increase on last year (for over 60s there was a 6% increase).[16] We submitted evidence to the House of Commons Justice Committee's inquiry into older prisoners and argued that the Prison Service should develop a national strategy for dealing with this group. The committee agreed with our view and it is therefore of concern that the Ministry of Justice rejected this. However, the number of older prisoners looks certain to continue to rise, new statutory obligations will affect prisoners who require social care and in my view the development of a national strategy remains essential.

At the other end of the age range, policy for young adults (18–21-year-olds) was in flux. The number of young adults in prison and YOIs continued to fall. Our inspection of the young adults held in HMYOI Feltham was the most concerning of the year, with high levels of violence, high levels of the use of force and far more use of batons than anywhere else in the prison system. In response to our findings, Feltham ceased its role as a remand prison for all young adults in London and young adults on remand were dispersed to adult prisons. The government then set out proposals to hold most sentenced and remanded young adults in adult prisons but this was then put on hold pending the conclusions of an independent review into the deaths of young adults in custody. The close examination of the complex needs of this age group that the review will undertake is welcome, but in the interim we found a significant number of young adults in adult prisons with too little done to adapt to their lower levels of maturity.

From April 2013, NHS England took over commissioning of heath care in prison from local commissioners. Although this created some uncertainty, standards of clinical care remained good. The problem of prescribed medications being stolen or sold continued to grow and pharmacy services needed to do more to respond to this. There was a welcome continuing trend to provide integrated pathways of mental health care and although we saw some good mental health practice, the care for prisoners with mental health needs was inconsistent and too few discipline staff were trained to identify prisoners with mental health problems and respond appropriately.

In view of the pressures on the system, it was a real achievement that the purposeful activity outcomes we reported on in 2013–14 were an improvement on the year before. We inspect learning, skills and work provision in prisons with Ofsted in England and Estyn in Wales. They assessed provision as 'good' or better in just over half the adult establishments inspected. No provision was outstanding overall. Vocational training was often the best part of the provision available and in some prisons there was decent work available that reflected a real working day. However, in others there were too few activity places available and those that were available were often unacceptably under-used. Not enough was done to help prisoners improve basic literacy and numeracy skills and this was not sufficiently coordinated with sentence plans and other rehabilitation activity. Equipping prisoners with the skills, experience and habits they need to get and hold down a job is an essential part of the rehabilitation process – in my view, probably the most important. It was clear that the improvements we reported on were

16 www.gov.uk/government/publications/offender-management-statistics-quarterly-october-december-2013-and-annual

fragile, so although disappointing, it was not unexpected that the pressures on the system led to a sharp decline in outcomes in those inspections that took place in the latter part of the year and were published in 2014–15.

Resettlement outcomes were the best of our healthy prison tests in reports published in 2013–14 as prisons responded to the proper priority Ministers gave to this area. There was often a sharp contrast between reasonably good and very important practical resettlement services and the much weaker offender management processes designed to manage a prisoner's risks and address their behaviour. Our joint thematic report with HM Inspectorate of Probation on offender management, published in December 2013, concluded that a fundamental review of the current offender management model was required.

We also worked with HM Inspectorate of Probation on a thematic review of life sentence prisoners published in September 2013. We found that in open prisons preparation for release relied heavily on release on temporary licence (ROTL) which was badly planned. These deficiencies were sadly highlighted in summer 2013 when there were three major ROTL failures in which very serious crimes were committed. The Justice Secretary asked me to review these incidents and I submitted my report to him in January 2014. ROTL should be an important resettlement tool and the failure rate is low. Less than 1% of releases on temporary licence fail and of these, 6.1% involve an arrestable offence. However, when these failures do occur the consequences can be terrible. The ROTL system has not kept pace with the growth in the number of eligible prisoners and the higher proportion coming to the end of indeterminate sentences for serious offences. The Justice Secretary accepted my recommendations and quickly introduced these and other measures to improve the system. My report will be published once the remaining trial of one of the men involved is concluded.

2014–15 will be a critical year for rehabilitation work in prisons as they prepare for the introduction of the Transforming Rehabilitation agenda and many for a new role as a resettlement prison. We found little evidence of effective preparation in 2013–14, although it was early days. The decline in outcomes already evident in 2014–15 is of more concern and population pressures and restricted regimes create a real risk to the development of resettlement prisons.

Women

We inspected relatively few women's prisons in 2013–14. However, in contrast to adult male prisons, it was very welcome that almost all outcomes were reasonably good or good. Our inspection of HMP Holloway, for instance, was our most positive yet of that prison. These improved outcomes in women's prisons have been sustained into 2014–15.

Many women in prison have very complex needs with high levels of mental health difficulties, substance misuse problems and histories of abuse. Overall, safety outcomes in women's prisons improved and this coincided with the introduction of better first night and other support procedures, better substance misuse services and better mental health care. Nevertheless, levels of self-harm in women's prisons are still disproportionately high, although falling. There were three self-inflicted deaths in women's prisons in 2013–14. Some of the most vulnerable women are also some of the most challenging and their care is less well developed than it would be in a men's prison. At HMP Bronzefield we found one woman with acute needs who had been kept in segregation for over five years in conditions which, in our view, amounted to cruel, inhuman and degrading treatment.

Relationships between staff and prisoners in women's prisons were generally good but the proportion of female staff in some remained too low. About a quarter of the women in our surveys were foreign

nationals. The needs of these women were insufficiently recognised and they needed more help to stay in touch with children and other family members. Young women were no longer held in young offender institutions and could, therefore, move straight from a secure training centre (STC) for children to an adult prison. We found good, sensitive support for young women at HMP Holloway. There was more to be done to improve the leadership, quality and outcomes in learning, skills and work in women's prisons. However, in contrast to men's prisons, women's prisons had sufficient activity places and, other than at Holloway, women enjoyed good time out of cell. Resettlement outcomes were reasonable overall.

Children and young people

This was another year of major change for the children and young people's custody estate. The average secure estate population (including a few 18-year-olds) fell from a high of 3,451 in 2002–03 to 1,708 in 2012–13, and again to 1,334 in 2013–14 – a fall of 22% in one year alone and more than 60% from its highest point. The fall was concentrated in young offender institutions (YOIs); the numbers in STCs remained relatively stable.[17] The reduction in the population inevitably led to shrinking of the estate. All the remaining small units for girls closed during the year. Ashfield YOI was re-roled as an adult prison and other YOIs had their capacity significantly reduced.

The fall in the number of children in YOIs is very welcome but has had profound implications. The reduced population is a much more concentrated mix of boys with both great vulnerability and challenging, sometimes very violent, behaviour who are a danger to themselves, other boys and staff. Establishments struggled to control violence and bullying. In all establishments, there were fights and assaults almost every day. At the boys' site at Feltham we watched CCTV of very violent group attacks on individuals in which staff intervened courageously to protect the victims. At Warren Hill there were 137 assaults on young people, 48 assaults on staff and 112 fights in the six months before the inspection. One member of staff at Warren Hill required hospital treatment for multiple injuries including broken bones, concussion, stab wounds and black eyes. A new restraint process, 'minimising and managing physical restraint' (MMPR), began to be rolled out during the year and we will publish a full review of restraint processes in the juvenile estate once a sufficient number of establishments have implemented the new process.

There were no self-inflicted deaths involving children in the year and the reduced size of establishments enabled some better and more individualised care. Nevertheless, we were concerned that learning from earlier tragedies had not been fully applied. The care of the most vulnerable boys in small units such as Keppel in Wetherby YOI was very good. In all the establishments we inspected relationships between staff and boys were generally good. We saw some evidence that staff had raised their expectations of the boys and were more confident about challenging poor behaviour at an early stage, and this helped to avoid it escalating. Health care and mental health services were generally good. Most boys were out of their cells for about eight hours a day, although this might be much less for those subject to disciplinary procedures.

Achievements, quality and leadership were good in education in about three-quarters of the YOIs inspected and there were signs that this was improving further. A third of the boys in our surveys said they had been in local authority care. The shrinkage of the children and young people's estate meant that boys were held further away from home, and contact with their families and relevant agencies in their home areas, essential for their successful resettlement, was much more difficult.

17 Youth custody data August 2014, Youth justice statistics, youth custody data, Ministry of Justice and Youth Justice Board for England and Wales, 2014 www.gov.uk/government/collections/youth-justice-statistics

2013–14 was the first year in which we jointly inspected STCs with Ofsted. Our overall assessment of each STC was that they were 'good'. The quality of accommodation was high, and children benefited from the education and resettlement activities offered. We found that the use of 'separation' – in which children are isolated from others – needed improvement and there were some frailties in child protection work. The monitoring of outcomes for children from minority groups also needed improvement. All the STCs we inspected responded positively to our recommendations and we evidenced improvement on our return.

During the year, the government confirmed plans to establish a network of secure colleges to replace most of the existing YOIs and STCs. The first 320 bed secure college is planned to open in 2017. The changes in population that have occurred since the policy was first announced mean this secure college will hold about a quarter of all children in custody and it will be challenging to provide these very troubled children with better education than that delivered in YOIs, where provision has improved significantly. I am concerned that the plans do not yet provide assurance that they have considered and will be able to adapt to the changes in the size and complexity of the juvenile custody population.

Immigration detention

We inspected a wide range of immigration detention during the year – immigration removal centres (IRCs) for men and women, short-term holding facilities (STHFs) and overseas escorts. Women detainees were particularly vulnerable. Women we spoke to individually and in groups at Yarl's Wood IRC were largely positive about their treatment. However, two staff had been dismissed before the inspection because they had engaged in sexual relations with a detainee. The distress and despair of many of the women held at Yarl's Wood was very apparent. Many had suffered abuse before arriving at the centre and most were fearful about would happen to them in future. Some staff were unacceptably insensitive to this distress and too few women staff were employed.

Women detainees were rarely handcuffed but at other centres handcuffing was thoughtlessly routine, regardless of risk. This led to the appalling incidents when one elderly, confused man died in handcuffs and another man was kept cuffed while sedated and undergoing an angioplasty in hospital and died just after the handcuffs were removed. 'Rule 35' procedures, which should ensure detainees who are unfit to be detained, because they have been tortured or are suicidal for instance, had improved but too many remained poor.

We inspected seven non-residential and one residential STHF. The UK-run STHFs in Calais were inspected jointly with our French counterpart, the Contrôleur Général des Lieux de Privation de Liberté. Most held detainees for just a few hours after arrival or before departure. STHFs have improved since inspections began and most provided reasonable conditions. Children were sometimes held in STHFs with their carers or unaccompanied. Some children were held for much too long and child safeguarding procedures needed to be strengthened. We inspected two overseas removals and remained concerned that accredited restraint techniques had still not been developed for use on aircraft.

Police custody inspections

In 2013–14 we completed our first six-year programme with HM Inspectorate of Constabulary (HMIC), part of the criminal justice inspectorates joint inspection programme, to inspect all places of police custody. Physical conditions have improved over the time we have been inspecting police custody, facilitated by the move to concentrate custody in a smaller number of suites. Officers are now making more use of alternatives to custody, leading to a reduction

in its use. It remains a significant concern that unlike every other form of custody we inspect, the use of force in police custody is not recorded centrally. The records that we see on police custody inspections are not adequate to provide assurance that the use of force is properly managed nor or to identify trends and patterns of concern.

Seventeen-year-olds were now treated as children for the specific purposes of access to Appropriate Adult services. However, while this was a significant improvement, we still found too many children held in custody overnight because no alternative local authority bed could be found. Our joint thematic inspection with HMIC, the Care Quality Commission and Health Inspectorate Wales (HIW) found police custody was still too frequently used as a place of safety for people with a mental health problem.[18] Furthermore, while the number of deaths in police custody has reduced, the number of self-inflicted deaths within 48 hours of people leaving custody was the highest for 10 years and many of those involved appear to have had mental health problems. In 2014 the Home Secretary commissioned HMIC to review the treatment of vulnerable people in police custody and we look forward to working with them on this.

Court custody

Court custody is a relatively new area of inspection for us and we continued to be concerned by what we still found as we inspected cells around the country. Some escort vehicles were dirty and assessments of detainees when they arrived in custody were often haphazard. Safety was heavily dependent on the good sense and decency of custody officers and while this was normally evident we found some unacceptable treatment. Detainees were not usually kept long in custody and the focus was on court proceedings. Nevertheless, physical conditions were frequently unacceptable. At the heart of the problem was poor partnership working. Too often there was no clearly identifiable accountability for the treatment and conditions of detainees and this created a real risk of an adverse incident being allowed to develop unchecked. This is a matter we will pursue in 2014–15.

The Inspectorate

As ever, I am grateful to the Inspectorate's staff and partner inspectorates for their contribution to the work described in this report.

2013–14 was a demanding year for the Inspectorate. Our budget was reduced further and this represented a total reduction of 17.65% on our inflated baseline in this spending review period. We have continued to find ways of using our resources more efficiently and were able to implement a more demanding inspection programme than ever before. We published 98 inspection reports. We completed the first year of a new programme of joint inspections of Secure Training Centres with Ofsted and completed planning for our first inspections of UK Armed Forces Service Custody Facilities, which have replaced the old 'guard house' system. I regret that Ministers have decided that the development of our role in military detention in the UK will not be extended to the detention of foreign national detainees by UK forces abroad,[19] contrary to the recommendations of Sir William Gage's 2011 inquiry into the death of Baha Mousa in Iraq in 2003.[20]

We revised our prison inspection methodology which we published in a new inspection manual. We introduced a new programme of almost entirely unannounced inspections. All YOIs holding children are now inspected annually. We also completed

18 A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs, HMIC, HMIP, CQC, HIQ, 2013 http://www.hmic.gov.uk/media/a-criminal-use-of-police-cells-20130620.pdf
19 www.publications.parliament.uk/pa/cm201314/cmhansrd/cm140327/wmstext/140327m0001.htm#14032769001887
20 *The Report of the Baha Mousa Inquiry*, The Stationery office, London, 2011 Recommendation 44.

the development of our first 'Expectations' or inspection standards for women's prisons which will be consistent with the Bangkok Rules, the UN rules on the treatment of women prisoners.

HM Inspectorate of Prisons is one of the bodies that makes up the National Preventive Mechanism (NPM) by which the UK discharges its obligations as a party to the UN Optional Protocol to the Convention Against Torture (OPCAT) to ensure the independent inspection of all places of detention. We coordinate the NPM. In July 2013 we presented the UK NPM to the Sub-Committee on Prevention of Torture (SPT), the UN body that oversees OPCAT, and in March 2014 we invited external reviewers to evaluate its compliance with the treaty. The work of the UK NPM was well received by the SPT and we welcomed a number of suggestions about how it could be improved further. Work to take this forward included planning for a conference in April 2014 for NPM members and stakeholders to mark five years since the designation of the UK NPM. The conference provided a platform for further work to strengthen the NPM in the remainder of 2014–15.

The work of the UK NPM and HM Inspectorate of Prisons continues to be regarded as a model by other states and international institutions. In addition to regular visits from other countries, we continued our work with the support of the Foreign and Commonwealth Office to support the development of an independent inspection system in Bahrain, and delivered training in Albania. In November 2013 we organised a conference with the Council of Europe, attended by European NPMs and relevant intergovernmental bodies, to develop and promote minimum standards for the detention of immigration detainees.

The work described in this report provides many examples of the improvements the Inspectorate has helped to encourage across the whole range of custody settings and demonstrates the validity of the core OPCAT principle that regular, independent inspection against clear, human rights-based standards can prevent ill-treatment. The concerns we reported about adult male prisons were therefore disappointing but I hope the warnings we gave created some urgency for the improvements we are now just beginning to see as 2014–15 progresses. However, there remains a real risk that the price of restoring stability and safety to prisons will not just be the costs involved but a prolonged period in which prisoners have reduced access to the work, education and resettlement activities on which the rehabilitation of many depends.

In my annual report for 2012–13, I warned that the cracks were beginning to show in some prisons and that:

> ' politicians and policy makers should not put the valuable policy and savings gains they have already made at risk by ignoring those signs and piling on the pressure regardless'.

The cracks widened in 2013–14. However uncomfortable it may be, our independent reports will continue to shine a light on how that situation develops in 2014–15.

Nick Hardwick
Chief Inspector of Prisons

2

The year in brief

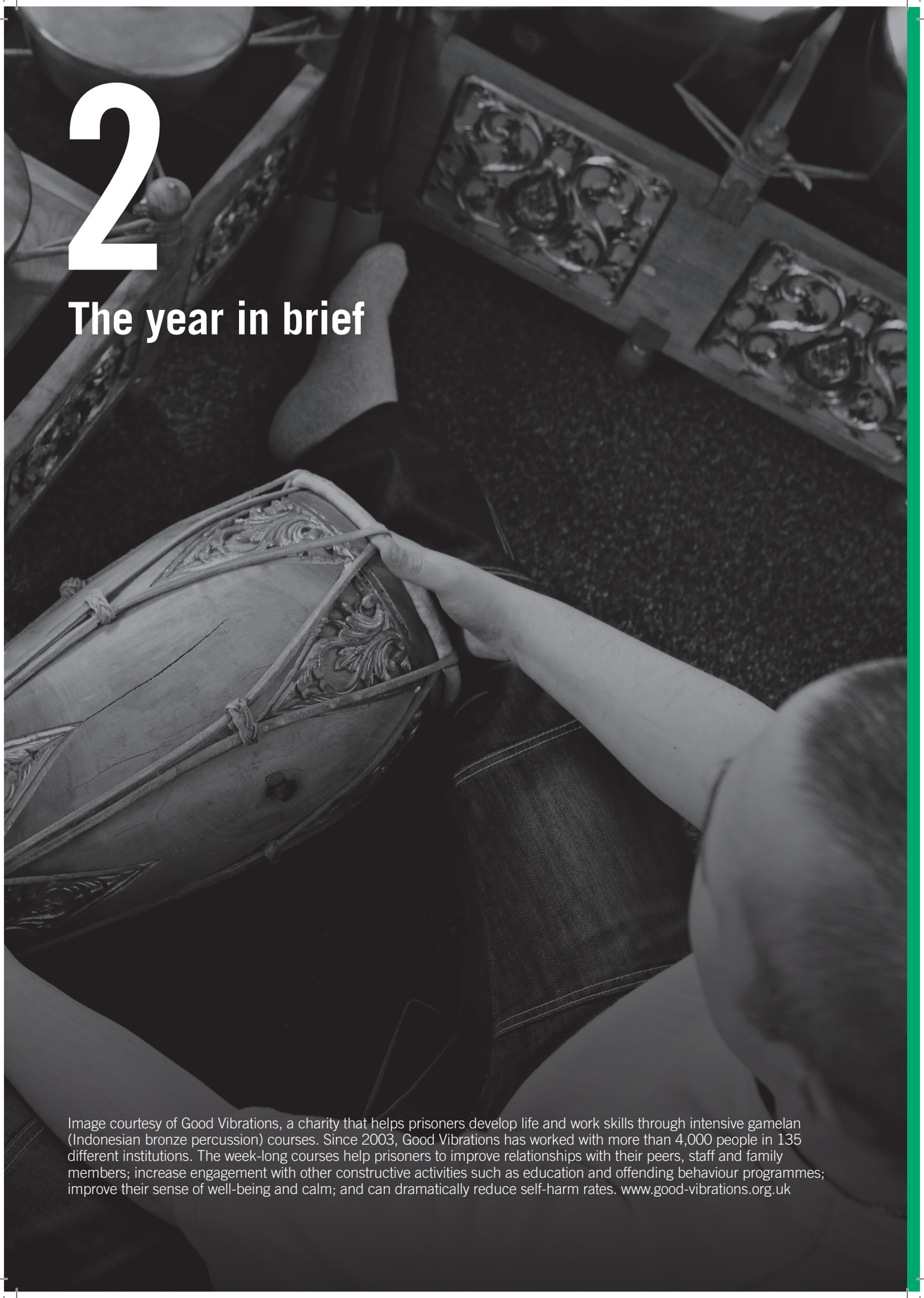


Image courtesy of Good Vibrations, a charity that helps prisoners develop life and work skills through intensive gamelan (Indonesian bronze percussion) courses. Since 2003, Good Vibrations has worked with more than 4,000 people in 135 different institutions. The week-long courses help prisoners to improve relationships with their peers, staff and family members; increase engagement with other constructive activities such as education and offending behaviour programmes; improve their sense of well-being and calm; and can dramatically reduce self-harm rates. www.good-vibrations.org.uk

Between 1 April 2013 and 31 March 2014, we published 98 inspection reports.

Adult prisons (England and Wales):
- 42 prisons holding adult men
- four prisons holding adult women.

Establishments holding children and young people:
- nine young offender institutions (YOIs) holding children and young people under the age of 18
- six inspections of four secure training centres (STCs) holding children and young people aged 12 to 18, jointly with Ofsted.

Immigration detention:
- five immigration removal centres
- seven short-term holding facilities
- short-term holding facilities in France with Contrôleur Général des Lieux de Privation de Liberté
- two overseas escorts.

Police custody:
- police custody suites in 14 forces and London boroughs with HM Inspectorate of Constabulary (HMIC).

Court custody:
- three court custody areas covering six counties.

Military Corrective Training Centre:
- the national Military Corrective Training Centre (MCTC).

Extra-jurisdiction inspections:
- two prisons in Northern Ireland
- the prison in Jersey
- the prison at the Cyprus Sovereign Base Area.

We also conducted an unpublished pilot inspection of service custody facilities in the armed forces for the Ministry of Defence.

Other publications in 2013–14:
In 2013–14 we co-published two thematic reports:

- *A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs* (jointly with HMIC, the Care Quality Commission (CQC) and Healthcare Inspectorate Wales)
- *A joint inspection of life sentence prisoners* (jointly with HM Inspectorate of Probation).

We also published two findings papers:

- *People in prison: Gypsies, Romany and Travellers*
- *People in prison: Ex-service personnel.*

In February 2014, we published Expectations for the inspection of UK Armed Forces Service Custody Premises in preparation for inspections of these premises commissioned for 2014–15.

Other publications included:

- *Children and young people in custody, 2012–13* (jointly with the Youth Justice Board)
- *Children and young people in custody: secure training centres 2012–13* (jointly with the Youth Justice Board)
- *Monitoring places of detention. Fourth annual report of the United Kingdom's National Preventive Mechanism 2012–13* (on behalf of the NPM)
- *Third aggregate report on offender management in prisons* (jointly with HM Inspectorate of Probation).

We also made submissions to the following consultations:

- Transforming youth custody, 30 April 2013
- Transforming legal aid, 4 June 2013
- Joint Committee consultation on the Draft Voting Eligibility (Prisoners) Bill, 13 June 2013
- Home Office consultation on the treatment of 17-year-olds in police custody and the translation and interpretation of essential documents for non-English-speaking detainees (jointly with HMIC), 23 September 2013
- Joint Committee on Human Rights inquiry into proposed legal aid reforms, 23 September 2013
- Home Office consultation on the scheduling of tramadol, and a review of exemptions for temazepam prescriptions, under the Misuse of Drugs Regulations 2001, 9 October 2013
- National Offender Management Service consultation on changes to the prison rules and YOI rules in respect of foreign national prisoners on whom a deportation order has been signed in respect of their eligibility for open conditions and for release on temporary licence, 16 December 2013
- Transforming management of young adults in custody consultation, 20 December 2013
- Home Office consultation on the immigration detention of persons with mental health issues, 18 March 2014
- Justice Committee inquiry on prisons' policy and planning, 28 March 2014.

In September 2013, the Lord Chancellor and Secretary of State for Justice commissioned HMIP to undertake an independent review of some high-profile failures of release on temporary licence (ROTL) to assess whether these releases had been appropriate. We submitted this review and recommendations in January 2014, and the report will be published following the conclusion of relevant legal proceedings.

We have also commented on a number of draft Prison Service Instructions and draft Detention Services Orders throughout the reporting year.

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

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

3

Men in prison

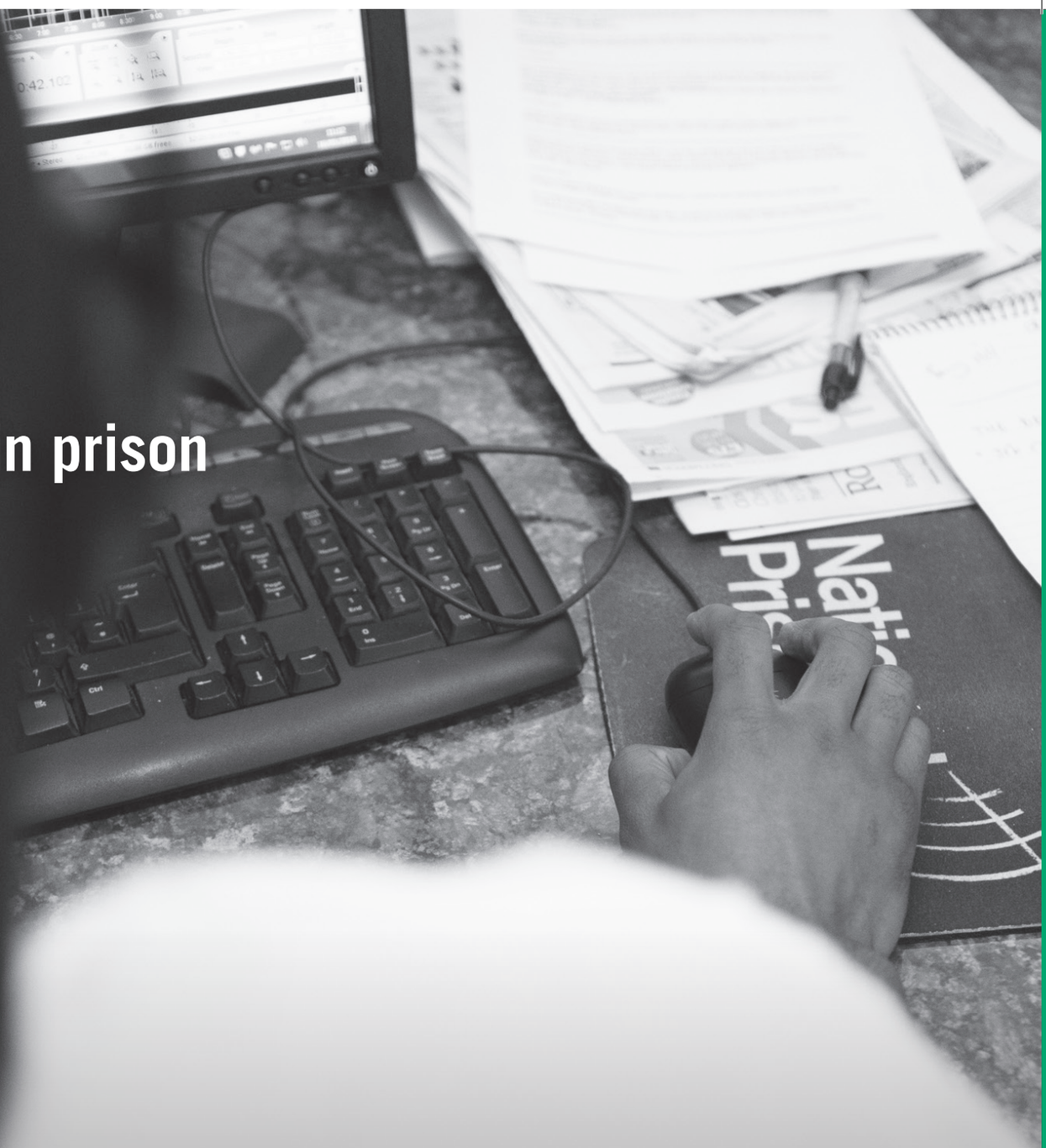


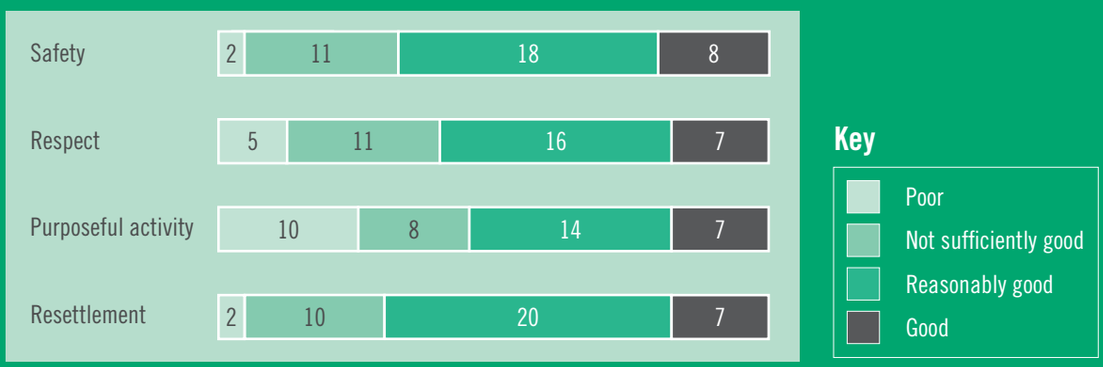
Image courtesy of the Prison Radio Association. From its origins at HMP YOI Feltham in 1994, the Prison Radio Association was formed in 2006 to offer guidance and expertise to prisons interested in setting up and running their own radio projects. Prison radio offers a unique, innovative and effective way to communicate with prisoners and engage them in education, debate and community. Working alongside serving prisoners, the PRA produces and delivers National Prison Radio, broadcasting information and educational materials which support the National Offender Management Service (NOMS) reducing reoffending agenda. www.prisonradioassociation.org

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

Until April 2013, prisons received a full inspection every five years and either a full or short follow-up inspection in the intervening period. Since April 2013, nearly all inspections have been full inspections and (unless the previous inspection was a short follow-up) almost all have followed up the recommendations of the previous inspection. This annual report includes the findings of four short follow-up inspections of adult male prisons in 2012–13 that were published in this reporting period.

In full inspections, we assessed outcomes for prisoners as good, reasonably good, not sufficiently good or poor against the healthy prison tests of safety, respect, purposeful activity and resettlement. During our full inspections published in 2013–14, we made 39 healthy prison assessments covering 38 adult male prisons.[21]

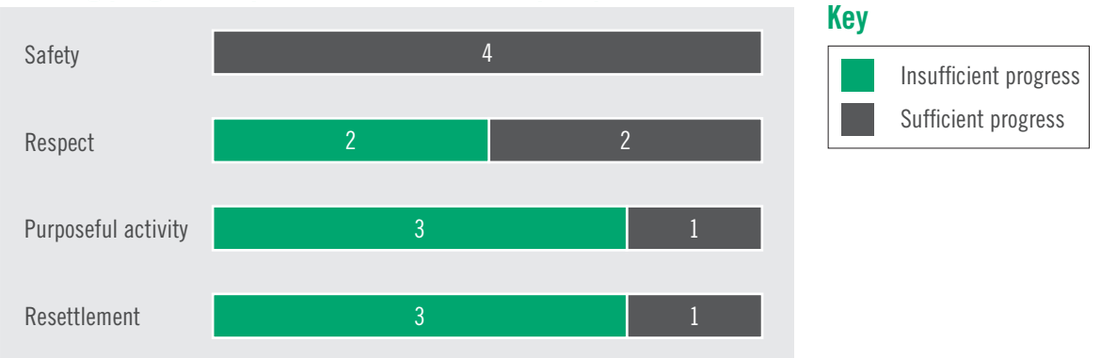
Published outcomes in all adult male prisons and YOIs receiving a full inspection



21 Including separate assessments for the category C and D sides of HMP Lindholme; excluding extra-jurisdiction inspections.

The four adult male prisons receiving short follow-up inspections were assessed as either making sufficient progress (efforts had been made to respond to our recommendations in a way that had a discernible positive impact on outcomes for prisoners) or making insufficient progress (overall progress against our recommendations had been slow or negligible and/or there was little evidence of improvements in outcomes for prisoners).

Charting progress in published short follow-up inspections



Safety concerns increase

- Safety outcomes for adult male prisoners were not good enough in a third of the prisons we inspected.
- There had been a significant and concerning increase in deaths in custody, reversing a downturn in the previous decade.
- There was an upward trend in self-harm incidents in male prisons, and too many prisoners in crisis continued to be segregated and in poor conditions.
- We found gaps in the identification of risks for new prisoners, at a time when they were most vulnerable.
- Prisons had become less effectively focused on tackling violence.
- Services for opiate-dependent prisoners were satisfactory, but the development of new and non-detectable psychoactive substances, alongside the continuing diversion of prescribed medication, was a dangerous new trend.

Figure 6: Published safety outcomes in adult male establishments – full inspections

	Good	Reasonably good	Not sufficiently good	Poor
Locals	0	5	7	0
Trainers	4	8	3	0
Therapeutic communities	1	1	0	0
Open	3	2	0	1
High security	0	2	0	0
Young adults	0	0	1	1
Total	**8**	**18**	**11**	**2**

Figure 7: Published safety outcomes in adult male establishments – short follow-up inspections

	Sufficient progress	Insufficient progress
Locals	3	0
Trainer	1	0
Total	**4**	**0**

The early days for new prisoners

The first experience of imprisonment for all prisoners is at a local prison. New arrivals rely on staff and other prisoners for accurate and consistent information about 'how things work here', to understand the language, navigate procedures to help them feel safe, and maintain a sense of well-being. Arranging a visit, securing their accommodation so they have a home to return to, obtaining clean clothes or, if in a shared cell, using the toilet in private can become major challenges. As one prisoner told us:

> 'It doesn't matter how many prisons you've been in, arrival at a new nick is one of the most stressful things you can go through'. Brixton

Yet in our surveys of local prisons this year, only 4% of prisoners said they had received any written information before they arrived to help to structure their expectations, and less than half (43%) said that they were offered information about what was going to happen to them when they first arrived.

Some prisoners find it easier to turn to other prisoners for help. Designated 'Insiders' may have a formal role in providing information and support to new arrivals; orderlies engaged in domestic duties around the reception area may provide informal support. Listener schemes (where prisoners are trained by the Samaritans to provide confidential support to prisoners in distress) are now established in most prisons. We find prisoner 'peer supporters' in a variety of other roles, such as carers for prisoners with disabilities and as learning assistants in education or mentors in 'Toe by Toe' reading schemes. Properly organised and supervised, these arrangements provide valuable support to prisoners who need it and opportunities for the peer worker to benefit from the

responsibility they take on. However, we found too many prisoner peer supporters who lacked oversight, sufficient training or support from staff.

At Norwich, we found that prisoners were used to carry out critical first night risk interviews with new arrivals – this potentially dangerous and inappropriate practice was stopped during the inspection. At Sudbury, there was no first night interview with an officer unless requested by the prisoner, and at Erlestoke, prisoner reception orderlies had access to sensitive and confidential information about new arrivals.

Less focus on reducing violence

The levels of violence varied widely across the establishments that we inspected. It was routinely high at Hewell (a closed site), Oakwood and Pentonville (but less than previously), but comparatively low at Brixton, Coldingley, Sudbury, Usk and Full Sutton (where it was significantly lower than in previous years). Statistics from NOMS showed a 14% increase overall in assaults in adult male prisons, from 8,667 in 2012–13 to 9,867 in 2013–14. This continued a general trend, where the number had risen year after year since 2005–06 (with the exception of a small dip in 2009–10), but the 2013–14 figure was the steepest increase in that period. Serious assaults in adult male prisons rose by a concerning 38%, from 979 in 2012–13 to 1,351 in 2013–14, the highest they have ever been.

Poor data analysis at many prisons failed to monitor trends over time, so it was difficult to gauge changes in patterns of violence. We were not always assured that all incidents were reported and often found evidence of under-reporting in prisons. We also found inconsistencies between assaults data and the incidents identified in health and adjudication records and wing logs.

> The recorded levels of bullying and assaults on staff and prisoners were unreliable. Not all incidents were reported and the recorded level of assaults was different on the various databases. All recorded levels were considerably higher than at other category C prisons. Oakwood

> There were gaps in the log [of violence-related incidents] which meant data about unexplained injuries was unreliable and of those identified, 20 had not been investigated. Hewell

Victimisation in prisons might range from verbal threats to physical assaults. In our survey, prisoners routinely reported being victimised by other prisoners (25% of adult male prisoners) or by staff (32%). The levels of victimisation reported to us by prisoners were often much greater than those the prison was aware of, and many prisons needed to do more to understand and address these concerns.

As many as 44% of prisoners at Bristol and 48% at Liverpool said they had felt unsafe in the prison, and responses on feeling safe were almost universally poorer for black and minority ethnic, foreign national and Muslim prisoners and those who considered themselves to have a disability, but there was rarely any awareness of or inquiry into this by the prisons we inspected.

Following a Prison Service instruction in 2011, prisons had replaced specific actions to monitor and challenge bullies with sanctions under the incentives and earned privileges (IEP) scheme.

Behaviour was monitored, but there were no formal interventions to address the underlying reasons for the behaviour other than demotion through the incentives and earned privileges (IEP) scheme. The strategy included a disclaimer: 'I have named the alleged perpetrator(s) but DO NOT wish for staff to interview them or take any action.' If signed by victims, some investigations would have been curtailed even where bullying had been associated with self-harm. Frankland

The strategic approach to the management of violence varied widely, and most prisons no longer had a distinct violence reduction strategy and had reduced their focus on dealing with violence. We found a general decrease in the resources allocated to violence reduction, following staff restructuring in most prisons.

The support offered to victims of bullying and violence had also reduced and often amounted to little more than their location on vulnerable prisoner wings or long waits in segregation units (often in poor conditions) to transfer to other establishments. In some prisons, we also found prisoners too frightened to leave their cells due to real or perceived threats of violence, often with little contact with any staff and feelings of abandonment.

Some prisoners told us they felt unsafe and unsupported and were too scared to leave their cells, and consequently received little or no access to a regime. Some spoke of threats and intimidation. Norwich

However, where there were effective interventions with good individual support for victims, including reviews of activities and enhanced observations to reduce threats, prisoners told us they felt safe.

A few such prisoners had been reintegrated to normal location, supported by good reintegration plans, and all those we spoke to said that they felt supported and safe. Aylesbury

Use of force and segregation

The use of force against prisoners should always be a last resort and proportionate to the threat. We expect to see determined efforts to de-escalate a situation and rigorous governance of the use of force. But in the inspections at Belmarsh and Norwich, among others, we found poor management supervision of the use of force by officers in the incidents we examined, and we were concerned that the safety of prisoners was not given a high enough priority. In some incidents, officers made no attempt to de-escalate the violence; we also saw examples of excessive force by officers in videos of planned removals.

Planned interventions were generally filmed but were not reviewed. We watched some concerning footage, including incidents where force was disproportionate and one where a prisoner had a seizure and his handcuffs remained in place for too long. Belmarsh

Data analysis and written reports on the use of force showed signs of improvement, but we found many examples of poor governance and recording of incidents.

Although the use of batons by staff was rare, there was too little scrutiny when they were used. We were also particularly concerned by the unprecedented frequency of the drawing of batons against young adults at Feltham. In some cases this was disproportionate to the incident, and it seemed to have become a routine response.

'Special accommodation' is the most extreme form of custody in any prison and consists of bare cells that may be used to hold a prisoner who is violently refractory for a few minutes or hours until they have calmed down. Use was generally not excessive, but records in prisons such as Brixton and Norwich indicated that prisoners sometimes remained there for too long when they were calm, and they were routinely placed into strip clothing without good reason.

Living conditions in segregation units at older prisons were often poor, and strip searching of prisoners on admission remained routine. The environments at Leeds, Liverpool and Pentonville were particularly poor, with dark and dreary corridors, and dirty and poorly furnished cells. Some in-cell toilets were filthy, and small cage-like exercise yards were particularly grim. In contrast, conditions in some newer prisons, such as Parc and Thameside, were usually much better.

Day-to-day life for segregated prisoners was impoverished. Although they could usually have daily showers, a 30-minute exercise period and access to a telephone, most prisoners spent nearly all day locked in their cell without anything meaningful to do. Meanwhile, planning to return segregated prisoners to normal location remained undeveloped.

Relationships between segregation unit staff and prisoners were generally good. Officers dealt patiently with difficult individuals, and residents often said that they were kind and helpful.

Addressing suicide and self-harm

Sharp rise in deaths in custody in 2013–14

There were 219 deaths in male prisons in England and Wales – a 25% increase from the previous year. These included:

- 85 self-inflicted deaths, a rise of 67% from the 51 recorded in 2012–13
- a further 124 deaths from natural causes (up from 113 in 2012–13)
- three deaths resulting from homicides and one from other non-natural causes (six other deaths were yet to be classified).[22]

Self-harm among adult male prisoners continued to show an upward trend at 17,474 incidents in 2013–14, compared with 16,399 in 2012–13, following increases over several years.

We continue to be extremely concerned by the upward trend in self-inflicted deaths in adult male prisons, as well as the rise in self-harm.

In almost half of our reports of men's prisons (19) we were critical of many of the key factors that can contribute to prisoner self-harm or even suicide. In 22% of reports we made recommendations about improvement of early days' arrangements; in 56% we made recommendations about the care of prisoners already identified as at risk of suicide or self-harm; and in 20% we made recommendations around the segregation of at-risk prisoners with no exceptional circumstances to warrant such an extreme measure.

Around a third of the prisoners who took their own lives during the year were on an open assessment, care in custody and teamwork (ACCT) document. ACCT is the

22 Ministry of Justice, Safety in Custody statistics, England and Wales, March 2014.

care planning system used to support prisoners at risk of suicide or self-harm. We frequently reported concerns about the quality of ACCT documentation and the actual care and support for prisoners at risk. We also noted an under-reporting of self-harm incidents in two prisons – Norwich and Liverpool – both of which had experienced self-inflicted deaths.

> There had been 104 incidents between January and the end of July 2013, which were 29 fewer than a similar period before the previous inspection. However, there was some evidence of under-recording. For example, we found two self-harming incidents that had not been recorded by the safer custody team. Norwich

Our previous concerns that too many prisoners in crisis and at risk of suicide or self-harm were segregated not only continued this year but in some cases were sadly warranted – at least seven segregated prisoners took their own lives, of whom at least four were on an ACCT at the time of their death and one had an ACCT closed shortly beforehand. In around a quarter of reports, including Huntercombe, Moorland, Norwich, Rochester and Thameside, we found that segregation was used too frequently for prisoners on an ACCT and without full consideration of whether this was the right place to care for them.

As in previous years, we found insufficient focus on safer custody refresher training for staff, despite the importance of this in identifying prisoners' risk factors and offering support.

Despite the impact of deaths in custody for the individuals and establishments involved, some prisons still failed to give sufficient attention to implementing and reinforcing the recommendations of the Prisons and Probation Ombudsman, who investigates all deaths in custody. This was the case at Exeter, Hewell, Holme House, Liverpool and Pentonville, all of which had experienced further self-inflicted deaths in 2013–14.

Changes to the incentives scheme

In November 2013, a new national IEP scheme was introduced in prisons in England and Wales amid some controversy. We had criticised the previous IEP scheme for focusing too much on poor rather than good behaviour, and encouraged establishments to have a more sophisticated approach to behaviour management. The key changes in the new scheme were:

- prisoners would now have to demonstrate they were working towards their own rehabilitation and helping others, not merely avoiding bad behaviour to earn enhanced status
- all newly convicted and recalled prisoners would be placed on a new 'entry' level for the first two weeks of their sentence, with restricted privileges and a requirement to wear prison clothing
- whatever their IEP status, prisoners were also no longer allowed to have privilege items, such as clothes or reading material, sent in from family and friends
- new standard facilities lists dictated what prisoners could and could not have in their possession.

Although in this year we reported on only two prisons inspected since the implementation of the new scheme (Kirkham and Sudbury), we identified some early inconsistencies in its application, and staff and prisoners were also generally unaware of how the scheme now operated. There were almost no references to the scheme in the electronic case notes for prisoners.

We were particularly concerned by suggestions that the new scheme was being interpreted incorrectly to mean that prisoners could only gain enhanced status if they participated in formal volunteering activities, and that where these did not exist, prisoners who were otherwise displaying positive and helpful behaviour were losing their enhanced status, and so the scheme was counterproductive.

The new standard facilities list had created some obvious anomalies that needed to be reviewed, and more common-sense local discretion allowed.

Prisoners turn to new substances, as well as diverted medication

We have seen a general decline in the positive rates resulting from the mandatory drug testing (MDT) of prisoners – both in random testing and that carried out under 'reasonable suspicion'.

However, this trend does not mean that prisoners' illicit drug use has reduced. While MDT rates provide an indicator, they do not reliably measure drug availability in establishments – nor does testing necessarily deter prisoners' use of illicit drugs. In our survey, 31% said that illegal drugs were easy or very easy to obtain in their prison, and 7% told us they had developed a problem with illegal drugs and 7% with diverted medications since coming to prison.

The main reason for this is that the current MDT does not detect new psychoactive substances (NPS) and most diverted prescribed medications.

The list of drugs detectable under MDT rules had remained unchanged since the addition of buprenorphine (Subutex) in 2009. Two widely diverted and misused drugs – tramadol (a painkiller) and Gabapentin (an anti-epileptic) – were not on the MDT panel, although tramadol was reclassified as a controlled drug in June 2014 and will be added. In this reporting year, diverted medication (that taken by someone other than for whom it was prescribed) was reported as an issue in 19 (50%) of adult male prisons fully inspected.

NPS, specifically 'Spice' and 'Black Mamba', were cited as causes for concern at 14 (37%) of the adult male establishments inspected, particularly local and category D jails. Although many prisons had taken steps to promote awareness of this problem, we highlighted the need for some to give prisoners and staff accurate and up-to-date information on the acute health dangers associated with NPS.

As well as the limitations in MDT, reduced staffing to conduct tests had made some suspicion testing programmes virtually inoperable.

> Suspicion testing was not conducted in line with Prison Service Order (PSO) 3601; tests were regularly, rather than exceptionally, conducted outside the required three-day window. A further 63 requested tests had not been completed in this period, mostly because of testing officer redeployment. Aylesbury

We reported that suspicion tests had been not completed on time, or at all, in 34 adult male establishments (89%) inspected. The problem was compounded by the lack of monitoring of non-completed tests in 10 adult male establishments (26%) inspected.

Sixteen per cent of adult male prisoners told us that alcohol was easy or very easy to obtain in the prison. As well as an obvious health risk, illegally brewed alcohol or 'hooch' is an obvious threat to the security of a prison.

Substance misuse services

In April 2013, NHS England became the commissioner for substance misuse services (SMS) in prisons, formerly known as integrated drug treatment services (IDTS).

Our inspections found that most prisons had strategies for substance misuse and supply reduction, but a quarter were not focused enough on the needs of prisoners with alcohol problems, some lacked sufficient detail or targets for achievement, and one in eight were based on out-of-date or inadequate needs assessment.

Our survey found that around 26% of new arrivals at prison had substance misuse and 19% had alcohol misuse needs. Prisons continued to focus on recovery working, which was appropriate, usually with active peer support and service user engagement.

Prisoners typically stayed in the recovery unit for six weeks, where they had access to regular one-to-one support, IDTS psychosocial group work, Narcotics Anonymous and Alcoholics Anonymous groups, and a good range of clinics and classes. The unit also provided peer support from prisoner 'recovery champions'. Similar support was available on the post-recovery unit. Leeds

In a minority of services, recovery working was undermined by enforced reduction or inflexible prescribing, which did not adhere to best practice guidelines. Prison substance misuse services offered psychosocial support to prisoners and clinical management of opiate substitution therapy. However, full psychosocial support was not available in a quarter of services and prisoners' needs were not met. Where there was good availability, such as at Belmarsh, Brixton, Coldingley and Kirkham, individual prisoners were offered psychosocial support as well as a range of group work to address their needs, although this work was no longer accredited.

Clinical management in most prisons was flexible and catered to individual need. However, some options were limited by the refusal of the prison or SMS provider to prescribe buprenorphine, which was contrary to national guidance.

New psychoactive substances

'Spice' is formed from herbs or plant material that has been sprayed with chemicals ('synthetic cannabinoids'), producing a cannabis-like effect when smoked. The negative physical effects reported are similar to strong forms of cannabis, including fast or irregular heart rate, decreased blood pressure, occasional dizziness and, in some cases, short-term loss of consciousness, as well as vomiting, seizures and loss of motor control. Psychological effects can include psychotic symptoms, paranoia, increased anxiety and hallucinations. These dangers are exacerbated by uncertainties about the composition of any sample, and by taking them with other prescribed or illegal drugs.

'Spice' is now the generic term for a wide variety of products, including 'Black Mamba', which contain synthetic cannabinoids, although some contain only the psychoactive herbs. Some cannabinoids have been classified as class B controlled substances under the Misuse of Drugs Act (1971) since 2009. However, only samples containing controlled cannabinoids are illegal; those containing only the base psychoactive herbs are not.

The use of Spice in prisons, while not widespread, can have consequences for the security of the establishment and the safety of other prisoners, as well as potential damage to the users.

More prisoners reported victimisation than at the last inspection and at similar establishments. This appeared, at least in part, to be due to the availability of 'Spice' – a synthetic cannabinoid – and associated debt and bullying. Current testing methods did not detect Spice, so the very low positive drug testing rate did not give an accurate picture of the availability of drugs in the prison. Blantyre House

Respect outcomes decline

- Overcrowding continued to be a problem in more than 60% of prisons inspected, with prisoners sometimes living in squalid conditions.
- Strong staff-prisoner relationships mitigated the often poor environments, but in a few cases inexperienced staff failed to challenge poor behaviour, which was a risk to safety.
- Prisoners complained about the quality of the food, and with a budget of only £1.96 a day per prisoner, some prisons struggled to provide a varied and healthy diet.
- There had been little progress in enabling equality and diversity.
- Too many foreign nationals continued to be imprisoned after they had served their sentence.
- Although there had been a dramatic fall in the number of young adult male prisoners, those held were often the most troubled individuals and establishments struggled to manage them safely, wherever they were held.
- Health care was generally good, but there was still not enough mental health provision.

Outcomes in the area of respect for prisoners this year deteriorated. While we found that 59% of adult male prisons inspected still provided outcomes for prisoners that were good or reasonably good, this was a marked decrease from 70% in 2012–13.

Although the majority of establishments were still doing well in maintaining a respectful prison, some of the strains on the system were starting to affect the ability of managers and staff to provide decent and respectful environments. This was especially marked in the outcomes for local prisons, and particularly the training prisons inspected.

Figure 8: Published respect outcomes in adult male establishments – full inspections

	Good	Reasonably good	Not sufficiently good	Poor
Locals	1	6	3	2
Trainers	2	4	7	2
Therapeutic communities	2	0	0	0
Open	2	3	0	1
High security	0	2	0	0
Young adults	0	1	1	0
Total	**7**	**16**	**11**	**5**

Figure 9: Published respect outcomes in adult male establishments – short follow-up inspections

	Sufficient progress	Insufficient progress
Locals	2	1
Trainers	0	1
Total	**2**	**2**

Overcrowding and poor living conditions continue

As we have reported for many years, too many prisoners were held in overcrowded conditions. Our measure of overcrowding is the number of prisoners held as a percentage of the certified normal accommodation.[23] For example, at Wandsworth, 1,223 prisoners were held in cells designed to accommodate 712, an overcrowding rate of 172%, the highest we saw this year. Only two of the local prisons inspected this year were not overcrowded at the time of our inspection – Belmarsh and Liverpool. Local prisons hold many prisoners who are new to custody, often unknown to staff, and therefore especially vulnerable. This year, 62% of the prisons we visited were overcrowded, similar to the previous two years, and 28% were more overcrowded than the last time we inspected them.

In too many of the worst examples, we found two prisoners sharing a dirty cell meant for one, with broken or insufficient

23 Certified normal accommodation is the uncrowded capacity of a cell.

furniture and fittings, and prisoners forced to eat their meals sitting on their bunk next to an unscreened toilet. Many showers continued to be in a poor state of repair. In some prisons, for example, Bristol, Liverpool, Pentonville and Rochester, we saw evidence of vermin in cells, including cockroaches and mice, and we described Feltham as being 'overrun with rodents'.

A number of single cells held two prisoners and these were far too small. In many cells, furniture was missing or broken and prisoners did not have lockable cupboards. Some cells were in an unacceptable condition and were dirty, with walls covered in offensive graffiti, and the repainting programme was not effective. Holme House

We continued to find – and be critical of – 'night sanitation' systems in some prisons, such as Blundeston and Coldingley, where there were no in-cell toilets and prisoners used an electronic queuing system to access external toilets. These systems sometimes break down, leaving prisoners little option than to use buckets.

Food and the shop

According to NOMS, the catering budget for public sector prisons in 2013 was only £1.96 per prisoner per day, an 11% reduction from the average food costs of £2.20 a day in 2012. It is, therefore, not surprising that the vast majority of prisoners remained very negative about the quality and quantity of food in prisons – in our survey, only 22% said that the food was good or very good.

Despite this, inspectors generally found the quality and quantity of food to be acceptable but monotonous and served much too early in the day, leaving long gaps between prisoners' last meal in the afternoon, a breakfast pack delivered in the evening and usually eaten then, and lunch served mid-morning the next day.

New arrivals in prison continued to experience significant delays in receiving their first order from the prison shop, with the potential risk of getting into debt or being bullied. Private prisons were often the exception to this, as they were not tied to the national prison shop contract and could be more flexible.

Applications and complaints

In our survey, only 42% of prisoners reported that applications (made, for example, to access activities or answer basic queries) were answered within seven days, causing significant frustrations. In contrast, where applications were dealt with well, outcomes were generally much better.

Prisoners could use electronic kiosks on wings, known as ATMs, to carry out a range of activities, including book visits, order meals and make shop purchases. Most applications were made using the ATMs and could be tracked. More prisoners than the comparator said it was easy to make an application and that responses were fair. Dovegate

Many prisoners had limited faith in the complaints system to resolve their problems fairly or promptly. Only 54% of prisoners said that it was easy to make a complaint and of those who had made a complaint, just 32% said that it had been dealt with fairly. Many of our inspections confirmed these negative perceptions. Responses to complaints were too often unhelpful and dismissive, and some were not fully answered, or even legible.

Complaint forms and envelopes were not available on all wings. Most complaints boxes were emptied by the night orderly officer. Prisoners generally lacked confidence in the complaints system and complained to us about them going missing and not being responded to; we were told that some had gone missing and been found in the security department, rather than going through the complaints system. Hewell

However, there was some good practice.

Most complaints were answered quickly. The standard of responses was generally good, with most addressing the prisoner by his preferred name, demonstrating sufficient investigation of the issue and answered at the appropriate level. Featherstone

Changes to legal aid

In 2013, the government consulted on proposals to restrict prisoners' access to legal aid for prison law matters. In our response in June 2013, we highlighted concerns raised by our inspection findings:

We are concerned by the proposal that criminal legal aid for prison law matters should be restricted to the criteria set out in the consultation paper, and that it is reliant on both an effective complaints system and on reasonable adjustments being made to ensure prisoners with learning difficulties and/or mental health problems can use the complaint system. Our inspection evidence suggests a distinct lack of confidence in the prisoner complaints system, particularly amongst those prisoners reporting as having a disability or a mental health issue. It is our view that prisoners with identified communication, mental health problems and learning difficulties should be able to obtain legal aid on the current basis.

We are also concerned that some important sentence issues such as parole related sentence planning and the use of segregation and 'deep' custody will not be eligible for legal aid for these matters. Given the very severe consequences of these matters for the individual concerned, we do not think it is consistent with even the other proposals in this consultation paper to exclude these matters from legal aid.

Strong staff-prisoner relationships are critical

Strong relationships between staff and prisoners often offset the poor physical conditions in prisons. In our survey, the majority of prisoners, 74%, said that most staff treated them with respect, and this matched what we saw. Good relationships were usually based on mutual respect and the clear expectation that such behaviour would be reciprocal. Specialist staff, such as offender supervisors, health care staff and teachers, managed this particularly well.

However, in a smaller number of establishments many staff failed to form positive relationships with prisoners. Their low expectations were often reciprocated by the prisoners at the receiving end, and could pervade many aspects of life in the prisons concerned.

Some discipline staff had low expectations of prisoners and did not appear to believe they could reinforce positive behaviour change. This was evident in a range of areas from day-to-day interactions to the management of more challenging prisoners. The impact of this staff culture was pervasive and influenced much of what happened at the prison. Risley

We also inspected some newer prisons where staff lacked the confidence and skills to challenge poor behaviour by prisoners, thus putting the safety of the institution at risk.

We witnessed many occasions where prisoners were abusive to staff and openly flouted wing/prison rules without being challenged, with staff adopting a compliant attitude to avoid confrontation. Staff on the landings were often isolated because of the location of the wing offices and we saw evidence of this situation being exploited by prisoners to intimidate them. Oakwood

More to do in addressing equality

Minority groups continued to report more negatively than the majority of prisoners about key outcomes.

In our survey, black and minority ethnic prisoners were often more negative about safety, being treated with respect, relationships with staff and their daily experience of prison life. They repeatedly raised a lack of cultural awareness among staff. At Grendon, for example, black and minority ethnic prisoners said that some staff misinterpreted their body language and colloquialisms.

Prisoners were often dependent on diversity representatives to take their views to prison managers, but this did not always result in action.

> We found evidence that prisoner representatives had raised the issue of racism and explained that prisoners felt their views were not valued. This had not been satisfactorily addressed. Swansea

> Prisoner representatives had identified prisoners in general did not have confidence in the discrimination incident reporting system but no action had been taken to remedy this. Lindholme

Managers often did too little to understand and address these concerns and worries. There were too few support groups for prisoners from minority backgrounds and consultation arrangements were often weak. Most prisons monitored data on race and ethnicity to identify adverse outcomes, but few looked at the treatment of prisoners from other minority groups. This meant that prison managers could not say with any confidence that outcomes for all prisoners were equitable.

The percentage of foreign nationals in the prison population had remained stable at around 13% since 2006, yet services for them often still did not match their needs. Most prisons failed to make adequate use of professional interpreting or translation services, and other prisoners were too often used to interpret in confidential interviews.

> One prisoner told us via an interpreter that he could not understand what staff said to him, and that he had not been provided with written material in his language; he felt very isolated. Translation services had only been used for him at annual sentence planning boards. Frankland

Some prisons did provide good services – Liverpool had a monthly immigration advice service run by an independent legal aid law firm, and Parc had designated a room for professional interpreting. However, we continued to find a lack of independent immigration advice.

Foreign nationals detained in prisons

In most prisons we inspected, we found foreign nationals detained beyond the end of their sentence. Their treatment and conditions, at best, equated to those of a remand prisoner, but fell far short of the facilities and regime they would experience at an immigration removal centre.

[Foreign nationals] were subject to the same regime as remand prisoners, rather than to a more relaxed regime, which would have been provided in an immigration removal centre (IRC). Foreign nationals who had reached the end of their sentence would often only be told on the day they were due to be released that they would be detained for immigration reasons following Home Office instructions. This could cause considerable unnecessary distress. Given these problems, levels of overcrowding and the extremely limited regime offered, we did not consider Pentonville to be an appropriate place in which to hold immigration detainees. Pentonville

Muslim prisoners usually responded more negatively in our survey on a range of indicators, including feeling safe, being victimised by staff and being treated with respect. Prisons did not generally monitor the treatment of or consult with these prisoners to investigate their perceptions, although there were some exceptions.

The prison had taken steps before our inspection to understand Muslim prisoners' perceptions through a Muslim prisoners' engagement meeting and had taken action to address some of the issues raised – such as finding a more suitable space in the workshop area for prayers. Full Sutton

Gypsies, Romany and Travellers in prison

During the year we published a findings paper on Gypsies, Romany and Travellers, which reported that this group were generally more negative in our survey about their prison experience, including feeling unsafe while in custody. We also found that Gypsies, Romany and Travellers were greatly over-represented in the prison population compared with the general population – in our 2013–14 surveys, 4% of prisoners said they were from this group although only 0.1% of the population identified as Gypsy, Romany or Traveller in the 2011 census. On inspections we usually found more prisoners who self-identified as from this group than were known to the prison; for example, at Wandsworth, where surveys were returned from 15% of the prisoner population, eight prisoners identified as being Gypsy, Romany or Traveller. There was positive work with these prisoners at some prisons, such as Wayland, often with involvement from chaplains, but we found a lack of support at many others.

Traveller prisoners told us that they had problems booking visits as their families often did not have permanent addresses; the prison could not provide reassurance that this did not happen. Lindholme

[Gypsy, Romany and Traveller prisoners] told us that their needs were not understood or met, and little was done to support this group. Oakwood

The number of prisoners with disabilities was also often underestimated, although reasonable adjustments to assist them had been made in many prisons. For example, Parc had a very good assisted living unit for those requiring enhanced care. However, equality of physical access to buildings and facilities was a problem for many prisoners. Risley had provided trained and paid prisoner carers to assist those with mobility difficulties,

but at Sudbury we found a prisoner who had used his canteen to pay other prisoners to assist him because this was not available from the prison. At Holme House, staff refused to push prisoners in wheelchairs.

Prisons were generally unaware of how many prisoners had learning disabilities. However, at one we found:

> … a nurse had been appointed to work with prisoners with learning disabilities and develop a care pathway. This project was working well and was being evaluated. Risley

Parc also provided very good support for prisoners with additional learning needs – including a supportive living plan and one-to-one peer support, which ensured a consistent approach to their care and education. However, we often found poor coordination in prisons to meet and manage the specific needs of such prisoners.

During the year, we began a joint thematic investigation with HMI Probation and the Care Quality Commission into prisoners with learning disabilities, to be published in the next reporting period.

On 31 March 2014, there were 7,172 prisoners aged 50–59 and 3,577 aged 60 and over, an 8% increase on last year (for over 60s there was a 6% increase).[24] In July 2013, the House of Commons Justice Committee published its report on older prisoners, to which we had provided evidence. The Committee agreed with our view that a national strategy for the care of older prisoners was needed, and that the Ministry of Justice (MOJ) should develop such a strategy. We were disappointed that the MOJ response to this was that a generic older prisoner strategy was not 'an appropriate way forward', and that the management of older prisoners should focus on addressing individual need.

In the absence of a national strategy for the management of the growing number of older prisoners, we continued to find that provision remained patchy. Some prisons offered decent services, including regular older prisoner groups, specific gym sessions and involvement of external agencies, such as Age UK.

> There were 183 prisoners over the age of 50; the oldest was 84… Several activities coordinated by the gym were specifically for the over 50s, including a bowls club, which had 26 teams... During the inspection a wellbeing day was held for older prisoners, providing the prison with a good opportunity to consult them about their needs. Bure

However, at other prisons we reported that older prisoners felt uncared for and unsupported, and there was inconsistency in their regime and services.

> We found one older prisoner who felt unsafe in the shower area and consequently had not taken a shower for 18 months. Brixton

We continued to find retired prisoners who were left locked up during the day, or if unlocked, with nothing to do.

> Provision for older prisoners had not been developed. They were not routinely unlocked during the working day and paid for their television if they were retired. A dedicated gym session for them had been discontinued and older prisoners were managed within general sessions. Holme House

We noted growing awareness of gaps in the social care of older and disabled prisoners on the wings, and the health services in some prisons were addressing this, although beyond their contractual obligations.

24 www.gov.uk/government/publications/offender-management-statistics-quarterly-october-december-2013-and-annual

The Care Act 2014 will be implemented in April 2015, and statutory agencies were starting to consider how changes would affect provision for prisoners who required social care. However, turning this into concrete positive changes was still some way off.

Ex-service personnel in prisons

During the year we published a findings paper on ex-service personnel in custody. While accurate figures for their number were hard to obtain – in our surveys for 2013–14, 6% of prisoners indicated that they were ex-service personnel – our findings paper indicated that ex-service personnel were more likely than other prisoners to be in custody for the first time and serving a longer sentence, with the highest proportions in high security and category B prisons.

Although we found they had some specific assistance from service charities, much of this was ad hoc and depended on individual goodwill. In our inspections this year, we found good initiatives for ex-service prisoners at Kennet and Kirkham, where they could meet regularly and received practical support from a range of external organisations.

Our findings paper highlighted the need for a national strategy to ensure that ex-service personnel in prisons were identified, their needs assessed and that they were given effective support – both in custody and on release.

Provision for gay and bisexual prisoners was generally underdeveloped, with few men identifying themselves as such. Support groups had failed to attract participants at some prisons, and more needed to be done to enable prisoners to feel safe in attending such a group.

Young adults in adult prisons

Figures from NOMS showed that the number of young adults (aged between 18 and 21) held in custody had reduced dramatically from an average of 9,941 in 2010 to 6,396 in 2013 (January–September). An important factor in this was the Crown Prosecution Service's move to acknowledge the maturity levels of young adults at the charge and prosecution stage. However, those who remained in custody were some of the most vulnerable, troubled young adults with complex needs.

Young adults were held in a wide range of establishments, including those holding only young adults, those where young adults and adults were totally integrated, and those in separate young adult wings in adult establishments. Their management and provision for them varied significantly.

In response to the reduction in numbers, the volatility in establishments holding just young adults, and the plans to return prisoners to their local area for pre-release work, the prisons minister launched a consultation in November 2013 on a proposal to hold all young adults in mixed institutions. In our response, we said that a range of settings was required to meet young adults' different needs. But wherever they were held, specific regulations were needed to identify and address young adults' particular risks, needs and circumstances, as well as effective staff training. This consultation was put on hold pending an independent review into self-inflicted deaths in custody of young adult men aged 18 to 24.

This review arose because of an increase in self-inflicted deaths in this age group from nine in 2012–13 to 13 in 2013–14.[25] In our consultation response, we said more needed to be done to anticipate, identify and act on vulnerability – including stronger risk assessment processes and information sharing across the prison estate, and greater emphasis on learning lessons from previous deaths in custody and 'near-misses'.

25 Prisons and Probation Ombudsman.

During the year, NOMS undertook work to improve the arrangements for prisoners moving from the children's estate to young adult establishments. More prisoners were transferred between the two than were released from the children's estate, and we had concerns that transition arrangements were often poor and did not take the specific needs of the individual into account.

Our survey results showed that young adults held in establishments dedicated to their age group felt safer and more positive about their treatment than those held alongside adults.[26] However, other data gathered during inspections presented a more complex picture.

At Feltham, a split site holding boys under 18 and young adults on adjacent sites, we found high levels of violence, use of force and segregation among the young adults – and were concerned by the unprecedented frequency of incidents where batons were drawn and/or used (see also safety section, page 27). As a consequence of our report and recommendation that NOMS should urgently review the current viability of Feltham as a suitable location for large numbers of young adult male prisoners, the prison re-roled. Feltham B (the young adult site) transferred young adults held on remand to adult establishments in Greater London and moved to holding only convicted young adults. Our announced follow-up inspection of Feltham B in the next year will look at whether the change has made it a safer and more respectful prison.

In contrast to Feltham, at Norwich, where young adults made up 9% of the prisoner population, they were fully integrated into prison life:

> Those we spoke to said that they were not discriminated against, and the data we analysed showed that this was the case in access to the regime and disciplinary measures. Norwich

Our expectation is that all staff should take the maturity levels of young adults into account in their relations with them, but we found this was often not the prisoner's experience. Mutual expectations between staff and young adult prisoners were too often low, and staff were not always positive role models.

> Too many staff were disinterested in building a positive relationship with prisoners, and many staff had low expectations of the young adults in their care. We conducted several more in-depth interviews with prisoners which supported the view that relationships were very mixed, and often at best distant and at worst dismissive. Feltham

There is currently no specific Prison Service training for staff working with this age group, a point we raised in our response to the prisons minister's consultation.

Changes to prison health services

In April 2013, NHS England became the commissioner of prison health services, heralding a new period of contract tendering. Throughout the year, service providers were unwilling to recruit to vacancies while out to tender. Initially, it was unclear who was responsible for health needs assessments, and 29% of health services in the adult male prisons we inspected had assessments that were out of date or not comprehensive. NHS England's approach from 1 April 2013 was to commission health services for groups of prisons. This should enable sharing of resources and generalisation of learning through the establishment of quality monitoring groups, although it was too early to assess this in the period of our inspections.

26 Analysis carried out for a young adult scoping paper, completed in 2013–14 using survey data from 2012–13.

Generally we saw good clinical care, but in 18% of adult male services, nurse triage was not accompanied by algorithms or protocols to guide practice. In a quarter of services, care for patients with lifelong conditions was not supported by up-to-date care plans or registers that enabled clinical monitoring. There continued to be long waiting times to see a dentist in some prisons.

Despite the absence of national planning, we found palliative care suites for prisoners nearing the end of their lives at several prisons, such as Exeter and Holme House, usually in association with the King's Fund health services charity and local end-of-life care providers. These suites heightened the opportunity for individual end-of-life care.

Many prisons had no clinics for prisoners to consult pharmacists about their medications, and too few had arrangements for nurses and other health professionals to supply and administer prescription-only medicines, relieving pressure on GPs. In one in five services we found problems with the administration of medicine – including supervision of medicine queues, confidentiality and medicines not administered at the prescribed times due to regime restrictions. Of prisoners currently taking medication, 74% had medicines in their possession, but in a quarter of prisons there were inadequate risk assessments or a lack of secure in-cell storage facilities.

> The majority of medicines were supplied in possession, including a large number of tradable medicines and those liable to be abused. Not all prisoners had access to a secure locker… In-possession risk assessments took into account a prisoner's risk, but not the risk of medicine being traded or the prisoner being bullied for their medication. Risley

Many prison health services occupied rooms that were not designed for purpose, and a quarter failed to comply with relevant infection control standards. Thirty-eight per cent of adult male prisons we visited had problems with emergency medical equipment, including its range, readiness for use, staff training in how to use it and awareness of where it was sited.

In our survey, 31% of prisoners reported having an emotional well-being or mental health problem. Usually, we found prison staff were keen to support such prisoners, although in one in five of adult male prisons inspected, staff had insufficient training to identify prisoners with mental health problems and refer them for assessment.

We observed the continuing trend to provide integrated pathways of mental health care, but primary mental care was insufficient to meet demand in a quarter of prisons and not enough counselling was provided in one in 10.

> Mental health services were provided by a senior registered mental health nurse (RMN) from the primary care team, and a psychiatrist… The support provided was very good but was too limited, as there was no access to counselling, groups or psychologically informed therapies… very few prison officers had attended mental health awareness training. Kennet

However, we did observe some centres of good practice in mental health care.

> Prisoners could self-refer by visiting the Harbour facility, a discrete unit offering a range of focused group work, including sleep clinics and anger management. Prisoners we spoke to praised the support they had received. Leeds

Not all services were able to transfer patients with serious mental health problems from prison to a hospital within the Department of Health's expected transfer time of 14 days, due to delays at receiving units. This left some very ill patients without the level of urgent treatment and care they needed.

Too much time locked up with too little to do

- Activity outcomes continued to be weak, and were poor in a quarter of prisons.
- Too many prisoners, especially young adults, spent too long locked in their cells.
- Most prisoners were locked up from 6.30pm, and they had little time out in the open air.
- There were insufficient activity places in many prisons, and too many of those that did exist were unfilled, with prison staff not always supporting prisoner attendance.
- There was little evidence that the new learning and skills contracts had improved outcomes for prisoners.
- The quality of vocational training was generally good but provision was still limited, even in training and resettlement prisons.

During 2013–14, most adult male prisons (but not young adult, open or high security prisons) were subject to a core day and regime review as part of the 'transformation of justice and prison unit cost programme'. This introduced new benchmarked standard core days (according to prison type), which were trialled throughout the year with the intention of maximising prisoners' time out of cell. Running alongside this core day was a regime review aimed at increasing prisoner work, activity and learning.

Throughout the year, most prisons were in the early stages of the project, applying the new benchmarked core days in preparation for full implementation with the necessary resources and activities in 2014–15. The picture we found was inconsistent, with prisons at different stages of application of the core day, and variations in interpretation and practices that led to unpredictability for prisoners. It was too early to comment on its overall success, but we had yet to see any evidence of increased time out of cell or activity for prisoners.

Purposeful activity outcomes in adult male prisons had remained as weak this year as last, with only around half of prisons reported on assessed as good or reasonably good – and in over a quarter of prisons, outcomes were poor. Of particular concern were the poor outcomes in the two young adult establishments we inspected.

Figure 10: Published purposeful activity outcomes in adult male establishments – full inspections

	Good	Reasonably good	Not sufficiently good	Poor
Locals	1	3	4	4
Trainers	3	6	3	3
Therapeutic communities	0	2	0	0
Open	2	2	1	1
High security	1	1	0	0
Young adults	0	0	0	2
Total	**7**	**14**	**8**	**10**

Figure 11: Published purposeful activity outcomes in adult male establishments – short follow-up inspections

	Sufficient progress	Insufficient progress
Locals	2	1
Trainers	1	0
Total	**3**	**1**

Still too little time out of cell

It remained the case that too many prisoners had too little time out of their cells. On average, only 17% of adult male prisoners said they spent more than 10 hours out of cell on a weekday. In local prisons the proportion was only 8%.

Figure 12: How long do you spend out of your cell on a weekday?

	Spend more than 10 hours out of cell (weekday) (%)	Spend less than two hours out of cell (weekday) (%)
Locals	8	29
Category C trainers	18	12
High security	18	8
Young adults	4	38
Open	56	2
Therapeutic communities	50	2
Average	**17**	**19**

In random roll checks during our inspections, we found that there were still too many men locked in their cells during activity periods – around a third in local prisons. However, there was significant variation. At Thameside, 60% were locked up – this was somewhat offset by good in-cell facilities (including an electronic application system, telephone, toilet and shower), but was still the highest proportion we have seen in two years. In category C training prisons, the average was 15%, but in three prisons more were locked up than in most locals. In sharp contrast, Leeds locked up fewer than 1% of prisoners during activity periods.

It was commendable and very unusual in a local prison to find nearly all prisoners unlocked during the working day, which equated to approximately 7.5 hours every weekday. Most prisoners were unlocked four evenings a week until 6.30pm, but standard level prisoners on B and F wings had fewer evenings out of cell because of low staffing levels. Leeds

It was especially concerning that only 4% of young adults said they spent more than 10 hours out of cell each weekday. In our random roll checks during the core day, we found about 37% of young adult prisoners locked up. In our survey, young adults reported the worst outcomes of all prisoner groups for their access to the gym and outside exercise, and time out of cell.

At Feltham, the maximum time out of cell on a weekday was 4.5 hours, compounded by the fact that 43% of the population were unemployed and unlocked for as little as one or two hours a day. These outcomes were exacerbated by poor management of the regime.

We found a daily slippage in the regime, and observed that prisoners were often unlocked late. 'Full' association in reality did not mean everyone on a unit was unlocked, and often this was further curtailed with even fewer prisoners being facilitated. These decisions were made by unit staff using unregulated discretion, which varied from unit to unit. Feltham

However, some prisons showed that it was possible to enable adequate time out of cell.

Most prisoners could spend nearly 10 hours out of their cell from Monday to Thursday and told us that this was never curtailed. There was no evening association from Friday to Sunday, but prisoners still had 8.5 hours out of cell. Roll checks during the working day showed that only about 6% of the population was locked up, most of whom had refused to work or were unwell. Huntercombe

In many prisons, activities were allocated to prisoners full time, and while time out of cell for employed prisoners was reasonable, those without activities were often unlocked for less than four hours a day. Where unemployment rates were high (reaching 60% of category C prisoners at Brixton), this resulted in very poor outcomes.

Fully employed prisoners were unlocked for over 10 hours a day, but the large number of other prisoners, and especially the unemployed, had much less time out of their cells, at only around four hours. Prisoners on the basic level of the incentives and earned privileges (IEP) scheme were only unlocked for around an hour a day. Oakwood

Under the new standardised core day trialled this year, most prisoners were locked up for the night at 6.30pm. This reinforced an issue we reported last year that some prisoners did not have enough time to contact family or friends or complete basic routines, such as showering or cell cleaning. Prisoners in local prisons were the most likely to say that they had association less than twice a week – this is a particular concern given that most local prisons are to become resettlement prisons, where many prisoners will spend the last few months of their sentence and should be preparing for their release.

We expect prisoners to have access to one hour in the open air every day, but this was routinely only available for 30 minutes. This had potential implications for prisoner well-being, particularly where time unlocked was poor. Unscheduled regime restrictions, uninviting exercise yards and conflicting priorities further restricted participation.

Exercise took place during the core day for prisoners on the wing, but there was no opportunity for fully employed prisoners to undertake a period of exercise, other than moving to and from work. Aylesbury

Activity places

Too many prisons lacked sufficient activity places to ensure all prisoners had good access to education or vocational training. Only 22 prisons inspected had enough activity places for the population. This shortfall continued to be a particular problem in local prisons, as well as those holding young adults. Many prisons offered part-time education and vocational training to manage these shortfalls.

The widespread and unacceptable failure to fill the places that were available not only continued but had deteriorated. Three-quarters of all prisons inspected failed to use their activity places, leaving prisoners without work or training when they need not have been.

Some of this failure to take up places was as simple as weak administration, delayed allocation and poorly managed activity waiting lists. But even when allocation processes were good, some prison staff did not give enough support to prisoners to attend learning and skills, often allowing them to miss classes and not challenging them sufficiently to attend.

The effectiveness of allocations was being undermined by informal arrangements, which meant that prisoners were withdrawn from allocated sessions or failed to be challenged when they refused to attend. Hewell

Other prison activities also often took precedence over education, with prisoners removed from class without notice to attend, for example, the gym, which had a negative impact on learning. All too often, disruptions to the working day and learning and training were due to insufficient management attention and staff shortages.

Operational issues and staff shortages had affected activities detrimentally, leading to cancellation or suspension of all vocational courses. These challenges had not been managed well enough to ensure continuity of provision. Belmarsh

Well-managed physical education can be valuable for prisoners' learning, well-being, employability, time out of cell and the management of frustration. Most facilities and provision were good, but in our survey, only 32% of prisoners said that they used the gym three or more times a week. Some of those who did attend achieved some useful qualifications, although many prisons could have improved the range offered, as at Liverpool.

The prison had restructured the timing of PE activities and improved access for all prisoners. All prisoners could attend three times a week. An appropriate range of sport and health related fitness activities were offered, including in the evening and at the weekend for those in work or education, with discrete sessions for older and vulnerable prisoners. Liverpool

The quality of learning, skills and work

The new contractual arrangements for the provision of learning and skills and work, which came into force in 2012, were now well established. However, we have not yet seen any evidence of improved prisoner outcomes as a result, and the providers are not required to measure the number of prisoners going into employment, training or education on release.

Our inspections of learning and skills and work in prisons are conducted in partnership with Ofsted (Office for Standards in Education, Children's Services and Skills) in England and Estyn in Wales. Both Ofsted and Estyn make assessments of the quality of learning and skills provision.

Figure 13: Published Ofsted assessments in adult male establishments in England (full inspections)*

	Achievements of prisoners engaged in learning and skills and work	Quality of learning and skills and work provision	Leadership and management of learning and skills and work
Outstanding	0	0	0
Good	16	16	10
Requires improvement	15	13	15
Inadequate	3	5	9
Total	**34**	**34**	**34**

* Excludes category D site, Lindholme.

Figure 14: Published Estyn assessments in adult male establishments in Wales (full inspections)*

	Current performance	Prospects for improvement	How good are outcomes for prisoners?	How good is provision?	How good are leadership and management?
Excellent	0	0	2	0	0
Good	3	3	1	3	3
Adequate	-	-	-	-	-
Unsatisfactory	-	-	-	-	-
Total	**3**	**3**	**3**	**3**	**3**

* Includes combined score for Usk and Prescoed.

The overall standard of teaching and learning was rated as good in fewer than half of the English prisons inspected. Outstanding teaching and learning were rare, even in the better prisons. We were particularly concerned that English and mathematics were often not sufficiently prioritised, with weak teaching reflected in poor achievement of accredited qualifications in most prisons. Even where prisoners needed to develop these skills, too few were encouraged to follow qualifications.

Take-up of English and mathematics courses was particularly low in comparison with the high level of need identified on induction… learning tasks in English and mathematics were not set in sufficiently meaningful contexts such as work activities or plans for employment on release… achievement rates in English and mathematics were low; only 14 and 16 learners, respectively, had achieved a qualification at level 1 or 2 in the previous academic year. Sudbury

In contrast, the standard of coaching in vocational training was generally good.

The quality of training, learning and assessment in vocational training was good, and tutors and instructional officers were industry credible. Tutors provided constructive feedback to prisoners on what they needed to do to improve. Holme House

Prisoner peer mentors to support learning were generally used well and provided valuable support.

Peer mentors, who were all appropriately qualified, provided effective support for learners, extending their learning, and helped create a good learning environment. Full Sutton

The range of learning provision offered too few opportunities for prisoners to progress.

Opportunities to progress were limited. Courses were not always accredited at a high enough level, with many providing only a level 1 qualification. As a result some took courses to gain qualifications that were at too low a level and not sufficiently challenging. Cardiff

Some prisons had a good emphasis on vocational and employment-related work – for example, Full Sutton had introduced a new core day reflecting a working day, with prisoners remaining at their workplace over lunchtime.

However in most prisons, while the variety of vocational training had improved there were still too few places available, even in training and resettlement prisons such as Blantyre House. Too much prison work remained mundane, with many of the typical wing cleaning jobs not fully occupying prisoners enough to encourage and develop a good work ethic. At Thameside, the only vocational training available was in the kitchen and gym, and 30% of prisoners were employed as wing cleaners.

Skills development and achievement of qualifications in vocational training were generally good. However, prisoners often developed good employability skills that were not recognised or recorded by the prison; such recognition would have enhanced their job prospects on release.

The role of prison libraries

Prison libraries can offer prisoners valuable personal development opportunities. The best are easily accessed by prisoners, run a range of activities to stimulate their interest, support learning activities and prisoner interests, and have study space and computer facilities. Other activities run in libraries included Toe by Toe (a peer mentor scheme for emerging readers), Storybook Dads (in which fathers record a story for their children), book clubs and formal training opportunities for library orderlies.

> ... library use was good. There was an inter library loan system to provide access to books that were not stocked. Stock loss was low. The writer-in-residence had been excellent and had offered a wide range of activities to stimulate and extend prisoners' interest in literacy. Hewell

However, some libraries had access problems. On average, only 38% of prisoners told us they visited the library at least once a week, a missed opportunity to help them prepare for release and resettlement.

> ... the number of prisoners using the library was exceptionally low, with only around 55 prisoners using the facility each week. The library was not open in the evenings or at weekends. Brixton

Prisoner resettlement needs more focus

- Our assessments for prisoner resettlement work were better than for other healthy prison tests but we continued to have concerns, despite the preparations to implement government reforms in this area.
- Offender management and resettlement work were still uncoordinated and inconsistent, and not always central to the prisoner's experience.
- Many prisoners went through their sentence with little – or no – assessment of their needs.
- The role of offender supervisors was not always clear and their work not always supervised or quality checked.
- Release on temporary licence was an important resettlement tool but its management needed to be significantly improved.
- Planning for prisoner reintegration into the community was inconsistent.
- Prisoners still had limited access to programmes that addressed their offending behaviour, which was a particular concern for sex offenders.

In May 2013, the government published its radical plans to transform prisoner rehabilitation, which we outlined in our 2012–13 report. This year we saw many changes in prisons in anticipation of these reforms, yet we continued to find some key concerns we have raised previously.

Resettlement outcomes for prisoners were assessed as good or reasonably good in around two-thirds of all adult male prisons inspected this year. However, while seven prisons received good assessments this year, it was concerning that two open prisons were assessed as poor.

Figure 15: Published resettlement outcomes in adult male establishments – full inspections

	Good	Reasonably good	Not sufficiently good	Poor
Locals	1	7	4	0
Trainers	1	9	5	0
Therapeutic communities	1	1	0	0
Open	1	3	0	2
High security	2	0	0	0
Young adults	1	0	1	0
Total	**7**	**20**	**10**	**2**

Figure 16: Published resettlement outcomes in adult male establishments – short follow-up inspections

	Sufficient progress	Insufficient progress
Locals	2	1
Trainers	1	0
Total	**3**	**1**

Strategic approach

Most prisons continued to have a comprehensive strategy for managing resettlement, but in many cases offender management and public protection work were managed separately from other aspects of resettlement. At Kennet (a semi-open prison with category D and C prisoners), the policy focused almost exclusively on resettlement pathway provision and release on temporary licence (ROTL).

> … there was scant coverage of the role and function of offender management. This was a significant omission given that ROTL was managed through the offender management unit. Kennet

In contrast, at Wayland (a closed category C prison):

> Separate policies with key delivery targets had been developed for the reducing reoffending and resettlement services, but they were both appropriately integrated. The overarching strategic plan 2012–2015 outlined strategic development objectives for both services. Wayland

The separation of offender management and resettlement work in some prisons also led to offender management working in isolation, rather than at the centre of a prisoner's activity. In Featherstone, for example, although prisoners were assessed for their employment, training and education needs during their induction, the outcomes were rarely integrated into their wider sentence planning. By contrast, the integrated approach at Parc meant that offender supervisors:

> … were involved in many aspects of work that we do not usually see, including IEP and ACCT reviews along with wider prisoner assessment. Parc

Many offender management departments were going through a transition with the recruitment of offender supervisors to a dual role of both offender supervisor and supervisory officer on wings. Full Sutton had had this model for some time and it worked well, but in some prisons the new role had affected the availability of staff resources. The situation was compounded further by the regular redeployment of offender supervisors to other tasks in some prisons, including Aylesbury, Belmarsh and Erlestoke.

The government has now identified those prisons that will be designated as resettlement prisons under its transforming rehabilitation plans, where most prisoners will be held or returned to at least three months before their release. Despite this major change, few of the prisons we inspected had begun to plan how to manage this transformation and develop staff to meet the new demands.

Offender management and resettlement

All prisoners serving over 12 months should have the risk of harm they pose and the factors that led to their offending assessed through the offender assessment system (OASys), and a sentence plan developed to address them.

As in previous years, many prisons continued to have backlogs of OASys assessments. Aylesbury, Feltham and Hewell, among others, had significant backlogs, and these had the knock-on effect of delaying prisoner access to other programmes and interventions, such as home detention curfew and offending behaviour programmes. At Wayland, at the time of the inspection, over 100 prisoners had no OASys and a further 40 had one that was over a year out of date. At some prisons, prisoners had been transferred in before the OASys had been completed at the sending establishment. This was a particular concern where sex offenders were involved.

> Approximately 10% of the population were sex offenders and a quarter of these did not have a completed OASys assessment. Huntercombe

Offender supervisors should be working with prisoners to help them achieve their sentence plan. Yet their role continued to be unclear in many prisons. At some prisons, offender supervisor contact with prisoners was largely reactive, irrespective of their risk level.

> We saw some examples of regular contact that focused on offending issues, but in many other cases, especially those managed by officer offender supervisors, the reason for contact was unclear. Many case files contained comments such as 'seen on free-flow' or simply 'seen, no concerns'. Belmarsh

In contrast, at Norwich, which included some high risk prisoners, contact focused on risk management and reinforcing learning from accredited offending behaviour programmes, and at Wayland, individual prisoner work had been built into the contract for offender supervisors. Some prisons had agreed the frequency of contact with high risk prisoners, although this was not always achieved.

The supervision of offender supervisors and quality assurance of their work was very mixed. There needed to be a focus on this area to ensure improvements in the quality and quantity of contact with prisoners. Some prisons had no routine case supervision of offender supervisors or regular case sampling, despite our previous concerns about this.

Although offender supervisors at Sudbury felt 'overwhelmed and were not delivering an effective service', they received little direction or appropriate training to help them. In contrast, Exeter had introduced practice supervision for prison officer offender supervisors, and at Blundeston:

> The OMU [offender management unit] manager quality assessed the work of the offender supervisors and fed back results to them. Blundeston

Public protection arrangements were in place in virtually all prisons we inspected and were mostly sound. However, there was still too much variation in practice and quality. At Erlestoke, for example, security were still not routinely involved in the interdepartmental risk management team (IDRMT) meetings, and at Blantyre House the role of the IDRMT was unclear. At Pentonville and Wayland offender supervisors played an active role in the reviews undertaken through the IDRMT, but involvement was minimal at Featherstone and Leeds.

> Public protection arrangements were good. All new arrivals were comprehensively screened and individual offender supervisors completed risk assessments that were signed off by the senior probation officer responsible for public protection. Parc

Concerns about high risk prisoners

On our inspections of adult prisons and young offender institutions, we are joined by colleagues from HM Inspectorate of Probation, who work with us in inspecting offender management provision.

In December 2013, we jointly published the third aggregate report outlining findings from our offender management inspections in the year up to April 2013. The findings broadly matched those of previous years, and we raised concerns about how effective the offender management model was in meeting the needs of high risk prisoners – for example, the report found only two prisons where offender supervisors had good enough frequent and meaningful contact with high risk prisoners.

The report recommended a review of the offender management model, particularly in light of the new transforming rehabilitation plans, and made other recommendations for action in the interim. These included: the importance of needs analyses of the prison's population; the availability of accredited programmes; the quality of risk management plans; and the need to use prisoners' electronic case history notes.

Reintegration planning

There continued to be considerable variation in work on reintegration planning. Most high risk prisoners were managed appropriately, with meetings facilitated by community offender managers before their release. But such arrangements were less reliable for low and medium risk prisoners or those serving less than 12 months. For example, Kirkham 'had a good focus on reintegration from arrival onwards', but at Belmarsh, where prisoners were invited to pre-discharge boards two or six weeks before their release:

> … although these were generally well attended and the information collated was appropriate… there was no link to offender supervisors. As most prisoners attending the board were to be released on licence to the community offender manager, this was a major oversight. The lack of integration meant that the offender supervisors could not consistently inform offender managers about arrangements made through pathway providers. Belmarsh

As a local prison, Leeds had clearly defined its role as reducing the reoffending of those serving less than 12 months, and transferring those serving over 12 months to appropriate establishments, where possible. The prison demonstrated how such work could be well managed, despite the high turnover of prisoners.

> Dedicated and proactive staff on the resettlement (C) wing provided prisoners nearing the end of their sentence with good support… The use of ROTL for prisoners attending voluntary and paid employment in the community was excellent… it was impressive that prison staff were seconded to community agencies focused on reducing reoffending. Leeds

Addressing offending behaviour

Although the Prison Service offers a range of accredited programmes to help prisoners address their offending behaviour, we continue to find that prisoner access to them is too limited. For example, Kennet had no accredited programmes, and no real assessment of the needs of its prisoners. Aylesbury, Erlestoke and Wayland had generally good offending behaviour work facilities, but at Lindholme 'there were no accredited offending behaviour programmes or structured ways of addressing offending behaviour at either site', and little evidence that prisoners were going elsewhere to attend them. At Rochester, apart from drug and alcohol programmes, only the thinking skills programme was available.

> Sampled OASys and sentence plans contained targets to complete interventions not available at Rochester. Conversations with offender supervisors confirmed that prisoners' needs were not met consistently. Rochester

Of greater overall concern was the continuing limited access to sex offender treatment across the prison estate, and considerable variation in what was available. Frankland and Full Sutton did good work with sex offenders in denial of their offence, but this was in contrast to Moorland, where 'although a third of the population were sex offenders, no sex offender treatment programmes (SOTPs) were delivered'. Although the specialist sex offender prison Bure had exceeded its target for SOTPs in the previous year:

> … the volume of courses available was insufficient and there was evidence that several dozen indeterminate sentenced prisoners had passed their tariff date while waiting for the course. Bure

Release on temporary licence

This year saw several failures of prisoner release on temporary licence (ROTL) that hit the headlines. In September 2013, the Secretary of State for Justice asked the Chief Inspector to undertake an independent review of recent such failures. The findings were submitted in December 2013, with publication due once the relevant cases have been dealt with by the courts.

ROTL is an important and cost-effective part of preparing prisoners for release. It enables low risk prisoners to put something back into society while completing their sentences, through community placements or paid work, and helps them to maintain important family and other community links.

> Those [prisoners] we spoke to told us that the experience had improved their readiness for open conditions, given them new experiences of employment and in some cases led to offers of a job on release. Blundeston

For prisoners coming to the end of longer sentences for serious offences, ROTL, properly managed, contributes to their acclimatisation to life beyond prison walls and tests their readiness to live in the community without reoffending. As such, it has an important role in protecting society from the harm offenders might do if they reoffend having been released at the end of their sentences without adequate preparation.

The number of releases on temporary licence has grown to over 400,000 releases each year. Our inspections found considerable variations in its application. While Prescoed released about 90 prisoners a day to work in the community, and there had been 26,000 separate uses of licences in the six months before the inspection, at Sudbury, these levels were relatively rare.

Not only have the numbers of prisoners released on temporary licence increased, but the type of prisoners released has also changed – with the number serving indeterminate sentences rising significantly. This increase has arisen as many prisoners assessed as dangerous and serving indeterminate sentences of imprisonment for public protection (introduced in 2005) have now progressed through the system to open prisons and become eligible for ROTL.

The number of prisoners who fail ROTL is extremely low. Figures from the Ministry of Justice for 2012 show that fewer than 1% of releases on temporary licence were recorded as failures, and the proportion of recorded failures resulting from an arrest while on licence was 6.1%, or around five arrests per 100,000 releases on temporary licence.[27]

> … 787 prisoners had been granted 23,797 ROTL opportunities in the previous six months… Given the high use of ROTL, the failure to return rate (18 in the year to date) was not excessive. Kirkham

Any arrangements to release prisoners into the community cannot be risk-free. However, the system for agreeing and managing ROTL has not kept pace with the increase in number and risk level of eligible prisoners.

The significant rise in the number of indeterminate prisoners in open conditions in recent years means that open prisons manage more prisoners who pose a significant risk of harm, but ROTL processes do not differentiate between such prisoners and those who present less risk of harm to the public. Our inspections found that the quality of risk assessments were often poor, with insufficient evaluation of risk-based information from a wide range of sources. Many staff – those completing risk assessments as well as those chairing

27 *Release on Temporary Licence (ROTL) failures. A review by HM Inspectorate of Prisons* (forthcoming).

ROTL boards and recommending release – had not received sufficient training, and needed a much better understanding of the nature of risk and how to manage it.

Despite the significant rise in temporary releases, the resources available to open prisons for this work were, at times, insufficient. For example, ROTL boards sometimes had less than five minutes on average to discuss each case. We do not think that prisoners who pose a significant risk of harm, particularly those new to ROTL, can be managed safely in this way.

Thematic report on life sentence prisoners

In September 2013, we published the report of our joint inspection with HM Inspectorate of Probation on the management of life sentence prisoners. It focused on the transition of such prisoners from closed to open prisons and release on life licence.

We found that life sentence prisoners tended to be treated much the same as other prisoners, with little attention to their particular circumstances or the importance of retaining family ties to support their eventual rehabilitation.

Once in open conditions, preparation for release relied heavily on release on temporary licence. The quality of offender assessments left room for improvement, particularly those completed in custody. Most of those on life licence formed positive relationships with their offender managers, did not reoffend and, despite the stigma of the life sentence, were able to lead useful and productive lives after release.

This report highlighted the importance of both the work with the prisoner throughout their sentence to address their behaviour, and the need for effective joint work between the prison and community to plan and prepare for their safe release.

Preparing for re-entry to the labour market

Few prisons had good links with employers and there was too little focus on ensuring that prisoners were fully equipped to progress into education, training or employment on release. However, Cardiff had used a comprehensive needs analysis of the labour market to develop appropriate courses, and had good partnerships with employers and social enterprises to promote and encourage employment. These approaches had resulted in positive outcomes for prisoners.

Careers advice was not generally well planned, with insufficient links to other aspects of resettlement work in the prison. The 'virtual campus' – which gives prisoners access to community education, training and employment opportunities through the internet – was rarely fully operational and supporting prisoners in job search and preparation for resettlement.

Support with accommodation and financial issues

Although securing appropriate accommodation and resolving debt issues is extremely important for prisoners returning to the community, prisons continued to provide support services of varying quality. Many provided specialist accommodation advice from organisations such as Nacro, the St Giles Trust or Shelter, while others delivered the service through staff within the establishment. At Holme House Shelter worked with prisoner peer advisors and at Kirkham a similar model, combined with effective pre-release assessments, ensured that 'settled accommodation was in place for virtually all prisoners before their release'. In contrast, some prisons, such as Coldingley, Exeter and Sudbury, offered no specialist support. At Belmarsh the dedicated housing officer had received no training despite our finding that:

> … the number of prisoners released with no fixed accommodation was higher than we usually find at 18% in the previous six months. Belmarsh

The level and range of support for prisoners with finance and debt issues also varied. Cardiff, Exeter and Thameside provided no debt management support and while most offered some level of debt management, Rochester and Kennet were particularly effective:

> There was good debt management provision… In the previous six months Shelter had helped to write off £17,000 of debt and to freeze a further £53,000 of prisoner debt. Kennet

Supporting family contact

Most prisons provided reasonable support to help prisoners maintain family contact and relationships through provision for visits and visitors. However, delays in access to visits still often meant considerable variations in what prisoners and their friends and families experienced. At Aylesbury, where visits started at 2.15 pm:

> … on one day during the inspection some visitors did not reach the hall until just before 3pm. On this occasion, the process and management was chaotic, with visitors being given contradictory information, and long waits to get through the gate. Aylesbury

There was also inconsistency in the provision of family support and prisoner access to parenting courses and other services. For example, Risley offered no family support worker, parenting course or opportunity for general relationship counselling while, by contrast, Blundeston, Exeter, Holme House and Leeds had family support workers and a range of parenting courses and relationship support, and at Parc the provision was impressive.

'A whole prison approach to working with children and families which was innovative and extremely positive'

Parc offered 'outstanding' work to help prisoners develop and sustain constructive relationships with their families, as well as work with the families themselves. Foreign national prisoners could use Skype to contact their families abroad, there was a homework club where prisoners could work alongside their children, and a free bus service for visitors to the local station. Over 190 volunteers had been recruited from the local community to support these projects. A family interventions unit provided a range of programmes to support family relationships, and the 'invisible walls' multiagency parenting and relationships project engaged with up to 20 highly dysfunctional families a year.

4

Women in prison

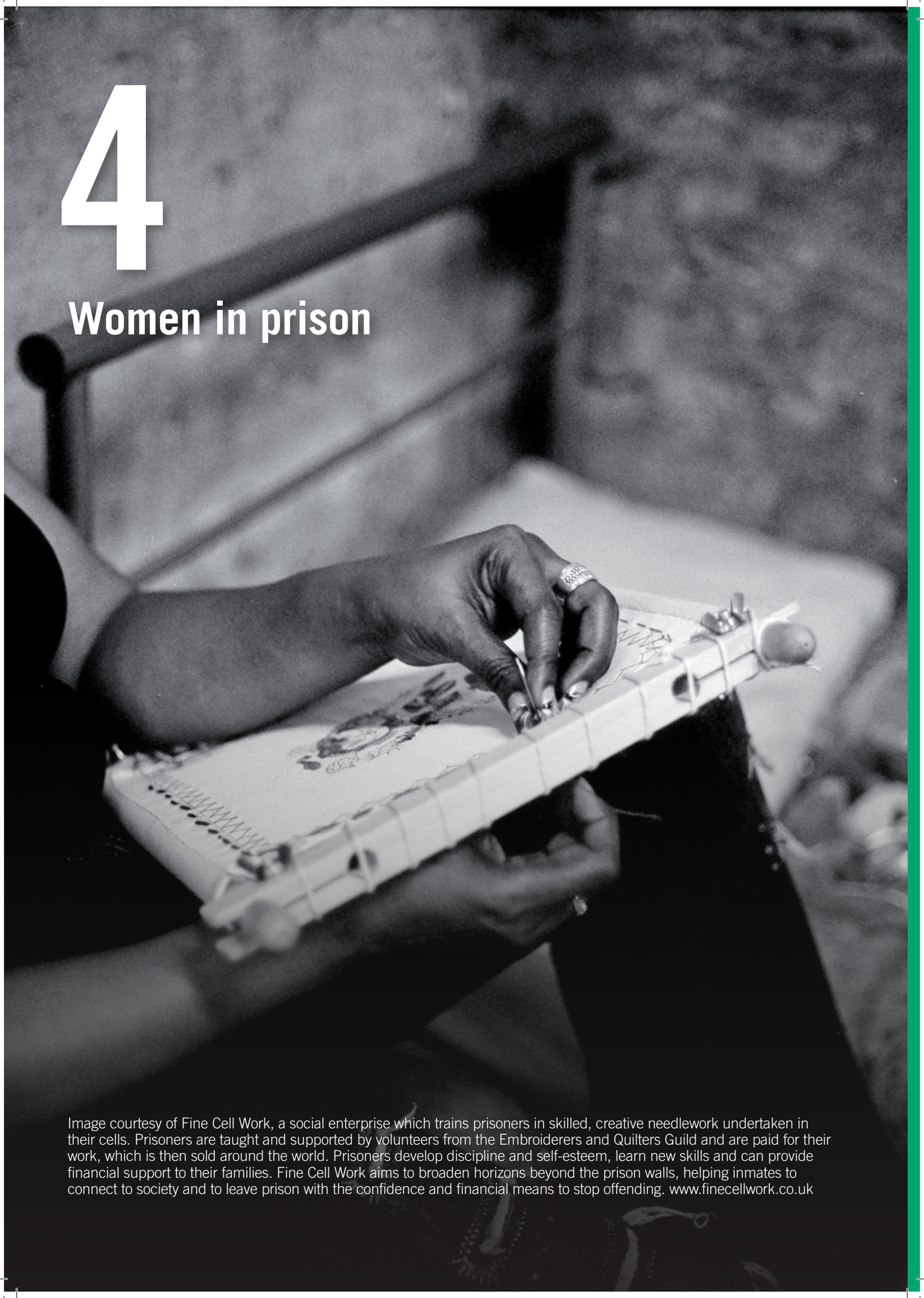


Image courtesy of Fine Cell Work, a social enterprise which trains prisoners in skilled, creative needlework undertaken in their cells. Prisoners are taught and supported by volunteers from the Embroiderers and Quilters Guild and are paid for their work, which is then sold around the world. Prisoners develop discipline and self-esteem, learn new skills and can provide financial support to their families. Fine Cell Work aims to broaden horizons beyond the prison walls, helping inmates to connect to society and to leave prison with the confidence and financial means to stop offending. www.finecellwork.co.uk

This section draws on four full inspections of women's prisons, and also reviews some key strategic developments related to women prisoners. All the findings from prison inspections in this section are based on the fourth edition of our *Expectations: Criteria for assessing the treatment of prisoners and conditions in prisons,* published in January 2012. We are currently producing additional Expectations for the inspection of the treatment and conditions of women in prison, and these will be published during 2014–15.

- The women's prisons inspected during the year were safe and respectful, and mostly performing reasonably well in activity and resettlement.
- The incidence of self-harming among women in prison was still disproportionately high, but had decreased.
- The needs of women prisoners who had children were not sufficiently addressed.

In 2013–14 we reported on four full inspections of women's prisons – two locals and two training prisons. All of the prisons inspected were at least reasonably safe and respectful, and most were performing reasonably well in our purposeful activity and resettlement tests. Overall, these outcomes were more positive than the average in the male estate.

Published outcomes in all women's prisons receiving a full inspection (4)

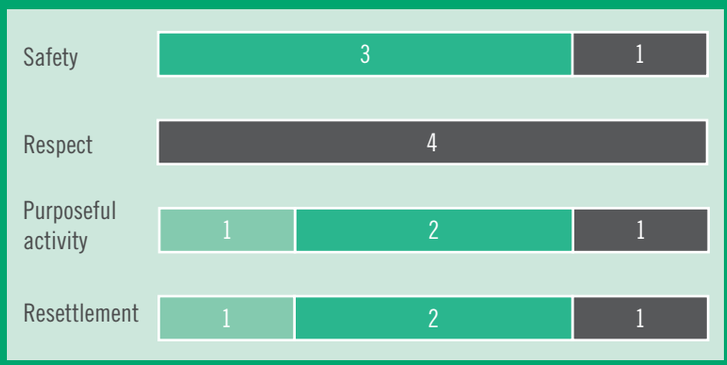


Figure 17: Published outcomes in full inspections of women's prisons

	Safety	Respect	Purposeful activity	Resettlement
Bronzefield	Reasonably good	Reasonably good	Reasonably good	Reasonably good
Downview	Reasonably good	Reasonably good	Good	Not sufficiently good
Drake Hall	Good	Reasonably good	Reasonably good	Good
Holloway	Reasonably good	Reasonably good	Not sufficiently good	Reasonably good

Strategic context

The steady improvement in outcomes for women in prisons that continued this year reflects a greater focus on the specific needs of women prisoners at a strategic and local level.

The Justice Select Committee published the report of its inquiry into women offenders in July 2013.[28] The report assessed progress five years after Baroness Corston's groundbreaking *Review of women with particular vulnerabilities in the criminal justice system* called for fundamental

28 House of Commons Justice Committee: Women offenders: after the Corston Report.

changes in the way women offenders were dealt with. In the introduction to the report, the committee noted:

> "In our view there is general agreement that the majority of women offenders pose little risk to public safety and that imprisonment is frequently an ineffective response. It is also now well recognised that it is not permissible for women offenders to be dealt with in the same way as men within a criminal justice system designed for the majority of offenders. This is not about treating women more favourably or implying that they are less culpable. Rather it is about recognising that women face very different hurdles from men in their journey towards a law abiding life, responding appropriately to the kinds of problems that women in the criminal justice system bring into it, and taking the requisite action to be effective in addressing their offending behaviour."

In his evidence to the committee, the Chief Inspector said:

> "The fundamental things that Corston talked about, it seems to me, are that you have women in prison who probably should not be there in the first place, and that those who are there are in prisons that are too big and in the wrong place, and that is because there has not been the drive from the centre to sort that out."

The committee's report reflected these concerns. It was critical of the hiatus in efforts to make headway on implementing the important recommendations made by Baroness Corston in the early years of this parliament, and the failure to provide strong political leadership in that period. The committee found that the 'women's prison population has not fallen sufficiently fast' and urged the gradual reconfiguration of the female estate with the sort of smaller units and more responsive regimes that Baroness Corston recommended.

We have seen evidence of a positive response to the concerns the committee addressed.

Under the government's 'transforming rehabilitation' programme, all women's prisons will become resettlement prisons. This is intended to ensure that women serving short sentences and those who are within six months of release are held closer to home and receive 'through the gate' support and statutory supervision after release. A late amendment to the Offender Rehabilitation Act (enacted March 2014) will support efforts to ensure that contracts to run resettlement services include women-specific provision. These are welcome developments.

However, we share the concern of the committee that the 'transforming rehabilitation' programme is designed mainly with male offenders in mind with not enough consideration to the specific needs of women. Women will still be held in a relatively small number of large establishments, and so many cannot be held close to home (there is no women's prison in Wales, for instance).

This inspectorate attends the Ministerial Advisory Board on Female Offenders in an observer capacity. The board's cross-departmental work has been strengthened and it has provided an important focus for driving progress, although it is unfortunate that circumstances have prevented consistent ministerial leadership.

The Women's Custodial Estate Review was published in October 2013.[29] The Review made some welcome recommendations, but the overall approach continues to fall short of the radical change in strategy required to reduce imprisonment of low risk women. Key elements include:

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

- the intention to close the two open women's prisons and replace capacity with 'open' units on existing sites
- the closure of the mother and baby unit at Holloway
- plans to provide additional capacity for women from the South West, Wales and the Midlands.

We are encouraged to see that NOMS and ministers are now taking a more women-specific approach to financial efficiencies in the women's estate than previously, and the specific needs of women have been considered in the introduction of policies such as the new incentives and earned privileges scheme.

A wide range of complex needs

Women in the prisons we inspected continued to have a wide range of very complex issues and needs. For example, in the two local prisons, about half of women prisoners said that they had emotional well-being or mental health problems. Across all women's prisons inspected in this reporting year, 59% of women said they were in prison for the first time, and 30% said they felt depressed or suicidal on arrival. Approximately half (51%) said they had children under the age of 18, and 24% said they had a disability. Just under a third (30%) said they had substance misuse problems on arrival into prison.

This mix presented significant challenges to staff in keeping women safe and ensuring their wider needs were met.

This year, we continued to find that too many women had unacceptably long waits in court cells before they were transported to prison. They then regularly shared escort vehicles with male prisoners, and some reported having experienced verbal abuse. Some vehicles did not have screens to separate cells holding men and women. Men's prisons have more restrictive reception arrangements than women's prisons so women were routinely subject to longer journeys than men who were dropped off first. Proportionately, many more women were delivered late to Holloway than male prisoners to nearby Pentonville, for instance.

Physical violence among women prisoners remained at low levels, and was usually limited to a few individuals. Women's experience of victimisation in prison was characterised by problematic personal relationships, exclusion, name calling, theft and personal verbal insults. We saw some innovative approaches to these challenges.

> STEPS (support towards encouraging positive solutions) was a new approach to reducing antisocial behaviour… It aimed to have a greater focus on supporting women displaying problematic behaviour.
> Bronzefield

Women prisoners often present challenging behaviour (including a risk of harm to self or others) requiring the personalised and coordinated support of multiple service providers. We saw improved awareness of the complexity of women's needs, and the use of multidisciplinary case management.

> Weekly MASH [multi-agency safety and health] meetings reviewed care for vulnerable prisoners; they included representatives from disciplines such as health care, residential and education. These meetings were an effective tool in keeping the most vulnerable women safe.
> Drake Hall

We were concerned that segregation units did not provide a suitable environment for these women. We had particular concerns at Bronzefield, where we found one woman who had been held in segregation for over five years in poor conditions and without adequate daily activity – we judged this to constitute cruel, inhumane and degrading treatment. At Drake Hall, we criticised the use of a gated cell in the segregation unit for women in self-harm crisis.

Despite these examples, the care provided to most women in prison was reasonably good. We also noted the continuing low number of self-inflicted deaths compared with the male estate and to earlier years. In 2013–14 there were three self-inflicted deaths compared with one in 2012–13.[30]

While the rate of self-harm among women continued to be higher than for men in prison, this had reduced (whereas it had increased for men). Women accounted for a disproportionate number of self-harm incidents in prisons (26%), despite constituting only 5% of the prison population.[31]

We noted improvements in the first night care of vulnerable women, including prisoner peer support and more active and supportive case management.

NOMS has made commitments to implement more specialist care for women with personality disorders and to manage those on 'restricted status' (who require the highest security) more actively, which we welcome.

The Holloway experience

HMP Holloway is the largest women's prison in Europe. In the past we have criticised its treatment of women, but the most recent inspection was encouraging. Holloway's size and poor design do not assist good care, but its central London location brings distinct advantages in the community support services available.

Over half the women were in prison for the first time, some had complex needs and many were very vulnerable. In the early days of custody, officers interacted sensitively with women to identify the needs of those feeling isolated, lonely or frightened and to provide support.

The Timeline initiative, which involved the consistent, detailed analysis of wing observation books to identify risks to the safety of individual women from others or themselves, was good practice and should be used elsewhere. Holloway

On average 30% of women said that they had a drug problem when they came into prison (compared with just over a quarter of men), although significantly fewer women than men reported developing a problem with illegal drugs or diverted medication in prison. This year we saw that substance misuse services continued to improve. Clinical and psychosocial services were increasingly well integrated, flexible and responsive. Bronzefield offered impressive provision to aid women who had problems with alcohol.

Good outcomes on respect

Strong relationships between staff and prisoners underpinned reasonably good respect scores in all the women's prisons we inspected this year. Overall, living conditions were reasonable and better than we see in the male estate.

30 www.gov.uk/government/uploads/system/uploads/attachment_data/file/305614/safety-in-custody-to-dec-2013.pdf
31 Ministry of Justice, Safety in Custody statistics, England and Wales, March 2014.

We expect women's prisons to have at least 60% female staff. Bronzefield and Downview had still not achieved this.

An average of 38% of women reported that they were from a black and minority ethnic background. In our survey black and minority ethic women were more likely to say that they felt unsafe at the time of the survey, compared with those from a white background, and were less likely to say they felt most staff treated them with respect. However at Holloway, where, unusually, the proportion of black and minority ethnic staff reflected the prisoner population, black and white prisoners had similar perceptions.

Although around 24% of women in our survey reported that they were foreign nationals, interpreting and translation services were not used often enough to support those who reported they did not understand spoken English (about 12% of foreign nationals). Foreign national women were generally given one free telephone call a month to their home country, but only if they did not have visits. In some cases, this meant that women had to make an invidious choice between seeing friends and family in the UK or keeping in contact with those at home.

In contrast to what we find in prisons for men, issues around sexuality were openly discussed in women's prisons and the support offered to lesbian and bisexual prisoners was generally good.

The small number of young women entering prison from secure training centres (previously girls' units) need particular support to integrate into the main population. Holloway showed what can be done to support this vulnerable and needy group.

> Forums for young women were run once a month and there were social meetings twice a month with age appropriate activities. The support group Life Choices helped young women reflect on their past and improve decision making in the future. Pecan, another external group, offered resettlement support for 18- to 22-year-olds in prison and for up to a year after release. Holloway

Women who considered themselves to have a disability were more likely to report that they had felt unsafe compared with those women who did not consider themselves to have a disability, and were less likely to say that there was a member of staff they could turn to with a problem. We continued to find a lack of individual multidisciplinary care planning for such women. In contrast, women over the age of 50 were less likely to report that they had felt unsafe at their establishment, compared with those under 50. Women over 50 were also more likely to report that most staff treated them with respect.

Health services for women prisoners were reasonably good, but we had concerns about the mental health provision at Downview and excessive delays transferring women to NHS facilities under the Mental Health Act at Holloway. Positive initiatives included a skin camouflage clinic at Downview to help women who had self-harmed. At Drake Hall, there was evidence of exceptional integrated care for a patient with end-of-life needs, which included health care staff escorting her to her home country to die with her family because waiting for a Border Agency (now Home Office Immigration Enforcement) escort might have left her too ill to travel.

Activity and resettlement

Good activity provision is often particularly important for women. It can improve well-being, and help vulnerable women settle into prison and recognise their capacity to learn and to change. In contrast to many men's prisons, women's prisons inspected this year had sufficient purposeful activity places for the population.

Figure 18: Published Ofsted assessments in women's prisons, 2013–14

	Achievements of prisoners engaged in learning and skills and work	Quality of learning and skills and work provision	Leadership and management of learning and skills and work
Outstanding	0	0	0
Good	2	1	1
Requires improvement	2	3	3
Inadequate	0	0	0
Total	**4**	**4**	**4**

At Downview, Ofsted judged activity provision as good across all three of its tests, but most provision elsewhere required improvement. It was weakest at Holloway, where time out of cell was also poor. Weaknesses included low achievement rates, failure to record and accredit skills, inefficient use of activity places and poor attendance.

> Attendance rates and punctuality in observed sessions were low, with too many prisoners arranging to attend other activities in preference to education and training. Drake Hall

Resettlement outcomes were good or reasonably good in all the prisons except Downview, where there were significant backlogs in the assessment of prisoner risks and needs, and children and families work was underdeveloped. The challenge of finding accommodation for women prisoners is substantial, because they are often held further from home than men in prison and women's prisons need to manage and maintain a large number of contacts across a wide area. The reducing stock of social housing and more limited choice of hostel locations are also a challenge. Despite some excellent support in the prisons we inspected, many women only learned where they would be living the day before their release.

Women in prison need support to maintain contact with their families and friends, but none of the prisons we inspected this year routinely identified the number who were mothers, or monitored if mothers maintained contact with their children. Support varied between prisons. For instance, at Downview women who were primary carers or who did not receive visits were not routinely identified and there was no family support worker, whereas Bronzefield ran a programme designed to help women develop support for their children through play. We welcome the decision by NOMS to fund a family support worker in every women's prison.

At Drake Hall in Staffordshire, where we met women from Plymouth and South Wales (and, on average, women were 91 miles from their home), no prisoners had been able to transfer temporarily to a prison closer to their home to receive visits in the previous six months. None of the prisons we inspected offered Skype facilities, even for foreign nationals, who often have particular difficulties maintaining contact with their families. Visits provision was generally depressingly similar to the male estate, with few opportunities for women to play with or care for children.

Children and families provision met basic needs but lacked imagination. The prison did not identify the children and family issues relevant to women on arrival at the prison, including those who were primary carers or who did not have visits. Only a limited number and range of family visits were offered, and there was no provision for some groups, such as those with grown up families. Downview

The mother and baby units at Bronzefield and Holloway provided good opportunities for mothers to have babies with them in custody up to 18 months of age. Care in the units was good, although there were some unnecessary restrictions on mothers. The unit at Holloway has since closed because of under-occupancy. We consider that the available capacity could be used more flexibly and imaginatively to support mothers and children, even where the child is not resident with its mother.

We saw a host of non-accredited interventions, which fostered confidence and self-esteem and were highly valued by prisoners.

The Safe Choices: Nia Project… helped young women involved with male gangs, sexual exploitation or violence explore their identity and relationships. Using creative arts and discussion, the I AM course helped women deal with child loss. Holloway

The provision to support women who had been traumatised by experiences of abuse, rape, domestic violence and sex work was still inconsistent, although there was some good practice.

Women who had been involved in prostitution were invited to a monthly Street Safe group held in the chapel. Some chose to take part in a two-day safer sex course organised in partnership with the NHS, which was sometimes run exclusively for sex workers. Bronzefield

We also noted support for victims of human trafficking at one prison.

Three women had been identified as victims of trafficking, and the Poppy Project, which supports women trafficked into the UK, had referred them to the national referral mechanism (NRM). (The NRM was put in place in the UK in April 2009 to identify, protect and support victims of trafficking.) All Listeners and some staff had received awareness training. Drake Hall

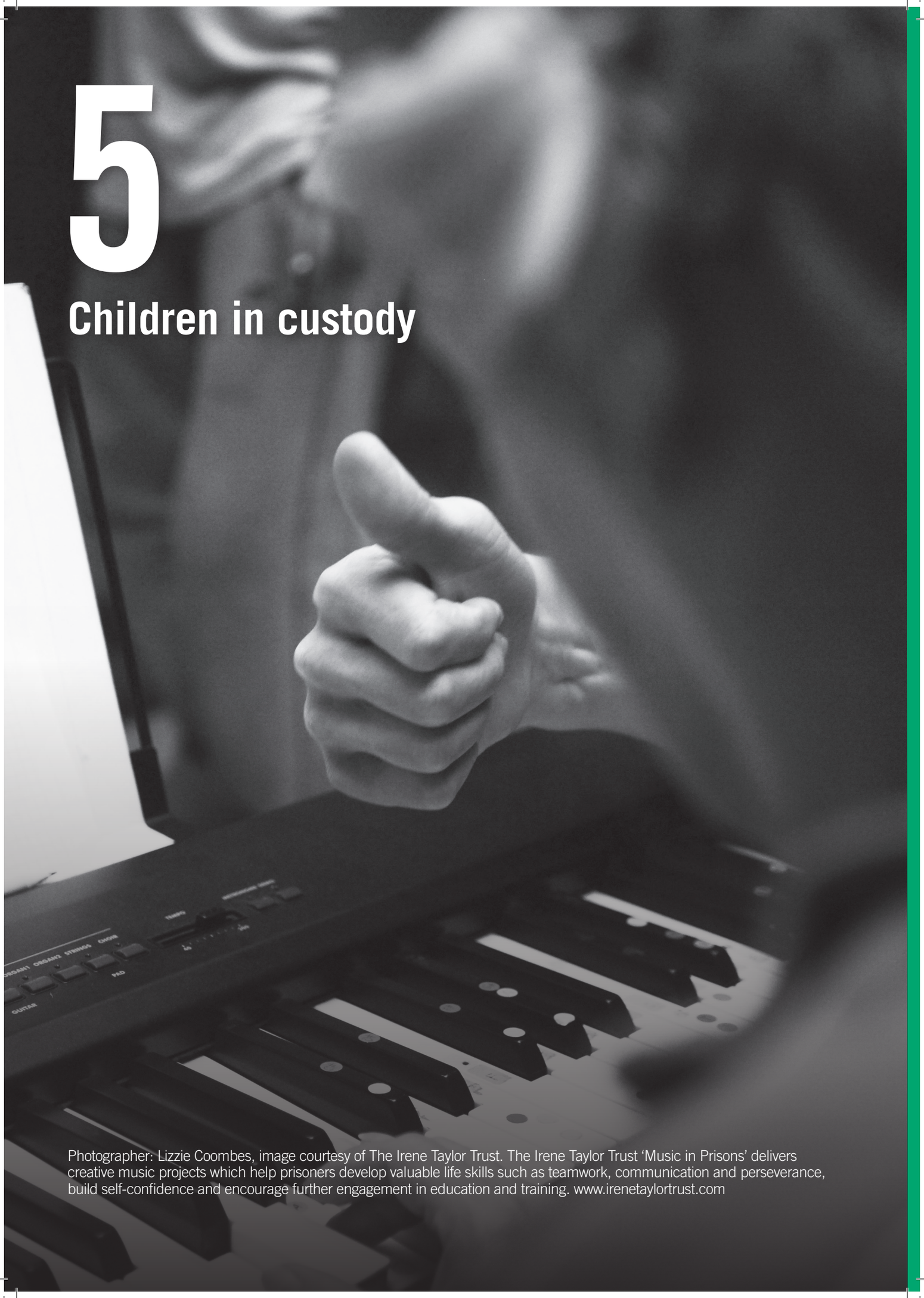
Our new Expectations for women prisoners

Our inspections are conducted within the framework of criteria – *Expectations* – for assessing the treatment of those held in detention and their conditions. In the past year, and in consultation with our range of stakeholders, we have used our evidence gained from inspecting women in prison to develop a version of these *Expectations* that also assesses the specific needs of women in prisons. These incorporate more fully the Bangkok Rules – which set out internationally agreed standards that should govern the treatment of women in prison.[32] The Expectations for women prisoners include similar criteria to those for men, but give a greater focus where provision needs to be different to meet the specific needs of women.[33] Our *Expectations* for women will be used in our 2014–15 inspection programme to drive further improvements in outcomes for women, and we hope that prisons will be able to respond positively to the challenges they contain.

32 United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders.
33 www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria

5

Children in custody



Photographer: Lizzie Coombes, image courtesy of The Irene Taylor Trust. The Irene Taylor Trust 'Music in Prisons' delivers creative music projects which help prisoners develop valuable life skills such as teamwork, communication and perseverance, build self-confidence and encourage further engagement in education and training. www.irenetaylortrust.com

This section draws on nine full inspections of young offender institutions (YOIs) holding children aged 15 to 18 and, jointly with Ofsted and the Care Quality Commission, six inspections of four secure training centres (STCs) holding children aged 12 to 18. All the findings from inspections in this section are based on *Expectations for Children and Young People*, published in June 2012, and the framework for inspecting STCs published in October 2012.

In 2013–14, we made healthy prison assessments covering eight establishments holding children.[34]

- The number of children held in custody fell sharply, but we had concerns about the implications for the safety of those still held.
- More children were held far from their home, affecting their family contact and prospects for resettlement.
- While outcomes in the YOIs we inspected were at least reasonably good, half of the establishments that still remain were not safe enough, and the high levels of violence continued to be a concern.
- Outcomes for children were better in the smaller units.
- Children who had been in local authority care were over-represented in custody and had a poorer experience in some areas than those who had not been in care.
- STCs were effective in supporting the children in their care.

Rapid scale and pace of change

Since April 2013, the number of children held in custody continued to reduce sharply, but those who remain are now held further away from home and represent a greater concentration of very challenging behaviour and vulnerability. Establishments have struggled to manage these children safely.

The total held in young offender institutions (YOIs) on 29 March 2013 was 1,034, including 12 girls – by 28 March 2014 provisional figures show that there were 877 in YOIs, all boys. There had been a slight increase in the number held in secure training centres (STCs), from 258 in March 2013 to 276 in March 2014.[35]

This decline in numbers accelerated the trend over the previous decade, when the total number of children in custody, including 18-year-olds, fell by an average of four per cent per year from 2002–03 (where there was an average of 3,451) to 2011–12 (where there was an average of 2,141). In the last two years numbers have been reducing much more rapidly, by around 20% each year.[36]

34 HMYOI Ashfield was also inspected but no assessments were made as it was decommissioning as a YOI at the time of the inspection and held very few children.
35 Figures from Youth Justice Board placements team, May 2014.
36 Calculations based on data published in www.gov.uk/government/collections/youth-justice-statistics

Who is in custody?

Demographic findings from our surveys of children in YOIs[37] show that:

- 41% were from a black or minority ethnic group
- 4% were foreign nationals
- 22% were Muslim
- 6% considered themselves to be Gypsy/Romany/Traveller
- 19% considered themselves to have a disability
- 33% said they had been in local authority care
- 53% said it was their first time in custody in a YOI, STC or secure children's home
- 11% were 18 years old.

Demographic findings from our surveys of children in STCs[38] show that:

- 13% of the population were girls
- 43% were from a black or minority ethnic group
- 3% were foreign nationals
- 14% were Muslim
- 11% considered themselves to be Gypsy/Romany/Traveller
- 22% considered themselves to have a disability
- 37% were under 16 years old.

During this reporting period, five children's establishments were closed or stopped holding children, including all the remaining girls' units, and the number of beds commissioned at two others was reduced. This meant that the number of YOI sites still holding children had reduced from 11 to six.

Figure 19: YOI beds decommissioned 2013–14

Establishment	Beds decommissioned
Ashfield YOI (boys)	360
Eastwood Park YOI (girls)	16
Downview YOI (girls)	16
New Hall YOI (girls)	9
Hindley YOI (boys)	192
Wetherby YOI (boys)	120
Warren Hill YOI (boys)	192

In February 2013, the Ministry of Justice published its proposals for Transforming Youth Custody. The proposals aimed to use resources more efficiently, involve a greater range of providers, and improve education provision both in existing YOIs and by creating a network of 'secure colleges'.

In April 2013, we submitted a response to the consultation. We welcomed the reduction in the number of children in custody, but highlighted concerns about the safety of those who remained and that children were being held further away from home. While we were pleased that the government's proposals placed greater emphasis on education, with the opportunity for new providers to improve services, we stressed that the staff involved had to be properly trained to manage the complex needs and requirements of this population of children.

It is essential that the government's plans properly take account of the changes to the population of children in custody that have occurred since the policy was first developed and we are not yet assured that they do so.

37 Data from forthcoming HM Inspectorate of Prisons and Youth Justice Board report, Children in Custody 2013–14: An analysis of 12–18-year-olds' perceptions of their experience in secure training centres and young offender institutions.
38 Ibid.

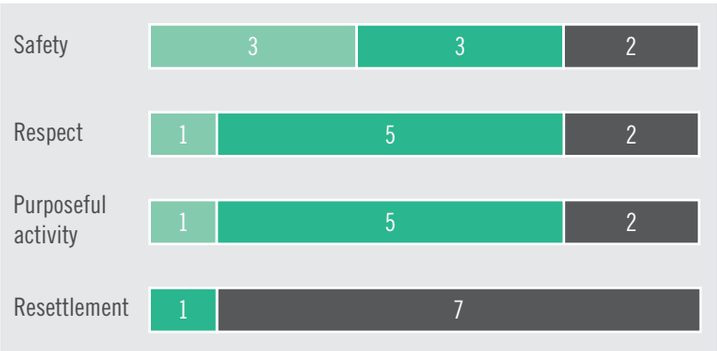
YOIs – a good picture but not safe enough

In 2013–14, our inspection findings showed a reasonably good picture, or even better, in the areas of respect, activity and resettlement. However, the most concerning finding from the inspections was the significant deterioration in safety outcomes. These had worsened in three establishments, which we found were not safe enough.

Figure 20: Published outcomes in full inspections of YOIs[39]

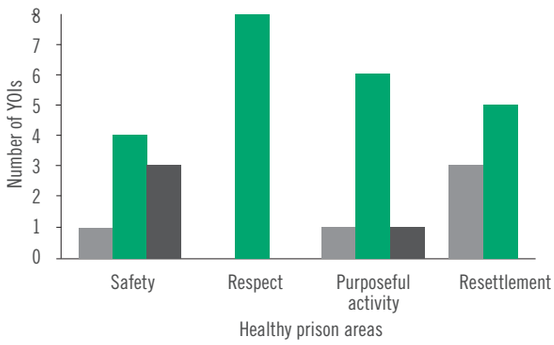
	Safety	Respect	Purposeful activity	Resettlement
Cookham Wood	Reasonably good	Reasonably good	Reasonably good	Good
Feltham	Not sufficiently good	Reasonably good	Reasonably good	Reasonably good
Hindley	Not sufficiently good	Reasonably good	Good	Good
Keppel Unit	Good	Good	Good	Good
Rivendell Unit	Good	Good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

Published outcomes in full inspections of YOIs (8)



Key

Figure 21: Change since the last inspection



Key

The first few days in custody

Late arrivals continued to be a problem in many establishments, and were often at the end of a day when the child had been kept at court after their case had been dealt with and then had a long journey sharing transport with adult prisoners.

The catchment area for Cookham Wood in Kent had expanded to include boys from some distance away in the South West, many of who felt unsafe on the journey.

> Many young people travelled on vehicles with adult prisoners, which was inappropriate. In our survey, only 73% of young people against the comparator of 83% said they felt safe on escort vehicles. Cookham Wood

39 Ashfield YOI was inspected but not scored.

Background information for children arriving in custody was commonly missing or out of date (amounting to 10% of cases at Wetherby, for example), making it difficult for staff to complete initial risk assessments; the quality of such risk assessments was also often variable.

However, at Hindley, where the population had almost halved since the previous inspection, reception staff were able to deal with children quickly, and thorough first night procedures, including an in-depth vulnerability assessment, positive staff attitudes and the use of peer mentors, helped to settle children on their difficult first night in custody.

> Following admission, staff continued to interact with newly arrived young people in a caring, supportive way and, in our survey, 86% of young people said they had felt safe on their first night. Hindley

Violence – a serious concern

There were fights and assaults in most establishments almost every day. Almost a third of boys overall told us they had felt unsafe in their establishment, and approximately one in 10 said they currently felt unsafe.[40]

We had serious concerns about safety at Ashfield. In the 12 months to January 2013, there had been 43 fights, of which 37 had resulted in serious injuries, and five staff had been assaulted in the same period. Use of force by staff was high, and two boys had suffered broken bones. Despite a reducing population, self-harm incidents had doubled to 10 a month.

Although the number of violent incidents at Feltham had fallen, there was still an average of two fights or assaults a day, often with a shocking level of violence. Some incidents involved premeditated group attacks on individuals. While staff usually managed these situations well, often putting themselves at risk, approximately one in six of the boys held there told us they did not feel safe at the time of the inspection – twice as many as our survey comparator – and over a third said they had felt unsafe at some point. We were very concerned to be told by senior staff that they no longer reported cases involving extreme violence to the police, as the police were reluctant to pursue them.

There were also high levels of violence at Warren Hill, with 137 assaults on boys, 48 assaults on staff and 112 fights in the six months before our inspection.

> Most injuries were minor, but five young people and one member of staff had required hospital treatment for broken bones, unconsciousness and multiple injuries, including black eyes, stab wounds and grazes. Warren Hill

40 Data from forthcoming HM Inspectorate of Prisons and Youth Justice Board report, *Children in Custody 2013–14: An analysis of 12–18-year-olds' perceptions of their experience in secure training centres and young offender institutions.*

'Minimising and managing physical restraint'

Since our last annual report, a new system of restraint has been introduced, replacing control and restraint (C&R) in YOIs and Physical Control in Care (PCC) in STCs. 'Minimising and managing physical restraint' (MMPR) incorporates a new approach to behaviour management of children and has been implemented in Rainsbrook, Medway and Oakhill STCs and at Hindley and Wetherby YOIs, including the Keppel Unit for vulnerable children. MMPR is due to be implemented in all children's establishments by the end of 2015. However, while force may be used to effect good order and discipline in YOIs, it will operate under different rules in STCs – undermining the aim to have one restraint system operating across both settings.

We will produce a full review on the use of restraint in children's establishments once a sufficient number have implemented the new process. While it is still too early to assess the full impact of these new measures, we have observed staff training in the new techniques, but this has not convinced us to change our view that it is wrong and unnecessary to use 'pain compliance' techniques when restraining children.

Despite the good training provided by the national training team, we remain concerned that, as in all models of restraint, children could be hurt unintentionally because some staff are not able to use the new techniques properly in a real-life situation. CCTV footage in secure establishments is not sufficiently clear to identify techniques being used and too much restraint occurs in cells where there is no CCTV coverage. We are concerned that in some establishments detached duty staff, who have not been trained in MMPR, are being deployed to cover staff shortages.

However, we welcome the new national scrutiny of restraint incidents to assess the new system and believe it should be a permanent arrangement. The collection and publication of restraint data have improved, and we will be analysing the data as part of our inspections to assess the treatment of children when it is necessary to restrain them.

Caring for vulnerable young people

There were no self-inflicted deaths within the juvenile estate over the period. Children identified as vulnerable and at risk of self-harm were generally well cared for on a day-to-day basis. However, we were concerned to find that at Hindley and Cookham Wood there was insufficient sustained attention given to learning lessons from earlier tragedies.

Conditions for children in segregation units were poor and they were locked up for far too long. At Cookham Wood many cells contained graffiti and the toilets were dirty. At Feltham some boys were confined to segregation unit cells for 22 hours a day, and this could continue for long periods after they returned to live on the mainstream wings. It was necessary to separate some boys for their own protection and for the safety of others; however, children should never be isolated in this way.

Living conditions, relationships and health care

Living conditions on the small units at Rivendell and Keppel, which were well-designed and relatively comfortable, were good. However, accommodation for many other children was not good enough. Cookham Wood was in the process of closing down old unsuitable units and opening new accommodation. The two new units at Warren Hill provided an excellent environment but the older units were run down and dirty. At Feltham the residential units were in a poor condition and cells were covered in gang-related graffiti. Some of the cells at Werrington were filthy and a few were not in a fit state to be occupied.

Relationships between staff and children were generally good. At Werrington the quality of relationships had improved and staff had raised their expectations about how the boys should behave; at Wetherby relationships were positive and staff were confident about challenging poor behaviour.

The quality of and access to health care was generally good. At Feltham boys were offered prompt appointments with a nurse or GP but the availability of escort staff made it more difficult to see a GP at the weekend. Mental health care at Wetherby and Hindley was particularly good, and the presence of a speech therapist at Hindley was good practice.

Better outcomes in the small units

In contrast to the deteriorating picture in the mainstream establishments, we found good provision at the two small units we inspected. Rivendell was one of the three small facilities holding girls, all of which closed during the reporting period due to falling numbers. The unit held just five girls at the time of the inspection. It was well run, and its staff supported the very needy and challenging girls extremely well. However, the declining number of girls in custody meant that these units became unable to provide a range of services to meet the needs of those who remained. Since the closure of the small units, girls requiring custody are now held in STCs, which with their wider range of services and facilities are better placed to meet their needs.

The Keppel Unit in YOI Wetherby was designed to look after almost 50 vulnerable boys. Staff in the unit were successful in creating a safe, caring environment where the boys could begin to settle and where many went on to thrive.

> One young person asked in the survey to describe the best thing for him on the unit wrote: 'The support of staff. Whenever you need it there is always someone to talk to'. Other young people echoed this with comments about 'help of staff' and 'being listened to and having people around that understand you'.
> Keppel Unit

The secure estate has much to learn from the positive way that the unit had developed to provide a high level of care, with consistent leadership, strong multidisciplinary teamwork, and a professional and caring staff approach to the boys.

Looked-after children

Looked-after children are heavily over-represented in the custodial population, and a third of children responding to our surveys in YOIs said they had been in local authority care. Such children reported a poorer experience of custody than those who had not been in care, and were more likely to say they had felt unsafe at some point in their establishment. Children who said they had been in care were also more likely to report having personal problems when they arrived in custody, were more likely to say they had received an adjudication and were more likely to anticipate difficulties with resettlement.

Since December 2012, all children remanded to youth detention are now treated as 'looked after', with a duty on the authority responsible for their care to assess their needs, coordinate services on their behalf and maintain links with their home communities.[41]

We commonly identify the positive impact of seconded social workers in YOIs in supporting looked-after children. However, the financial support provided by local authorities for looked-after children was inconsistent. While social workers at Feltham were mostly successful in obtaining a minimum of £10 a week, some children at Warren Hill and Cookham who had been on a voluntary care order were not receiving any financial support from their home local authority, and many looked-after children at the Keppel Unit did not receive adequate financial support.

41 *Youth Secure Remand Report 2014*,YJB and MOJ www.justice.gov.uk/downloads/youth-justice/courts-and-orders/laspo/youth-secure-remand-report-2014.pdf

All establishments tried to ensure that local authorities reviewed the circumstances of their looked-after children while in custody. But the picture was generally inconsistent, and looked-after children reviews did not take place as frequently as they should have.

> Good efforts were made to ensure that looked-after children were reviewed by their local authority while in custody. We were advised that in the four months from October 2012 to January 2013, 25 looked-after reviews had taken place, although it was not clear how many there should have been. Cookham Wood

Obtaining suitable accommodation for looked-after children on their release was a common difficulty. At Werrington, 26 boys had been released to supported accommodation in the six months before the inspection, but this accommodation was not monitored, even at the point of release – in most cases it was a hostel or bed and breakfast.

Taking part in activities

Only one establishment, Rivendell, achieved our expectation of 10 hours out of cell each day. Most children experienced closer to eight hours a day during the week, but for those subject to disciplinary procedures this could be much less. At Feltham and Cookham Wood some boys were only unlocked for two to three hours a day.

Children generally had limited opportunity to exercise in the open air, and we found no establishments which met our expectation of an hour outside each day. However at Werrington, where there had previously been no scheduled exercise, new exercise yards had been built which were just starting to be used. At Wetherby 67% of boys said they usually went outside to exercise every day and we were pleased that those who had recently been involved in serious disciplinary matters were still able to take part in exercise. At Feltham less than half the boys said they could go outside for exercise every day and the situation was similar at Cookham Wood. It was even worse at Warren Hill where only 35% said they usually went outside for exercise every day.

The provision of education and training was consistently good in half the establishments we inspected, and in these settings children's needs were being met. Elsewhere there were a number of weaknesses. At Warren Hill more needed to be done to monitor attendance and improve behaviour in class. At Cookham Wood poor behaviour was limiting progress and although there were sufficient activity places available, they were underused. Provision at Feltham had much improved since the last inspection but about 15% of boys did not attend for disciplinary reasons and provision for them was inadequate. At Werrington the quality of teaching and achievements, particularly in functional skills, remained too variable and required improvement, and the range of vocational training provided was too limited.

Overall most children had access to good PE and library facilities. However, almost a third did not use the gym at Hindley and boys at Cookham Wood did not have enough time to use the library.

Figure 22: Published Ofsted assessments in YOIs holding children in England*

	Achievements of prisoners engaged in learning and skills and work	Quality of learning and skills and work provision	Leadership and management of learning and skills and work
Outstanding	0	0	0
Good	6	5	6
Requires improvement	2	3	2
Inadequate	0	0	0
Total	**8**	**8**	**8**

*excludes Ashfield, which was inspected but not assessed.

Far from home

With the closure of YOIs and units, there is the potential for children to be held further from home. Figures for 2013–14 show that 21% of children were between 50 and 100 miles from their home youth offending team area, and 3% were were more than 100 miles away. The situation was particularly stark in some specialist units such as the Keppel unit, which holds boys with some of the most complex needs in the estate. Here 38% were between 50 and 100 miles from their home area, and 17% were more than 100 miles away. At the Anson Unit at Wetherby in Yorkshire, which catered for those serving long sentences, we found that 12 of the 35 boys held during our inspection were from London.

One consequence of this distance from home was that family members and professionals had further to travel, making visits, and preparation for a successful release, more difficult.

In our survey, only 37% of children said it was easy or very easy for family and friends to visit them, and only 39% said they had one or more visits a week from family and friends.

Secure training centres – first full inspections

In 2013–14, we carried out our first full cycle of inspections of the four secure training centres (STCs), which take place jointly with colleagues from Ofsted and the Care Quality Commission (CQC), and we published reports of six inspections during the year. STCs provide secure provision for children aged 12–18. They are modern, well-equipped, purpose-built units, smaller than the main YOIs and with relatively high staffing levels.

STCs are assessed against five criteria: safety, behaviour, well-being, achievement and resettlement. They are also given an overall assessment. The overall effectiveness of each STC was good and children were broadly looked after decently and in a safe environment. Staff understood the needs of the children and generally had positive and constructive relationships with them, helping to create a successful balance between care and control.

The environment and facilities in the STCs were better than those in YOIs, with smaller living units and more time for children to spend their evenings in off-unit activities.

All the STCs responded positively to our recommendations. This led to some clear improvements in outcomes for children.

> … there is improvement to the quality of care afforded to young people. This is demonstrable in practice that has led to a reduction in the use of restraint, the use of handcuffs for external medical appointments, removals from association and the undertaking of full searches.
> Medway STC, June 2013

Figure 23: Published outcomes in full inspections of STCs

Secure training centre	Overall effectiveness	Safety	Behaviour	Well-being	Achievement	Resettlement
Rainsbrook (December 2012)	Good	Good	Good	Good	Outstanding	Good
Hassockfield (February–March 2013)	Good	Good	Good	Good	Good	Outstanding
Oakhill (March 2013)	Good	Good	Good	Good	Good	Good
Medway (June 2013)	Good	Good	Good	Good	Good	Good
Hassockfield (September 2013)	Good	Good	Good	Good	Good	Outstanding
Rainsbrook (November 2013)	Good	Good	Good	Good	Good	Good

In our survey, most children were positive about their first days at a STC, and 89% said they felt safe on their first night. We found good processes for managing and addressing bullying, and supporting vulnerable children across the STCs.

We did not find evidence of pain-inducing holds used on children at any of the STCs, and generally the governance of the use of force was effective. In contrast to the YOIs, the use of restraint was generally lower and the incentives offered were more motivational. However, debriefs of children after they had been restrained varied in quality.

In inspections at the start of the reporting period we found that monitoring the use of 'separation' (the time children spend isolated from other children) needed improvement. The amount of time some children spend isolated remains an area of particular interest to us across all places of detention for children.

We found some frailties in child protection work. Across the four STCs these included a policy which did not comply with statutory guidance; written policies which were not consistent with practice; incomplete record keeping; and a need for more proactive communication with the local authority.

Relationships between the staff and children were mostly appropriate and effective, and 93% of children said that staff treated them with respect.

> 'If you treat staff with respect they give it back. Staff are generally alright.'
> Young person at Hassockfield, February – March 2013

Staff encouraged children to take responsibility for their actions and make reparation when appropriate. Most children had someone they felt they could turn to if they had a problem, but although just 3% of girls reported having no one they could turn to, this rose to 18% for boys.

Some of the written material given to the children needed to be more child-friendly. This included responses to some complaints made by children and a welcome pack which included too much jargon.

Work on equality and diversity was developing but more remained to be done, particularly in monitoring outcomes for children from minority groups and supporting them. Minutes of some diversity meetings indicated that discussions were generic rather than focused on diversity, and work to monitor outcomes over time was in its early stages.

All the STCs had a clear focus on education, with good initial assessments of children's ability and any additional learning needs. Attendance and behaviour at education were generally good and most children made progress. Vocational opportunities were available at all the centres.

Resettlement work at Hassockfield was judged to be outstanding and at the other STCs it was good. At Hassockfield, planning for the release of children started immediately on their admission and continued for the duration of their stay and beyond. Support provided at the centres included regular planning and review meetings, and opportunities to address offending behaviour. In our survey, 68% of sentenced children thought they had done something while at their centre that would make them less likely to offend in the future.

6

Immigration detention

‘Mother’s Guide’ courtesy of The Burnbake Trust Prison Art Project. The project supplies art materials to prisoners by post for in-cell recreation or as part of educational programmes. Prisoners submit finished work that is exhibited and, in most cases, sold for them. The artist receives 70% of the sale price, enabling them to purchase their own art materials to sustain their work. This builds confidence and self-worth, important steps in the prisoner’s rehabilitation. www.burnbaketrust.co.uk

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

- In Colnbrook IRC and Pennine House STHF the environment for women was less favourable than for men. In one centre, Yarl's Wood, we found inappropriate behaviour by staff.
- Detainees were routinely handcuffed without an assessment of their risk.
- The procedures to protect the most vulnerable detainees had improved, but still failed many of them. However, more detainees had been released as a result of the procedures.
- Detainees generally had good communication with the outside world, although could not use social networking sites or Skype to keep in touch with family and friends.
- Short-term holding facilities were generally safe and staff were responsive to detainees, but we had some concerns about the treatment of children.
- Detainees on overseas escorts were generally treated well, but staff had still not been trained in using force on board flights.

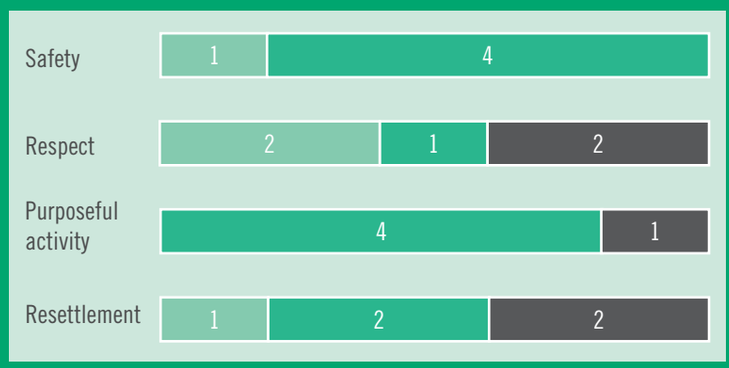
2013–14 inspections

In most of the centres we reported on, detainees were held reasonably safely, except for Harmondsworth, where a sense of humanity had been lost in the use of handcuffing on detainees who were dying. Activities were at least reasonably good across the centres inspected, and outcomes for respect and preparation for removal and release varied.

Figure 24: Published outcomes in full inspections of IRCs

	Safety	Respect	Purposeful activity	Resettlement
Colnbrook	Reasonably good	Not sufficiently good	Reasonably good	Reasonably good
Morton Hall	Reasonably good	Good	Good	Good
Brook House	Reasonably good	Reasonably good	Reasonably good	Not sufficiently good
Yarl's Wood	Reasonably Good	Good	Reasonably good	Good
Harmondsworth	Not sufficiently good	Not sufficiently good	Reasonably good	Reasonably good

Published outcomes in full inspections of IRCs (5)



Key

Women in detention

Women were held in two immigration removal centres that we inspected – Yarl's Wood and Colnbrook – and the residential short-term holding facility (STHF) Pennine House.

Yarl's Wood was an improving centre, and women were largely held safely and treated with respect. In our survey, approximately four out of five women at the centre told us that most staff treated them with respect – which was above the comparator. However, we were concerned to find that two staff had engaged in sexual relations with one detainee. Following an investigation by the Home Office's professional standards unit, the two staff were rightly dismissed.

Following further allegations of abuse we returned to the centre to interview 50 women confidentially. We found no evidence of systematic sexual abuse or a culture of victimisation. However, male staff were sometimes unacceptably insensitive towards the women, for example, by going straight into their rooms without knocking. Women were, at best, very anxious about their situation, and many had suffered abuse or other trauma before their detention. Such behaviour added to their distress. We recommended that the centre should employ more female officers, and that all staff should have training in the particular vulnerabilities of female detainees.

As at previous inspections, pregnant women continued to be held unnecessarily. Their medical care was good but there was too little attention to their emotional and practical needs.

> Pregnant women had been detained without evidence of the exceptional circumstances required to justify this. One of these women had been hospitalised twice because of pregnancy related complications. Although the medical care of pregnant women was good, too little thought was given to their wider emotional and practical support needs. Yarl's Wood

A few women were held at Colnbrook in the eight-bed Rose Unit. We found that women were generally treated less favourably than men held at the same centre. The unit was cramped and poorly ventilated. Women had poor access to the shop, legal advice surgeries, induction programmes, activities and peer supporters. They could only exercise in a yard overlooked by rooms occupied by male detainees, which discouraged some from exercising. When the Rose Unit was full, women were held inappropriately with men on the austere first night/last night unit.

> There was no overall strategy or policy document to describe the care of women at Colnbrook and we found that staff looking after them were ill-informed about issues affecting women detainees. Colnbrook

Some of these shortcomings were offset by the short time that women were held at Colnbrook, but more needed to be done to respect their dignity.

Women made up almost one in 10 detainees held in the three months before we inspected Pennine House residential STHF at Manchester Airport. The facility had made few concessions to meet the specific needs of women. Although women had separate rooms, they could not lock their doors and told us they felt insecure about sharing communal areas with men.

Handcuffing

Too many detainees were routinely handcuffed while being escorted to centres. They were also often handcuffed by the contractors responsible for escorting them to outside appointments, such as hospitals or foreign embassies. By contrast, detainees at Yarl's Wood and Colnbrook were no longer routinely handcuffed. Detainees should only be handcuffed following a written assessment of their individual case that clearly justifies the use of restraints. This did not always happen.

Restraints on the dying

An 84-year-old Canadian who suffered from Alzheimer's disease was detained at Harmondsworth. Despite the recommendation of a doctor at the centre that he be released immediately, he was taken to hospital in handcuffs on two occasions. During the second visit in early 2013, he tragically died while still in handcuffs.

In another case at Harmondsworth in November 2012, a detainee who was dying continued to be handcuffed while he was sedated and undergoing an angioplasty in hospital, although the handcuffs were removed before he died. The Home Office's professional standards unit has completed a critical investigation into this case.

Rule 35 and protection of the most vulnerable detainees

Rule 35 of the detention centre rules states that health care staff should make a report to the Home Office where they consider that a detainee's health is likely to be affected by detention, or if they might have suicidal intentions or have been a victim of torture. We found that although there was evidence of improvement in the quality of doctors' reports and caseworkers' consideration of them, too many were still poor, and we were not assured that the most vulnerable detainees were protected.

Rule 35 reports written by doctors at Brook House had improved and those at Morton Hall were some of the best we have seen.

> The quality of Rule 35 initial reports… was good; they were submitted regularly… and in some cases had led appropriately to the release of men who should not have been in detention. Morton Hall

Some reports contained clear diagnostic findings, which increased the likelihood of the detainee's release. Unlike in previous years, nearly all reports were written by a doctor, rather than a nurse, and contained 'body maps' documenting the location of scarring.

Despite these positive developments, too many reports at all centres merely repeated the detainee's account of ill-treatment without any diagnostic findings or comments on the consistency between scarring and the detainee's account. For example, one detainee at Colnbrook claimed he had been burned with cigarettes, but the doctor who documented the scarring failed to comment on whether its age, size and shape matched the detainee's account. Some reports were handwritten and difficult to read.

This year we started to see more releases directly as a result of rule 35 reports – in previous years, this had been extremely rare. For example, two detainees at Yarl's Wood and two out of 10 cases we examined at Brook House had been released as a result of rule 35 reports.

Despite these encouraging developments, too many responses to reports from caseworkers were cynical and dismissive. For example, a caseworker accepted that a detainee at Yarl's Wood had been tortured in her county of origin, but maintained detention on the grounds that her condition could be satisfactorily managed in the centre: this contradicted Home Office policy. In another case, a detainee at Colnbrook claimed she had been tortured in Iran, but one of the reasons for refusing to release her was 'you arrived without a valid travel document', which ignored the substantive issue.

Not enough health care staff in IRCs had received training in recognising and treating torture or trauma, although:

> … some mental health nurses had attended a one-day Freedom from Torture course on torture and trafficking. Brook House

In March 2014, we responded to the Home Office's consultation on immigration detention of persons with mental health issues. In addition to rule 35 failings, we noted how lengthy periods of detention impacted detainees with mental health problems.

Keeping in touch with the outside world

Keeping in touch with the outside world is particularly important to detainees, as communication affects their access to justice, family contact and preparation for removal or release. We found that detainees generally were able to communicate with the outside world. Telephone access was good, and most detainees could have a mobile phone – keeping their own if it had no camera or internet access. At Yarl's Wood, all detainees were issued a phone, but at Colnbrook there were sometimes not enough loan phones for detainees. Detainees could make landline calls in some centres, and all detainees could easily send and receive faxes and mail.

While all detainees had access to the internet, too many legitimate websites were blocked inappropriately, and the software used meant that staff could not easily unblock them. Detainees could use online email accounts, such as Google and Yahoo, but could not access social networking sites or Skype. Centre staff could not tell us why these sites were prohibited, even though they were not an unmanageable security risk.

Short-term holding facilities

This year we reported on seven non-residential STHFs (which usually hold detainees for no more than 24 hours before transfer to an IRC, removal or entry into the UK) and one residential STHF (which can hold detainees for up to five days, or seven if removal directions have been served). All the facilities were at ports or airports, except for one based at the East Midlands reporting centre in Loughborough.

STHFs were safe with little or no self-harm, bullying or use of force. The numbers held varied greatly between facilities. Only 10 detainees had been held in the three months before we inspected Portsmouth international port, while Gatwick South terminal had held 650 detainees in a similar period. Most detainees were held for a short time, but some at airports were held for almost 24 hours before they were removed. Many detainees were routinely handcuffed between facility holding rooms and escort vehicles, which was disproportionate. At Manchester Airport, detainees were handcuffed when transferring between the residential and non-residential facility with no individual risk assessment.

Detainee custody officers employed by the private contractor Tascor treated detainees with respect and understanding. We saw many positive examples where staff listened to detainees and tried to respond constructively to their requests.

> Staff were fair and courteous towards detainees. Pennine House STHF

Detainee custody officers based at airport holding rooms no longer used force to move detainees on to aircraft returning them to their country of origin. If a detainee did not comply, the removal was cancelled, the detainee taken to an IRC, and the removal rescheduled with an overseas escort to their country of origin.

Arrangements for the care of children held were generally sound, but not enough Border Force staff at Gatwick Airport had received safeguarding training or had their backgrounds checked by the Disclosure and Barring Service. However, Gatwick had good relations with West Sussex Social Services, which had a team based at the airport. Border Force staff repeatedly told us that social workers were slow to attend ports, especially in the evenings and at

weekends. We were concerned that a 13-year-old boy was kept at police station with his parents overnight in Portsmouth, and an unaccompanied child was held for 19.5 hours at Manchester Airport. Among frontline staff at all STHFs knowledge of the national referral mechanism to identify and support potential victims of trafficking was variable, and some had never heard of it.

In November 2012, we conducted our first joint inspection with our French equivalent, Contrôleur Général des Lieux de Privation de Liberté, of four STHFs in Coquelles and Calais. Border Force staff were based there to prevent illegal entry to the UK and to reduce the numbers of asylum claims in the UK. Conditions at the facilities varied – one required redecoration and refurbishment, while another was unfit for purpose and was closed following our inspection.

Overseas escorts

We inspected two overseas escorts. One was on a scheduled flight and involved the removal to Ghana of a family with a seven-year-old daughter from Cedars pre-departure accommodation via Cayley House at Heathrow Airport. The other was the removal of 29 detainees to Sri Lanka on a charter flight. The escorts were generally professional, efficient and provided good care.

> Staff, including control and restraint instructors, did not know of any progress on accredited training for use of force in the confined space of an aircraft.
> Sri Lanka escort and removals

Some security measures were disproportionate, such as leaving toilet doors ajar when in use and the use of light-touch compulsion by staff during some stages of the removal. On the charter flight, detainees were not given hot drinks, pillows or blankets, and too many were referred to by a number and not their name.

Working with the Commission for the Prevention of Torture

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) was set up under the Council of Europe's European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which came into force in 1989. It builds on Article 3 of the European Convention on Human Rights which provides that 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'. The CPT is not an investigative body; instead it provides a non-judicial preventive mechanism to protect persons deprived of their liberty against torture and other forms of ill-treatment. The Convention has been ratified by all 47 member States of the Council of Europe.

In September 2012 the CPT made its seventh periodic visit to the UK. It examined progress made in Scotland since its previous visit in 2003, as well as visiting two immigration removal centres in England – Colnbrook and Brook House. The report produced by the CPT following their visit can be found at **http://cpt.coe.int/documents/gbr/2014-11-inf-eng.pdf.**

In October 2012 the CPT also monitored a charter flight organised by the United Kingdom Border Agency between London and Columbo (Sri Lanka). The purpose of this visit was to monitor the treatment of foreign nationals during the removal operation, as well as the conditions under which the removal took place. The report produced by the CPT following their visit can be found at **http://cpt.coe.int/documents/gbr/2013-14-inf-eng.pdf.**

7
Police custody

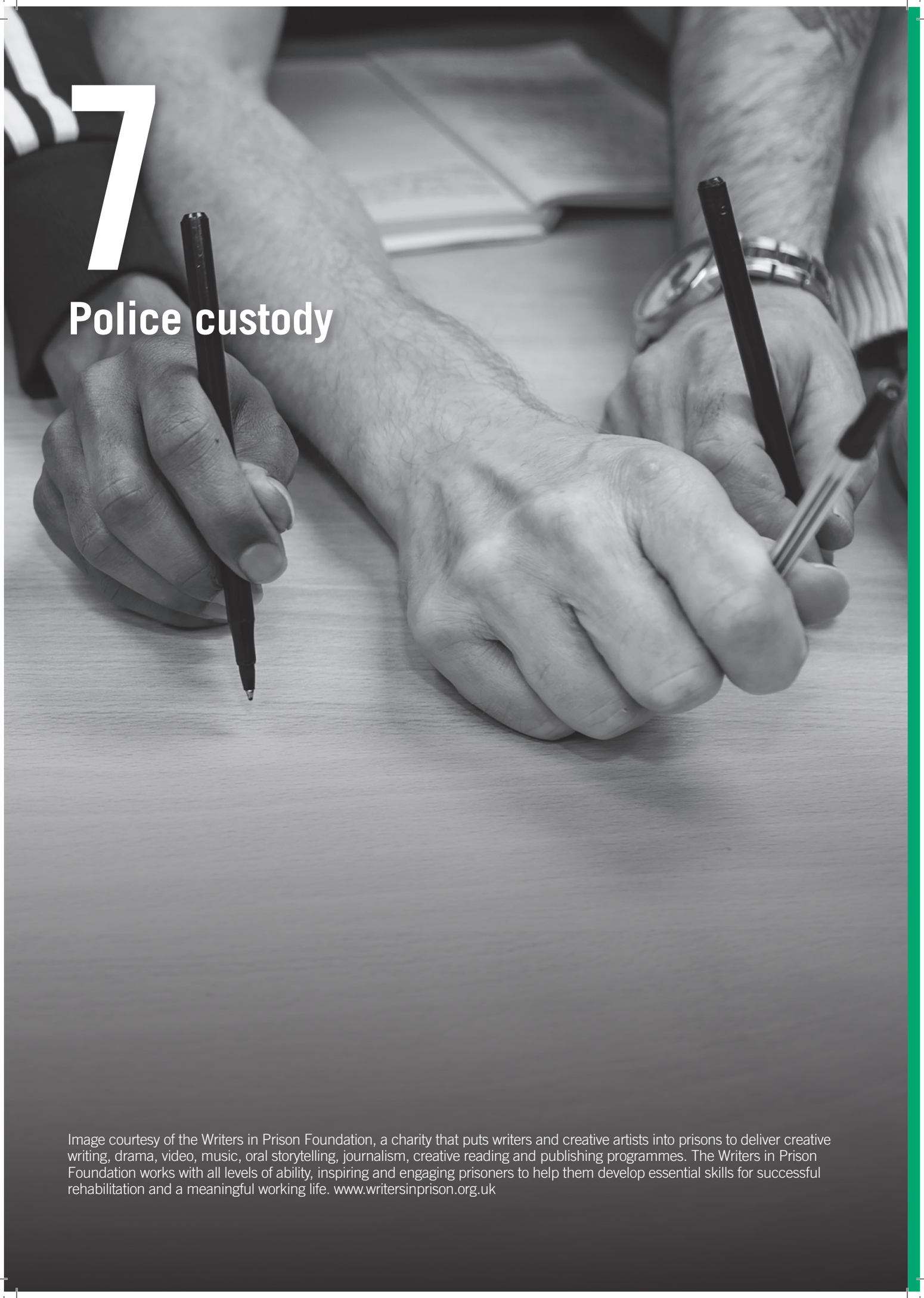


Image courtesy of the Writers in Prison Foundation, a charity that puts writers and creative artists into prisons to deliver creative writing, drama, video, music, oral storytelling, journalism, creative reading and publishing programmes. The Writers in Prison Foundation works with all levels of ability, inspiring and engaging prisoners to help them develop essential skills for successful rehabilitation and a meaningful working life. www.writersinprison.org.uk

There is a long history of collaborative working with criminal justice inspectorates. The police custody inspections we undertook with HM Inspectorate of Constabulary (HMIC) this year successfully concluded the first six-year programme to inspect custody arrangements in all forces in England and Wales.

HM Chief Inspector of Constabulary has described the current period for policing as one of 'significant institutional, structural and operational reform, with an intensification of financial pressures and the maintenance of high public expectations as to the service required'.[42] The improvements in physical custody conditions we found were therefore pleasing and, although each individual death represents a personal tragedy and a significant incident for the force concerned, it is welcome that the overall number of deaths in or following police custody in England and Wales has continued to decline.[43] However, we remain concerned that the number of detainees recorded as having apparently committed suicide within 48 hours of release is the highest for the last 10 years, and many of them appeared to have had mental health problems. We continue to be concerned about the number of children and people with mental health problems who are detained and welcome the fact that HMIC, following a commission by the Home Secretary, will be leading a joint thematic inspection on vulnerable people in police custody in 2014–15.

All the findings from inspections in this section are based on the second edition of *Expectations for police custody: Criteria for assessing the treatment of and conditions for detainees in police custody,* published jointly with HM Inspectorate of Constabulary (HMIC) in 2012. This section draws on inspections of custody suites in 14 police force areas or London boroughs. All inspections of police custody in England and Wales are conducted jointly with HMIC.

- Analysis of the use of force needed to improve.
- Officers were beginning to make more use of alternatives to custody.
- Appropriate adults were provided to support children in detention, but there was still too little local authority accommodation for children refused bail or who could not go home.
- There were still too many detainees with mental health needs in police custody.
- Physical conditions in police cells were better, but pre-release arrangements for detainees leaving custody were poor.
- The delays for detainees to appear in court continued.

Use of force

As we found last year, very few forces recorded the use of force in police custody adequately or analysed the data to inform training needs and custodial practice. Custody staff did not routinely complete available use of force forms when detainees were physically restrained, and in some cases did not perceive their intervention as a use of force. Where there were no separate forms, uses of force were only recorded in the custody log, which made it difficult to review, analyse and identify any trends to aid learning and improve outcomes for detainees.

As custody staff also received no feedback from their use of force forms, they generally believed that they were used exclusively for personal safety training, rather than as a safeguard to ensure that force was used as a last resort and with the minimum force necessary.

42 *Her Majesty's Chief Inspector of Constabulary, State of Policing, the Annual Assessment of Policing in England and Wales 2012–13*, HMIC, 2014

43 Teers. R, *Deaths during or following police contact: Statistics for England and Wales 2013–14*, IPCC Research and Statistics Series: Paper 27, Independent Police Complaints Commission, 2014

There was a requirement to record all use of force. However, staff were unsure about the level of force that could be used which required recording. For example, a detainee was brought into the custody suite handcuffed, and in a very belligerent state. Staff needed to remove his clothing for forensic purposes but the detainee would not comply. He was forcibly restrained by four officers and his clothing removed and replacement clothing put on. He was taken to another cell by several officers and still handcuffed. A use of force form was not completed, When we queried these incidents with the custody staff, it was clear that they were fully aware of the use of force form, but had not considered submitting one. Nottinghamshire

Alternatives to arrest and detention

Since November 2012, the revised Police and Criminal Evidence (PACE) code G has required officers to consider the 'necessity criteria' and, in particular, alternatives to custody. Throughout this year, we found examples of custody sergeants exploring the necessity for arrest, with some detentions not then authorised. Officers were becoming more familiar with the alternatives to arresting detainees, and some now consulted sergeants to ensure that they had fully considered all other options. However, not all forces were gathering data about the extent to which alternatives to custody were used, which we would have expected.

We were told that voluntary attendance by suspects at police stations, as an alternative to arrest and detention, was encouraged, and its increased use had reduced the use of custody during the past year… Officers had also received a briefing on code G of the Police and Criminal Evidence Act 1984 (PACE), the 'necessity test', which gives guidance on when an arrest is lawful – specifically the grounds to believe that it is necessary to arrest the person – and were aware of the need to be able to justify arrests. We saw posters explaining the code G 'necessity test' displayed in every booking-in area. Devon and Cornwall

The use of 'street bail' under PACE 1984 and the Criminal Justice Act 2003[44] was greater than we have seen elsewhere. Still classed as an arrest, it was used for lower level offences, including for children and young people, and enabled time in police custody to be kept to a minimum. We saw several people on street bail. All were interviewed immediately and none had to be placed in a cell. Dyfed-Powys

There were exceptions to this picture, and we had concerns in some forces about the emphasis on increasing arrest figures and insufficient implementation of the revised PACE code G.

Custody sergeants were aware of the renewed emphasis on reversing the decline in arrest numbers and advised that arrest targets had been introduced. Several sergeants told us they had never refused detention, even when there may have been options to deal with the detainee outside the custody environment. Many operational officers we spoke to appeared vague about alternatives to custody, such as voluntary attendance at police stations. Essex

44 These give a police officer the power to bail someone immediately after arrest and put them under a legal duty to attend a police station at a later time and date.

Better support for children in custody but too little alternative accommodation

Following a High Court ruling in April 2013, most forces had adopted Association of Chief Police Officers (ACPO) guidance, in anticipation of changes to PACE code C, and contacted 'appropriate adults' to support all young people under 18 in custody. This is something that we had consistently recommended in our previous police custody inspection reports. The Code of Practice (Code C) was changed in October 2013 to include 17-year-olds. Subsequent to the changes, all the forces we inspected complied with this.

Appropriate adult (AA) provision was mixed across forces. It was an improving picture for children and young people held in police custody but poor for vulnerable adults. Where it existed, the quality of AA services for young people was good, with trained, committed AAs attending custody suites to support young people, and in some cases vulnerable adults.

> Staff told us that they usually tried to find relatives to act as AAs, and that when they were unavailable, AA arrangements for detainees under 17 were very good. At Hornsey, Catch 22 charity provided volunteer AAs and operated a 24 hours a day, seven days a week service. Appropriate adult services for vulnerable adults were also said to be good. We observed community psychiatric nurses from the North London Forensic Services attending Hornsey custody suite to act as appropriate adults for vulnerable adult detainees. Haringey

Very few AA services ran for 24 hours, resulting in vulnerable adults and children remaining in police custody for too long, although a few custody sergeants had considered alternatives to keeping young people in custody, such as providing bail.

While the provision of AAs for children had improved, there was a notable lack of alternative accommodation provided by the local authority for young people under 17 who had been charged and had their bail refused or who could not immediately return to their family or guardians. There was a lack of partnership working between forces and local authorities to establish alternative accommodation (secure and non-secure) for young people held in police custody. In only two of our police custody inspections this year had alternative accommodation ever been found for young people in these circumstances. As a result, young people remained in custody overnight, which was not appropriate. Police forces did not give enough strategic focus to improve this outcome for this vulnerable group and minimise their time in police custody.

> Custody staff informed us that where possible they would try not to detain children in police custody overnight and contacted social services to arrange accommodation for young people; however, they were always informed that none was available. Camden

Detainees with mental health needs in police custody

'… what have I done to deserve this? I was ill; I was locked up because I was ill.' Person detained in police custody under section 136 of the Mental Health Act 1983

This joint thematic report from HMIP, HMIC, the Care Quality Commission and Healthcare Inspectorate Wales found that in the forces inspected, the use of police custody as a place of safety for people detained under section 136 (S136) of the Mental Health Act 1983 varied between 6% and 76% of all those detained.

The numbers detained nationally in police cells under S136 of the Mental Health Act continued to be a concern. Although there was no reliable year-on-year data collection across police forces, an ACPO report in June 2012 revealed that 9,378 people were taken to a police station as a place of safety after they had been detained under S136. Our inspections of police custody in 2013–14 did not discover many notable improvements, and the national figure is likely to be similar.

It was clear from our inspections that police officers were very reluctant to detain people in police custody under S136 but were often forced to do so – because of the unavailability of suitable alternative accommodation, or the reluctance or inability of other agencies to accept them. Nottinghamshire described this as a 'daily battle'. In Devon and Cornwall, almost 77% (604) of all those detained under S136 were kept in police custody, whereas in London the detention of S136 detainees in police custody was uncommon.

Although there were seven section 136 suites (health facilities for those detained on mental health grounds) across the force area, police custody was used regularly for the detention of people under section 136 of the Mental Health Act. In the previous six months there had been a decrease in the total number of those taken into police custody, from 63% to 43%, but the average was 53%, which was unacceptable. Hampshire

45 *A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs* – www.justiceinspectorates.gov.uk/hmiprisons/inspections/a-criminal-use-of-police-cells-the-use-of-police-custody-as-a-place-of-safety-for-people-with-mental-health-needs/

46 HMIP started its programme of joint inspections with HMIC in 2008.

Improved physical conditions

With a few exceptions, we seldom saw some of the poor physical conditions that we identified during our early police custody inspections.[46] Most suites were clean and free of excessive graffiti. Many forces were reducing the number of custody suites, refurbishing others, and in some cases building new ones or planning to do so.

> Custody suites, including non-designated suites, were mostly clean, bright and in good condition, with very little graffiti in cells, although there was graffiti in some exercise yards. Exeter, although clean, needed some refurbishment. The custody estates strategy (2011–15) included plans for a new 40-cell criminal justice centre in Exeter, as well as a programme of improvements to the custody suites. Devon and Cornwall

Insufficient assessment before release

The initial risk assessments of those in custody were well conducted, with good use of intelligence systems, and were largely carried out in a reassuring manner by experienced and competent custody staff (although a lack of privacy sometimes deterred detainees from fully engaging).

It was disappointing, therefore, that some of this good care and treatment was not replicated at the point of the detainee's release. Pre-release risk assessments were usually limited to ensuring that detainees had the means to get home or were transported home. The custody record analyses that we conduct during inspections highlighted the lack of detail to assure the safety of some vulnerable detainees before they were released. Custody records did not detail the risk factors that had been considered, any safeguards to reduce or offset any identified risk, and how custody sergeants had arrived at the overall judgement that it was safe to release the detainee.

> In our custody record analysis, most PRRAs [pre-release risk assessments] indicated that no risks had been identified. In cases where we considered there to be a high likelihood of risk, none had been described. There were several examples of detainees, including a young person, being released late at night or in the early hours of the morning for whom the PRRA indicated no risks, and with nothing in the record about how they would get home. Westminster

Delays in appearing at court

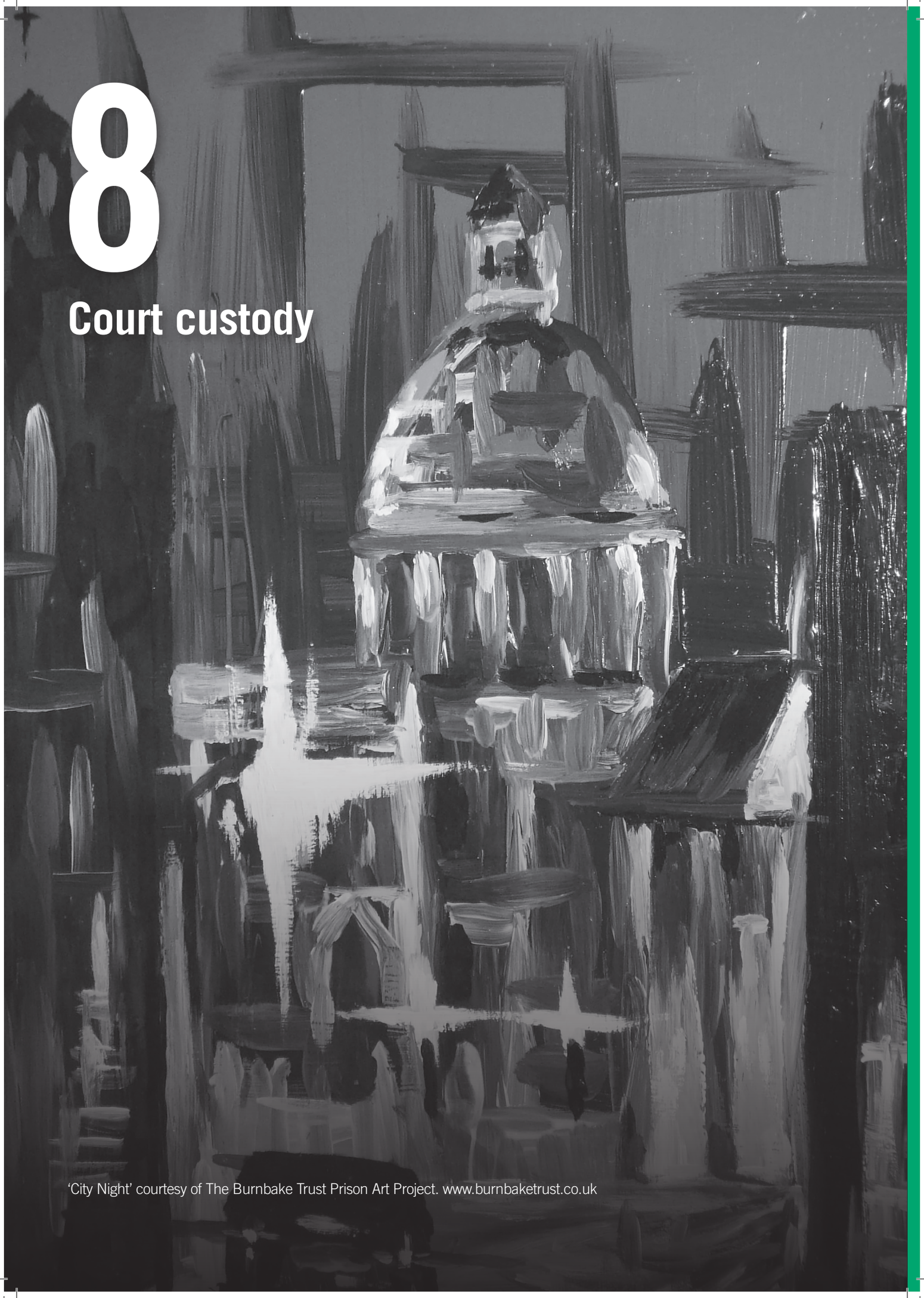
There continued to be unacceptable delays in detainees in police custody appearing before the courts because of unreasonably early court cut-off times. These could be as early as noon (Havering) or even 9.30am (Portsmouth) on a weekday, and 10am on a Saturday was frequently the norm. Early court cut-off times often meant that people were detained unnecessarily in police custody overnight, or even over the weekend.

> We saw five detainees, already in custody for 48 hours, being taken from Aldershot custody suite to Basingstoke magistrates' court at approximately 3.30pm. They were not accepted that day at the court and as a result were held at Basingstoke police custody suite pending transfer to court the following day. Hampshire

The unnecessarily long periods in police custody due to early court cut-off time could be exacerbated if Her Majesty's Courts and Tribunals Service makes further court closures, which would mean further distances for detainees to travel. We shall monitor this during our forthcoming court custody inspection programme.

8

Court custody



‘City Night’ courtesy of The Burnbake Trust Prison Art Project. www.burnbaketrust.co.uk

All the findings from inspections in this section are based on *Expectations: Criteria for assessing the treatment of and conditions for detainees in court custody*, published in June 2012. This section draws on three court area inspections covering court custody facilities in six counties.

- Detainees arriving at court were still not risk assessed systematically.
- The conditions of cells in some courts had improved, but too many detainees still spent too long in court custody, and most were not informed of their rights.
- There were delays in the movement of young people from court to young offender institutions.
- Courts lacked medical emergency equipment.
- There was little collaboration between all the partners involved in court custody to resolve problems.

Our programme of court custody inspection began in 2012, and inspecting court cells is still a relatively new area for us. During 2013–14 we published reports on inspections of court custody in Lancashire and Cumbria, Nottinghamshire and Derbyshire, and Norfolk and Suffolk, covering nine Crown courts and 25 magistrates' and youth courts.

Arrival in court custody

Most detainees came into court custody from police cells, or from prisons if already remanded in custody. We found that some cellular vehicles were dirty inside, with evidence of dried bodily fluids, and many had graffiti. Male and female detainees were often carried on the same vehicle, providing opportunities for men to harass women. We were also concerned about some unnecessarily long journeys: one defendant arrested in London was taken on a three-hour journey to Norwich magistrates' court for a five-minute hearing about a traffic offence.

Most court custody staff were friendly towards detainees, but as at our inspections last year, there were no systematic risk assessments of detainees when they arrived at court, and few staff attempted to determine their risks or welfare needs. In Norfolk and Suffolk, there were good arrangements for mental health in-reach teams to attend court cells to help detainees who had self-harm or mental health problems, but there were no similar services in most areas we inspected. In many courts, the care of vulnerable detainees depended far too much on individual staff. Custody staff relied on police or prison risk assessments to identify any concerns, and if new risk factors emerged, they did not necessarily update their knowledge about them.

Police officers brought a man subject to a bench warrant to court. He had a chronic drug abuse problem, deep vein thrombosis in both legs, which he claimed was causing him severe pain, and was struggling to stand up and stay awake… Despite our inspector inviting staff to consider obtaining medical advice, no such advice was sought. The court bailed him and he was released with a travel warrant, even though he would have struggled to walk to the railway station. Staff rebuked him for being slow to gather his belongings together and did not pursue our suggestion that the police should be asked to take him home.
Nottinghamshire and Derbyshire

We also saw many instances where confidential information, such as detainees' HIV status, was not properly safeguarded.

Conditions in court custody

The physical conditions of the cell areas in courts inspected this year were slightly better than those we found in 2012–13, although often mixed.

At most courts, cleanliness was better than we have observed elsewhere, though at two courts physical conditions were poor, with dirty floors and toilets, and much graffiti. At some courts, the temperature of the cells was unsatisfactory and there were no blankets or warm clothes that might have helped mitigate this shortcoming. Some cells were very small, with benches too short for detainees to be able to lie down despite them spending, in some instances, more than eight hours in them.
Norfolk and Suffolk

Staffing levels in the cell areas was sometimes too low to ensure the safety of detainees, staff and visitors. In Norfolk and Suffolk, Her Majesty's Courts and Tribunals Service (HMCTS) court staff told us they had raised concerns about this. The contractor had recently appointed new custody staff, but it was unclear why the issue had not been resolved earlier through Prisoner Escort and Custody Services (PECS) contract monitoring.

Detainees' rights in court custody

At almost every court we inspected, custody staff failed to inform detainees about their rights. Most pointed to a poster about rights on the wall as detainees entered and said 'you know your rights'. However, many detainees did not know them, even those who attended court frequently. Many were frustrated about the excessive waits for transport back to the prison, but staff did not tell them how they could complain. By contrast, at Carlisle and Ormskirk magistrates' courts, all detainees were handed a copy of a rights and entitlements leaflet.

In Norfolk and Suffolk, we were told about instances where the court had been unable to consider bailing detainees who could not speak English because the court interpreting contractor had failed to supply an interpreter. The problem was compounded by the lack of a professional telephone interpreting service in the custody suite. This resulted in some detainees being remanded in custody without knowing why, or where they were going next. Lay Observers (independent volunteers who check on the treatment of detainees under escort and while in court custody) had drawn attention to this six months previously, but the response of HMCTS had been slow.

Unnecessary detention

We saw little progress in reducing the unnecessarily long stays that many detainees experienced in court custody.

Sometimes these delays were due to bureaucratic processes. If someone fails to attend court, including for not paying a fine, a warrant is issued and the person might be arrested by a civilian court enforcement officer (CEO). At some courts, CEOs arrested people subject to warrants and took them to court, where they were allowed to wait until called. At others, CEOs took fine defaulters to

the police station where they were detained, possibly overnight, and then taken to court.

> We were told that it is not uncommon for people to attend court voluntarily when they became aware of outstanding warrants, but their treatment varied widely between the courts. At Kendal, such individuals were directed to attend the local police station, where the police arrested them, placed them in a cell and contacted GEOAmey [the escort contractor] to take them back to court. There, they were placed in a cell to wait for their court appearance. This practice was often disproportionate and unnecessary. At Workington, such people were often asked to wait in the court building while a court hearing was arranged. Lancashire and Cumbria

Many detainees also arrived hours before their court appearance and waited a long time to be taken back to prison, often after what was only a brief appearance for procedural reasons. We also found delays in moving young people from court to young offender institutions, as the Youth Justice Board, which arranged placements for those under 18, often took several hours to inform the contractor where the young person would be going. We saw a report of a 2011 Lay Observers' visit to Carlisle magistrates' court that drew attention to this longstanding problem.

Health services

Custody staff had access to a telephone advice service, which could also send a paramedic to court if a detainee were taken ill or injured in custody. Nevertheless, many staff did not know what the service provided, some were reluctant to use it, and some did not know how to contact it – consequently, it was underused.

All court custody staff had been first-aid trained. Each custody area had a first aid kit, but these were often inexpertly stocked and unsuitable, and were not always checked regularly. No court buildings had automated external defibrillators (AEDs).

Few court custody staff had received training in mental health awareness, and they often relied on probation staff to contact mental health services. At some magistrates' courts, there was no mental health diversion scheme, which could have secured community provision for people with mental health problems as an alternative to prosecution.

Partnership working

Our *Expectations* for court custody address joint working between the various organisations that provide court custody and escort services and their regulation. These include HMCTS, the custody contractor, PECS contract monitoring staff, Lay Observers, health care providers, cleaning and maintenance contractors, and sometimes a private company that owns the courthouse. Liaison arrangements are not straightforward but, nevertheless, we remained concerned about the lack of collaborative action to resolve problems.

Some local HMCTS court managers seemed to avoid visiting the cells in their courthouses and were not sufficiently aware of the conditions in which many detainees were held. We often found a lack of action on Lay Observer concerns, in particular about physical conditions and excessive stays in court custody. Some court user groups had ceased meeting because there were no items put forward for the agenda. Yet, many of the problems and deficits described here might have been resolved if HMCTS had exercised better leadership of inter-agency work.

> HMCTS staff expressed some uncertainty about the scope and nature of their role in custody, which had limited the extent to which they engaged proactively with the contractor.
> Nottinghamshire and Derbyshire

9 Appendices

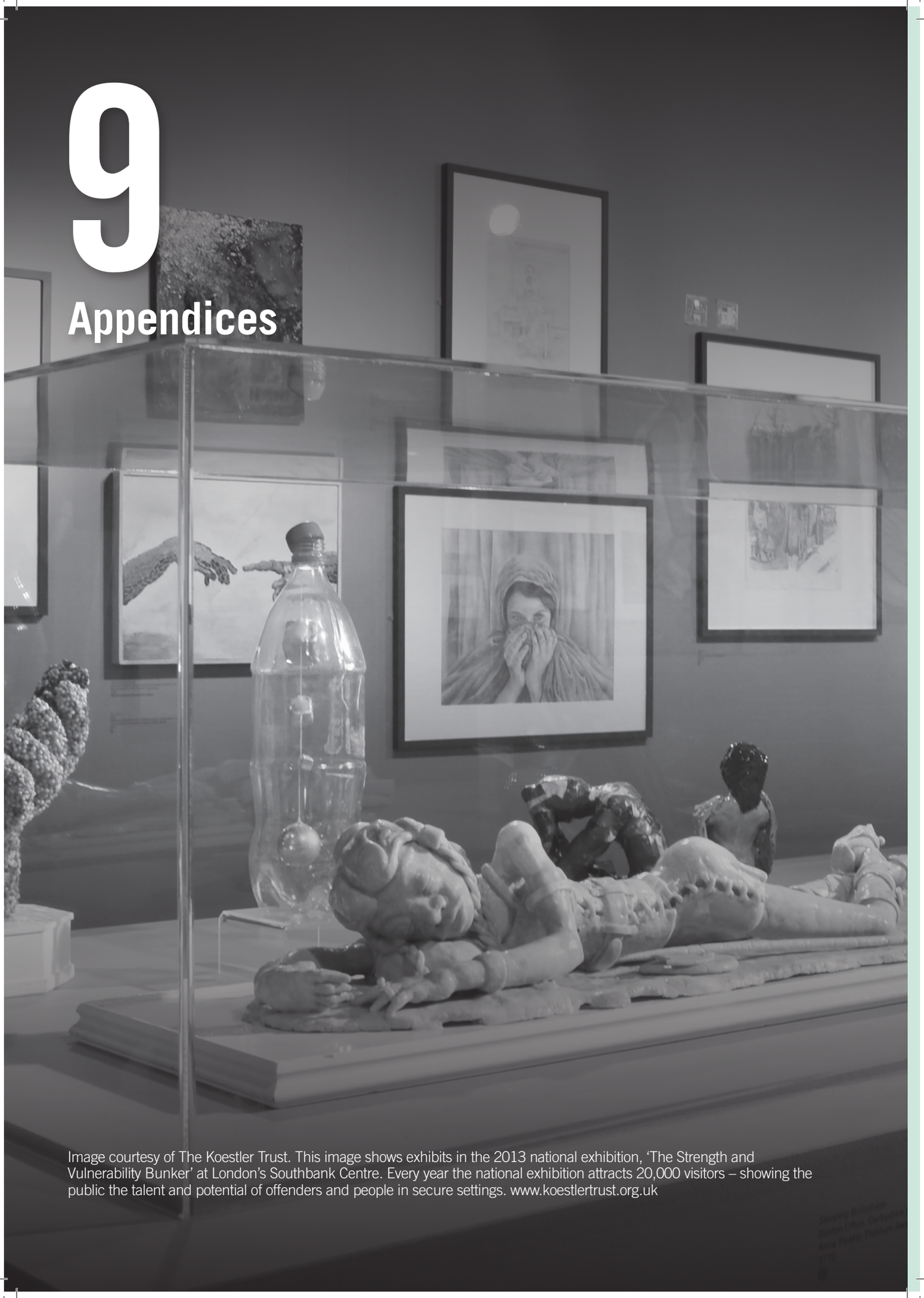


Image courtesy of The Koestler Trust. This image shows exhibits in the 2013 national exhibition, 'The Strength and Vulnerability Bunker' at London's Southbank Centre. Every year the national exhibition attracts 20,000 visitors – showing the public the talent and potential of offenders and people in secure settings. www.koestlertrust.org.uk

Inspection reports published 1 April 2013 to 31 March 2014

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Altcourse	Full unannounced	3 April
Haringey police custody suites	Unannounced	9 April
Sri Lanka overseas escort	Unannounced	10 April
Coquelles and Calais STHFs	Unannounced	10 April
Full Sutton	Full announced	11 April
Moorland	Full announced	16 April
Swansea	Full unannounced	17 April
Hewell	Full unannounced	23 April
Hindley	Full unannounced	25 April
Frankland	Full unannounced	30 April
Border Force customs custody suites	Unannounced	1 May
Hampshire police custody suites	Unannounced	7 May
Huntercombe	Full announced	8 May
Thameside	Full unannounced	14 May
Leeds	Full unannounced	21 May
Rochester	Full announced	30 May
Ashfield	Full unannounced	4 June
Colnbrook IRC	Full unannounced	11 June
Lindholme	Full unannounced	18 June
Essex police custody suites	Unannounced	19 June
Jersey	Full announced	25 June
Ghana overseas escort	Unannounced	2 July
London City STHF	Unannounced	2 July
Feltham A	Full unannounced	10 July
Feltham B	Full unannounced	10 July
Cardiff	Full announced	16 July
Morton Hall	Full announced	17 July
Nottingham	Full unannounced	23 July
Guys Marsh	Full unannounced	25 July
Lancashire and Cumbria court custody	Unannounced	30 July
Warren Hill	Full announced	31 July
Drake Hall	Full announced	6 August
Westminster police custody suites	Unannounced	7 August
Usk/Prescoed	Full unannounced	13 August
Coldingley	Full unannounced	14 August
Nottingham police custody suites	Unannounced	15 August
Aylesbury	Full unannounced	20 August
Bronzefield	Full unannounced	21 August
Cheshire police custody suites	Unannounced	28 August
Bure	Full unannounced	4 September
Cookham Wood	Full unannounced	5 September
New Hall (Rivendell Unit)	Full unannounced	10 September
Manchester Airport STHF	Unannounced	11 September
Pennine House STHF	Unannounced	11 September
Blundeston	Unannounced	12 September

Inspection reports published 1 April 2013 to 31 March 2014 *(Continued)*

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Bristol	Full unannounced	17 September
Derbyshire police custody suites	Unannounced	27 September
Brook House IRC	Full unannounced	1 October
Hydebank Wood	Full announced	1 October
Ash House	Full announced	1 October
Oakwood	Full unannounced	8 October
Holloway	Full unannounced	15 October
Nottinghamshire and Derbyshire court custody	Unannounced	22 October
Yarl's Wood IRC	Full unannounced	29 October
Dyfed-Powys police custody suites	Unannounced	30 October
Gatwick North STHF	Unannounced	5 November
Gatwick South STHF	Unannounced	5 November
Wandsworth	Full announced	12 November
Downview	Full unannounced	13 November
Kennet	Full unannounced	19 November
Risley	Full unannounced	26 November
Brixton	Full unannounced	17 December
Portsmouth STHF	Unannounced	19 December
Loughborough STHF	Unannounced	19 December
Exeter	Full unannounced	20 December
Havering police custody suites	Unannounced	7 January
Barking and Dagenham police custody suites	Unannounced	7 January
Harmondsworth IRC	Full unannounced	16 January
Parc	Full unannounced	21 January
Wayland	Full unannounced	22 January
Grendon	Full unannounced	28 January
Norwich	Full announced	29 January
Devon and Cornwall police custody suites	Unannounced	30 January
Holme House	Full unannounced	31 January
Wetherby (Keppel Unit)	Full unannounced	4 February
Barnet police custody suites	Unannounced	5 February
Camden police custody suites	Unannounced	5 February
Thames Valley police custody suites	Unannounced	12 February
Pentonville	Full unannounced	18 February
Norfolk and Suffolk court custody	Unannounced	25 February
Dovegate Therapeutic Community	Full unannounced	27 February
Blantyre House	Full unannounced	28 February
Werrington	Full unannounced	5 March
Sudbury	Full unannounced	12 March
Wetherby	Full unannounced	18 March
Erlestoke	Full unannounced	19 March
Belmarsh	Full unannounced	21 March
Liverpool	Full unannounced	25 March
Kirkham	Full unannounced	26 March
Featherstone	Full unannounced	27 March
Dhekelia (Cyprus)	Announced	28 March

Healthy prison and establishment assessments 1 April 2013 to 31 March 2014

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
LOCAL					
Belmarsh	FU	2	2	1	2
Bristol	FU	2	1	1	3
Cardiff	FA	3	3	3	2
Exeter	FU	3	3	2	3
Hewell Cluster	FFU	2	1	2	3
Holme House	FU	3	2	4	3
Leeds	FU	3	4	3	4
Liverpool	FU	2	3	2	3
Norwich	FA	2	3	2	3
Pentonville	FU	2	2	1	2
Thameside	FU	2	3	1	2
Wandsworth	FA	3	3	3	3
Altcourse	SFU	2	2	2	2
Nottingham	SFU	2	2	2	1
Swansea	SFU	2	1	1	2
TRAINER					
Blundeston	FU	3	1	3	3
Bure	FU	4	4	2	3
Brixton	FU	3	2	1	2
Coldingley	FU	4	2	3	3
Erlestoke	FU	3	3	3	3
Featherstone	FU	3	4	4	2
Huntercombe	FA	3	3	4	3
Lindholme – Cat C	FU	2	2	3	2
Moorland	FFU	3	2	1	2
Oakwood	FU	2	1	1	2
Risley	FU	3	2	2	3
Rochester	FFU	2	2	2	3
Usk	FU	4	3	4	3
Wayland	FU	3	2	3	3
Parc	FU	4	3	3	4
Guy's Marsh	SFU	2	1	2	2
Therapeutic Communities					
Dovegate TC	FU	3	4	3	3
Grendon TC	FU	4	4	3	4
OPEN					
Blantyre House	FU	3	4	2	3
Kirkham	FU	4	3	4	3
Kennet	FU	4	3	3	3
Lindholme – Cat D	FU	1	1	1	1
Prescoed	FU	4	4	4	4
Sudbury	FFU	3	3	3	1

Healthy prison and establishment assessments 1 April 2013 to 31 MARCH 2014 *(Continued)*

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
HIGH SECURITY					
Frankland	FU	3	3	3	4
Full Sutton	FA	3	3	4	4
WOMEN					
Bronzefield	FU	3	3	3	3
Downview	FU	3	3	4	2
Drake Hall	FA	4	3	3	4
Holloway	FU	3	3	2	3
YOUNG ADULTS					
Aylesbury	FU	2	3	1	4
Feltham YA	FFU	1	2	1	2
CHILDREN AND YOUNG PEOPLE					
Ashfield	Unannounced inspection of the decommissioning of Ashfield which focused on areas of concern and did not look at every area of the establishment. This was not graded against each healthy prison test.				
Cookham Wood	FU	3	3	3	4
Feltham CYP	FU	2	3	3	3
Hindley	FA	2	3	4	4
Keppel Unit	FU	4	4	4	4
New Hall – Rivendell Unit	FU	4	4	3	4
Werrington	FU	3	2	2	4
Wetherby	FU	3	3	3	4
Warren Hill	FA	2	3	3	4
EXTRA-JURISDICTION					
Hydebank Wood – Ash House	FA	3	1	1	2
Hydebank Wood	FA	2	2	1	3
Jersey – La Moye	FA	3	3	4	3
Dhekelia – Sovereign Base Cyprus	FA	3	2	1	1
IMMIGRATION REMOVAL CENTRES					
Brook House	FU	3	3	3	2
Colnbrook	FU	3	2	3	3
Harmondsworth	FU	2	2	3	3
Morton Hall	FA	3	4	4	4
Yarl's Wood	FU	3	4	3	4

KEY TO TABLE

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

Type of inspection:
FFU – Full follow-up
SFU – Short follow-up
FA – Full announced
FU – Full unannounced

Recommendations accepted in full inspection reports published 1 April 2013 to 31 March 2014

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant)	ACCEPTED	PARTIALLY ACCEPTED	REJECTED
LOCALS				
Altcourse	38	33	3	2
Belmarsh	-	-	-	-
Bristol	80	70	7	3
Cardiff	59	51	5	3
Exeter	52	46	4	2
Hewell	63	50	10	3
Holme House	-	-	-	-
Leeds	45	38	4	3
Liverpool	-	-	-	-
Norwich	85	67	10	8
Nottingham	68	54	10	4
Pentonville	-	-	-	-
Swansea	48	39	2	7
Thameside	71	68	1	2
Wandsworth	59	35	17	7
Total	**668**	**551 (82%)**	**73 (11%)**	**44 (7%)**
TRAINERS				
Blundeston[47]	7	3	0	4
Bure	56	38	15	3
Brixton	-	-	-	-
Coldingley	71	55	10	6
Erlestoke	-	-	-	-
Featherstone	-	-	-	-
Guys Marsh	77	48	23	6
Huntercombe	63	32	29	2
Lindholme	79	57	18	4
Moorland	68	57	9	2
Oakwood	70	66	3	1
Parc	42	29	10	3
Risley	70	61	9	0
Rochester	70	61	8	1
Usk/Prescoed	62	53	8	1
Wayland	-	-	-	-
Total	**735**	**560 (76%)**	**142 (19%)**	**33 (4%)**
THERAPEUTIC COMMUNITIES				
Dovegate	-	-	-	-
Grendon	39	30	5	4
TOTAL	**39**	**30 (77%)**	**5 (13%)**	**4 (10%)**
OPEN				
Blantyre House	-	-	-	-
Kirkham	-	-	-	-
Kennet	50	46	3	1
Sudbury	-	-	-	-
TOTAL	**50**	**46 (92%)**	**3 (6%)**	**1 (2%)**
YOUNG ADULTS				
Aylesbury	82	74	3	5
Feltham	84	66	16	2
TOTAL	**166**	**140 (84%)**	**19 (11%)**	**7 (4%)**

47 Although the inspection made 74 recommendations, due to the closure of this prison it responded to only seven recommendations in the action plan.

Recommendations accepted in full inspection reports published 1 April 2013 to 31 March 2014 *(Continued)*

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant)	ACCEPTED	PARTIALLY ACCEPTED	REJECTED
CHILDREN AND YOUNG PEOPLE				
Ashfield[48]	-	-	-	-
Cookham Wood	50	37	8	5
Feltham	54	42	7	5
Hindley	49	39	3	7
Keppel Unit (Wetherby)	25	16	6	3
Rivendell (New Hall)	-	-	-	-
Werrington	-	-	-	-
Wetherby	-	-	-	-
Warren Hill	47	36	8	3
TOTAL	**225**	**170 (76%)**	**32 (14%)**	**23 (10%)**
WOMEN				
Bronzefield	71	59	9	3
Downview	56	42	7	7
Drake Hall	52	36	15	1
Holloway	54	41	10	3
TOTAL	**233**	**178 (76%)**	**41 (18%)**	**14 (6%)**
EXTRA-JURISDICTION				
Ash House	-	-	-	-
Hydebank Wood	-	-	-	-
La Moye (Jersey)	-	-	-	-
PRISON TOTAL	**2,116**	**1,675 (79%)**	**315 (15%)**	**126 (6%)**
IMMIGRATION REMOVAL CENTRES				
Brook House	75	44	21	10
Colnbrook	53	26	24	3
Harmondsworth	-	-	-	-
Morton Hall	48	25	20	3
Yarl's Wood	56	27	25	4
TOTAL	**232**	**122 (53%)**	**90 (39%)**	**20 (9%)**
SHORT-TERM HOLDING FACILITIES				
Calais and Coquelles	58	8	39	11
Gatwick Airport North Terminal	19	8	6	5
Gatwick Airport South Terminal	18	8	5	5
London City Airport	30	8	18	4
Loughborough	10	6	3	1
Manchester	18	11	3	4
Pennine House	15	8	4	3
Portsmouth	19	9	6	4
TOTAL	**187**	**66 (35%)**	**84 (45%)**	**37 (20%)**
ESCORTS				
Ghana	9	3	4	2
Sri Lanka	17	6	10	1
TOTAL	**26**	**9 (35%)**	**14 (54%)**	**3 (12%)**
IMMIGRATION TOTAL	**445**	**197 (44%)**	**188 (42%)**	**60 (13%)**
OVERALL TOTAL	**2,561**	**1,872 (73%)**	**503 (20%)**	**186 (7%)**

KEY TO TABLE

Hyphen (-) – Indicates that outstanding action plans were not returned within the specified deadline following publication of the inspection report, or were not due until after the end of the annual reporting period (31 March 2014).

48 Ashfield was decommissioned by the time of publication.

Recommendations achieved in follow-up inspection reports published 1 April 2013 to 31 March 2014

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant)	ACHIEVED	PARTIALLY ACHIEVED	NOT ACHIEVED
LOCAL				
Altcourse	116	48	39	29
Belmarsh	152	50	30	72
Bristol	172	86	23	63
Hewell	159	89	20	50
Holme House	130	70	19	41
Liverpool	126	51	26	49
Norwich	73	24	25	24
Nottingham	136	57	33	46
Pentonville	155	60	30	65
Swansea	105	41	28	36
Wandsworth	171	116	24	31
Total	**1,495**	**692 (46%)**	**297 (20%)**	**506 (34%)**
TRAINERS				
Blundeston	119	65	22	32
Brixton	154	59	30	65
Bure	85	39	14	32
Coldingley	106	42	18	46
Guys Marsh	133	55	24	54
Moorland	143	68	27	48
Parc	79	59	14	6
Risley	67	29	12	26
Rochester	131	67	24	40
Usk/Prescoed	113	48	20	45
Wayland	141	69	30	42
Total	**1,271**	**600 (47%)**	**235 (18%)**	**436 (34%)**
OPEN PRISONS				
Blantyre House	63	26	13	24
Kirkham	117	60	20	37
Sudbury	137	59	25	53
Total	**317**	**145 (46%)**	**58 (18%)**	**114 (36%)**
WOMEN				
Bronzefield	56	20	22	14
Holloway	157	77	31	49
Total	**213**	**97 (46%)**	**53 (25%)**	**63 (30%)**
YOUNG ADULT				
Aylesbury	88	27	24	37
Feltham	119	45	24	50
Total	**207**	**72 (35%)**	**48 (23%)**	**87 (42%)**

Recommendations achieved in follow-up inspection reports published 1 April 2013 to 31 March 2014 *(Continued)*

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant)	ACHIEVED	PARTIALLY ACHIEVED	NOT ACHIEVED
CHILDREN AND YOUNG PEOPLE				
Cookham Wood	44	16	9	19
Rivendell Unit (New Hall)	34	23	7	4
Werrington	75	36	15	24
Wetherby	48	18	16	14
Total	**201**	**93 (46%)**	**47 (23%)**	**61 (30%)**
PRISON TOTAL	3,704	1,699 (46%)	738 (20%)	1,267 (34%)
IMMIGRATION REMOVAL CENTRES				
Brook House	129	52	19	58
Harmondsworth	138	32	46	60
Yarl's Wood	61	30	15	16
Total	**328**	**114 (35%)**	**80 (24%)**	**134 (41%)**
SHORT-TERM HOLDING FACILITIES				
London City Airport	30	6	8	16
Portsmouth	46	24	6	16
Total	**76**	**30 (39%)**	**14 (18%)**	**32 (42%)**
IMMIGRATION TOTAL	404	144 (36%)	94 (23%)	166 (41%)
OVERALL TOTAL	4,108	1,843 (45%)	832 (20%)	1,433 (35%)

Prisoner survey responses across all functional types: diversity analysis – ethnicity/nationality/religion/disability/age		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners	Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50	Christian denominations	Non-Christian denominations
	Number of completed questionnaires returned	2,124	4,973	922	6,186	978	6,063	1,477	5,632	878	6,291	3,592	3,449
		%	%	%	%	%	%	%	%	%	%	%	%
	SECTION 1: General information												
1.2	Are you under 21 years of age?	10	4	7	6	10	5	4	6			5	7
1.3	Are you sentenced?	80	87	74	87	81	86	84	85	91	85	85	86
1.3	Are you on recall?	8	8	3	9	8	8	9	8	5	8	8	8
1.4	Is your sentence less than 12 months?	10	13	17	12	10	13	12	12	6	13	12	12
1.4	Are you here under an indeterminate sentence for public protection (IPP prisoner)?	5	8	2	8	6	7	9	7	8	7	7	7
1.5	Are you a foreign national?	23	9			20	12	11	14	9	14	15	12
1.6	Do you understand spoken English?	97	99	89	99	97	98	99	98	97	98	98	98
1.7	Do you understand written English?	96	97	82	99	96	97	96	97	96	97	96	97
1.8	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories.)			51	26	88	20	22	32	16	31	20	40
1.9	Do you consider yourself to be Gypsy/ Romany/ Traveller?	2	5	9	4	1	5	7	4	4	4	6	2
1.1	Are you Muslim?	43	2	22	13			9	16	4	15		
1.11	Are you homosexual/gay or bisexual?	3	5	4	4	2	5	7	4	8	4	5	4
1.12	Do you consider yourself to have a disability?	16	24	17	22	14	23			37	19	24	18
1.13	Are you a veteran (ex-armed services)?	3	7	6	6	2	6	9	5	15	5	7	5
1.14	Is this your first time in prison?	46	36	64	35	43	38	32	41	50	38	39	39
1.15	Do you have any children under the age of 18?	54	50	51	52	52	51	50	52	24	55	52	51
	SECTION 2: Transfers and escorts.												
	On your most recent journey here:												
2.1	Did you spend more than 2 hours in the van?	37	33	37	34	38	34	35	34	37	34	34	35
2.5	Did you feel safe?	71	82	72	80	72	80	71	81	81	78	78	79
2.6	Were you treated well/very well by the escort staff?	62	72	62	70	60	71	68	70	78	68	72	67
2.7	Before you arrived here were you told that you were coming here?	58	66	52	65	55	65	61	64	65	63	64	62
2.8	When you first arrived here did your property arrive at the same time as you?	80	86	77	86	78	85	83	85	88	84	85	84
	SECTION 3: Reception, first night and induction												
3.1	Were you in reception for less than 2 hours?	50	50	50	50	49	50	45	51	52	49	50	50
3.2	When you were searched in reception, was this carried out in a respectful way?	74	84	73	82	72	82	77	82	89	80	82	80
3.3	Were you treated well/very well in reception?	63	72	65	70	61	71	69	70	80	68	71	68
	When you first arrived:												
3.4	Did you have any problems?	72	65	72	66	70	66	87	61	64	67	68	65
3.4	Did you have any problems with loss of property?	19	14	16	15	20	15	17	15	11	16	15	16
3.4	Did you have any housing problems?	17	15	12	16	16	16	23	14	13	16	17	15
3.4	Did you have any problems contacting employers?	4	3	5	3	4	3	3	3	3	3	3	3
3.4	Did you have any problems contacting family?	29	23	31	24	29	24	26	25	21	26	25	25
3.4	Did you have any problems ensuring dependants were being looked after?	3	2	5	2	2	2	3	2	1	2	2	1
3.4	Did you have any money worries?	19	19	21	18	16	18	24	17	16	19	20	17
3.4	Did you have any problems with feeling depressed or suicidal?	15	17	20	16	14	17	32	12	17	16	17	15
3.4	Did you have any physical health problems?	12	15	15	14	10	15	35	9	28	13	16	12
3.4	Did you have any mental health problems?	12	18	14	16	12	17	46	8	14	17	17	16
3.4	Did you have any problems with needing protection from other prisoners?	6	5	6	5	6	5	9	4	6	5	6	5
3.4	Did you have problems accessing phone numbers?	30	22	27	24	28	24	26	24	23	24	25	23

KEY TO TABLE

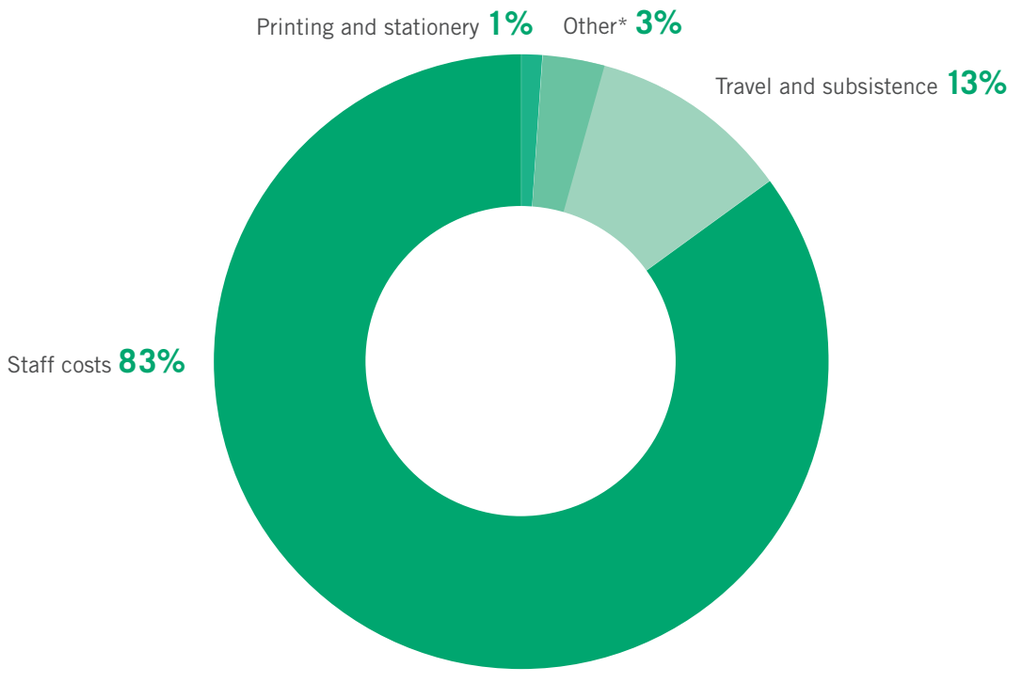
- Significantly better
- Significantly worse
- A significant difference in prisoners' background details
- No significant difference

	Prisoner survey responses across all functional types: diversity analysis – ethnicity/nationality/religion/disability/age	Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners	Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50	Christian denominations	Non-Christian denominations
		%	%	%	%	%	%	%	%	%	%	%	%
	When you first arrived here, were you offered any of the following:												
3.6	Tobacco?	66	75	67	73	69	73	75	72	51	75	73	72
3.6	A shower?	30	33	32	32	30	32	32	32	28	32	34	30
3.6	A free telephone call?	50	49	50	49	48	50	46	50	35	51	51	48
3.6	Something to eat?	64	64	67	63	60	64	62	64	56	65	65	62
3.6	PIN phone credit?	58	64	65	62	57	63	60	63	41	65	64	61
3.6	Toiletries/basic items?	49	52	58	50	46	52	52	51	51	51	54	49
	When you first arrived here did you have access to the following people:												
3.7	The chaplain or a religious leader?	46	49	51	48	43	50	47	49	41	49	51	46
3.7	Someone from health services?	66	69	66	68	64	69	69	68	67	68	69	67
3.7	A Listener/Samaritans?	29	35	28	34	26	34	31	34	29	33	34	32
3.7	Prison shop/canteen?	23	25	29	23	20	25	23	25	22	24	25	23
	When you first arrived here were you offered information about any of the following:												
3.8	What was going to happen to you?	42	50	42	48	42	48	44	49	45	48	48	47
3.8	Support available for people feeling depressed or suicidal?	33	41	34	39	30	40	38	39	35	39	40	37
3.8	How to make routine requests?	40	44	38	43	36	44	39	43	43	42	44	41
3.8	Your entitlement to visits?	40	42	39	42	37	42	36	43	38	42	43	40
3.8	Health services?	48	50	48	50	44	50	47	50	51	49	51	48
3.8	The chaplaincy?	43	45	44	44	40	45	41	45	40	45	47	42
3.9	Did you feel safe on your first night here?	70	81	70	79	69	80	67	81	79	78	79	77
3.10	Have you been on an induction course?	85	84	85	84	84	84	80	86	84	84	84	84
3.12	Did you receive an education (skills for life) assessment?	81	78	80	78	82	78	75	80	78	79	77	80
	SECTION 4: Legal rights and respectful custody												
	In terms of your legal rights, is it easy/very easy to:												
4.1	Communicate with your solicitor or legal representative?	43	47	39	47	44	46	43	47	57	44	46	46
4.1	Attend legal visits?	50	55	47	55	50	54	51	54	55	53	55	52
4.1	Get bail information?	13	17	16	16	13	17	15	16	13	17	18	15
4.2	Have staff ever opened letters from your solicitor or legal representative when you were not with them?	42	41	37	42	42	41	48	40	37	42	40	42
4.3	Can you get legal books in the library?	37	43	38	42	36	42	43	41	49	40	44	38
	For the wing/unit you are currently on:												
4.4	Are you normally offered enough clean, suitable clothes for the week?	64	65	66	64	63	65	62	65	78	63	65	63
4.4	Are you normally able to have a shower every day?	83	86	79	86	84	85	83	86	89	84	85	85
4.4	Do you normally receive clean sheets every week?	72	76	73	76	71	76	75	75	84	74	76	74
4.4	Do you normally get cell cleaning materials every week?	60	60	59	60	60	60	58	60	67	59	60	60
4.4	Is your cell call bell normally answered within five minutes?	33	33	39	32	35	33	32	33	43	32	35	31
4.4	Is it normally quiet enough for you to be able to relax or sleep in your cell at night time?	66	65	64	66	65	66	57	68	72	64	66	64
4.4	Can you normally get your stored property, if you need to?	21	24	23	23	20	24	22	24	33	22	25	22
4.5	Is the food in this prison good/very good?	20	23	27	22	20	23	23	22	32	21	24	21
4.6	Does the shop/canteen sell a wide enough range of goods to meet your needs?	36	50	43	46	34	48	46	46	53	45	48	44
4.7	Are you able to speak to a Listener at any time, if you want to?	44	58	43	56	41	56	57	53	66	53	57	51
4.8	Are your religious beliefs respected?	59	49	64	51	68	50	53	52	65	51	67	37
4.9	Are you able to speak to a religious leader of your faith in private if you want to?	59	55	54	57	65	55	59	56	65	56	66	47
4.10	Is it easy/very easy to attend religious services?	62	43	57	47	72	44	47	49	52	48	58	38
	SECTION 5: Applications and complaints												
5.1	Is it easy to make an application?	74	82	67	81	72	80	76	80	85	78	80	78
5.3	Is it easy to make a complaint?	50	56	48	55	48	55	55	54	57	54	58	51
5.5	Have you ever been prevented from making a complaint when you wanted to?	24	17	21	19	26	18	24	18	14	20	18	20
5.6	Is it easy/very easy to see the Independent Monitoring Board?	21	25	20	24	23	24	25	23	28	23	25	23

Prisoner survey responses across all functional types: diversity analysis – ethnicity/nationality/religion/disability/age		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners	Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50	Christian denominations	Non-Christian denominations
		%	%	%	%	%	%	%	%	%	%	%	%
	SECTION 6: Incentives and earned privileges scheme												
6.1	Do you feel you have been treated fairly in your experience of the IEP scheme?	41	51	36	50	41	49	44	49	55	47	50	47
6.2	Do the different levels of the IEP scheme encourage you to change your behaviour?	46	45	37	47	47	45	42	46	44	45	47	44
6.3	In the last six months have any members of staff physically restrained you (C&R)?	8	7	9	7	9	7	9	6	3	7	7	7
	SECTION 7: Relationships with staff												
7.1	Do most staff, in this prison, treat you with respect?	67	78	69	76	64	76	77	74	86	73	77	73
7.2	Is there a member of staff, in this prison, that you can turn to for help if you have a problem?	69	74	70	73	66	74	71	73	82	71	75	70
7.3	Has a member of staff checked on you personally in the last week to see how you are getting on?	26	31	30	30	24	31	35	28	39	28	31	28
7.4	Do staff normally speak to you most of the time/all of the time during association?	14	20	15	19	14	19	21	18	29	17	20	17
7.5	Do you have a personal officer?	57	61	55	60	57	60	58	60	75	58	60	60
	SECTION 8: Safety												
8.1	Have you ever felt unsafe here?	40	34	42	35	40	35	51	32	33	37	36	36
8.2	Do you feel unsafe now?	20	14	21	15	21	15	24	13	13	16	15	16
8.3	Have you been victimised by other prisoners here?	26	26	31	25	27	26	41	22	27	26	26	26
	Since you have been here, have other prisoners:												
8.5	Made insulting remarks about you, your family or friends?	10	12	11	11	9	12	19	9	11	11	11	11
8.5	Hit, kicked or assaulted you?	6	6	6	6	6	6	10	5	3	7	6	6
8.5	Sexually abused you?	1	1	2	1	1	1	3	1	2	1	1	1
8.5	Threatened or intimidated you?	12	15	12	14	12	14	23	12	16	14	14	14
8.5	Taken your canteen/property?	4	5	6	5	4	5	8	4	3	5	5	5
8.5	Victimised you because of medication?	3	5	5	4	3	4	10	3	4	4	4	4
8.5	Victimised you because of debt?	2	3	2	3	2	3	4	2	1	3	3	3
8.5	Victimised you because of drugs?	2	3	3	3	2	3	6	2	1	3	3	3
8.5	Victimised you because of your race or ethnic origin?	7	2	8	3	7	3	4	3	2	4	3	4
8.5	Victimised you because of your religion/religious beliefs?	5	2	4	2	6	2	4	2	1	3	2	3
8.5	Victimised you because of your nationality?	5	2	9	2	5	3	4	3	2	3	3	3
8.5	Victimised you because you were from a different part of the country?	4	3	4	4	2	4	6	3	3	4	4	3
8.5	Victimised you because you are from a traveller community?	1	1	1	1	1	1	2	1	1	0	1	1
8.5	Victimised you because of your sexual orientation?	1	2	2	1	1	2	3	1	2	1	1	2
8.5	Victimised you because of your age?	3	2	3	2	2	2	5	1	6	2	3	2
8.5	Victimised you because you have a disability?	2	3	4	3	2	3	12	0	5	3	3	3
8.5	Victimised you because you were new here?	5	5	5	5	5	5	8	4	3	5	5	4
8.5	Victimised you because of your offence/crime?	5	5	5	5	4	5	8	4	7	5	5	5
8.5	Victimised you because of gang-related issues?	4	3	3	4	5	3	5	3	2	4	3	4
8.6	Have you been victimised by staff here?	38	29	33	32	42	30	43	29	25	33	31	33
	Since you have been here, have staff:												
8.7	Made insulting remarks about you, your family or friends?	12	11	10	12	12	11	16	10	8	12	11	12
8.7	Hit, kicked or assaulted you?	4	4	4	4	5	4	7	3	1	4	4	4
8.7	Sexually abused you?	1	1	1	1	1	1	2	1	1	1	1	1
8.7	Threatened or intimidated you?	14	11	11	12	15	12	18	11	11	12	12	13
8.7	Victimised you because of medication?	3	4	4	4	4	4	10	3	4	4	4	4
8.7	Victimised you because of debt?	1	2	2	1	1	1	2	1	1	2	1	1
8.7	Victimised you because of drugs?	2	3	3	2	2	2	4	2	1	3	3	2
8.7	Victimised you because of your race or ethnic origin?	11	2	9	4	13	3	5	5	3	5	3	6
8.7	Victimised you because of your religion/religious beliefs?	8	2	5	4	14	2	5	4	1	4	2	6
8.7	Victimised you because of your nationality?	6	2	9	2	6	3	4	3	2	3	3	3
8.7	Victimised you because you were from a different part of the country?	3	3	3	3	3	3	4	3	2	3	3	2
8.7	Victimised you because you are from a traveller community?	1	1	1	1	1	1	2	1	1	1	1	1

Prisoner survey responses across all functional types: diversity analysis – ethnicity/nationality/religion/disability/age		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners	Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50	Christian denominations	Non-Christian denominations
		%	%	%	%	%	%	%	%	%	%	%	%
8.7	Victimised you because of your sexual orientation?	1	1	1	1	1	1	2	1	1	1	1	1
8.7	Victimised you because of your age?	3	2	3	2	2	2	4	2	4	2	2	2
8.7	Victimised you because you have a disability?	2	3	3	3	2	3	11	1	4	3	3	2
8.7	Victimised you because you were new here?	7	4	5	5	6	4	6	4	3	5	5	4
8.7	Victimised you because of your offence/crime?	5	4	5	4	5	4	7	4	5	4	4	5
8.7	Victimised you because of gang-related issues?	4	2	3	2	5	2	3	2	1	3	2	3
	SECTION 9: Health services												
9.1	Is it easy/very easy to see the doctor?	26	28	24	27	21	28	26	27	40	25	29	25
9.1	Is it easy/very easy to see the nurse?	46	51	44	50	43	50	50	49	63	47	51	47
9.1	Is it easy/very easy to see the dentist?	11	13	11	12	9	12	12	12	21	11	13	11
9.4	Are you currently taking medication?	39	52	44	49	36	50	79	40	74	45	53	44
9.6	Do you have any emotional well being or mental health problems?	26	35	31	32	25	33	67	23	29	33	33	31
	SECTION 10: Drugs and alcohol												
10	Did you have a problem with drugs when you came into this prison?	20	29	20	27	20	27	36	24	10	28	26	26
10	Did you have a problem with alcohol when you came into this prison?	12	22	16	20	13	20	28	17	14	20	21	17
10	Is it easy/very easy to get illegal drugs in this prison?	22	35	21	32	22	32	36	30	24	32	32	30
10	Is it easy/very easy to get alcohol in this prison?	13	17	11	17	15	16	19	16	11	17	16	16
11	Have you developed a problem with drugs since you have been in this prison?	5	7	6	7	7	7	10	6	3	8	7	7
11	Have you developed a problem with diverted medication since you have been in this prison?	5	7	8	6	6	7	12	5	5	7	7	6
	SECTION 11: Activities												
	Is it very easy/easy to get into the following activities:												
11	A prison job?	31	44	30	41	29	42	35	41	47	39	40	39
11	Vocational or skills training?	31	37	29	36	29	36	31	36	36	35	36	34
11	Education (including basic skills)?	46	52	42	51	44	51	45	51	53	50	52	49
11	Offending Behaviour Programmes?	18	22	15	22	18	21	20	21	23	20	22	20
	Are you currently involved in any of the following activities:												
12.2	A prison job?	45	56	43	54	43	54	47	54	60	52	54	51
12.3	Vocational or skills training?	15	11	15	12	14	12	10	13	11	13	13	12
8.7	Education (including basic skills)?	31	23	36	24	29	25	27	25	27	25	25	26
9.1	Offending Behaviour Programmes?	9	10	7	10	8	10	12	9	10	9	10	9
9.1	Do you go to the library at least once a week?	40	39	42	39	37	39	39	39	45	38	41	37
9.4	Does the library have a wide enough range of materials to meet your needs?	34	43	31	42	31	42	37	41	51	39	44	37
9.6	Do you go to the gym three or more times a week?	36	29	28	32	36	31	19	35	20	33	30	33
10.3	Do you go outside for exercise three or more times a week?	48	47	47	48	51	47	41	49	45	48	48	47
9.1	Do you go on association more than five times each week?	49	55	42	54	52	53	47	54	56	52	52	54
9.4	Do you spend 10 or more hours out of your cell on a weekday?	14	19	10	18	14	18	14	18	23	16	18	17
	SECTION 12: Friends and family												
8.2	Have staff supported you and helped you to maintain contact with family/friends while in this prison?	33	37	36	36	32	37	35	36	44	35	38	34
8.3	Have you had any problems with sending or receiving mail?	45	44	41	45	44	45	46	44	31	46	45	44
8.5	Have you had any problems getting access to the telephones?	30	26	34	27	30	27	28	27	21	28	27	28
8.5	Is it easy/very easy for your friends and family to get here?	33	35	24	36	31	35	27	36	29	35	36	33
	SECTION 13: Preparation for release												
8.3	Do you have a named offender supervisor in this prison?	52	59	41	59	54	57	56	57	68	55	57	57
8.5	Do you have a needs-based custody plan?	9	7	11	7	10	7	10	7	8	8	8	7
8.5	Do you feel that any member of staff has helped you to prepare for release?	13	16	16	15	13	16	16	15	17	15	16	14

Expenditure 1 April 2013 to 31 March 2014



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

PURPOSE	EXPENDITURE (£)
Staff costs[1]	3,881,906
Travel and subsistence	619,602
Printing and stationery	41,864
Information technology and telecommunications[2]	62,182
Translators	15,368
Meetings and refreshments	30,816
Recruitment	4,785
Conferences	1,528
Training and development	41,042
Total	4,699,093

1 Includes fee-paid inspectors, secondees and joint inspection/partner organisations costs, for example, General Pharmaceutical Council and contribution to secretariat support of the Joint Criminal Justice Inspection Chief Inspectors Group.
2 Includes one-off costs to migrate website from Justice.gov.uk to a joint website with other independent criminal justice inspectorates.

Inspectorate staff – 1 April 2013 to 31 March 2014

The Inspectorate staff come from a range of professional backgrounds. While many have experience of working in prisons, others have expertise in social work, probation, law, youth justice, health care and drug treatment, social research and policy. The majority of staff are permanent, but the Inspectorate also takes inspectors on secondment from NOMS and other organisations. Currently, six staff are seconded from NOMS and one from Greater Manchester West Mental Health NHS Foundation Trust. Their experience and familiarity with current practice is invaluable.

The Inspectorate conducts an annual diversity survey of our staff in order to monitor diversity within our workforce and to gather feedback on our approach to equality issues. The results of the survey are acted on but are not published due to the small size of the staff group and the possibility that individual staff members may be identified.

	Nick Hardwick	Chief Inspector
	Martin Lomas	Deputy Chief Inspector
	Barbara Buchanan	Senior Personal Secretary to the Chief Inspector
	Joan Nash	Personal Secretary to the Deputy Chief Inspector (Temporary)
A TEAM (adult males)	Alison Perry	Team Leader
	Sandra Fieldhouse	Inspector
	Andrew Rooke	Inspector
	Paul Rowlands	Inspector
O TEAM (women)	Sean Sullivan	Team Leader
	Joss Crosbie	Inspector
	Paul Fenning	Inspector
	Jeanette Hall	Inspector
N TEAM (young adults)	Kieron Taylor	Team Leader
	Andrew Lund	Inspector
	Keith McInnis	Inspector
	Angus Mulready-Jones	Inspector
	Kellie Reeve	Inspector
J TEAM (children)	Ian Macfadyen	Team Leader
	Angela Johnson	Inspector
I TEAM (immigration detention)	Hindpal Singh Bhui	Team Leader
	Beverley Alden	Inspector
	Colin Carroll	Inspector
	Fionnuala Gordon	Inspector
P TEAM (police custody)	Maneer Afsar	Team Leader
	Gary Boughen	Inspector
	Peter Dunn	Inspector
	Vinnett Pearcy	Inspector

HEALTH SERVICES TEAM	Elizabeth Tysoe	Head of Health Services Inspection
	Paul Tarbuck	Acting Deputy Head of Health Services
	Majella Pearce	Health Inspector
FEE-PAID ASSOCIATES	Michael Bowen	Health Inspector
	Anne Clifford	Editor
	Sarah Cutler	Inspector
	Fay Deadman	Inspector
	Karen Dillon	Inspector
	Sigrid Engelen	Drugs and Alcohol Inspector
	Francesca Gordon	Inspector
	Francesca Hands	Inspection Support Officer
	Brenda Kirsch	Editor
	Deri Hughes-Roberts	Inspector
	Martin Kettle	Inspector
	Adrienne Penfield	Editor
	Yasmin Prabhudas	Editor
	Nicola Rabjohns	Health Inspector
	Gordon Riach	Inspector
	Paul Roberts	Drugs and Alcohol Inspector
	Fiona Shearlaw	Inspector
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RESEARCH, DEVELOPMENT AND THEMATICS	Catherine Shaw	Head of Research, Development and Thematics
	Louise Finer	Senior Policy Officer
	Samantha Galisteo (nee Booth)	Senior Researcher
	Laura Nettleingham	Senior Researcher
	Ewan Kennedy	Researcher
	Rachel Murray	Researcher
	Danielle Pearson	Policy Officer
	Rachel Prime	Researcher
	Helen Ranns	Researcher
	Alissa Redmond	Researcher
	Joe Simmonds	Researcher
	Lucy Higgins	Research Trainee
	Gemma Quayle	Research Trainee
INSPECTION SUPPORT	Lesley Young	Head of Finance, HR and Inspection Support
	Jane Parsons	Head of Media and Communications (part-time)
	Tamsin Williamson	Publications Manager (part-time)
	Stephen Seago	Inspection Support Manager
	Vinota Karunasaagarar	Publications Assistant
	Mark McClenaghan	Inspection Support Officer
	Francette Montgry	Inspection Support Officer
STAFF WHO LEFT SINCE THE LAST ANNUAL REPORT	Rosemarie Bugdale	Caroline Elwood Alice Reid
	Helen Carter	Jennifer Kim
	Hayley Cripps	Kevin Parkinson
	Annie Crowley	Amy Radford