



Her Majesty's
Inspectorate
of Prisons
for England
and Wales

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Her Majesty's Inspectorate of Prisons for England and Wales

Statement of Purpose

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

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Introduction

This annual report draws on the 80 inspection reports published between September 2002 and August 2003. It describes a prison system under enormous and continuing pressure: as the prison population rose by 9% during the period covered by those inspections. It is also a testimony to the need for independent and robust inspection: both to monitor the effects of that pressure and to promote improvements.



Overcrowded prisons

The headlines are stark. This year, while the suicide rate in the community as a whole has been falling, the rate in prisons has increased. Almost two people a week kill themselves in our prisons: and they are the most vulnerable people: often new to prison, with mental health and substance misuse problems. One in four women in local prisons self-harm; some repeatedly. In the worst of our overcrowded local prisons, prisoners may spend 23 hours a day in a shared cell with an unscreened toilet. The best locals are working hard to sustain standards of humanity and respect; but even they are failing to deliver the activity and resettlement opportunities that prisoners need if society is to be protected from reoffending.

But the story behind the headlines is also alarming. Population pressure means that prisoners are decanted rapidly to whatever places there are in the system. Training prisons are finding it more difficult to deliver effective skills to an increasingly transient and volatile population. Only five of the 19 trainers we inspected were able to provide adequate employment and training. Similarly, open prisons find it hard to cope with prisoners who may still have drug problems or be unsuitable for working outside the prison: with a consequent rise in absconding. Some prisons cope better than others; and all prisons need actively to manage the population they have got, rather than the one they would like to have. But all prisons are feeling the strain: with an increasing risk not only of acute problems, such as deaths and disturbances, but of an insidious and chronic decline in expectations and achievements.

Prisons and society

However, there are also countercurrents. In spite of overcrowding, follow-up inspections of 22 prisons last year showed that they had been able to achieve, wholly or in part, 1500 of our recommendations for change.

Healthcare is showing noticeable and much needed improvement as management and funding passes to the NHS. In many prisons, there is now better mental health support and a perceptible movement towards the equivalence with outside services that this Inspectorate has long called for. The Department for Education and Skills' investment requires similar equivalence in prison education and training: as do our inspections, with the help of Ofsted and the Adult Learning Inspectorate. Drug detoxification and treatment work in some prisons is improving; though it is all too often undermined by the absence of support and treatment after prison, as shown in the joint inspectorates' report on the street crime initiative.

Following the *Howard League* judgment on children in Prison Service custody, and the publication of the joint inspectorates' report on children's safeguards, both local authorities and the Prison Service have begun to focus on the need to exercise properly their joint responsibility to protect children. Resettlement programmes, though patchy and under-resourced, are seeking to engage the outside world – local authorities, employers, colleges and community groups – in the task of integrating prisoners into society.

If these developments are able to take root and grow, prisons will no longer be hermetically sealed pods, forgotten islands around which community services and safeguards can flow. Prisoners should no longer be out of the sight and minds of those charged with providing healthcare, education, child protection or social inclusion. And the governance of prisons will need to change to reflect the different accountability, funding and standards of the outside bodies providing services inside.

However, as the prison population continues to rise (and the steepness of the rise is again increasing as I write), the fundamentals of prison life and regimes are under threat in many prisons: the ability even to provide a safe and decent environment for a growing, and increasingly damaged and demanding population. The pressure on prisons is real and debilitating, even if the potential support networks are now broader. Prisons will only be able to deliver what is right for prisoners, and what society needs, if that pressure is reduced. I therefore welcome the holistic approach being taken by the Carter Review of Correctional Services, with the need to build confidence in and increase the use of non-custodial sentences – fines and community penalties – as more effective and appropriate sanctions for those who do not need to be in prison, and for whom prison can do little.

Special needs

Within an overcrowded prison system, the needs of women are both acute and in danger of being neglected or disregarded. This Inspectorate now has a dedicated women's inspection team, which is able to focus on the specific needs of women in custody. However, the Prison Service has announced that it is to

disband the women's estate as such, and reintegrate women's prisons into area management. It is true that women's prisons need to benefit from local resettlement, drugs and psychology work – and this work will increasingly be carried out at regional level. However, it is vital that there should continue to be a strong women's policy group, and that the policies they develop – for example on detoxification, population management, self-harm and resettlement – are put into effect by area managers and carefully monitored by the Director of Operations. The special needs of women, many of whom will not come from the region or area, need to be promoted vigorously in a system in which they will always be a small, and easily marginalised, minority. This Inspectorate will continue to do that; we will expect the Prison Service to do the same.

This report also records the Prison Service's progress on race and foreign nationals. It shows some progress on race, but a patchy picture overall, with too many prisons still failing to put in place effective procedures, let alone promoting good race relations and celebrating diversity. This is an area that needs much closer management attention, at area and local level; and I welcome the fact that an Action Plan has now been agreed between the Prison Service and the CRE. Foreign nationals, who constitute 12% of prisoners (and one in four women prisoners), are even less well served. There is as yet no Prison Service standard or order on their treatment. This is reflected in practice in most prisons we have inspected: 32 had no foreign nationals policy at all. Those that did, such as Wandsworth, showed what can and should be done.

This year we published the first set of reports on immigration removal centres. They were ground-breaking reports that illuminated the experience of detainees and the actual treatment and conditions in centres. Frequently, they showed an 'inspection gap': between what was supposed to happen, and what did. They revealed a general sense of insecurity among detainees, heightened by the lack of information about their cases and future. They focused too on the detention of children: concluding with the inspection of Dungavel and recommending that children's detention should be exceptional, only for a matter of days, and that their welfare and developmental needs should be independently assessed and monitored.

The future

Inspectorates, like the prison system, are facing considerable change. Over the last year, our work has been scrutinised and reviewed closely, both by the Office of Public Service Reform in its review of inspection generally, and in the specific review of criminal justice inspectorates carried out by the three criminal justice departments. The former has drawn out some broad principles of inspection. They are ones that we can subscribe to: indeed in some, like the focus on outcomes rather than process, we have been ahead of the game. Annex 4 to this report sets our work and priorities against those 10 principles.

The criminal justice inspection review has focused on the need for criminal justice inspections to monitor the system as a whole: to undertake joint work that reveals and can eliminate the gaps that prevent the system working. At the time of writing, I have not yet been told what the outcome of that review will

be. I am clear that there are important interfaces – such as court cells and escort arrangements – that need to be jointly scrutinised, and we are working together with other inspectorates on those areas. It is equally clear that the Prisons and Probation Inspectorates must work together, and with others, to monitor and push forward the resettlement agenda, in the light of whatever new or regional structures emerge from the Carter report.

But my concern is that the specific focus of this Inspectorate – the treatment and conditions of those whom the state holds in custody – may be lost or blurred in any changes of emphasis or work; and that structures may be put in place that implicitly or gradually undermine Chief Inspectors' independence. Those concerns were set out fully in my recent lecture to the British Institute of Human Rights (available on our website). I have had assurances from the Minister responsible for prisons that four key elements of our current work will be retained. We will continue to inspect by our own criteria and methodology; we will inspect individual prisons and young offenders' institutions no less regularly than at present; I will retain the power and resources to authorise unannounced inspections without outside consultation; and I will continue to report only and directly to the Home Secretary. This is welcome; but it will nevertheless be important to examine any proposed changes to ensure that they fully reflect these principles, protect independence and provide a more effective, rather than simply a more expedient, structure.

This annual report, and the inspection reports that underpin it, are evidence of the value and necessity of detailed, objective and robust inspection of places of detention. That is something this Inspectorate has always provided, and, with a prison population of 74,000, the need for it has never been greater.

Anne Owers
HM Chief Inspector of Prisons
December 2003



Made by a young prisoner at Onley YOI.

The work of the Inspectorate

This annual report covers a period in which the Inspectorate's work has expanded and diversified but without losing its core focus: the conditions and treatment of prisoners. The workload remains heavy. During the year, we published 80 inspection reports, and inspected 66 establishments.

Core work

Last year, I voiced two concerns: that we were under-resourced for the task we needed to undertake, especially as the number of prisoners and prisons rose; and that we were still struggling with a backlog of reports that pre-dated the new Protocol for publication that I negotiated with the Prison Service.

I am glad to say that both of these concerns have been addressed. During the course of this year, we have received additional funding both for our core business, and for the inspection of immigration removal centres. As a result, we have been able to expand our inspection teams: with specialist teams for juveniles, young adults and women as well as for adult men. And we will also be able to recruit a specialist immigration team for IRCs. The Inspectorate infrastructure has also been reinforced, to ensure sufficient medical, research and administrative expertise and support.

We have been able to decrease substantially the turnaround time for publication of inspection reports. This year has seen the publication of 80 reports, as we have simultaneously caught up with the backlog and tried to publish reports of current inspections within four months. This is a great tribute to inspectors and support staff. Now that we have cleared the backlog, and have new resources in place, we are on target to meet, and sometimes surpass, our four-month deadline.

We are also a very effective Inspectorate. We have no power to enforce our recommendations; and indeed some, such as the recommendation that

Core work

Joint inspections

Children's
safeguards

Street crime
initiative

Area inspection

prisoners should not share single cells with unscreened toilets, are beyond the capacity of the Prison Service to deliver in current conditions. Nevertheless, in follow-up inspections carried out this year, we found that 1500 out of 2200 recommendations examined had been wholly or partly achieved (see Annex 3). In a prison system under the pressure that it now is, this is no mean achievement, either for prisons or for the Inspectorate. Inspection reports now differentiate between main recommendations and others; this will allow us to assess more accurately whether key concerns have been addressed.

Our remit is still increasing. During the year, we completed the first round of immigration removal centre inspections and reports. This has also resulted in the development of Expectations for IRC inspections, which will shortly be published. This role is now being expanded to include the short term holding centres where immigrants can be detained overnight. We are also in discussion with the Provost Marshal of the army to set up regular inspections of the military corrective and training centre in Colchester. And we inspect prisons and places of detention outside England and Wales. Our inspection of the Isle of Man prison was influential in underlining the need for a new prison there; and we are now in discussion with the new Chief Inspector of Criminal Justice in Northern Ireland to formalise arrangements for prison inspecting there. These developments reflect our acknowledged expertise in reporting on the conditions and treatment of those held in detention in a variety of custodial settings.



We have also been subject to an unparalleled level of external review during the year. The future of public service inspection in general was scrutinised by the Office for Public Service Reform (OPSR). In addition, there has been a separate review of the five criminal justice inspectorates. This has involved considerable work, to ensure that our views and work are fully fed into reviews, as the only inspectorate whose core business is to inspect the treatment and conditions of those the state holds in detention; rather than the operation of a service.

Nevertheless, there is no doubt that we meet the 10 principles of inspection set out by the OPSR in July 2003. Annex 4 sets out those principles and the way that they are applied in the Inspectorate.

Joint inspections

Most of our inspections involve work with other inspectorates: we work with the education inspectorates to examine education and training, and cross-deploy with the social services inspectorate in looking at children in custody. This year we have also been involved in three major cross-inspectorate joint inspections.

Children's safeguards

We joined with seven other inspectorates to produce a comprehensive report, *Safeguarding children* (2003) to assess the adequacy of the arrangements within and between the services that look after children or seek to prevent them from harm.

The report found that the safeguarding of young people held by the Prison Service was a major concern. The fact that the Prison Service was not bound by the Children Act meant that its requirements were not automatically applied in practice; protocols for investigating allegations of assault and abuse did not always exist, and there was often little involvement, or interest, from local social services. In all but one of the areas inspected, there was little engagement by the area child protection committee. Staffordshire, however, was a model of good practice: social services were investing staff time to work with probation and YOI staff at Brinsford YOI.

'Young people in YOIs still face the gravest risks to their welfare, and this includes those children and young people who experience the greatest harm from bullying, intimidation and self-harming behaviour.'
(*Safeguarding children*, 2003)

Youth offending teams were not at that point subject to inspection, though this is now taking place. An examination of files showed that they focused almost exclusively on offending behaviour, rather than welfare needs. They were also too detached from other agencies, such as social services.

The role of area child protection committees generally was examined. Few were equipped and able to exercise their responsibilities. In most cases, they lacked effective joint funding, and did not have the authority to require other local agencies to report to them on their safeguarding duties. Recommendations were made to strengthen their role and remit.

'The ACPC should have a protocol that specifically addresses the safety of all children and young people remanded or sentenced to custodial institutions.' (*Safeguarding children*; recommendation)

Street crime initiative

Together with six other inspectorates, we undertook an inspection of Stage 2 of the street crime initiative, publishing the report *Streets ahead* (2003).

The overall conclusion of the report was that the initiative was a groundbreaking new approach to tackling crime that had, in the immediate term, reduced robbery in the areas covered and led to some good partnership initiatives at local level. However, there was too little focus on the rehabilitation of offenders, once detected and convicted, with the result that they were likely to reoffend. A sustainable reduction in street crime required more emphasis on post-release treatment and support, particularly for drug offenders.

'To be effective, treatment must be accessed within 24 hours of release from custody. The inspection found a significant mismatch between reported success against this target and the reality in practice. Assessment of need was mostly accessed within 24 hours; this masked the fact that treatment routinely began 9–12 weeks later. Paradoxically, the availability of drug treatment inside prisons was of better quality and more immediate.' (*Streets ahead*, 2003)

This underlines what prison inspections already reveal: the lack of throughcare and support, particularly for short-term offenders. The street crime initiative targeted those with substance use problems, and set a target of 24 hours within which street criminals released from prison should be able to access treatment. Any greater gap was rightly seen to undermine the work done in prison and raise the likelihood of further drug use and offending. All SCI areas reported that this target was being met. However, in fact, all that happened within this period was an assessment: treatment typically did not begin until 9–12 weeks later.

The inspection also found that tracking systems between the different criminal justice agencies were ineffective, particularly from courts to prison; but it also identified good practice in those prisons that had dedicated staff to this exercise.

The report made many recommendations that would improve this, and similar, initiatives. They included:

- 'single pot' funding that extends beyond the short-term
- local consultation to balance local and national priorities
- protocols between all relevant agencies
- a common criminal justice tracking system, supported by integrated IT, to allow case management from arrest to resettlement
- a clear, measurable and achievable standard for the provision of drug treatment for offenders
- a strategy and structure for case management

“ There should be more emphasis on post-release treatment and support, particularly for drug offenders. ”

Area inspection

During the year, a great deal of work was done to prepare for the first pilot inspection of an entire criminal justice area, Gloucestershire, to be carried out by all the criminal justice inspectorates. It would particularly concentrate on the interface issues between the different agencies. This included a pre-inspection visit to brief the relevant agencies and chief executives.

The prisons Inspectorate was one of only two inspectorates which also took the opportunity to carry out routine inspections as part of the exercise: three Gloucestershire prisons were inspected.

We had a particular interest in two interface issues. The first was courts and escort services, including court cells and journeys to and from court. This will be prisoners' first experience of custody, affecting their safety and well being. Although it is not directly inspected; inspections have picked up escort problems, such as long journeys and too few stops. The second was resettlement: both reintegration and public protection. Initial indications were that little would be learnt directly about the latter, as few Gloucestershire prisoners were held in Gloucestershire prisons.

The area inspection report will be published in February.

Themes

Inspection reports throw up some of the key issues for the Prison Service, and the way that different prisons are tackling them. Overcrowding is a theme that runs through all the sections of this report, as it has in all our reports this year. Six other main themes deserve highlighting: safer custody, resettlement, race and foreign nationals, healthcare and drug treatment.

Safer custody

Resettlement

Health care

Substance use

Foreign nationals

Race relations

Safer custody

Last year's annual report focused on the rise in the number of suicides in prison. In spite of the commendable efforts of the Safer Custody Group, and of some individual prisons and officers, this has continued. This year, almost two prisoners a week have killed themselves in prisons in England and Wales. This is, of course, closely linked to overcrowding and prisoner movements.

The statistics of those who commit suicide in prison are shocking:

- Over a third are unconvicted
- One in five are women (though they account for only 8% of the average daily population)
- One in five are in prison hospitals or segregation units
- 61% are in male local prisons
- 40% die within their first month in custody

Those statistics sketch the profile of those who most commonly die in our prisons: they are likely to be newly in prison, often unconvicted, often so mentally ill or disturbed that they need segregation or treatment, and a disproportionate number are women, often young women. Many of them, at that stage in sentence, will be withdrawing from drugs.

Beyond those who die is the much larger number of prisoners who harm

themselves. This year, the Prison Service began collecting more accurate statistics of **self-harm** in prisons. This has resulted in a 30% increase in reported incidents: 7700 of them in the first six months of 2003. Again, a large proportion (40% of men and 33% of women) self-harm within the first month, often within the first two days. Self-harm is much more common among women than men, and more common in local prisons than in training prisons. The figures show that one in four women in local prisons self-harm. This is an indicator, if one were needed, of the extreme levels of distress among women in prison.

We have recommended that there should be internal inquiries into serious incidents of self-harm, which almost result in death. There would have to be a formal investigation if death had occurred, and there is much that can be learnt from such events to prevent a recurrence, or future deaths.

At national level, there have been developments during the year, not least to improve investigations into **deaths in custody**, to comply with human rights obligations. This has resulted in a new Prison Service Order, providing for independent advisers and the involvement of families in the investigation. It has also led to proposals for independent investigation, by the Prisons and Probation Ombudsman, and improvements in the way that coroner's courts tackle such deaths. In parallel with the piloting of the new PSO, the Ombudsman has been overseeing investigations into two deaths in custody. Debates about the most effective, transparent and independent way of investigating such deaths continue, and the Inspectorate is contributing to them.

We find that the quality, timing and implementation of death investigations vary considerably. Investigations may be delayed (as at Woodhill); or action plans not developed. Following one death in Frankland, specific recommendations had still not been followed, and at Holme House, where there had been five deaths, an action plan was only just being developed.

The three-year safer custody project ends in March 2004 and there are discussions on the new strategy, to which we are contributing. The concept of safer custody has made an important contribution to improving prison culture, even if rising numbers and movements have in practice overshadowed its effect, and it is vital that this work continues to develop and to inform prison practice.

The introduction of **suicide prevention** co-ordinators has been a helpful move – and some prisons are funding this themselves – but such posts need to be at senior level if they are to have a chance to challenge entrenched cultures and practices. It is also extremely important to involve other disciplines in suicide prevention: drug workers, social workers, psychologists and community mental health nurses may have access more quickly to full information about prisoners, and training that assists in identifying vulnerability.

Our reports, and the sections below, point out the importance of key elements in the safer custody agenda: early days in custody (including escort arrangements), suicide prevention and anti-bullying strategies, adequate detoxification, and positive regimes in which staff can engage with prisoners. All these elements are, of course, threatened by overcrowding and prisoner movement.

In the sections that follow, we highlight the inadequacy of **escort arrangements** that involve lengthy journeys, punctuated by too few 'comfort

“One in four women in local prisons self-harm.”

breaks' especially for some of the most vulnerable – women and young people. As a result, prisoners arrive with heightened anxiety, or in states of indignity or distress. As part of the area inspection of Gloucestershire, undertaken with the other criminal justice inspectorates, we will be examining escort arrangements, with a view to making recommendations about contracts and requirements.

John was 19. He had never been in prison before, had not expected to be remanded in custody and his court report showed that he was potentially vulnerable, having spent time in psychiatric care. He arrived at the YOI at 8.30pm, seven and a half hours after his court case finished. He had waited three and a half hours in court cells and travelled for four hours in the escort van. He did not get on to the induction wing until 9.30pm, too late to receive induction as staff had left for the night.

Those sections also feature the work that is being done in prisons of all kinds, as they struggle to provide safe environments for increasing numbers, and increasingly vulnerable prisoners. Good practice includes 'meet and greet' schemes, using other prisoners; a multi-disciplinary approach to identifying and supporting prisoners at risk (as at Doncaster); the development of support plans; and the increase in mental health in-reach teams (with 94 planned by 2004).

All suicide and self-harm reviews had taken place, and appropriate support plans devised. Prisoners on suicide watch told us that staff took time to talk with them. Forms followed the prisoner, so that landing officers were aware of their responsibility and observed changes in behaviour. Listeners said that staff made full use of them, often referring them to prisoners they were concerned about.' (Birmingham)

Poor practice includes a lack of staff training (in Winchester only 93 of 200 staff were trained); failure to carry out risk assessments (as at Holme House, which had run out of forms); a reactive and often superficial approach to F2052SH monitoring; inadequate detoxification; and the absence of activities or daycare provision for those with mental disorders. There is a general shortage of therapeutic, counselling and support provision for prisoners identified as being at risk; and a need for greater staff training and the involvement of other disciplines in providing appropriate interventions.

Throughout the prison estate it is important to tackle **bullying**, which takes different forms in different kinds of establishment. Inspection reports often record good processes, but ineffective implementation and interventions. At Wormwood Scrubs, for example, we found known bullies who had been given jobs as wing cleaners, with ample opportunity to carry on that activity. Whitemoor was the only high security prison we inspected that had an anti-intimidation strategy that recognised the sophisticated forms of bullying that take place in such prisons. Glen Parva and Swinfen Hall had programmes geared to the more overt bullying of young adults.

Many women's establishments neglected or failed to tackle the covert, as well as overt, bullying that can take place in relatively low security environments: Askham Grange being an exception. Outwardly relaxed training prisons, where

prisoners are free to move around and sometimes locked into spurs at night, can provide opportunities for bullying that are not always monitored: at Kingston, for example, prisoners talked about the extent of bullying, but there was little follow through of incidents or interventions for bullies or victims.



Resettlement

Resettlement in prisons can still best be described as ‘patchy’. There are some good initiatives, and examples of effective co-operation between prisons and prison areas, and local statutory and voluntary organisations. But there is still an absence of secure funding, strategies and planning, based upon an analysis of prisoner needs. And prisoner movements can undermine the best efforts of local managers.

Establishments have made significant efforts to ensure compliance with the new Prison Service Order on resettlement. For some this has meant meeting only the minimal requirements (such as the appointment of a head of resettlement and the establishment of a resettlement policy committee) – while others have taken the opportunity to look at broader issues and rethink the delivery of regime and resettlement services.

The approach taken is often reflected in the make-up of the **resettlement policy committee**. The most effective committees involve all prison departments and partnership agencies, or provide ‘practitioner forums’.

‘The approach to resettlement anticipated strong links with senior managers outside the prison, combined with an emphasis on integration of resettlement within the establishment.’ (Erlestoke)

‘The prison had exceptionally good links with community agencies which included the Birmingham City housing department, the employment service and community mental health agencies. High level links between prison management and businesses could result in offers of employment.’ (Birmingham)

However, too many committees were primarily involved in operational management, rather than taking a strategic overview, based upon the assessed needs of prisoners. The difficulties some prisons experience in filling in our standard population profile pro forma appears to indicate that they do not routinely interrogate information such as age, sentence length, nature of offence, ethnicity and home area to inform management decisions. A frequent finding is that a prison has no resettlement needs analysis to inform its strategy.

In some areas, there are area **resettlement strategies**, sometimes on a multi-agency basis (for example in South East 1, Kent and Eastern). Prisons and prison managers are being encouraged to develop relationships with local statutory and voluntary agencies in order to deliver 'through the gate' resettlement. This is an important framework, but individual prisons still need to have complementary local strategies, and most do not. There are exceptions: Highpoint South had one of the most detailed, yet user-friendly, action plans that we have seen.

'Most prisoners have received very little advice on resettlement matters beyond their induction programme and at this stage of their sentence are very anxious about coping with life outside.' (Conclusion of NACRO pilot, *Littlehey*)

Short-term prisoners in local prisons continue to be the worst served. There is no requirement for sentence plans, and those prisons that have tried to bring in their own custody plans are finding this work hard to implement effectively, given the rise in prisoner numbers and movements (see *local prisons*). Reintegration work usually relies heavily on voluntary and community sector organisations. There were 34 such agencies working in Doncaster; but some prisons have yet to develop such links. They work best when local agencies can assist prisoners being released into the local area – which is often not the case, due to overcrowding and population movement. In some prisons, there were pockets of excellent work – such as the reintegration package offered by the Foundation Training Company at Chelmsford – but this was rarely integrated into the work of the prison as a whole, and the funding base and continuation were usually fragile.

Failure to locate prisoners close to home and frequent, unpredictable moves make it difficult for prisoners to maintain family and community ties. In local prisons, where the demand is high, booking arrangements are rarely adequate. Conversely, in training prisons and some young offender institutions, where prisoners are held further from home, prisons need to make more effort to encourage and enable visits. Warren Hill, for example, was in a rural area with little weekend public transport – but had recently ended a private coach service from London. We raise the specific and acute problems faced by women prisoners in the section on women's prisons.

Few prisons provide structured **pre-release programmes**, though those under the care of specialist drugs or mental health workers often fare better. At Drake Hall, for example, those on the drug rehabilitation programme had the support of a probation officer, providing a quality housing and resettlement

service, whereas other women experienced major re-housing problems. And, except for those subject to public protection measures, there is little evidence of preparing prisoners for post-release supervision. Some prisoners do not know the implications of their licence requirements and in the worst cases only find this out when handed a copy of the licence by the discharge officer in reception: we found this at High Down, for example. This may well be contributing to the increase in secondary custody.

Sentence planning is now a core part of prison business, but its implementation remains patchy. It is rare to find a local prison that is up-to-date on sentence planning, let alone able to do it effectively. This leads to receiving prisons having incomplete information, either because work has not been done or because it has not been passed on. Where sentence plans are completed and moved with the prisoner, the receiving prison sometimes does not consult them, but starts its own plan afresh, thus subverting one of their main functions.

'74% of prisoners had no sentence plan' (Winchester)

'Sentence planning was in disarray at the time of the inspection' (Birmingham)

'Sentence planning was in complete disarray, with a backlog of over 160 initial plans and reviews' (Bullingdon)

'No sentence planning took place for prisoners in the main prison. 737 prisoners had no sentence plans' (Wandsworth)

'Sentence planning was so far behind that it was accepted that many prisoners would leave Liverpool without a plan'

Though there has been an overall improvement in the quality of sentence plans, we regularly find deficiencies in the quality of targets and the extent to which those plans are integrated into sentence. It is almost automatic for all prisoners to be targeted for programme assessments; or to be told to find or remain in work, irrespective of whether this meets the overall sentence plan. Few prisons prioritise targets: unlike Albany, where staff ensured that all prisoners with basic skills needs attended education prior to being allocated to a programme that required those skills. Population pressure and prisoner movements also inhibit prisons' ability to plan or to get prisoners to the right place, in time, for the right course.

Though home detention curfew is now more widely used, prisons remain risk averse in their use of release on temporary licence as part of structured resettlement.

Almost all prisons run **offending behaviour programmes**, and most reach high levels of quality assurance. However, expectations raised in prisoners cannot always be achieved: not all will be suitable, and long waiting lists often mean that not all can complete a programme in time for parole dates or before discharge. At Whatton, a prison whose stated aim was to provide treatment for sex offenders, only 47 prisoners had completed programmes during the year prior to the inspection, and many had been released without doing so; though the prison had plans to increase these numbers substantially. The involvement of residential staff is crucial in order to reinforce programme work on the wings.

“ It is rare to find a local prison that is up-to-date on sentence planning, let alone able to do it effectively. ”

This was evident at Usk; in contrast to Albany, where we reported 'limited wing support for those on programmes'.

All prisons claim to have a **personal officer** scheme: but we rarely find that such schemes are effective, even in training prisons and young offender institutions. Few have a clear job description, or contribute effectively to wing histories or the management and support of prisoners. They rarely operate as case managers for sentence plan targets, and in many cases this leaves the prisoner him or herself responsible for progressing the plan, between the annual or biennial sentence review. Erlestoke was unique in seeking to equip all staff to operate as case managers under the new OASys system; in most prisons this will be delegated to dedicated casework teams.



Healthcare

During the reporting year, preparations were under way to transfer the commissioning and funding of prison healthcare from the Prison Service to the Department of Health.

Increasingly, prisons are part of the local health economy, and this creates new responsibilities both for Primary Care Trusts and prison managers.

The benefits of **closer links to the NHS** are apparent in some prisons. They can bring in effective and professional management, improve the clinical supervision of staff and review the skills mix of healthcare staff in order to support prisoners' needs. At its best, this is allied with greater patient empowerment: with appointment systems for clinics and well-organised 'medication in-possession' policies.

'Central to the continued improvement in healthcare had been the secondment of an NHS senior healthcare manager as head of health care. This had resulted in a review of staffing levels, skill mix, the management and delivery of healthcare and action plans to improve the quality of care.' *(Pentonville)*

'Staffing difficulties meant that hospital escort duties were frequently cancelled: 14 outpatient appointments had been cancelled in the last three months, usually on the same day and at short notice. While we were present, a man who had removed the plaster of Paris from his arm had four appointments cancelled.' *(Parc)*

However, this process is patchy. We have come across local PCTs that are reluctant to engage fully with their prison (such as Full Sutton and Lewes), probably because they recognise the level of need and demand. We have also come across prisons whose managers are reluctant to share control and management with 'outsiders' and where the rifts between operational and medical staff and managers result in unacceptable outcomes for patients. We were often particularly concerned about the qualifications and supervision of night staff, for example at Blundeston and Gloucester.

Overcrowding also affects healthcare, and it is a repeated recommendation that healthcare beds should not be part of a prison's certified normal accommodation, and be used for overflow prisoners, who are inappropriate for any therapeutic regime. Admission to a healthcare bed should be a matter of clinical, not operational, judgment. Sometimes the non-clinical admissions were new arrivals, placing a great strain on already depleted staff; and all those in healthcare also frequently missed induction.

Many establishments continued to have **staffing difficulties**, with problems of recruitment and retention leading to use of expensive and temporary agency and locum staff. Patients lacked continuity of care. This problem was exacerbated by inordinately slow security clearance processes, which often meant that nurses who had been appointed took up other posts in the interim. Lack of secretarial and administrative staff also increased the burden on nursing staff, as they had to carry out administrative tasks which wasted their time and skills. Staffing shortages in the prison as a whole could affect healthcare badly; both in terms of missed appointments in the prison and missed outpatient appointments. This was the case at High Down, where one third of patients failed to attend GP appointments.

Some healthcare centres were unacceptably **unhygienic and dirty**: this was the case in Liverpool and Gloucester. In some it seemed as though staff had simply stopped noticing the state of wards and rooms. In some cases, we recommended a commercial cleaning contract, to reduce pressure on nurses.

Mental health continues to be a major problem in prisons, with a large number of prisoners who have either acute or chronic mental disorders. We have noticed some improvement in moving seriously mentally ill patients to NHS care, following the new target that this should happen within three months of assessment (though sometimes the assessment itself is delayed for too long).

“ Inordinately slow security clearance processes often meant that nurses who had been appointed took up other posts in the interim. ”

Nevertheless, three months is a long time for prisons to hold seriously ill, often potentially violent, prisoners that they cannot treat and who deteriorate visibly. The regimes available in healthcare centres rarely provided the support and stimulation that such patients need.

'Patients had a very impoverished day, with very little activity: only out of their rooms for two to three hours at most on many days. Disturbed young men should have some space and human contact.' (Winchester)

'Five registered psychiatric nurses provided a community health team service to the prisoners and were able to give guidance on mental health and related issues to staff. The day care centre was open daily and prisoners could use it for recreational and educational purposes as an alternative to being locked up.' (Wandsworth)

The arrival of mental health in-reach teams in many prisons has been of benefit both to prisoners and staff, enabling those with chronic mental disorder to be better managed on the wings. It would improve matters even further if they could train and support wing staff. This is part of a general move away from in-patient treatment, towards managing healthcare problems on the wings. Few training prisons now have inpatient facilities at all, and in general this has improved the quality of **primary care**, and prevented the prison hospital being used too much and inappropriately.

Local prisons, too, are reducing the number of beds, sometimes replacing them with day care centres, which can offer support to prisoners who find it hard to cope on normal location. Wandsworth, for example, had only 15 inpatient beds (not on the CNA), supported by a day care centre and a strong mental health in-reach team. Some prisoners and staff find these changes hard to accept, since they have been accustomed to being able to use healthcare for respite or refuge; where these changes had not been carefully managed, as at Drake Hall, there was considerable dissatisfaction and resentment.

Dental services remain a problem in many prisons. While the standard of care was generally good, the extent of provision was rarely adequate, with long waiting lists for treatment.



Substance use

Many of those entering prison have substance abuse problems, which are often at the root of their offending. The provision of effective detoxification, treatment and throughcare is critical. Our reports show that this combination is rarely achieved; but we also record good practice that should be emulated.

Effective **detoxification** is a critical part of the safer custody agenda, and it is lacking in most prisons we inspected. We refer to inadequate procedures both in women's and local prisons, with particular concerns in relation to Styal and Birmingham (see pp 37 and 29). However, other establishments, such as Lewes and Holloway, show what can be done, given proper cross-disciplinary support and sufficient resources.

We do, however, detect a welcome move away from merely providing symptom relief, towards more effective interventions and treatment. Critical to this are effective links and co-operation between healthcare, residential and drug workers. In some prisons there were gaps and stand-offs through which the treatment of prisoners fell: in those prisons, we found inadequate medication to manage withdrawal, poor supervision of care planning and support for those undergoing detoxification, and non-specialist nurses involved in the assessment and care of drug users.

Prisons also need to be able to offer effective treatment and **throughcare**. The absence of the latter was something that we highlighted in the joint inspectorates' report on the street crime initiative. Very few prisoners were able to obtain the promised treatment on release: those areas that claimed to be providing treatment within the promised 48 hours were in fact providing assessment only.

We regularly report that CARAT teams in prisons focus on assessment rather than treatment. They are driven by key performance targets that prioritise assessment, even of prisoners who have already been assessed (sometimes more than once). This is made worse when, as in many prisons, the CARAT service is under-staffed. We strongly believe that KPTs should reflect the type of establishment, recognising and targeting case work and pre-release planning in training and resettlement prisons.

'The CARATs team had key performance targets to undertake 70 initial assessments and 200 full assessments a year. This was an extremely bureaucratic and time-consuming obligation, which detracted from the team's ability to provide services and undertake direct work with prisoners. Support for resettlement was not a priority in terms of their contract.' (Lindholme)

'Approximately 50% of prisoners known to the CARAT team had taken up treatment or supported housing on release and the outreach worker could offer two months' follow-up to newly released prisoners.' (Lewes)

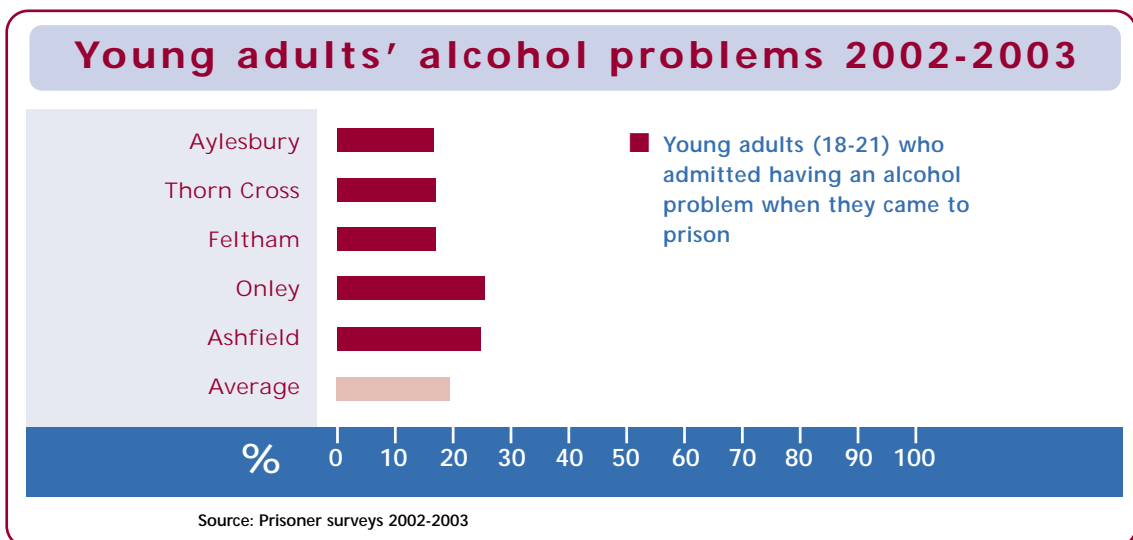
We saw some examples of **good practice**, which should be replicated across the estate. These included: induction programmes that dealt with harm reduction and overdose prevention; group work and courses that are less intense than structured rehabilitation programmes to give prisoners a choice; courses for cocaine or crack users, given that 40% of drug users may have a cocaine or crack problem. Some prisons showed examples of good multi-disciplinary working, including healthcare staff, probation and the voluntary sector.

Different kinds of structured **programme** were available, from offending-related, to cognitive behavioural and therapeutic communities. Some training prisons, however, still had no specific programmes, or had programmes that did not meet the needs of the population. For example, there were therapeutic communities in prisons where the average sentence was too short, or intensive 12-step programmes for young offenders, for whom they are inappropriate. Frankland was actively assessing prisoners' needs, so as to provide alternatives to the FOCUS programme provided in high security prisons, as only around a third of prisoners meet the criteria. There is a great need to develop programmes specifically for young offenders: at Warren Hill, Turning Point had developed a specific six-week drug and alcohol programme, with a completion rate of 85%, which we regarded as 'a model of good practice for the juvenile estate'.

Not all prisons met targets for **mandatory drug testing**, and there was little evidence of target testing. Some did not test at weekends. Prisons focused on reducing the supply of drugs, sometimes with dubious use of a drug dog: in several establishments an indication by a dog automatically resulted in closed visits, even though there is much evidence of false positives in dog identification. However, the establishments that were most successful in reducing drug use integrated this with demand reduction, by establishing a good detoxification service (in Lewes, MDT positives declined from 33% to 11% after introducing the subutex programme).

Many prisons have **voluntary testing units**, for prisoners who wish to be drug-free. Such units can easily be destabilised by placing 'lodgers' there, due to overcrowding, or by the redeployment of staff to other duties. Some so-called voluntary testing is in fact compliance testing (for example, when it is a

“ There is a great need to develop programmes specifically for young offenders. ”



precondition of enhanced status). Some establishments had introduced peer support schemes (PADS in the high security estate) who were often trained Listeners. More such schemes are needed, and peer supporters also require clear role boundaries and support.

It remains a matter of great concern that there is still no Prison Service policy, programme or target for **alcohol reduction**. This is particularly important for young offenders, where alcohol is likely to be a more frequent trigger to offending than drugs. Very few prisons had an alcohol strategy, and many expected that CARATs would deal with this, although it is technically outside their remit and funding. Increasingly, as drug-specific funding is being ring-fenced, there must be dedicated resources and a national strategy on alcohol reduction.

Resettlement and **throughcare** remain major problems: some CARAT teams had good links; others only managed to make a post-release appointment with the local community drug service, which in many cases would have a lengthy waiting list. There were, however, some good examples of work with community agencies, both in-reach and out-reach.

Foreign nationals

Twelve per cent of prisoners are foreign nationals: in the women's estate this is one in four. Yet few prisons have developed specific policies and practices for these prisoners.

Prisoners from abroad generally serve very long sentences and receive few, if any visits. They have particular problems in maintaining family links, especially fulfilling their roles as parents. Prison staff need to understand the implications of different national cultures in the prison and managers should have in place appropriate pre-release support and effective links and procedures to manage deportation or repatriation. And the Immigration Service needs to actively ensure that those who wish to leave can do so speedily at the end of sentence.

Of all the men's prisons that we inspected, only two, Wandsworth and High Down, had fully effective policies and practices, led by a foreign national co-ordinator who understood the specific needs of this group and could liaise with the immigration authorities on their behalf. Lewes was developing work, having taken on a co-ordinator from the voluntary sector who had learnt from Wandsworth's experience. The Verne, with nearly 50% foreign national prisoners, had no strategy for identifying or meeting their needs.

'Over half the prisoner population were foreign nationals, from 40 different countries. The prison had no strategy for its work with these prisoners, no needs analysis had been undertaken, some staff time had been allocated to liaison work but this was very much ad hoc, and staff had received no specific training in this area.' (*The Verne*)

“1 in 4 women in prison are foreign nationals.”

'A part-time probation officer worked as the foreign national officer. The establishment paid for a representative of the Detention Advisory Service one day a week. The foreign national team had produced a wide-ranging up-to-date policy and a resource pack and a survey of all foreign national prisoners had been conducted annually for the last few years.'
(Wandsworth)

Foreign nationals in the **women's estate** have suffered a year of disruption and uncertainty – as have the establishments where they are held. This has particularly been the case in training prisons. Send, when we inspected it, was the training prison catering specifically for foreign nationals, though not one where they felt respected or treated equally. By the time we inspected Drake Hall and Morton Hall, later in the year, the great bulk of foreign national women had been moved there, with very little warning or time for preparation. A third of Drake Hall's population and over half of Morton Hall's were foreign nationals (see section on *women's estate* for details).

In many reports, we have commended the excellent and essential work done by Hibiscus, the women foreign nationals support group. This needs to be properly supported and resourced: but it should be complementary to, rather than a substitute for, an effective Prison Service policy for this vulnerable group of women.

This institutional blind spot for foreign nationals as a whole is evident from the fact that 32 prisons that we reported on had no specific foreign national work, and many did not know how many they held until inspectors informed them. This was not helped by the dilatory attitude of the Immigration Service, which, unless pressed, was not monitoring those liable to deportation, and

making arrangements for this to take place as soon as sentence had expired. In many prisons, we found prisoners well beyond sentence with no idea when they might be released and go home. In others, we found detainees held solely under administrative powers; some displaced from Yarl's Wood but others apparently forgotten about.

“ 32 prisons inspected had no specific foreign national work. ”



Race relations

The Prison Service has come under considerable scrutiny and criticism with regard to race relations. The picture that emerges from inspection reports is a patchy one. While prisons as a whole are reaching towards compliance, there is still too little evidence of commitment to the promotion of positive race relations.

Most of the prisons that we inspected this year had the minimum structures in place. This included a race relations management team that met regularly (though regularly could mean only quarterly); and a race relations liaison officer. However, a considerable number of RRLOs said that they had not enough time to carry out their duties, and some had less than the minimum eight hours a week that should be available. In practice, most prisons were unable to go beyond essentially reactive processes, to work actively to promote good race relations; and some lacked even the basic structures or understanding.

Most prisons carried out **ethnic monitoring**, though, unaccountably, Morton Hall, with 59% minority ethnic prisoners, did not. Some, however, failed to interrogate or act on the data that was produced. Aylesbury had a disproportionate number of black and minority ethnic young prisoners on the basic regime, and Werrington's response was reactive, rather than proactive.

In most prisons, prisoners had access to confidential racial incident **complaints** forms, and this improved during the reporting year. However, the quality of the investigations of incidents, and the timeliness of response, varied greatly. In some prisons, prisoners expressed little confidence in the system.

What was common to nearly all prisons was the need for more staff **training**. In 30 prisons inspected, we identified clear deficits in staff training; in only five were we confident that enough staff were trained, or were shortly going to be. This is an area in need of particular attention and direction, now that training responsibilities have been devolved to establishments. We came across instances of local trainers who were not themselves sufficiently expert to be able effectively to train others.

It is clear that more management attention needs to be paid to the promotion of race equality and diversity in prisons. Our inspections show that at present, the internal monitoring systems – through area managers and audits – are not sufficiently focused on this area; though it is now a responsibility of the Prison Service under the Race Relations Act.

The patchy practice that inspections revealed across the prison estate is best illustrated in this collection of quotes from inspection reports during the period.

'There was no race relations liaison officer, a race relations management team that had not met for 11 months, and no information about racial incidents investigated over the last six months. Black prisoners described the prison as "institutionally racist". *(Parkhurst)*

'In the last six months the race relations liaison officer had been granted only four hours to complete his work. There was a significant backlog of complaints. We found unacceptable racist graffiti in cells, reception and the education block.' *(Chelmsford)*

'There were at least ten assistant race relations liaison officers and each residential unit had its own nominated prisoner representative. The RRLO had the necessary facility time. Training had a high priority: 228 out of 280 staff had received race relations training.' *(The Verne)*

'Young black prisoners spoke of "favouritism" that in practice favoured white young people. There was a wholly disproportionate number of black prisoners in segregation and of white prisoners on the highest, enhanced, privilege level. The race relations committee met infrequently, did not interrogate the statistics, and there was no positive promotion of diversity.' *(Aylesbury)*

'Attendance at the RRMT meetings was poor. With two previous meetings having significantly more staff apologies than attendees, RRMT prisoner representatives expressed serious concerns about the amount of racist verbal abuse by staff. Racial incident forms were investigated in what appeared to be a generally superficial way. One reply read "As this problem has now stopped, I have instructed the prisoner to tell me if there is a repetition".' *(Dartmoor)*

'The Governor gave race relations high priority. The imam told us that all senior managers were genuinely committed to race relations. He said he was confident that issues would be treated seriously and investigated thoroughly. Prisoners from minority ethnic groups confirmed this.' *(Blakenhurst)*

'From records, it appeared there had been no race relations training since 1998. The RRLO did not receive sufficient time to carry out his duties. He did not have a base to work from where he could interview people privately and store documents. There was no prisoner representation on the RRMT. Ethnic monitoring included range setting but the information collected was very limited.' *(Woodhill)*

'The Governor had set high standards for race and diversity work; a well-trained and highly committed RRLO and diversity committee had followed these through. The prison had some good initiatives, such as a black prisoner support group led by members of a minority ethnic group from the community.' *(Lindholme)*

Different establishments

Reports issued this year described inspections carried out between December 2001 and April 2003. During that time, the prison population rose by 9%. All establishments are feeling the effects of this pressure; though some are coping better than others.

Local prisons

This year, we issued reports on 19 adult male local prisons in England and Wales, three of them 'core' locals, holding category A prisoners, and two of them privately-run. They show that local prisons are finding it increasingly difficult to provide activities and resettlement opportunities for the short-term prisoners they hold; and some are not even able to ensure safety and decency.

All local prisons are at the sharp end of overcrowding, and this became increasingly acute during the period. This puts safety and respect under great pressure. Yet two things were apparent. One was the variation in what they were able to provide by way of the fundamentals of a **decent regime**; and this related to attitudes and culture, as much as staffing levels and plant. The second was that, in those prisons failing to provide the basics of decency, managers were often not aware of the discrepancy between the regime they thought they were providing and what was actually happening on the wings.

'Liverpool was not delivering an acceptable regime, or standards of hygiene and cleanliness... showers, association and exercise were far below the average for other local prisons.'

'At Forest Bank, association and exercise were regular and prioritised; prisoners had daily access to showers and telephones, and there was a welcome emphasis on cleanliness in cells and communal areas.'

Local prisons

Training prisons

Open/resettlement
prisons

Dispersal prisons

Women

Young adults

Juveniles

Immigration
removal centres

Northern Ireland

Isle of Man

“ One local prison had to settle in 436 new prisoners every month. ”

The **safer custody** agenda is most necessary, but also most difficult, in local prisons. Forty per cent of those who kill themselves in prison do so within the first month of imprisonment. But the large number of movements and prisoner ‘churn’ in local prisons make it extremely difficult to identify and interact with the most vulnerable. One local prison that we inspected had to settle in 436 new prisoners every month. It is also in local prisons, where prisoners may most need support, that they are least likely to encounter an effective personal officer scheme.

Court and escort problems and late arrivals in prison can compromise both safety and respect. Local prisons often reported problems with late arrivals: Gloucester had had to lock out to police cells, and Wandsworth was receiving prisoners after 8pm. Prisoners often arrived without the minimum documentation, sometimes on interim warrants, making the task of assessing vulnerability and risk very difficult in pressured reception areas. The most extreme problems were at Birmingham, where, during the inspection, ‘Operation Safeguard’ meant that prisoners could arrive after six or seven days in police cells and go to court not knowing whether they would be able to return.

Once in a prison, initial **reception, first night and induction** processes are crucial. Those processes should provide opportunities for concerns to be expressed and dealt with, risks to be assessed, and essential information, family contacts, and hygiene requirements provided.

The Inspectorate has seen improvements in many prisons, with a much more integrated approach. Lewes, for example, had excellent first night and induction procedures, which led to nearly twice as many prisoners saying that they felt safe and confident on arrival. But in others, significant elements were missing: risk assessments not completed, or completed badly; no effective first night provision with new prisoners being placed anywhere there was space; staff who were redeployed or untrained; induction programmes that failed to reach all prisoners or were cancelled or truncated. The physical environment is also important: in Liverpool, for example, it was unacceptable that prisoners on their first night were held in dirty, poorly maintained and unhygienic conditions, which we described as among the worst we have seen.

‘All new receptions MUST be given the first night interview upon arrival in the first night centre. There are no exceptions to this rule. If a problem occurs DON’T just write it down and forget it, make sure you deal with it and rectify it.’

Instructions to first night and induction staff at Lewes

‘Night staff are available for emergencies only... chances are, once you are in your cell and the door is locked, you will not see anyone until the next morning. Your cellmate can answer many of your questions and help you get settled in.’

Extract from Wandsworth’s first night leaflet for prisoners

Effective **drug detoxification** is a crucial part of safety in the early days, with 80% of prisoners in some prisons arriving with substance misuse problems.

Detoxification is still inexcusably patchy: in too many prisons we report that even the basics of the relevant Prison Service Order are not being complied with; in too few prisons are there dedicated detoxification units that can effectively monitor and support the process. Birmingham, for example, was providing only a cursory short-term programme of dihydrocodeine; staff highlighted the relationship between self-harm and poorly managed detoxification.

Safer custody is also, however, the product of a **safer environment**: where there is integration between procedures on suicide and self-harm, the prevention of bullying, and support for those with mental health needs. Again, we can record some progress across the prison estate. All prisons monitor those perceived to be at risk of self-harm: though some do it more perfunctorily than others, not all take proactive steps to prevent self-harm, and it is rare to find developed support plans. Nearly all prisons have Listener schemes, and some have specific 'meet and greet' arrangements where prisoners can assist new arrivals. There are more mental health in-reach teams (see *healthcare* section).

Overall, though, local prisons are struggling to meet the extensive needs of those who arrive in increasing numbers. Good processes and systems, and awareness of risks and dangers are essential: but they cannot be expected to compensate for the effect of lengthy periods of incarceration in overcrowded cells on people who already have significant drug and mental health problems.

Activity is important, both as a means of preventing self-harm and so that prisoners can acquire the skills and work patterns that they need. Yet very few local prisons, even otherwise good ones, manage to provide **purposeful activity** of sufficient quantity or quality. It is clear that one of the consequences of overcrowding is that prisons struggle (and some fail) even to provide humane containment; ensuring positive activity for the majority of the population is largely beyond them.

'the lack of activity for most prisoners was a cause for great concern'
(Wandsworth)

'woefully inadequate' (Birmingham)

'activity was not seen as a priority at the prison' (Bullingdon)

'a prison with insufficient activity places for its population and that was regularly failing to fill those it had' (Norwich)

'too little activity for too many prisoners ... significant numbers were spending too long in their cells, often in their beds' (Doncaster)

'fewer than half the prisoners were engaged in meaningful work or education' (Forest Bank)

'95% of prisoners were at or below level one basic skills; only 18% of prisoners had access to part-time education' (Liverpool)

All local prisons are trying to grapple with the **resettlement** agenda. Their predominantly short-term population is the one least well served by traditional methods of pre- and post-release supervision. Some local prisons are seeking to fill that gap, but few can do so, as they struggle with an increasingly transient population. Many prisoners are unable to serve their sentences near their home area. Lewes, for example, was seeking to provide resettlement opportunities for

“Local prisons are struggling to meet the extensive needs of those who arrive in increasing numbers.”

its local population, only to find that they were regularly moved out to Parkhurst.

There are three key elements to resettlement in a local prison: it should start immediately on arrival, it should be based on prisoner needs and should be part of an integrated strategy. This is rare, though there were some good examples. Some prisons do good work at the beginning of sentence (such as Birmingham); others (such as Parc) target prisoners immediately pre-release: but it is rare to find continuity and consistency throughout sentence.

Some prisons do not even know the make-up of their population: Norwich was surprised to learn from the Inspectorate that most of its prisoners were not from East Anglia. Others, like Doncaster, were buying in services from outside, predominantly the voluntary sector, without any strategic direction or analysis of the needs of the population.



Training prisons

This year, we reported on 19 closed male training prisons. During the reporting period, the consequences of overcrowding have become significant even in this part of the prison estate. All training prisons are receiving prisoners earlier in sentence, often for shorter periods, and sometimes unsuitable for the environment or opportunities on offer.

Proper reception, induction and safer custody procedures have become essential with the arrival of recently sentenced prisoners. Some establishments had inadequate facilities or resources for this.

- 12 training prisons had defects in their reception arrangements: either in layout, supervision, information provision or privacy
- 5 had no access to telephones in reception
- 6 had no first night procedures
- 7 needed more staff awareness and training in suicide and self-harm
- 10 had no group or individual work to challenge bullies or support victims

A number of category C prisons have **low security units** where prisoners are locked in together at night, and locked off from staff. Ranby had two such wings: on one there had been disturbances or incidents at least once a week, and in the other, there had been incidents of self-harm. More of these units are being built at speed in the category C estate because of population pressure. These units present considerable safety and security risks, particularly with a more volatile and frustrated population.

The fragility of some parts of the category C estate was evident during the inspection of Lindholme. One wing had a 'fundamentally unsafe physical layout' where intimidation and bullying were rife, and where during the inspection prisoners destroyed a whole spur.

Population pressure at Kingston, the only prison to have a specialised unit for **elderly** life sentenced prisoners, was part of the reason for the 'unacceptable and degrading' physical conditions we found there. Prison Service managers, alerted to this, have since taken steps to improve matters.

'Some elderly prisoners were held in cubicles divided by wooden partitions. Movement was severely restricted, there was little privacy or natural light, poor ventilation and sometimes no power points.' (*Kingston*)

The core work of training prisons – **education, training and treatment** – was also compromised by population pressure. Channings Wood, for example, was sent prisoners unsuitable for the specialist therapeutic and programme work, who were then difficult to move elsewhere, compromising both the programmes and their own progress. The same was true for Lindholme's specialist voluntary drug treatment wing. At Highpoint South, the average length of stay per prisoner at the time of the inspection was six weeks. Erlestoke, which had always prided itself on full employment, now had 10% of prisoners unemployed and, although it would be receiving more resources, would also be receiving even more prisoners. Most training prisons were finding that they had to initiate sentence planning virtually from scratch, as little work had been done in locals.

Only five training prisons had what we considered to be sufficient **work and activity** for all prisoners; and in some prisons a high percentage were cleaners or orderlies. Indeed, we describe some training prisons as 'training prisons in name only'. This was true of the two prisons that had previously been higher security establishments and seemed not to have adapted to their new role. In Parkhurst, we found 348 of the 521 prisoners locked up; Dartmoor had spaces for only half its prisoners. It was also true of Highpoint South, which provided meaningful work for only around half of its prisoners. Other prisons were significantly short of activity spaces: Moorland by 14%, Ranby by 25%. At some prisons, unemployed prisoners spent far too much time in their cells: all

“ At Highpoint South training prison, the average length of stay per prisoner was six weeks. ”



but four hours in Dartmoor and Highpoint South, most of the time at Swaleside.

Nine 'training' prisons in fact offered little or no nationally accredited training. The Verne, for example, trained only 11% of its prisoners, though a further 53% were in work that could have been accredited. Four prisons had weak links between education and workshop training, though at others there was a welcome increase in delivering key skills in work settings, where prisoners who have avoided formal education may be more willing to learn.

However, some training prisons showed what could be done to improve the life and work chances of prisoners.

- 'A policy-driven link had been established between prisoner employment, qualifications, future work and resettlement; a thorough prisoner needs analysis was available to inform local strategies' (*Stocken*)
- 'one of the few training prisons that has excellent training workshops, geared specifically to prisoners' employability' (*Usk*)
- 'every prisoner had accommodation on discharge; 25% had been helped into rehabilitation units and 25% into employment' (*Blundeston*)
- 'a good range of employment and training opportunities was available; work allocation was linked into resettlement initiatives' (*Lindholme*)

Many training prisons had very good staff-prisoner relationships: The Verne, Erlestoke and Stocken were examples. Relationships and regimes were worst in training prisons that had a self-image as 'hard' places dealing with serious offenders: Parkhurst, Dartmoor and Swaleside. They had some way to

travel to develop the culture and opportunities necessary to provide a training, rather than a containment, environment. Ten training prisons had no effective personal officer schemes, to ensure that residential staff engaged with prisoners to motivate them through sentence.

'Overcrowding, an impoverished regime, and poor procedures combined to produce an environment where the safety of prisoners and staff could not be guaranteed. Around half the prisoners were locked up. Sentence planning had virtually been abandoned for six months.' (Parkhurst)



Open/resettlement prisons

During the reporting year, we published reports on one open prison, and follow-up inspections into three others and a resettlement prison. Open prisons play an important role as a bridge between custody and the community, but they too are now receiving different kinds of prisoners for shorter periods.

Population pressure has meant that open prisons are receiving prisoners who would not formerly have been sent to **open conditions** at that point in sentence. Some arrive without even sentence plans, let alone work to address offending behaviour. Some also arrive barely detoxified. By definition, open prisons are poorly placed to control the supply of drugs to those still dependent on them; nor do they have the resources to offer treatment. In addition, more prisoners are unsuitable for some of the opportunities open prisons offer: in particular, work outside the prison. At North Sea Camp, some prisoners were arriving with only a week of their sentence to serve. Nearly half of Ford's community workspaces were unfilled.

“ **Some prisoners were arriving at North Sea Camp with only a week to serve; nearly half of Ford’s community workspaces were unfilled.** ”

Finally, overcrowding has led to deterioration in the already unsatisfactory **physical environment** of some open prisons, many of which are ex-army camps. At Ford, for example, we found storerooms and waiting rooms pressed into service in conditions that we described as ‘appalling, providing neither privacy nor dignity’.

However, open prisons themselves need to take a much more **proactive approach** to their prisoners and their role. They have tended to rely upon having ‘easy’ prisoners, who can manage themselves, and whose resettlement is largely managed through providing employment outside the prison. Three out of the five prisons had no personal officer scheme worthy of the name: this may be excusable in a hard-pressed local prison, but not in an open prison. It reduces effective engagement with prisoners, as well as the opportunities to spot and challenge bullying.

Those prisons also provided few useful **qualifications**: too many prisoners were either in menial cleaning jobs, or jobs that provided income for the prison, rather than skills for prisoners. In spite of the reliance on outside work, Standford Hill had only one prisoner working out, and Ford could not fill its out-work places. Prescoed and Blantyre House were the only prisons taking seriously the need to engage with prisoners and provide them with active help to acquire skills and achieve successful resettlement.

‘Opportunities to gain vocational qualifications were few; work within the prison related more to income targets for the prison than future employment prospects for prisoners; only 18 of the 50 community out-work places were taken up.’ (Ford)

‘In some workshops, there was substantial evidence of quality training, which led to the acquisition of transferable skills to equip prisoners for work. An innovative resettlement scheme was being drawn up.’ (Prescoed)

Blantyre House was the only **resettlement** prison inspected; but some training prisons, such as Dartmoor, had excellent resettlement units. A common problem for such units and prisons is the restriction on prisoners working outside the prison during their first six months. Resettlement environments provide an excellent opportunity for managing the transition between custody and the outside world. A blanket restriction, without individual risk assessment, deprives suitable prisoners of that chance for too long; and this should be reviewed.

‘Prisoners’ educational needs had not been assessed. Too much of the work that was available would not help prisoners into employment. Astonishingly for an open prison, only one prisoner was working out in the community. Sentence plans were described as “abysmal”.’ (Standford Hill)

‘We commend the sentence planning process, the links into employment, the levels of trust between staff and prisoners and the wide and successful use of release on temporary licence.’ (Blantyre House)

Dispersal prisons

This year, we published reports on three of the five high security dispersal prisons, which hold some of the most serious and dangerous offenders in the prison system.

Some high security prisons have in the past been sites of considerable unrest. This was not the case in any establishment we inspected. Maintaining a safe and ordered environment, given the nature of the population, is itself a considerable achievement. However, Full Sutton was doing little more than that: we were concerned at the distance between staff and prisoners: staff appeared disengaged and prisoners were disenchanted. By contrast, Frankland and Whitemoor had developed appropriate relationships, with proper boundaries, so that staff could engage with and seek to motivate prisoners, the great majority of whom will be released at some point.

'In most parts of the prison, the gap between staff and prisoners was very evident. There was a culture of non-engagement on both sides. Most staff did not interact with prisoners, but rather observed them.' (Full Sutton)

'It was a largely safe environment, based upon good relationships between staff and prisoners, with appropriate levels of interaction and good staff understanding of prisoners and their needs.' (Frankland)

“ All recent suicides in dispersal prisons have been in segregation units. ”



Two themes emerged from inspection reports. One was the increasing number of prisoners who remain within the **segregation units** in high security prisons, on a 'merry-go-round' between one unit and another. These prisoners are often

mentally ill and may be dangerous, but they are often also in need of specialist healthcare and at serious risk of suicide or self-harm. All recent suicides in dispersal prisons have taken place in segregation units. The balance between care and control in relation to such prisoners is difficult, but in Full Sutton and Frankland it had swung too much in the direction of control. In the latter, only 23% of staff had been trained in suicide and self-harm prevention. There was little positive engagement with prisoners to encourage their reintegration into a normal regime, and insufficient mental health support in general.

The second theme, common to all three, was the need to develop an effective **resettlement** strategy for the increasing, though small, number of prisoners released directly from high security conditions into the community. This is running at around one a week in most dispersal prisons. The release of prisoners from high security conditions directly into the community raises some concerns. Public protection measures in relation to those prisoners were well developed. However, there was little preparation and assistance towards their practical reintegration needs, which will be particularly acute given the length of time they have spent in prison and the secure conditions in which they have been held. We recommended that each prison should either develop its own resettlement strategy, incorporating assistance with housing, employment and reintegration, or should move prisoners before release to a 'core local' high secure prison that has a well-developed resettlement strategy.

Some dispersal prisons fail to provide sufficient purposeful activity, in spite of their relatively stable population and considerable resources. Both Frankland and Whitemoor were criticised for short working days, and for providing too few skills qualifications. Full Sutton, however, had greatly increased its education provision over the previous year.

Finally, increasing sentence lengths mean that a greater proportion of those held in dispersal prisons are **elderly**. We did not find that these prisons had well-developed strategies to deal with the accommodation, healthcare and activity needs of an ageing and sometimes infirm population; and they will need to do so before new disability legislation comes into force.

“ There should be a strategy to deal with the healthcare, accommodation and activity needs of an ageing population. ”

Women

We published reports on eight women's prisons this year, representing all the different kinds of establishments for women, except for those few held in high security conditions. All the problems of overcrowding in prisons as a whole can be seen sometimes in a concentrated form in the women's estate.

The women's estate has been under considerable pressure this year. Attempts have been made to develop consistency and share good practice, but this has not so far resulted in visible benefits to prisoner care, as the women's estate struggles to meet the needs of an expanded, changing, and increasingly needy population.

Women in prison are at ever greater risk of **suicide and self-harm**. There were 14 self-inflicted deaths this year, and six of them occurred within the first eight days in prison (see *safer custody* section). This places local prisons, which receive women directly from the courts, in the front line. The key elements they need to have in place are effective strategies on self-harm and bullying, effective detoxification, proper mental health support and a sufficiently active regime. None of the three local prisons that we reported on this year met all these requirements; though between them they showed that it is possible to have effective practice in all these areas.

At Brockhill, many women were at risk of suicide and self-harm, partly because there was no inpatient healthcare provision to support the large proportion of women with mental disorders and histories of substance misuse. Yet it had particularly inadequate self-harm and anti-bullying procedures; no manager was responsible for them and there was no anti-bullying strategy. Nor did it have sufficient activity to occupy distressed or depressed women, with less than 20 hours activity per prisoner per week, little educational provision for over-18s and no vocational courses.

Proper **detoxification** is a key part of safer custody. Holloway had extremely good detoxification, which we say should be a model of good practice. But sadly it is not a model that is followed elsewhere. In our inspection of Styal, we found that inadequate detoxification severely affected women's physical and mental health and future chances. We noted that the Governor's two bids for additional resources for detoxification had been rejected. Our report was unequivocal: 'Our strongest recommendation is that drug detoxification programmes should be introduced immediately'. It is inexcusable, that, 18 months after our inspection, this was still not the case and, in the interim, six women drug users had died there within a month of admission.

'The standards and protocols of the detoxification unit were equivalent to those of best practice in the community. Despite the pressure of numbers and the complex needs of the women, they were providing a model of good practice that should be followed across the prison estate.' (*Holloway*)

'Styal had no proper detoxification unit. We describe women, in their early days there, fitting and vomiting in their cells, with staff unable to do more than observe and try to alleviate their distress. This had profound and damaging effects, both on women's safety and on their chance of effective education and training.'

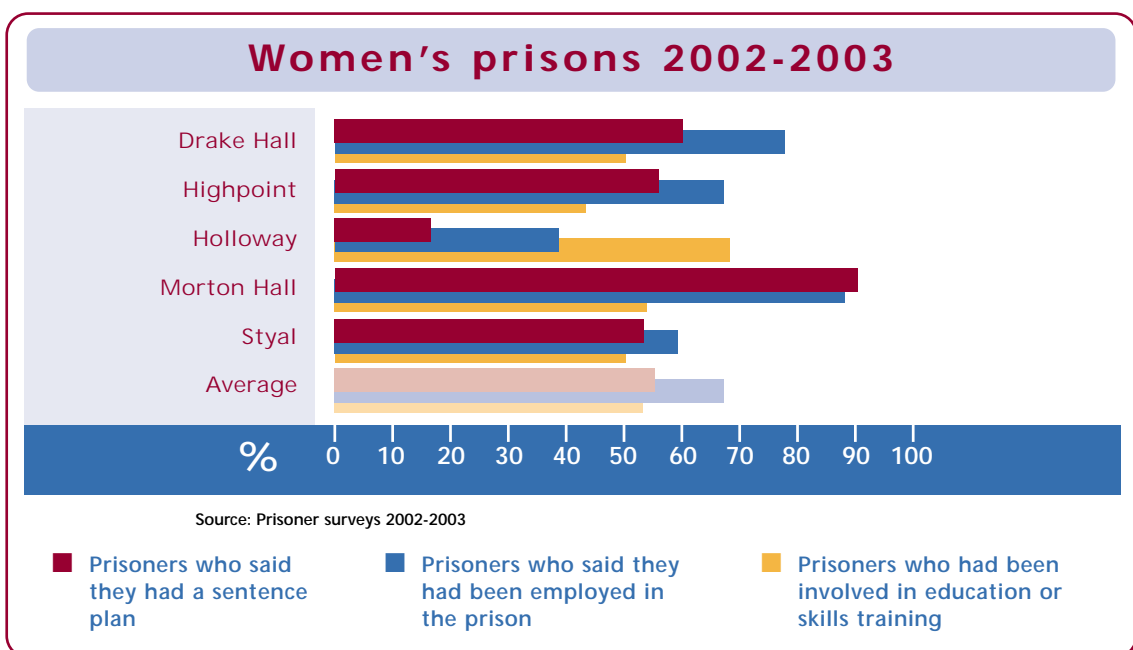
Detoxification is also, however, becoming a problem for other prisons that have not previously had to deal with it. Training prisons like Drake Hall, Morton Hall and Highpoint North were all receiving recently sentenced women who had not properly completed detoxification and were in need of more support than the prison could provide. Nor were they providing adequate reception and induction facilities or procedures for recently sentenced women; and some staff did not recognise the particular vulnerabilities of some of the women they were now receiving.

“ One of the effects of overcrowding is that many women's prisons have constantly had to change their roles. ”

The **regime and facilities** available to women are also important factors in a safe and respectful environment. Holloway continued to lag unacceptably behind the standards that we expect. Women were unable to shower or have association more than twice a week. Personal hygiene and contact with families both suffered. By contrast Styal, with extremely good staff-prisoner relationships, had levels of association that were among the highest we have seen. Staffing difficulties undoubtedly exacerbated Holloway's problems: but they also reflected a lack of flexibility and imagination among staff and middle managers; it was disappointing that so little had changed since our last inspection.

Lack of association in prisons has particular consequences for women prisoners, many of whom have primary care and family responsibilities. Staff and managers see it as loss of recreation time: but it also has a significant effect on family contact, because of reduced access to telephones. This was particularly the case at Brockhill, Highpoint North and Holloway.

One of the effects of overcrowding is the **instability** caused when many of the relatively few women's prisons constantly have to change their roles.





Highpoint North became a local prison the week before our inspection. Drake Hall and Morton Hall had become 'semi-open' prisons, a designation that was not clear either to managers or prisoners. An allocation strategy was beginning to be developed, but was difficult to sustain in such a small, and increasingly pressured, estate. Send, however, had managed to remain relatively stable: as a result, we were able to commend it as a 'fundamentally healthy prison, where both staff and women prisoners felt safe and respected'. Nearly all the women were engaged in activity, 30 of them working in the community.

Other training prisons did not match this level of **activity**. Askham Grange's education and resettlement had noticeably declined since the last inspection, due to budget cuts. At Highpoint North, staffing shortages and overcrowding drafts were undermining both activities and resettlement. Drake Hall, with fewer women able to work outside the prison, did not have enough work and education spaces inside. Morton Hall had a high level of participation, but few qualifications on offer.

The **physical design** of prisons did not necessarily suit the new roles they were playing. We had serious concerns about the ability to guarantee safety in the units at Drake Hall and Highpoint North: in the latter there was significant evidence of bullying in units where women were locked in together, without easy staff access, during the night. Styal, too, which had changed its role some time ago from a training prison to a local, had not properly addressed issues of bullying in its low supervision house units.

Mental health is another key issue in the women's estate, where there is high incidence of mental disturbance. Holloway's day centre was a model of good practice, but its provision for women with acute mental illness was less so; Styal by contrast had an excellent acute psychiatric unit, but no provision for women with less serious mental health problems. As with detoxification, training prisons were receiving women with problems that they were not equipped to manage: some of whom were returned to sending prisons almost immediately, which can hardly have assisted their mental health.

The rise in **foreign national prisoners** (see *foreign nationals* section) is particularly noticeable in the women's estate, which contains a high proportion of women convicted of drug smuggling, most of them small and unsophisticated cogs in a very large machine. One in four of women prisoners are now foreign nationals, and the consequences for such a small estate are even greater than for prisons as whole.

There was a distinct contrast between the two women's local prisons inspected. Styal had an experienced liaison officer, with good links with other prisons, voluntary groups and the Immigration Service. By contrast, at Holloway, where one in four women were foreign nationals, systems and procedures had withered, and the establishment was essentially relying on the good work of voluntary organisations.

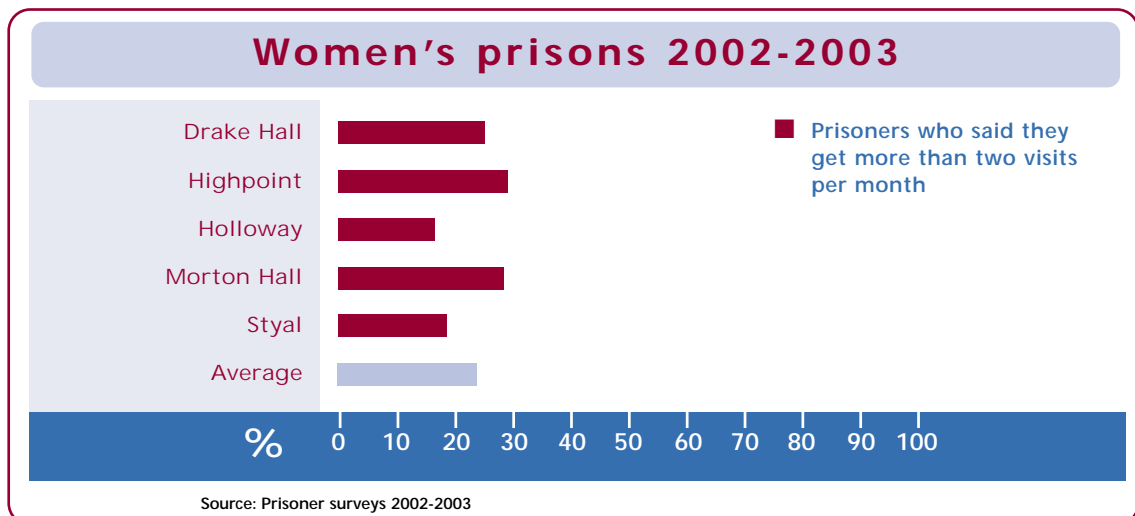
Among training prisons, Drake Hall and Morton Hall (with a third and over a half of foreign national prisoners respectively) had appointed active foreign national liaison officers, though there was much to do, and insufficient evidence of overall staff or senior management support. Morton Hall, however, had excellent relationships with the immigration authorities and with Hibiscus, the voluntary organisation, which has continued to provide good and much-needed support to this vulnerable group of women.

'At the time of the inspection, 63% of prisoners were foreign nationals. They came from 23 different countries and, according to our survey, 13% did not have English as their first language.' (Morton Hall)

“ Both Holloway and Styal lost their family visits provision during the year. ”

The provision for visits was very varied. Women's prisons hold a high proportion of primary carers, but there was evidence of a decline in visit arrangements. Highpoint North was a model of good practice, as it had a full-time social work qualified family support worker, who assisted in contact with children under social work or court supervision, played a key role in child protection and managed family visits; but there was no visitors' centre. Holloway, however, had an excellent visitors' centre, but no provision for family visits. Styal had family visits at the time of the inspection but, like Holloway, these later ceased due to staffing pressures.

One impressive factor in the women's estate was the consistently good **chaplancy** provision. Chaplains had responded to the mixed nature of the



population by providing access to a wide range of religious traditions and observances; they also frequently provided valuable input into diversity issues, prisoner and staff welfare and links with communities.

Finally, we urged the operational manager last year to exert pressure to end the demeaning and patronising practice of staff referring to adult women as 'girls'. Nevertheless, this continues to be endemic in all the prisons inspected and there is still no consistency in the way women are addressed or referred to in written documents. This practice should be addressed and eliminated.

The situation of those who are in fact **girls** (those between 15 and 18) continues to cause us great concern. In spite of repeated assurances, they are still held in prisons, though numbers have reduced. Those who are unsentenced will be held in adult prisons, without age appropriate care or activity and in some cases without appropriate vulnerability assessments. Holloway was the most extreme example: of such concern that I immediately wrote to the Director General and the Chairman of the Youth Justice Board urging immediate action. A return visit, six months later, however, found that vulnerable children were still being held there: one sharing accommodation in the healthcare centre with extremely disturbed adult women.

There has been a move to concentrate sentenced girls in prisons with qualified staff and separate regimes. This has been evident during the year and has clearly led to improvements in some establishments. Around 80 girls were held at Bullwood Hall and New Hall, which had developed education, community partnerships, and case conferences; Brockhill had also improved, though it did not have enough education provision to provide an acceptable curriculum for the 15 girls there. However, all were suffering in some degree from 'planning blight': unsure whether these skills and facilities would be needed in the near future. In all those establishments, too, this increased provision was at the expense of young adult women, whose needs, though they were just as great, were often unmet.

Young adults

This year, we published reports on seven young offender institutions holding 18–21 year olds; of those, three were 'split sites', also holding juveniles. In addition, seven of the local prisons we inspected were designated as YOIs and held convicted young adults. It is disappointing to report that there continues to be no coherent national strategy, standards or new funding for this important group of young prisoners.

All the YOIs that we inspected suffered from a **lack of resources** for crucial work and education. At every YOI inspected, we called for more resources, and better co-ordination of those that there were.

This was most apparent in the three split sites, by contrast with the resources and the throughcare available for under-18s. At Feltham, the disparities between young adults and juveniles were apparent. However, it was

evident at Onley and Thorn Cross that managers were trying to find resources and use them flexibly and creatively to narrow the gap. This often involved providing part-time education and work for young adults, to maximise participation; or drawing in Custody to Work funding. It could not, however, disguise the fact that both the quantity and quality of opportunity for young adults was deficient: only 42% of young prisoners at Onley were engaged in accredited training or education, while a large number were engaged in menial work on the wings.

'In reception, physical conditions and staffing levels were significantly worse for young adults than for juveniles. So was the induction programme. Only 42% of young adults were in accredited training or education.' (Onley)

'The bulk of the population of young adults had noticeably less of everything – education, training and resettlement.' (Thorn Cross)

In most establishments, young prisoners spent far too much time in their cells. This was directly related to the availability of **work and education** spaces. At any one time, 30% of prisoners in Glen Parva and 50% at Aylesbury could be in their cells. Those not in employment at Aylesbury could be locked in their cells for all but one and a half hours a day, if association was cancelled, which it often was. However, for a few prisoners, Aylesbury also provided extremely high quality training in motor mechanics, in partnership with Toyota, which led directly to employment – showing what can be done.

'Toyota had invested substantial sums in the motor mechanics workshop, where young prisoners worked on the latest vehicles, with high quality training materials. The manufacturer quality assured the programme and provided employment opportunities for young prisoners on release... Overall, there were insufficient work and education places for young prisoners, half of whom were unoccupied at any one time.' (Aylesbury)

'a central co-ordinator procured work placements and then used mentors to match the home areas where young people were returning to on release.' (Thorn Cross High Intensity Training Scheme)

Those establishments that offered the most activity were also those with the best **staff-prisoner relationships**. Northallerton had a 'relaxed atmosphere with easy rapport between staff and prisoners; young prisoners generally praised the prison and its staff and compared it favourably to other establishments'. Swinfen Hall was described as an establishment 'founded on a commitment to fundamental values of decency and care', with good processes and good relationships. At Glen Parva and Aylesbury, by contrast, there was little positive interaction between staff and young people: staff at the former were most likely to be found in their offices.

All establishments had focused on **anti-bullying** and **suicide and self-harm** awareness. Some had high levels of staff training and awareness, and innovative schemes. Others were still putting these into place. Feltham had made

noticeable progress: though it should not rely on the initial improvements achieved through the provision of in-cell television, which reduced the obvious intimidation of shouting through windows. In others, such as Onley and Thorn Cross, more work on anti-bullying was needed.

Only two establishments, Swinfen Hall and Thorn Cross, managed both to complete sentence plans and integrate them into young prisoners' experience. It was significant that they were also the only YOIs to have effective **personal officer** schemes.

Disappointingly, nearly all YOIs were deficient in **resettlement** planning, in spite of the fact that support and aftercare is critical to a population with a 76% reoffending rate. This was particularly depressing at Thorn Cross: it had previously done excellent resettlement work, but this had effectively stopped because of the ending of the European funding that had sustained it. The exception was the High Intensity Training scheme, for a small number of young adults, which provided focused activities within prison and help with employment and mentoring after release. It is an exception that proves the rule – that overall, for young adults, there is nothing that compares with the joined-up, centrally funded training and resettlement for under-18s.

Seven **local prisons** inspected were also designated as YOIs and held convicted, as well as remanded, young offenders. In most of those prisons, we could distinguish little difference between the treatment of young prisoners and adults. Young prisoners tended to experience the same advantages or disadvantages as adults: long periods of lock-up in cell at Woodhill, insufficient activity or education at Norwich, Chelmsford and Doncaster, plenty of time out of cell at Forest Bank. Young prisoners may serve their entire sentence in these local prisons; and they are at present poorly catered for in prisons that are themselves under great pressure.

“ For young adults, there is nothing that compares with the joined-up, centrally funded training and resettlement for under-18s. ”



Juveniles

This Inspectorate visits every establishment holding under-18s every year, either for an announced or a short education inspection. This year, we produced reports on full inspections of seven such establishments, three of them on split sites; as well as eight education inspections.

The picture in relation to under-18s in prison service custody is mixed, and fast moving. The judgment in the *Howard League* case has galvanised the Prison Service and Youth Justice Board into looking at the extent to which provision in juvenile establishments is compatible with the principles of the **Children Act**. It is, however, unarguable that conditions for children in Prison Service custody are not equivalent to those in other secure settings, and they will not be until there is an equivalence of resources.

Our inspection reports were cited at length in the *Howard League* case. The court was particularly concerned about those establishments where we considered that children could be at risk of significant harm. Ashfield, Onley, Feltham and Huntercombe were all mentioned. It is welcome that this year's reports on Onley and Feltham have shown considerable improvement, though a great deal of work is still to be done. These changes are both a measure of the effectiveness of our inspection process, and evidence of the need for continued monitoring. Reports published during the year on Huntercombe and Ashfield raised serious concerns about the safety of children there; and further inspections have been carried out into both establishments since.

One of the consequences of the judgment will be the need for establishments to ensure that they have proper **child protection** procedures in place, including closer links with area child protection committees, and those committees will need to take seriously the needs of children in prison establishments in their areas. This has not by any means always been the case; as was highlighted in the joint inspectorates' report on children's safeguards to which we contributed, and which expressed particular concern about the protection of children held by the Prison Service.

Child protection arrangements in juvenile establishments remain patchy. We described them as 'ground-breaking' at Huntercombe, but in decline at Werrington, where they had previously been exemplary. At Ashfield, they were rudimentary, and there was an urgent need for staff guidance and training. In other establishments, child protection was associated only with the actions of staff; and not with the need to protect children from one another, or deal appropriately with disclosures of historic abuse.

Some common themes run through our reports. The first is the inadequacy of **escort arrangements** for children and young people, who usually face long journeys. We found evidence of excessive journey times and lengthy waiting periods in court. At Feltham, we analysed 67 prisoner escort records: this revealed that over half the young people had waited over six hours, in court cells or vans, between the conclusion of their court case and their arrival in

Feltham, and one in 10 had spent over four hours in escort vans. As a result, many arrived late: sometimes as late as 9pm. Werrington staff reported the same problems: one boy had finished in court at 11am but not arrived at the establishment until 7pm.

'Reception staff provided vivid accounts of how ill and washed out with fatigue some young people had been, after long escort journeys. They quoted one instance where a boy had collapsed on the floor due to lack of food.' (Werrington)

This is unacceptable. So, too, is the failure to provide sufficient comfort breaks during those journeys: to the extent that young people are reduced to urinating in property bags. We had evidence of this at five of the seven establishments subject to full inspections. At Onley, this degrading treatment was amplified by the fact that the contractors required the young people to clean the vans before leaving them.

Second, there are a number of areas where **Prison Service Orders**, drawn up for adults, are simply inappropriate for children and do not reflect child protection principles. Routine strip-searching, and the use of force if this is resisted, can be extremely damaging for children, particularly those who have suffered abuse in the past. It is our view that strip-searching should be done only after risk assessment, and force used only as a last resort, when all other methods have failed. The use of force in general needs to be consistently recorded and carefully monitored.

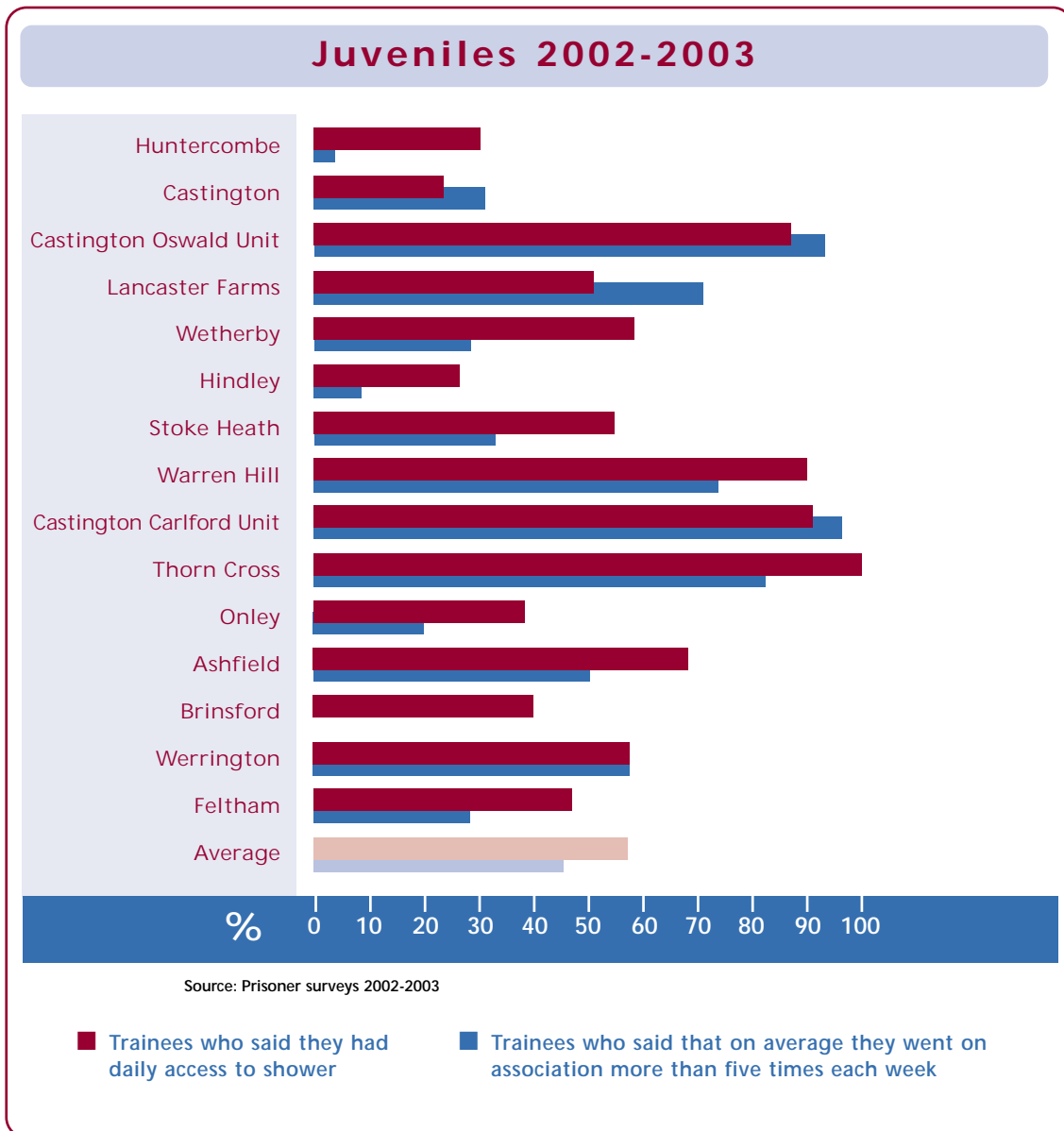
We are also concerned about the use of segregation, or **removal from unit**, for days or weeks, often in impoverished regimes: for example at Warren Hill, 29% of young people said that they had been in the segregation unit, some for several weeks. Adult adjudication procedures are also inappropriate for children; and we welcome the fact that some establishments are developing more informal and less threatening processes, and that the Youth Justice Board is piloting an advocacy scheme for children and young people.

Third, we believe that the **size of establishments**, and the units within them, need to be reduced. This was a key factor in the dysfunctionality of Huntercombe and Ashfield. It has implications for the safety of young people and staff; and it also inhibits the positive socialising work that should be carried out among young people – for example, by eating out of cell – and between young people and staff. Regimes in some larger establishments were unacceptably poor, with fewer than a quarter of young people having association five or more times a week. By contrast, the small units at Carlford (Warren Hill), Oswald (Castington) and Thorn Cross were providing excellent regimes and opportunities.

There has been additional funding for education, but in general this has not trickled down into the residential areas, where children spend 70% of their waking time. Too many juvenile establishments still had no effective **personal officer** scheme, or regimes that reinforce, rather than undermine, the education and training work done elsewhere. Huntercombe's excellent caseworkers and specialists were quite separate from residential staff, who felt disenfranchised.

“ At five of the seven establishments inspected, we found evidence that young people had to urinate into property bags during escort journeys. ”

“ There are a number of areas where Prison Service orders, drawn up for adults, are inappropriate for children and do not reflect child protection principles. ”



Similarly, at Brinsford and Wetherby there was resentment and little evidence of joint working or consistent approach to behaviour between education and residential staff. By contrast, 86% of young people at Warren Hill had personal officers, and 78% of personal officers at Werrington were attending training plan meetings. The role of personal officer is key to the overall development of children in custody, and should be reinforced.

'There was a full programme of evening activities. Staff from the unit involved themselves in games such as table tennis and pool. They also arranged competitions and some informal organised activity such as bingo and karaoke.' (Thorn Cross)

'We were disappointed with the limited range and quality of activities for young people. They felt strongly that evening association was boring and did not know how to occupy themselves. Staff should examine good practice elsewhere and replicate what is relevant.' (Warren Hill)

Our education inspections, jointly with Ofsted, provide an annual check on **education** provision throughout the juvenile estate. This year has certainly seen improvements, as a consequence of the significant additional funding that has been provided – an additional £40 million – though the cost per child, at £60 per week, is still significantly less than in other secure settings. Within establishments, learning support assistants, special educational needs co-ordinators and heads of learning and skills have been appointed; though the recruitment and retention of appropriately qualified teachers remains a problem: in one establishment 44% of the teaching was unsatisfactory or poor. Centrally, the Offenders’ Learning and Skills Unit at the DfES has appointed two specialist advisers.

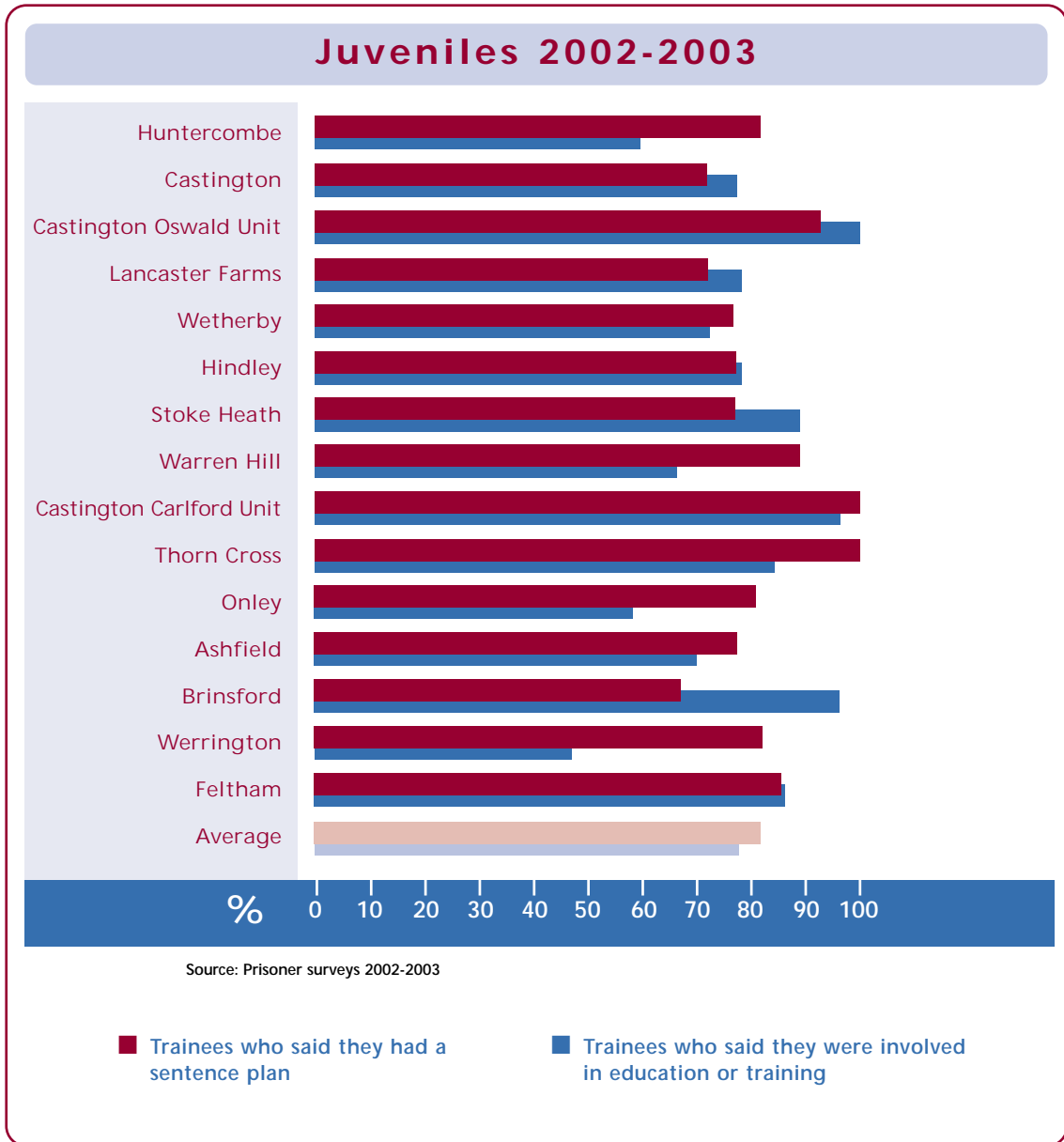
However, education contracts were still in many cases out of kilter with the increasingly demanding requirements of the Youth Justice Board. No juvenile establishment had yet succeeded in meeting the new YJB target of 30 hours per week education and training; though the majority reported that they were now able to reach the previous target of 15 hours. Nevertheless, we would treat these figures with some scepticism: in most establishments that we inspect, there is significant slippage, with late arrivals to and early departures from class. Levels of accreditation remain low, partly because of short stays and poor attendance. Some establishments also had shortages of space: one establishment had space for only 20% of students at any one time. At Warren Hill, there had been no additional capital investment, in spite of the fact that this was fundamental to being able to meet the YJB specification: we therefore reported a major deficit in purposeful activity.

There is still a sense that the excellent intentions of the YJB, to put training and education at the heart of sentence, are being frustrated by unco-ordinated planning, both of resources and personnel; and that there is insufficient recognition of the operational and resource barriers that prison managers face. It is to be hoped that the new YJB structure, with regional managers, is better able to co-ordinate requirements and provision. It is also important that the priorities and requirements of the YJB and the OLSU reinforce each other, rather than collide.

Nevertheless, the position in relation to training plans and education and training is improving. Our surveys this year show that in many establishments 80% of trainees said that they had training plans, and were involved in education and training. It is noticeable, though, that the most consistently high rates of participation are in the smallest units: the specialist Carlford and Oswald units at Warren Hill and Castington, and the small unit at Thorn Cross: whether this is in access to association, or to education and training.

Training planning should be at the heart of the custodial experience of children. We have chronicled some improvements in this area over the year and most establishments work hard to secure the attendance of families and youth offending team (YOT) workers. This is, of course, made much more difficult by the dispersal of children to establishments far away from home, due to overcrowding. Though this has receded somewhat, with the welcome decline in the number of children in prison, at its height it led to Feltham children being displaced to Castington, in Northumberland; and Werrington needed to maintain links with 32 YOTs. We saw excellent partnerships with YOTs at Huntercombe, Feltham and

“It is noticeable that the most consistently high rates of participation in association, education and training are in small units.”



Werrington, despite some of the distances involved; as well as greatly improved planning meetings. However, the attendance of all the relevant staff – including education and personal officers – remains a rarity; and those chairing meetings need training and support.

Immigration removal centres

We published six inspection reports on immigration removal centres, four run by private contractors and two by the Prison Service. We have now received funding for this important task, and so will be able to institute a regular cycle of inspecting, with reports published in our usual four-month timeframe.

As in prison inspections, the reports were informed by seeking the views of **detainees** themselves, through surveys and focus groups. A questionnaire was translated into 26 languages. For many detainees, this was the first time they had been able directly to express their views to any official body. We tested those views against our own observations, centre records, and the views of staff. We applied our usual four tests of a healthy establishment: that detainees were safe, treated with respect, able to engage in constructive activity and prepared for release or removal.

Common themes emerged. Feelings of **insecurity** were widespread among detainees, sometimes despite a conscientious level of custodial care that included positive relationships with staff. This was attributed to the circumstances of detention that often occurred without notice or explanation, the uncertainty about length of stay and the ultimate outcome, and the difficulty detainees had in obtaining information about the progress of their cases. Competent legal advice and representation was scarce and communications were made difficult by language barriers, the lack of funds to use phones and the absence of email.

'How can anyone feel safe when there are bars on the windows ... I often get palpitations, my hands shake and I cry endlessly... I need to let someone know I am here ... No one is looking after my family.'
(Dungavel)

Most of the centres had developed their policies and practices in isolation and there were no formal operating standards for the estate or opportunities for providers to consult together to develop their practice. The Detention Centre Rules provided some guidance, but there were significant variations in **treatment and conditions**, particularly between privately managed centres and Prison Service managed establishments. Detainees felt humiliated by their detention, particularly those held in establishments run by the Prison Service. They were very sensitive to their treatment by staff who were not sufficiently alert to or trained in the specific needs of immigration detainees. Prison Service procedures had been introduced to manage self-harm, bullying and race relations with varying degrees of success, but without an adequate appreciation of the differences between offenders and detainees.

'Detainees were full of praise for the staff and the standard of custodial care. We were told that the staff were courteous and respectful, that detainees felt safe and that "we are treated as equals".' (Oakington)

'Detainees were generally negative in terms of their treatment by staff and the standard of custodial care. We were told that staff attitudes were "disrespectful and no one was kind"; 80% said that staff had never asked after their well-being.' (Lindholme)

We examined the **activities** available in the centres. Detainees were not able to work, though many wanted to, and a significant number said they did not have enough to do. Occupation was provided in the form of education and leisure activities, often in impressive facilities, but the take-up was variable. The frustrations associated with being under-occupied within an environment that

offered extensive freedom of movement, coupled with the stresses of detention and an uncertain future, raised potential control problems in some establishments.

There was no recognition on the part of the Immigration Service of either the impact of sudden detention or of the importance of preparing for **release, transfer or removal**. Independent welfare support was needed at all centres. There was wide variation in provision for phone and visits contact with family, friends and legal representatives. Prison Service establishments were the poorest in terms of facilitating outside contact. However, the Immigration Service did not require this service of its providers. Immigration staff themselves at times employed hurried, even deceptive, arrangements to disguise the fact that removal was imminent. Though this was designed to minimise the security and self-harm risks posed by those who were anxious about removal, we believed that this simply transferred those risks to the next centre, or increased the likelihood that individuals would create security and control problems at the point of departure.

“ The detention of children should be an exceptional measure, and should not in any event exceed a very short period – no more than a matter of days. ”

We examined facilities for the detention of families with **children**. We concluded that such detention should be exceptional, as detention inevitably compromises the educational, welfare and developmental needs of children and in any event should not exceed a very short period – no more than a matter of days. The two English centres holding families rarely held them for longer than a week, and their provision was unsuitable for any lengthier stay. At Dungavel, in Scotland, children were held for longer periods, and, though educational provision there was better, the Scottish educational inspectorate (HMIE) concluded that it was suitable only for stays of up to two weeks, and became clearly unacceptable after six; even during this time the wider developmental needs of children were not met.

We have made a number of strategic, as well as specific, recommendations about the immigration detention estate. Centres have drawn up action plans in response to our recommendations, and we will monitor implementation in future inspections.

Northern Ireland

We published reports on two of the three prisons in Northern Ireland: Maghaberry prison and the young offender centre at Hydebank Wood.

We were inspecting at a time of considerable change within the Northern Ireland Prison Service, in transition from a culture that was principally one of containment to one of positive engagement between staff and prisoners. In the process, many new procedures and new forms of working have had to be developed.

‘The transition to a culture of positive engagement and trust, and a regime focusing on purposeful activity and resettlement, was a major task for the prison and the Prison Service.’ (Maghaberry)

At **Hydebank Wood**, we stressed the need for better support and training for residential staff in their new role, particularly as personal officers; better suicide and self-harm procedures; more activities, education and training; and a resettlement strategy. We were also concerned at the absence of a separate regime for 17-year-olds, who are children in international law; and at the continuation of stopping out for some young people.

Maghaberry is the most complex prison in the United Kingdom: holding remanded and convicted men and young adults and, in separate accommodation, women, girls and immigration detainees. It is very hard to manage these different populations, and to provide progressive moves for long-term prisoners who may spend decades in the same wing of the same prison. Once again, we stressed the need for better self-harm and anti-bullying procedures, not least because the prison was trying to run an integrated regime, without separating members of different paramilitary groups, or vulnerable prisoners. Purposeful activity and resettlement were also in need of considerable development.

Mourne House, where women are held, lacked a separate identity and regime. We recommended that it should have its own management and trained staff to meet the particular needs of women and girls. Though there were good interactions between staff and prisoners, we believed that an excessive level of security had developed and that staff needed specific training in working with women. We were particularly concerned that it had no specific healthcare provision; and about its ability to care adequately for girls, particularly those who were clearly mentally disordered, like the one held there during the inspection.

Discussions are taking place on the shape of the Northern Ireland **prison estate**. We recommended that there should be a number of smaller establishments, catering for specific populations, and allowing progressive moves from one security category to another.

“ Mourne House needs its own management, and trained staff, to meet the particular needs of women and girls. ”

Isle of Man

The Isle of Man prison is very small, but has to fulfil the functions of an entire prison system: holding men, women, young adults, boys and girls.

For many years, there have been plans to build both a new prison and a new secure unit, and we considered that both were necessary and urgent in order to provide the fundamentals of a modern and positive custodial setting.

‘Without a new prison, it will be very difficult for the Manx authorities to fulfil their obligations under international human rights law. In particular, the present facilities and activities fall far short of the standards required for children and young people under 18.’

We also recommended actions that could be taken immediately, and would

build on the good staff–prisoner relationships we observed. They include increasing purposeful activity, providing alternatives to slopping out, particularly for children and young people, and more formalised procedures to deal with bullying, drugs, self-harm and sentence planning. We were particularly concerned about children. This included those 17-year-olds held on the main wing, with little purposeful activity and no integral sanitation; and those under 17 who were simply being contained and where no child protection procedures had been developed. We did not consider that these arrangements met the requirements of international law in relation to the treatment and detention of children.

It is welcome that, since the report was published, the Manx government has settled on a site and a timetable for constructing the new prison; and that a new secure unit for children has been opened. In the meantime, we hope that our recommendations will enable the prison to improve current conditions and manage the transition to the new prison.

Annexes

1 Inspections undertaken

1 September 2002 – 31 August 2003

2 Inspection reports published

1 September 2002 – 31 August 2003

3 Recommendations assessed in follow-up reports

August 2001 – August 2003

4 OPSR principles of inspection

5 Staff of the Inspectorate

1 September 2002 – 31 August 2003

6 Expenditure

April 2002 – March 2003

Inspections Undertaken 1 September 2002 – 31 August 2003

Establishment	Full Announced	Full Unannounced	Unannounced Follow Up	Education
Acklington			28 Apr-1 May 2003	
Aylesbury	28 Apr-2 May 2003			
Belmarsh	27 May-4 June 2003			
Birmingham		21-25 Oct 2002		
Blantyre House			7-9 Jan 2003	
Brinsford				30 Oct-1 Nov 2002
Brixton	16-20 Sept 2002			
Brockhill			12-15 Nov 2001	12-15 May 2003
Bullington		2-6 Sept 2002		
Cardiff	9-14 Feb 2003			
Castington	2-6 June 2003			
Channings Wood	28 Oct-1 Nov 2002			
Dartmoor	17-21 Feb 2003			
Deerbolt			16-18 June 2003	
Doncaster			7-9 Apr 2003	
Dovegate	31 Mar-4 Apr 2003			
Downview	9-13 June 2003			
Drake Hall	18-22 Nov 2002			
Dungavel	7-10 Oct 2002			
Durham			18-21 Aug 2003	
East Sutton Park			21-23 July 2003	
Elmley			12-14 May 2003	
Erlestoke	7-11 Apr 2003			
Frankland	3-7 Mar 2003			
Full Sutton	6-10 Jan 2003			
Harmondsworth	16-18 Sept 2002			
Haverigg	5-9 May 2003			
Hewell Grange			23-25 June 2003	
Highpoint North	30 Sept-4 Oct 2002			
Highpoint South	30 Sept-4 Oct 2002			
Hindley				4-6 Sept 2002
Holme House			31 Mar-3 Apr 2003	
Huntercombe	23-27 June 2003			
Kingston			5-7 Nov 2002	

Inspections Undertaken 1 September 2002 – 31 August 2003

Establishment	Full Announced	Full Unannounced	Unannounced Follow Up	Education
Lancaster	9-13 Dec 2002			
Latchmere House			4-6 Aug 2003	
Leeds		30 June- 4 July 2003		
Leicester	7-11 July 2003			
Lewes	10-14 Mar 2003			
Lindholme	17-21 Mar 2003			
Littlehey	2-6 Dec 2002			
Long Lartin	14-19 July 2003			
Low Newton			7-9 July 2003	
Morton Hall	3-7 Feb 2003			
Moorland			2-6 Dec 2002	
New Hall				2-4 Oct 2002
Northallerton			7-9 Jan 2003	
Norwich			17-19 Sept 2002	
Onley	27-31 Jan 2003			
Parc		9-13 Sept 2002		
Parkhurst			28-30 Oct 2002	
Pentonville			2-4 Sept 2002	
Risley			6-8 May 2003	
Rye Hill	16-20 June 2003			
Send			3-5 Sept 2002	
Spring Hill	21-25 July 2003			
Stafford			21-23 May 2003	
Stocken			15-17 Oct 2002	
Stoke Heath				11-13 Sept 2002
Swinfen Hall			19-21 Nov 2002	
The Verne	3-7 Feb 2003			
Thorn Cross	14-18 Oct 2002			
Wandsworth		20-24 Jan 2003		
Warren Hill	11-15 Nov 2002			
Wellingborough	4-8 Aug 2003			
Werrington				21-24 July 2003
Total	32	5	23	6
Grand Total: 66				

Inspection Reports Published 1 September 2002 – 31 August 2003

Establishment	Inspection Dates	*Type of Inspection	Date of Publication
Albany	10-14 June 2002	FA	22 Jan 03
Ashfield	1-5 July 2002	FA	5 Feb 03
Askham Grange	5-7 Mar 2002	SU	19 Sep 02
Aylesbury	28 Apr-2 May 2003	FA	14 Aug 03
Birmingham	21-25 Oct 2002	FU	11 Apr 03
Blakenhurst	13-15 May 2002	SU	20 Nov 02
Blantyre House	7-9 Jan 2003	SU	25 Apr 03
Blundeston	5-7 June 2002	SU	14 Nov 02
Brinsford	30 Oct-1 Nov 2002	E	31 Jan 03
Brockhill	12-15 Nov 2001	SU	1 Oct 02
Bullington	2-6 Sept 2002	FU	15 Jan 03
Bullwood Hall	17-19 July 2002	E	25 Sep 02
Campsfield House	18-20 Mar 2002	FA	8 Apr 03
Castington	26-28 Feb 2002	E	25 Sep 02
Channings Wood	28 Oct-1 Nov 2002	FA	3 Apr 03
Chelmsford	12-16 Aug 2002	FA	9 Jan 03
Dartmoor	17-21 Feb 2003	FA	15 Jul 03
Doncaster	7-9 Apr 2003	SU	24 Jul 03
Douglas (IOM)	2-7 Dec 2001	FA	27 Jan 03
Dungavel	7-10 Oct 2002	FA	15 Aug 03
Drake Hall	18-22 Nov 2002	FA	17 Apr 03
Erlestoke	7-11 Apr 2003	FA	29 Jul 03
Feltham	14-23 Jan 2002	FA	15 Oct 02
Ford	7-9 May 2002	SU	30 Oct 02
Forest Bank	17-21 June 2002	FA	27 Nov 02
Frankland	3-7 Mar 2003	FA	16 Jul 03
Full Sutton	6-10 Jan 2003	FA	16 Jul 03
Glen Parva	4-6 Mar 2002	SU	6 Sep 02
Gloucester	29 Apr-3 May 2002	FA	13 Nov 02
Harmondsworth	16-18 Sept 2002	SA	29 Sept 03
Haslar	25-27 Feb 2002	FA	8 Apr 03
High Down	19-23 Nov 2001	FA	5 Sep 02
Highpoint North	30 Sept-4 Oct 2002	FA	11 Feb 03
Highpoint South	30 Sept-4 Oct 2002	FA	11 Feb 03
Hindley	4-6 Sept 2002	E	31 Jan 03
Holloway	8-12 July 2002	FA	18 Feb 03
Holme House	31 Mar-3 Apr 2003	SU	12 Aug 03
Hull	2-4 July 2002	SU	22 Nov 02
Huntercombe	15-19 Oct 2001	FA	16 Oct 02
Hydebank Wood (NI)	4-8 Feb 2002	FA	9 Oct 02
Kingston	5-7 Nov 2002	SU	30 Apr 03
Lancaster Farms	31 Jan-1 Feb 2002	E	25 Sep 02

Inspection Reports Published 1 September 2002 – 31 August 2003

Establishment	Inspection Dates	*Type of Inspection	Date of Publication
Lewes	10-14 Mar 2003	FA	1 Jul 03
Lindholme	17-21 Mar 2003	FA	30 Jul 03
Lindholme	21-21 Mar 2002	FA	8 Apr 03
Littlehey	2-6 Dec 2002	FA	29 Apr 03
Liverpool	10-14 June 2002	FU	28 May 03
Maghberry (NI)	13-17 May 2002	FA	26 Feb 03
Moorland	2-6 Dec 2002	SU	15 Apr 03
Morton Hall	3-7 Feb 2003	FA	25 Jul 03
New Hall	2-4 Oct 2002	E	31 Jan 03
North Sea Camp	23-25 July 2002	SU	19 Nov 02
Northallerton	7-9 Jan 2003	SU	1 May 03
Norwich	17-19 Sept 2002	SU	7 Jan 03
Oakington	4-6 Mar 2002	FA	8 Apr 03
Onley	27-31 Jan 2003	FA	23 Jul 03
Parc	9-13 Sept 2002	FU	2 May 03
Parkhurst	28-30 Oct 2002	SU	4 Jun 03
Pentonville	2-4 Sept 2002	SU	20 May 03
Prescoed	22-24 Jan 2002	SU	10 Jan 03
Ranby	11-15 Feb 2002	FA	19 Sep 02
Send	3-5 Sept 2002	SU	18 Dec 02
Standford Hill	7-11 Jan 2002	FA	5 Dec 02
Stocken	15-17 Oct 2002	SU	16 Jan 03
Stoke Heath	11-13 Sept 2002	E	6 Dec 02
Styal	4-8 Feb 2002	FA	15 Nov 02
Swaleside	15-19 July 2002	FA	20 Dec 02
Swinfen Hall	19-21 Nov 2002	SU	4 Apr 03
The Mount	4-6 Mar 2002	SU	2 Apr 03
The Verne	3-7 Feb 2003	FA	18 Jun 03
Thorn Cross	14-18 Oct 2002	FA	16 Apr 03
Tinsley House	18-20 Feb 2002	FA	8 Apr 03
Usk	22-24 Jan 2002	SU	10 Jan 03
Wandsworth	20-24 Jan 2003	FU	3 Jun 03
Warren Hill	11-15 Nov 2002	FA	21 May 03
Werrington	11-15 Mar 2002	FA	31 Oct 02
Wetherby	19-20 Feb 2002	E	25 Sep 02
Whatton	18-22 Mar 2002	FA	8 Nov 02
Whitemoor	15-17 Jul 2002	SU	22 Jul 03
Winchester	20-24 May 2002	FA	20 Dec 02
Woodhill	18-22 Feb 2002	FA	19 Feb 03
Wormwood Scrubs	10-19 Dec 2001	FU	3 Sep 02

TOTAL 80

Key: FA – Full Announced

E – Education

SU – Short Unannounced

FU – Full Unannounced

Breakdown of recommendations which were assessed in follow-up visit 2002-3

Prison	Recommendations	Achieved	Partly Achieved	Not achieved
Askham Grange	86	56	5	25
Blakenhurst	119	63	18	38
Blantyre House	57	37	9	11
Blundeston	132	61	20	51
Doncaster	133	97	11	25
Ford	133	62	18	53
Glen Parva	86	49	15	22
Holme House	130	47	23	60
Kingston	79	45	13	21
Moorland	141	72	29	40
North Sea Camp	55	20	9	26
Northallerton	114	63	20	31
Norwich	149	81	20	48
Parkhurst	79	25	12	42
Pentonville	85	34	14	37
Prescoed	42	34	3	5
Send	162	88	34	40
Stocken	110	69	10	31
Swinfen Hall	108	80	13	15
The Mount	119	60	15	44
Usk	31	18	2	11
Whitemoor	87	42	4	41
Cumulative	2237	1203	317	717
Average		54%	14%	32%

Breakdown of recommendations which were assessed in follow-up visit 2001-2

Prison	Recommendations	Achieved	Partly Achieved	Not Achieved
Bristol	140	80	16	44
Buckley Hall	38	22	5	11
Chelmsford	69	40	18	11
Cookham Wood	126	77	13	36
Drake Hall	90	60	16	14
Eastwood Park	109	36	21	52
Erlestoke	55	33	7	15
Exeter	138	92	26	20
Garth	58	38	3	17
Guernsey	43	19	6	18
Haverigg	159	81	21	57
Kirkham	111	63	18	30
Leicester	97	53	27	17
Lincoln	146	86	22	38
Long Lartin	127	99	10	18
Magilligan	18	9	2	7
New Hall	136	72	24	40
Portland	168	82	42	44
Preston	181	110	20	51
Reading	154	87	26	41
Sudbury	113	77	11	25
Swansea	175	83	36	56
The Weare	79	38	10	31
The Wolds	101	59	24	18
Wandsworth	72	37	17	18
Winchester	149	70	26	53
Wymott	81	52	10	19
Cumulative	2933	1655	477	801
Average		56%	16%	27%

Total average recommendations achieved or partly achieved 71%

OPSR principles of inspection

- **Improvement in services.** Our role and purpose, as set out in statute, is to provide independent scrutiny to improve the conditions and treatment of prisoners and detainees. This is reflected in the improvements in individual establishments, and across the Service, which result from our inspections. All reports contain clear recommendations and examples of good practice; they are followed up in Prison or Immigration Service action plans, Inspectorate monitoring and unannounced follow-up inspections. Follow-up inspections last year found that over 1500 of the 2200 recommendations we had made had been wholly or partly achieved.
- **Focus on outcomes.** That has always been the focus of this Inspectorate. As opposed to audits, which check processes, our inspections set out to reveal and record the actual, as opposed to intended, outcomes for prisoners; in terms both of securing their safety and respect, and of protecting society by reducing reoffending.
- **Ensuring a user perspective.** We pioneered the use of confidential prisoner and detainee surveys, to ensure that their views are part of the evidence base. They also provide data for assessment of progress over time, and for comparison with other similar establishments. This data is now shared with performance managers in the Prison Service, Correctional Services and Youth Justice Board.
- **Proportionate to risk.** The closed and hidden nature of custodial settings means that they always contain inherent risks and that we must maintain a regular cycle of inspections. This is supported by unannounced inspections, where we assess them to be necessary, and a new intelligence system that will provide continuous monitoring of establishments inspected to determine the timing and extent of follow-up inspections.
- **Encouraging self-assessment.** Programmes for announced inspections are issued in advance and prisons are encouraged to examine themselves by reference to our published Expectations. Some area managers are undertaking thorough pre-inspection assessments on this basis. Because of the nature of closed institutions, however, these self-assessments always need to be checked against real outcomes, some of which we find are unknown to local or regional managers.
- **Providing impartial evidence.** Our inspection methodology, which is about to be published, ensures that findings are evidence-based, consistent and objective. We use a powerful triangulated approach – using prisoner surveys, rigorous analysis of documentary evidence, and inspectors’ own observations and discussions with staff, managers and prisoners.
- **Clear and disclosed criteria.** We have a detailed set of criteria (Expectations) against which establishments are assessed. They are based upon best practice and domestic and international human rights standards. We are currently revising these, in consultation with relevant bodies, with a view to publication later this year. This will be followed by the publication of separate juvenile, immigration removal centre, and military corrective and training centre criteria.
- **Open and transparent processes.** Our processes are entirely open and transparent; with the exception of the essential need to carry out unannounced inspections at will. Draft reports are seen by the prison and Prison Service to ensure that there are no factual inaccuracies; though the analysis remains ours. Feedback is provided to local and area managers during and immediately after the inspection; and we carry out exit surveys with prison managers after inspections.
- **Value for money.** We do not inspect the Prison Service and its VFM. We ourselves produced 80 reports and carried out 66 inspections. This workload reflects significant output efficiencies; and additional resources have now been provided to ensure that we can meet our inspection and reporting targets. We also maximise efficiency by inspecting jointly with the education inspectorates and in carrying out cross-cutting inspections with other criminal justice inspectorates.
- **Continuing to learn.** The development of Expectations, the move into new areas such as immigration and military detention, and the development of joint methodologies for joint work are indications of learning and change. Our reports are clear and readable, but we are seeking to make them even more user-friendly by developing a new report template, in consultation with stakeholders.

Staff of the Inspectorate

HM Chief Inspector
of Prisons



Anne Owers CBE

HM Deputy Chief
Inspector of Prisons



Nigel Newcomen

Inspectors J Team
(*Juveniles*)



Fay Deadman
(Team Leader)



John Rea Price
(p/t)

Inspectors N Team
(*Young Adults*)



Jacqui Mosley
(Team Leader)



Peter Titley



Ian Macfadyen



Stephen Moffatt

Inspectors O Team
(*Women*)



Michael Loughlin
(Team Leader)



Joss Crosbie



Gabrielle Lee



Paul Fenning

Inspectors A Team



Gary Deighton
(Team Leader)



**Ruth
Whitehead**



Gail Hunt



Pat Mosley

The Inspectorate Teams have been accompanied by members from OFSTED (led by Bill Massam) and the Adult Learning Inspectorate (led by Lesley Davies). Specialist Inspectors have also been provided by the British Pharmaceutical Society and the Dental Practice Board.

Staff of the Inspectorate

Head of Thematic Reviews



Monica Lloyd

Health Care Team



Dr Tish Laing-Morton
(Head of Health Care)



Elizabeth Tysoe



Bridget McEvilly

Specialist Inspectors



Sigrid Engelen
(Drugs)

Research & Development



Louise Falshaw
(Head of R&D)



Lucy Richardson



Sarah Leask



Mark Challen



Thea Walton

Administrative Support



Jennifer Riach
(Head of Administration,
Finance & Personnel)



Barbara Buchanan
(Senior PS to the
Chief Inspector)



Michelle Reid
(PS to the Deputy
Chief Inspector)



Heather Case



Fiona Kennedy



Brian Bell

Staff who left during the reporting period

John Podmore, Jane McKay, Richie Dell, Eddie Killoran, Maurice Raymond, Beatrice Leung, Marjorie Simonds-Gooding, Violet Huggins, Victoria Richardson, Mukesh Kanani, Sarah Tam, Annie Carrington, Stavy Styllis, Susan Abigail

Student support: Jodie Chapel (*Brunel University*) Jageet Singh-Sohal (*Brunel University*) Lucy Wainwright (*Portsmouth University*) Kelly Whitter (*Cabinet Office Summer Development Programme*).

Editorial Support: Inspection reports have been edited by Emily Wood, Brenda Kirsch and Pam Ratcliffe.

Expenditure for April 2002 – March 2003

Staff costs	1,594,041
Recruitment	7,476
Prof. subscriptions	80
Training & development	35,475
Travel & subsistence	240,460
Conferences	2,599
Meetings & refreshments	17,541
Printing & reprographics	46,371
Publicity	1,185
IT & telecommunications	18,977
Office equipment	5,454
Books & stationery	8,641
Postage	3,916
Total	£2,287,788

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