HM Chief Inspector of Prisons for England and Wales

Annual Report 2012–13

HM Chief Inspector of Prisons for England and Wales

Annual Report 2012–13

Presented to Parliament pursuant to Section 5A of the Prison Act 1952
as amended by Section 57 of the Criminal Justice Act 1982.

Ordered by the House of Commons to be printed on 23 October 2013.

HC 682 London: The Stationery Office £21.25

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

You can download this publication from: www.justice.gov.uk/publications/corporate-reports/hmi-prisons

ISBN: 9780102986921

Printed in the UK by The Stationery Office Limited on behalf of the Controller of Her Majesty's Stationery Office

ID: 2594806 10/13

Printed on paper containing 75% recycled fibre content minimum.

CONTENTS

WHO WE ARE AND WHAT WE DO

Our purpose

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

Our values

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

Our approach

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

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

- **Safety** – Prisoners, particularly the most vulnerable, are held safely.
- **Respect** – Prisoners are treated with respect for their human dignity.
- **Purposeful activity** – Prisoners are able, and expected, to engage in activity that is likely to benefit them.
- **Resettlement** – Prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending.[1]

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

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

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

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

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

1 All the Inspectorate's Expectations are available at: www.justice.gov.uk/about/hmi-prisons/inspection-and-appraisal-criteria.

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

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

Most inspections take place with the support of other inspectorates including Ofsted, HM Inspectorate of Constabulary (HMIC), the Care Quality Commission (CQC), HM Inspectorate of Probation and the General Pharmaceutical Council, appropriate to the type of establishment. Until 1 April 2013, each adult prison and immigration detention centre received a full main inspection at least every five years and a follow-up inspection to review progress against recommendations in the intervening period. Inspections were 'announced' or 'unannounced'. Follow-up inspections were 'full' or 'short', according to our assessment of risk. Establishments holding children and young people received a main inspection on a three-year cycle. From the start of our 2013/14 programme, all inspections have been unannounced (other than in exceptional circumstances) and most inspections have followed up recommendations made at the previous inspection. We will report more fully on our changed approach in our 2013–14 report.

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

OPCAT and the National Preventive Mechanism

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

1 INTRODUCTION
by the Chief Inspector of Prisons

In February 2010, Robert Francis QC published the first report of his independent inquiry into the care provided by the Mid Staffordshire NHS Foundation Trust. The press release summarising his first inquiry findings stated that he:

> '…concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care.'[2]

Three years later, in February 2013, Francis published the report of his second, public, inquiry into why the various organisations and structures that should have identified and addressed the terrible failings of the Mid Staffordshire NHS Foundation Trust failed to do so. He warned of the danger of 'a culture focused on doing the system's business – not that of patients'.[3]

Reading both reports, it is clear to me that that they have lessons for all organisations responsible for providing or inspecting services to vulnerable individuals. It is undoubtedly true for prisons and other places of detention, both because of the well documented personal vulnerabilities of many of those held and the vulnerabilities created by the detention experience itself.

All the sectors I inspect have had to focus on, in Francis' words 'cost cutting, targets and processes' in 2012–13. The National Offender Management Service (NOMS) as a whole (that is, prison, probation and headquarters functions) had to make savings of £246 million on top of the £228 million savings delivered in 2011–12. This represented a further reduction of seven per cent of NOMS' resource budget against the spending review baseline. Public sector prisons alone had to find savings of around £80 million. NOMS overall savings were delivered by a combination of workforce restructuring; market testing and privatisation of entire establishments and specific services; standardising costs and services; and reconfiguring the prison estate by closing some smaller, older prisons and increasing the size and number of very large establishments. On top of all this, ministers launched proposals to 'transform rehabilitation' outcomes for all offenders and began major reviews of the juvenile and women's custodial estate.

2 Robert Francis QC; Press release: Final Report Of The Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust

3 Robert Francis QC; Letter to the Secretary of State: Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Table 1: Percentage of establishments assessed as 'good' or 'reasonably good' in full inspections

	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
	%	%	%	%	%	%	%	%
Safety	75	57	69	72	78	84	82	80
Respect	65	63	69	69	76	74	73	73
Purposeful activity	48	53	65	71	68	69	73	50
Resettlement	68	62	75	75	76	71	84	64

Other forms of custody faced similar financial pressures and organisational change. The UK Border Agency (UKBA), which was responsible for immigration detention, was abolished and its functions passed back to the Home Office. Faced with their own budget pressures, many police forces began to centralise their custody functions, and Police and Crime Commissioners took over the responsibilities of police authorities for police custody.

No one should fool themselves that these financial and organisational pressures do not create risks. In prisons, there are fewer staff on the wings supervising prisoners, there are fewer managers supervising staff and less support available to establishments from a diminished centre. Quite apart from the impact of the savings themselves, there is clearly a danger in all forms of custody that managers become 'preoccupied with cost cutting, targets and processes' and lose sight of their fundamental responsibilities for the safety, security and rehabilitation of those they hold.

Prisons

Figure 1 sets out our full inspection findings against each of our four 'healthy prison' tests – safety, respect, purposeful activity and resettlement – over the past eight years. Care has to be taken comparing one year with another as the same prisons will not be inspected each year and over time inspection standards may have changed.

Given the pressures that establishments are under, it is welcome that safety and respect outcomes have been maintained overall. Our findings are reflected in the key data relating to the safety of prisoners and the conditions in which they are held.

- The number of deaths in custody reduced from 211 in 2011–12 to 182 in 2012–13.
- Self-inflicted deaths fell from 66 to 51 over the same period.
- Self-harm incidents continued to fall to 22,687 in 2012–13 – a drop of almost 14% over a two-year period.
- Recorded assaults fell from 15,577 to 14,052 over the year, a drop of about 10%.
- The total prison population fell from 87,868 at the end of March 2012 to 84,596 at the end of March 2013, a welcome fall of almost 4%.
- The extent to which the total prison population was overcrowded or operating above its certified normal accommodation in use fell from 11% to 7.1%.

However, these positive overall findings and data hide some concerning exceptions.

Figure 2: Safety outcomes in inspected prisons

	Good	Reasonably good	Not sufficiently good	Poor
Locals	0	6	5	1
Trainers	3	11	3	0
Open	2	2	0	0
High security	0	1	0	0
Foreign national	2	0	0	0
Young adults	1	0	0	0
Total	**8**	**20**	**8**	**1**

Safety

As in previous years, safety outcomes are just not consistent enough and while it is welcome that 80% of the prisons we inspected were safe or reasonably so, 20% were not. As Figure 2 shows, this was a particular concern in local prisons where in half of those we inspected (Durham, Lincoln, Liverpool, Norwich, Winchester and Woodhill) safety outcomes were poor or not sufficiently good.

Furthermore, while the number of self-harm incidents in the adult estate has fallen in total, this is exclusively driven by a very large (and impressive) fall in the number of self-harm incidents in women's prisons from 11, 516 in 2010–11 to 6,317 in 2012–13. The number of self-harm incidents in men's prisons rose from 14,769 to 16,370 over the same period. We repeatedly reported concerns about the management of prisoners identified as being at risk of suicide or self-harm. Too many were held in segregation without evidence of the exceptional circumstances required to justify this. Suicide and self-harm prevention processes were often poorly managed with the needs of the individual prisoners subsumed by the requirements of the process.

The fall in the number of assaults appears to result from the sharp fall in the number of young people in custody. From January 2011 to December 2012 the number of young people and young adults aged 15 to 20 who were assailants fell by about 8.5% to 3,350 – but the number of those in this age group in custody fell by more than twice this percentage. The number of adults aged 21 to 39 who were assailants rose by just over 3% to 3,779. Contrary to what might therefore be suggested by the headline figures, the levels of violence in too many adult male prisons have risen. Some prisons we inspected had little idea of the trends or patterns of violence in their establishment and were doing too little to address the underlying causes, tackle perpetrators or support victims.

The integrated drug treatment system (IDTS) improved treatment for opiate-dependent prisoners and there has been a reduction in the illicit use of heroin in prisons. However, there has been a steady increase in the reported abuse of prescribed medication, where medication is 'diverted' to someone to whom it was not prescribed. The risks of diverted medication include bullying, drug debts, unexpected drug interactions and overdose. Many divertible medications cannot be detected by mandatory drug testing (MDT) and, as I have warned before, MDT underestimates illicit drug use in prisons in England and Wales. In 2013–14 we will conduct a major thematic inspection with partner inspectorates into the changing patterns of substance abuse.

Respect

The level of overcrowding across the prison estate may have decreased during the year, but it was still a major problem for the establishments we inspected. Overcrowding is not simply an issue of how many prisoners can be crammed into the available cells but also affects whether the activities, staff and other resources are available to keep them purposefully occupied and reduce the likelihood they will reoffend. A prisoner who is unemployed because there is no activity available for him might spend 22 hours a day, and eat all his meals, with another prisoner in a small cell designed for one, perhaps eight foot by six foot, with an unscreened toilet.

We found that poor physical conditions were often mitigated by good staff-prisoner relationships and over three-quarters of prisoners told us staff treated them with respect. This was a real achievement. However, in a few prisons, a small number of rogue officers undermined the good work of their colleagues; in a greater number relations between prisoners and staff were friendly enough but officers were not sufficiently proactive in challenging poor behaviour or supporting rehabilitation work.

Prisoners from minority groups, such as those from black and minority ethnic backgrounds, Muslim prisoners and disabled prisoners, almost always reported much more negatively than the main population about their experience in prison and their relationships with staff. Prisons monitored outcomes for prisoners from black and minority ethnic backgrounds but rarely did so for other groups with protected characteristics and, as a whole, did too little to understand the concerns of minority groups. Older prisoners were generally positive about their treatment and we saw some examples of good care. However, as they were a largely compliant part of the prison population, their needs were also often overlooked. The number of older prisoners is rising rapidly and the prison service is becoming a major provider of care and accommodation for older people. It needs a much clearer strategy for meeting this growing need.

Older and disabled prisoners could usually rely on health care services that had improved. However, almost one in three prisoners reported emotional well-being or mental health issues. While some prisons had developed good integrated mental health services, there was too little provision to meet need and, in the most severe cases, transfers to secure mental health facilities were still taking too long.

Purposeful activity

Our judgements about the quantity and quality of purposeful activity in which prisoners are engaged plummeted over the year. Put simply, too many prisoners spend too long locked in their cells with nothing constructive to do, and when they are in classes or work, these are often of insufficient quality. Equipping prisoners with the skills, habits and attitudes they need to get and hold down a job is an essential part of the rehabilitation process. Only a few years ago we heard a lot about 'working prisons' and making prisons places of productive activity. More recently there has been a deafening silence on this topic and prisons might be excused if they believe this is no longer a priority.

It is a priority for this inspectorate and Ofsted, who inspects this area in partnership with us. Our findings reveal unacceptable outcomes. In local prisons we found, on average, a third of all prisoners locked in their cells during the working day, rising to almost 60% in one prison. In HMP Lincoln for instance, even a 'fully employed' prisoner spent more than 18 hours a day locked in his cell. On average, in the local prisons we inspected, a fifth of prisoners spent less than two hours a day out of their cell. Even in category C training prisons, we found 14% of prisoners locked up. In part, the lack of activity was a symptom of overcrowding and reflected a sometimes woefully inadequate number of activity places to meet the size of the population. However, all too often, the activity places a prison did have were badly underused and those that were in use were badly disrupted by poor coordination between work, training and education activities and other aspects of the prison regime.

A new contract for the provision of training and education began in August 2012 for most prisons in England. We have seen little sign of improvement so far. The range and quality of activity on offer required improvement, there were insufficient opportunities for prisoners to

obtain vocational skills or qualifications that employers valued. Of course, there were exceptions to this generally dismal picture. Some prisons did provide a realistic working day, release on temporary licence gave some prisoners very valuable opportunities to obtain real work experience and in most prisons there were some activities of a high standard.

Resettlement

Providing the support and skills needed to get a job or training place on release is one aspect of the practical help prisoners need to successfully resettle and stay out of trouble.

Rehabilitation is, of course, a major priority for the current government. It published its plans to 'transform rehabilitation' in January 2013. The elements that directly affect prisons – a greater focus on outcomes, more support and supervision for short-term prisoners and 'through-the-gate' services for prisoners as they leave prison and return to the community – address many of the concerns our inspections have identified. For many prisoners the most important 'resettlement agency' that helps them find a job, accommodation and other support on release is their family; the government's proposals do not say enough about encouraging prisoners to maintain and develop their family links.

Just as important as providing practical resettlement support are efforts to address prisoners' offending behaviour and manage the risk they pose to others. However, this has often been too low a priority. While reducing the risk that a prisoner will reoffend should be seen as a key part of the job of everyone working in a prison, it was frequently relegated to a specialist role that was insufficiently integrated with the activities of the prison as a whole. Specific programmes to address offending behaviour were sometimes inadequate to meet need and we were concerned to identify, in a number of prisons, a shortfall in the number of places on sex offender treatment programmes that were needed to meet the needs of the population.

Women

2012–13 was the fifth anniversary of Baroness Corston's groundbreaking review of the needs of women offenders. We inspected a relatively small number of women's establishments over the year but these reflected some longstanding trends. There were improvements in the women's custody estate but women's prisons still struggle to meet the needs of an often very vulnerable population with different needs from the 95% male prison population. I welcomed the opportunity to give evidence to the Justice Committee's enquiry into the issue and was pleased when, in March 2013, the government announced new strategic priorities for women offenders. I hope that we will not have to wait another five years before there is significant progress.

Youth custody

The welcome and dramatic fall in the number of young people in custody continued in 2012–13. The number of young people under 18 in custody fell by 35% over the year to 901. In January 2013 the Youth Justice Board announced plans to decommission HMYOI Ashfield and other decommissioning decisions were announced later in 2013. In February the government announced plans to review the youth custody estate and put education at its heart.

Of course, a greater emphasis on education is welcome but the challenge of doing this should not be underestimated. Eighty-six per cent of children and young people in young offender institutions (YOIs) tell us they were excluded from school and 36% tell us they were 14 or younger when they last attended school. It is also clear that as the number of young people in custody reduces, those that remain are the most troubled and exhibit the most challenging behaviour.

Young people will not learn if they are constantly looking over their shoulder and feel frightened. Almost a third of young people told us they had felt frightened at some point in their establishment and more than one in five said they had been bullied. In some

cases, staff lacked confidence in dealing with poor behaviour and had low expectations. There were no self-inflicted deaths of young people in YOIs and young people at risk of suicide or self-harm were usually well cared for. However, given the vulnerability of many of the young people held, the pointless strip searching to which they were all subject on arrival (two finds from 729 searches at Cookham Wood for instance, see page 59) was worse than useless and it is welcome that the prisons minister has agreed to pilot phasing out this procedure.

In March 2013, the Justice Committee published its report on youth justice. We share the Committee's concern about the increase in the use of physical restraint by staff. A new restraint policy has been introduced and I welcome the committee's recommendation that I review its operation. That work has now started.

The standard of education currently provided in YOIs is variable and needs improvement. However, good work was done to prepare young people for release in all establishments, although finding young people somewhere to live was often a severe problem. Many young people were held a long way from home which made it difficult for their family to visit them and to maintain relationships. Better support was needed for those young people who were transferring from YOIs to adult prisons.

Provision for the ever smaller number of young women held in YOIs was generally good but the very small size of the units made them increasingly unviable. It was no surprise when later in 2013 the Youth Justice Board (YJB) announced that it would no longer commission places in the girls units and that girls would, in future, be held in Secure Training Centres (STCs).

Immigration detention

Immigration detainees are not held because they have been charged with an offence or detained through a normal judicial process and their treatment and conditions should reflect this. The centres we inspected this year were accordingly generally safe, although some security procedures were disproportionate and the environment at Harmondsworth was too prison-like.

What caused detainees most anxiety was the progress of their immigration case. Our joint thematic inspection with the Independent Chief Inspector of Borders and Immigration of immigration casework found trafficking victims inappropriately detained and some detainees held much too long with little attempt to progress their cases. It is a real concern to me that individuals can be administratively detained for long periods by relatively junior officials on behalf of ministers without any routine independent scrutiny. It carries with it a real danger of unchecked injustice and I hope that even now ministers will give further consideration to our recommendation that there should be some process of routine independent review for those detained for long periods.

The need for proper checks and balances was underlined by High Court judgements between 2011 and 2012 that the detention of four mentally ill detainees amounted to 'cruel and degrading treatment' in breach of Article 3 of the European Convention on Human Rights. We found mental health services remained underdeveloped even after some of those judgements. One staff member described an inpatient unit to us as a 'forgotten world' – exactly the sort of environment where the risk of ill-treatment or neglect occurs.

We inspected the Cedars pre-departure accommodation where families with children may be held for up to a week before removal. The accommodation was exceptionally good, Barnardos staff played an important role and parents told us

they were pleased they could spend a few days at the centre rather than being taken straight to a flight. The Cedars has set a standard that other forms of immigration detention should seek to emulate. However, we were concerned about the number of occasions in which force had been used to effect removal. On one occasion unapproved techniques were used on a pregnant woman, showing an entirely unacceptable disregard for the safety of the unborn child. We were pleased to note subsequent Home Office guidance stating that force would no longer be used on pregnant women except to prevent harm.

We continued to examine escort arrangements closely. Too many detainees underwent night-time transfers between establishments. We accompanied one overseas escort to Afghanistan and it is a concern that no safe restraint technique has yet been developed for use on aircraft.

Police and court custody

Most detainees in police custody were held safely in decent conditions. The challenge for forces was to ensure they could deliver that for the most vulnerable detainees.

In some cases, risk management processes were disproportionate and too liberally applied – and so risked distracting attention from the most vulnerable rather than focusing on them. In other cases, arrangements with other agencies to identify and care for the most vulnerable were inadequate. Our review of the Person Escort Record – the record that accompanies all detainees as they move between police custody, courts and prisons and should help each agency be aware of prior risks – found that many were poorly completed by personnel who did not know their purpose and often failed to include vital information. Far too many people who were unwell were detained under Section 136 the Mental Health Act and taken to police custody as a place of safety; we inspect police and court custody jointly with Her Majesty's Inspectorate of Constabulary and our joint thematic review of Section 136 later in 2013 made important recommendations for change. Police custody has been one of the few places where 17-year-olds are not recognised as children – older children but children nonetheless. We consistently recommended that 17-year-olds should be treated as children and afforded an 'appropriate adult', and were pleased that, following a court judgement, this was agreed in 2013.

In 2012–13 we began a programme of inspection of court cells. The fact they had not been specifically inspected before showed. Staff generally treated detainees decently but the treatment of vulnerable detainees was inconsistent, the condition of some cells was disgraceful and health services were rudimentary.

The Inspectorate

The Inspectorate's core processes have been established and developed by my predecessors and applied consistently for many years. We inspect against our own human rights-based 'Expectations' which set out the minimum outcomes a detainee can expect. In 2012–13 we completed the revision of all our Expectations to make them more outcome-focused and less about process. In 2012–13 we continued a system of regular announced main inspections that were followed by 'short' or 'full' unannounced follow-up inspections. Follow-up inspections checked progress on implementing recommendations made at the previous main inspection. In 2012–13 we found that across all types of establishment, 77% of recommendations had been fully accepted, 16% partly accepted or accepted in principle and 5% rejected. When we checked, two-thirds had been achieved or partially achieved.

During the year we consulted on and agreed some major changes to the way we organise the inspection programme and almost all our inspections will now be unannounced, and scheduled according to a clear risk assessment model.

In 2012–13 we began inspections of court custody, planned and began a programme of joint inspections of Secure Training Centres with Ofsted and began planning inspections of Service Custody Facilities (which are replacing the military guardhouse system).

In delivering our inspection programme we work closely with a range of other inspectorates. We contributed to a number of joint thematic inspections as part of the Criminal Justice Joint Inspectorates process. I am grateful to all of our partner inspectorates for their cooperation and I hope that by working together in this way and by liaising closely with other relevant bodies such as the Prisons and Probation Ombudsman, we can continue to hold the most comprehensive picture possible of both individual establishments and cross-cutting themes.

My independence is underpinned by the Inspectorate's role as one of the bodies that make up the National Preventative Mechanism (NPM), by which the government discharges its obligations arising from its status as a party to the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The work of the UK NPM is described in its own annual report.

Our work continues to attract interest from a variety of overseas jurisdictions and during 2012–3 we provided training and support to inspection bodies in Albania and Jamaica. We worked closely with the Foreign and Commonwealth Office and human rights institutions to assist the government in Bahrain to establish a system of independent inspection of places of detention; a Royal Decree issued in 2013 reflects much of our input – but as Bahrain officials accept, what matters is what now happens on the ground.

The Inspectorate has not been immune from the financial pressures affecting the institutions we inspect. Our budget will be reduced in 2013–14 by a further 4.7%, representing an overall reduction on like for like activities of 19.1% on our inflated baseline. We have managed to achieve these reductions while delivering a more robust inspection schedule.

All the establishments we inspected during the year were under pressure to do more with less and, in some, the cracks were beginning to show. In most cases, these were necessary reforms. Nevertheless, maintaining standards of safety and decency in prisons has been a challenge for all and is not always achieved. Other priorities, such as providing work and other purposeful activity in prisons, have fallen away. Young offender institutions sometimes struggled to deal with a more challenging cohort of young people. The cases of too many people held in immigration detention were not progressed quickly enough. Police custody was too often the refuge of last resort for the mentally ill and vulnerable. It is a credit to those who work out of sight in these establishments that, for the most part, they have not been distracted from their fundamental responsibilities to those in their custody and the wider public they serve. However, the warning signs are there. Politicians and policy makers should be very careful not to put the valuable policy and savings gains they have already made at risk by ignoring those signs and piling on the pressure regardless. I hope that a continuing robust, independent inspection programme, focusing on what is actually happening to prisoners and detainees, will help them strike the right balance.

Nick Hardwick
Chief Inspector of Prisons

2 THE YEAR IN BRIEF

Between 1 April 2012 and 31 March 2013, we published 87 inspection reports.

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

Establishments holding children and young people:
- six young offender institutions (YOIs) holding children and young people under the age of 18
- one secure training centre (STC), holding children and young people aged 12 to 17, jointly with Ofsted.

Immigration detention:
- four immigration removal centres
- one pre-departure centre
- eight short-term holding facilities
- one overseas escort.

Police custody:
- 12 police custody suites with HM Inspectorate of Constabulary (HMIC).

Court custody:
- two court custody areas covering five counties.

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

Extra-jurisdiction inspections:
- one prison in Northern Ireland (disaggregated into two inspection reports)
- the prison in the Cayman Islands
- police custody in the Cayman Islands.

In 2012–13 we published/co-published six thematic reports.

- *Remand Prisoners*
- *The Use of the Person Escort Record with Detainees at Risk of Self-harm*
- *The Effectiveness and Impact of Immigration Detention Casework* (jointly with the Independent Chief Inspector of Borders and Immigration)
- *Facing Up To Offending: Use of restorative justice in the criminal justice system* (jointly with HMIC, HM Inspectorate of Probation (HMI Probation) and HM Crown Prosecution Service Inspectorate)
- *Transitions: An inspection of the transitions arrangements from youth to adult services in the criminal justice system* (jointly with HMI Probation, Care Quality Commission (CQC), Ofsted, Healthcare Inspectorate Wales and Estyn)
- *Examining Multi-Agency Responses to Children and Young People who Sexually Offend* (jointly with HMI Probation, Care and Social Services Inspectorate Wales, CQC, Estyn, Healthcare Inspectorate Wales, HMIC and Ofsted).

Other publications in 2012–13:
In January 2012, we published revised *Expectations* for adult prisoners to take account of our growing experience and changes to the prison environment; all the findings from prison inspections in this report relate to the revised *Expectations*. We also published revised and updated *Expectations* for three other types of establishment in 2012: inspections of police custody suites (January), children and young people's establishments (June),

and immigration detention facilities (September); inspections of these types of establishment relate to the revised Expectations from their date of publication.

Other publications included:

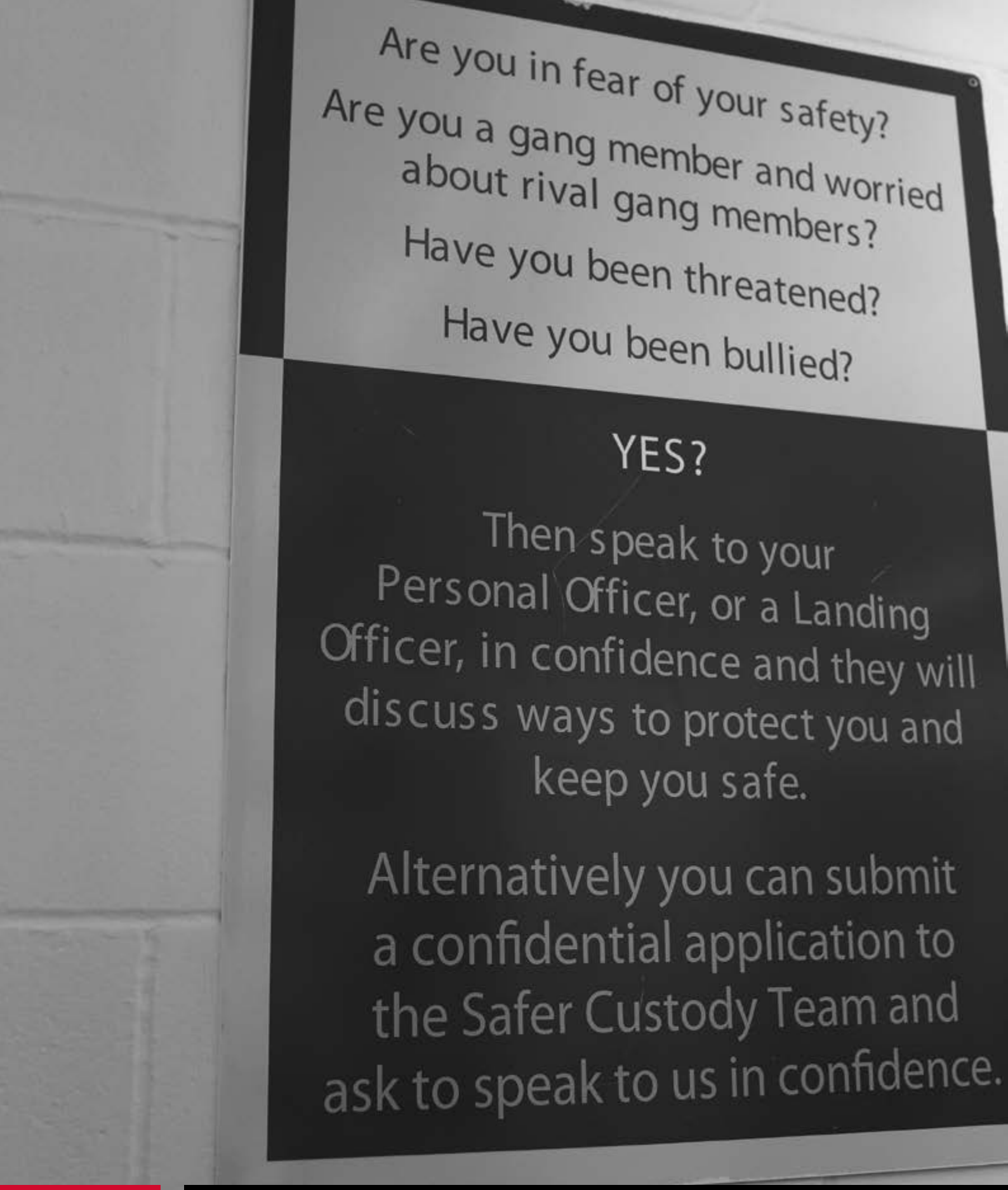
- *Children and Young People in Custody, 2011–12* (jointly with Youth Justice Board)
- *Monitoring Places of Detention. Third annual report of the United Kingdom's National Preventive Mechanism 2011–12* (on behalf of the NPM)
- *Court Custody Expectations*
- *Border Force Expectations*
- *Second Aggregate Prison Offender Management Report* (jointly with HM Inspectorate of Probation).

We also made submissions to the following consultations:

- Draft mandate to NHS Commissioning Board, August 2012
- Justice Committee inquiry into female offenders, September 2012
- Inquiry into rights of unaccompanied migrant children by the Joint Committee on Human Rights, October 2012
- Home Affairs Select Committee inquiry into drugs policy, November 2012
- Proposals for new Care Quality Commission strategy, November 2012
- Independent Police Complaints Commission consultation into the way that deaths following police contact are investigated, January 2013
- Triennial review of the Youth Justice Board, February 2013
- Transforming rehabilitation: A revolution in the way we manage offenders, February 2013
- Justice Committee consultation on older prisoners, March 2013
- Draft amended instruction on the care and management of young people (Prison Service Instruction 08/2012), March 2013
- Revision of the close supervision centre operating manual, March 2013.

Our reports and publications are published online at:
www.justice.gov.uk/about/hmi-prisons

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



3 PRISONS AND YOUNG OFFENDER INSTITUTIONS IN 2012–13

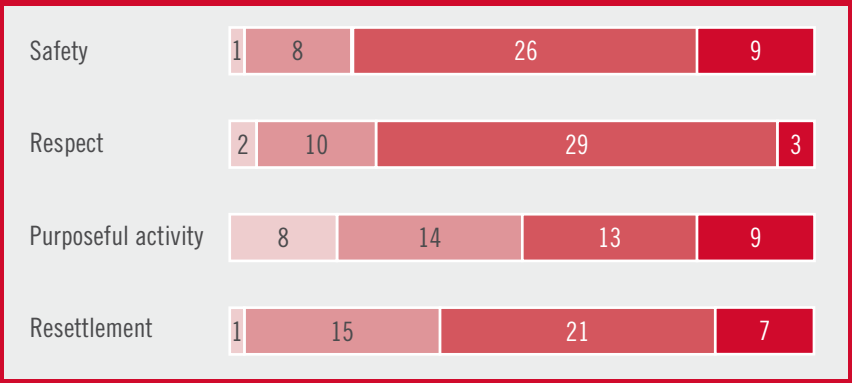
All the findings from prison and young offender institution inspections in this report are based on the fourth edition of our *Expectations: Criteria for assessing the treatment of prisoners and conditions in prisons,* published in January 2012 and *Expectations for Children and Young People*, published in June 2012.

Until April 2013, prisons received a full inspection every five years and either a full or short follow-up inspection in the intervening period. Young offender institutions holding children and young people received a full inspection on average every three years with a follow-up inspection in the interim.

In full inspections, we assessed outcomes for prisoners as good, reasonably good, not sufficiently good or poor against the healthy prison tests of safety, respect, purposeful activity and resettlement. During our full inspections we made 44 healthy prison assessments,[4] including 37 adult male prisons, two adult female prisons and five establishments holding children and young people.

Healthy prison assessments

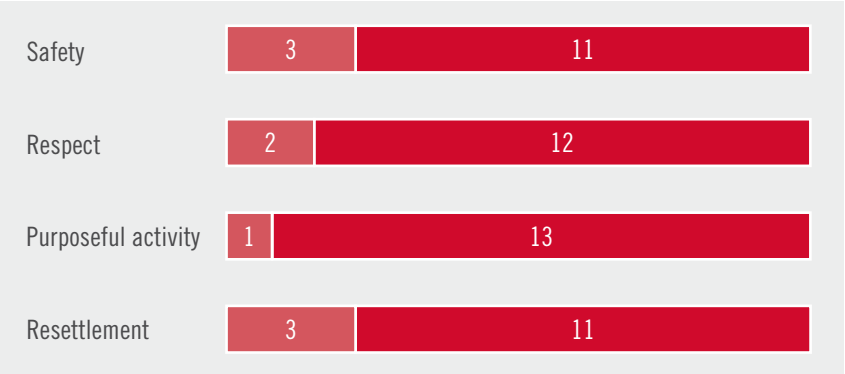
All prisons and YOIs inspected



4 At establishments with more than one function, we made separate assessments of each function; this applied to Isle of Wight and Winchester.

Prisons receiving short follow-up inspections were assessed as either making sufficient progress (efforts had been made to respond to our recommendations in a way that had a discernible positive impact on outcomes for prisoners), or making insufficient progress (overall progress against our recommendations had been slow or negligible and/or there was little evidence of improvements in outcomes for prisoners). We carried out 14 short follow-up inspections, including 11 adult male prisons, two adult female prisons and one establishment holding children and young people.

Charting progress in short follow-up inspections



Not safe enough

This section draws on 37 full inspections and 11 short follow-up inspections of adult male prisons.

- We assessed safety outcomes for adult male prisoners in most establishments as good or reasonably good, but they were not good enough in a quarter of the prisons we inspected and we had significant concerns about safety in half of local prisons.
- Deaths in custody had reduced from the previous year and the number and rate of self-inflicted deaths have been on a downward trend over the last 10 years.
- The number of self-harm incidents in male prisons had continued to rise.
- Too many prisoners in crisis were locked up in segregation.
- Suicide and self-harm procedures were too frequently poorly managed, with too much emphasis on process rather than outcomes for prisoners who self-harmed.
- New services had improved treatment for opiate-dependent prisoners, but the diversion of prescribed medication was a growing problem.

Figure 3: Safety outcomes in adult male establishments – full inspections

	Good	Reasonably good	Not sufficiently good	Poor
Locals	0	6	5	1
Trainers	3	11	3	0
Open	2	2	0	0
High security	0	1	0	0
Foreign national	2	0	0	0
Young adults	1	0	0	0
Total	**8**	**20**	**8**	**1**

Figure 4: Safety outcomes in adult male establishments – short follow-up inspections

	Sufficient progress	Insufficient progress
Locals	2	1
Trainers	2	0
Open	3	0
Young adults	2	1
Total	**9**	**2**

We expect that prisons will take all necessary action to ensure that prisoners, particularly the most vulnerable, are looked after and held safely from the moment they are received into custody. They should have effective processes to identify any individual concerns, and take appropriate action to keep prisoners safe from others and themselves. In addition to effective safety procedures, safety is enhanced by dynamic security in which relations between staff and prisoners are good, there is plenty to keep prisoners purposefully occupied and they make progress towards their resettlement.

HMP Onley demonstrated many of the characteristics of a safe prison, although levels of drug use were higher than we normally see.

> The prison was a safe institution. New arrivals were well supported and inducted, with very effective peer support a feature. Violence was very limited but the prison remained focused on ensuring perpetrators were challenged and victims properly supported. Case management for those at risk of self-harm was good, with useful input from mental health services. Provision for the relatively few segregated prisoners was reasonable. Substance misuse services were generally good, although drug testing found that about 11% of prisoners tested positive, a level of illicit drug use higher than we normally see in this type of establishment. Onley

In addition, inspectors found HMP Onley was a fundamentally respectful establishment with sufficient good quality activity available and a reasonable focus on resettlement.

The majority of adult male prisons where we had full inspections shared many of the characteristics of HMP Onley and we assessed safety outcomes for prisoners as good or reasonably good. However, there were some significant and unacceptable exceptions. Local prisons in particular were less safe than other types of prisons.

Responding to assaults

According to National Offender Management Service (NOMS) data[5], 13,542 assaults took place in all male establishments in 2012–13, down from 14,888 in 2011–12. This, at least in part, reflects a significant drop in the number of young people in custody – those most likely to be involved in assaults. The number of young people involved in assaults fell sharply but the number of prisoners aged between 21 and 40 involved in assaults rose slightly. There was a slight rise in the number of assaults involving weapons across the prison estate. Our inspection evidence confirms that keeping prisoners and staff safe from violence remains a significant challenge for most prisons.

How prisons responded to the threat of violence varied widely. Some placed a high priority on violence reduction, identified emerging issues and introduced effective measures to combat violence. However, others could only demonstrate minimal reporting of incidents and little tangible action.

> The prison gave a high priority to dealing with violence and antisocial behaviour. The monthly safer community meeting monitored issues and progress on both violence reduction and suicide and self-harm strategies. Meetings were reasonably well attended and were properly focused. Good data were generally collated for all types of violent and antisocial behaviour from sources including the incident reporting system, observation books, security reports and complaints. Lewes

> The monthly safer custody meeting did not fully analyse all the available data and we were not assured that all incidents were investigated thoroughly. Perpetrators of bullying were monitored but there were no formal interventions for them. Bullying for prescribed medication, and staff undermining confidence in the anti-bullying strategy, were problematic across all three sites. Isle of Wight

Responses to individual perpetrators and victims also varied. Most attributable assaults were subject to the prison disciplinary process, with some referred to the police for action. We found few specific interventions which aimed to address violent behaviour. Prisoners suspected of or found to have committed assaults were often reduced to the basic level of the incentives and privileges (IEP) scheme for a month and observed, and then returned to the standard level.

5 www.gov.uk/government/uploads/system/uploads/attachment_data/file/225109/safety-custody-summary-mar13.xls

> The three-stage process to deal with bullying and antisocial behaviour was used infrequently and inconsistently. The logs to monitor perpetrators at the different stages were poor, and there were no interventions to challenge their behaviour. Support for victims was limited to either moving them or informal contact with staff. Gloucester

By contrast:

> Formal arrangements to deal with bullying had also been reviewed and modified to produce a simple two-stage system to identify, monitor and change antisocial behaviour. This was based chiefly on IEP sanctions supported by regular reviews to monitor behavioural changes. Norwich

We were concerned that many new arrivals waited up to 10 days to receive their first shop order, which risked exposing them to debt and bullying in their vulnerable early days.

Disciplinary procedures and security

Most records of adjudication hearings showed that proceedings were conducted fairly and that punishment was appropriate and consistent. However, a few examples indicated that prisoners were not always given the opportunity to fully explain their version of events or that evidence was properly examined. At Forest Bank the number of adjudications was reasonably low but many records showed insufficient investigation. Records of hearings at Lincoln were variable and quality assurance required improvement. Adjudication standardisation meetings generally took place quarterly but at some prisons attendance was inconsistent and minutes did not always reflect sufficient discussion about relevant issues.

Procedural security was usually properly managed and security committee meetings were well attended by staff representatives from relevant areas. On the whole, security departments managed complex intelligence systems and used them to identify and deal with risks proportionately. This helped prisoners to engage fully in prison regimes and contributed to keeping them safe. However, at Winchester, there were disproportionate procedures for locking up prisoners between regime activities and unnecessary unlocking of half a landing at a time for collecting meals and for association. At Lincoln, prisoner access to the regime was severely restricted by the inability of staff to reconcile the roll and account for prisoners.

Use of force and segregation

We found that governance of the use of force had improved overall and greater efforts were being made to de-escalate incidents before force was used. Governance arrangements were generally effective and incidents were usually discussed at the monthly security committee and safer custody meetings, with emerging patterns and trends identified. However, the recording of planned incidents was sometimes sporadic and although most prisons had the resources to video record removals, many did not use them.

Prisoners were routinely strip searched on admission to segregation units, and living conditions on the units in older prisons, such as Lincoln, Winchester and Durham, were often poor. Apart from a shower and a phone call, most prisoners remained locked in their cells nearly all day with nothing to do, and prisoner care planning was usually underdeveloped, although we found some improvements, particularly in large local prisons such as Birmingham and Winchester. Relationships between staff and prisoners were usually good: officers dealt patiently with difficult individuals and residents often said that they were kind and helpful. However, the analysis and documentation of segregation were inadequate in many prisons. Monthly segregation management and monitoring meetings were poorly attended and we

frequently found insufficient discussion of issues relating to segregation. Information about the amount and length of stay of segregated prisoners was not analysed properly and there were not always good enough links with other relevant areas of the prison, such as violence reduction committees and suicide prevention structures. For example at Norwich, comprehensive data on segregation was collated but was not used in any meaningful way. At Liverpool, other than the number of times prisoners had been held in segregation, there was little information to inform analysis.

Keeping prisoners safe from self-harm

The early days in custody are a particularly vulnerable time for prisoners who may be at risk of suicide or self-harm. Many of those who arrive in prison will never have experienced the environment before and it can be a daunting prospect even for those who have. Risks in the early days of custody can be heightened by fear of the unknown, guilt or shame about the offence, loss of or diminished family support, mental or other health problems and substance misuse issues. Support to allay new prisoners' anxieties can include use of prisoner peer supporters – such as Samaritans-trained 'Listeners' – as well as first night risk assessments, prepared and welcoming first night cells, and proper handover arrangements to night staff.

Deaths in custody have reduced but self-harm has risen

In 2012–13 there were 176 deaths in male prisons across England Wales, 31 fewer than the previous year. The number of self-inflicted deaths declined from 65 to 50 in 2012–13. A further 108 prisoners died from natural causes (down from 131 in 2011–12) and two as a result of homicide. There were 16 other deaths, of which 15 were yet to be classified.[6]

Incidents of self-harm continued to rise among men to 16,370 in 2012–13, compared with 16,202 in 2011–12 and 14,769 in 2010–11.

We found there were no peer supporters in reception in two of the local prisons we inspected where there had been self-inflicted deaths: Lincoln and Gloucester. Others, including Durham, Norwich and Birmingham, used peer supporters well and this was valued by new arrivals.

Sharing good quality information about a prisoner's history and risk of self-harm is crucial to keeping them safe. Many prisons, including Durham, Whatton, Woodhill, Buckley Hall, Channings Wood, Forest Bank and the Isle of Wight, had effective first night arrangements which included a private interview with a member of staff, which was then used to complete a risk assessment on the prisoner. However, we identified concerns in other prisons about how information on new arrivals was dealt with.

6 Ministry of Justice , Safety in Custody statistics England and Wales, March 2013

> One prisoner arrived with a suicide risk warning form but this was not mentioned in his P-Nomis [electronic] case notes on arrival or in written records of interviews with reception staff. Wing staff were not alerted to the warning until the following day. A similar warning about a prisoner whose death was being investigated by the Prisons and Probation Ombudsman had been misplaced in June 2011. Liverpool

Most prisons had comprehensive suicide and self-harm prevention policies, but most did not use them to identify trends and patterns, understand why prisoners were self-harming and take action to address this. The few prisons that used such data well included Dartmoor, Durham, Forest Bank, Stoke Heath and Thorn Cross.

Despite the importance of staff training to identify prisoners' risk factors and offer individual support, we were repeatedly told that because safer custody refresher training was not mandatory it was not prioritised – including in prisons that had experienced self-inflicted deaths. In many prisons we also found too few staff trained in first aid or the use of defibrillators.

We also found that only a minority of prisons had good quality assessment, care in custody and teamwork (ACCT) self-harm monitoring documentation and individual care plans for prisoners in crisis. The ACCT document, which can be initiated by any member of staff, is used to assess risk, identify triggers for thoughts of suicide or self-harm and put appropriate, individualised care plans and support in place, including irregular monitoring of pre-arranged frequency of the person at risk. Ongoing records should not just observe the prisoner but demonstrate that staff have had meaningful engagement with them.

> The quality of entries in ACCT documents was generally good and showed that staff were aware of and cared about the personal needs of their prisoners… We found that prisoners at risk of self-harm or suicide generally received personal and consistent care and support to address their individual needs. Dartmoor

However, we identified serious shortfalls in monitoring and care plans at a number of prisons, including Whatton, Woodhill, Lewes, Birmingham and Winchester. All of these prisons, with the exception of Whatton, had had self-inflicted deaths in the year of this report or the year before.

Despite the need for staff to be aware of how to handle emergencies, we too often found them reluctant to enter cells on their own, even when they believed a prisoner's life was at risk. Again this was the case even at some prisons such as Elmley that had recently experienced self-inflicted deaths.

> Night staff lacked confidence in how to respond to emergency situations. They told us that they would not enter a cell alone in any circumstances, and several (and some day staff) did not have a ligature knife. Some were unable to open the cell key pouches with which they were issued for use in an emergency. Elmley


2

If...

- something is bothering you
- you have a complaint about your treatment
- you need independent help about a

we may be able to help you

We are independent of the prison. You can speak to us in complete confidence.

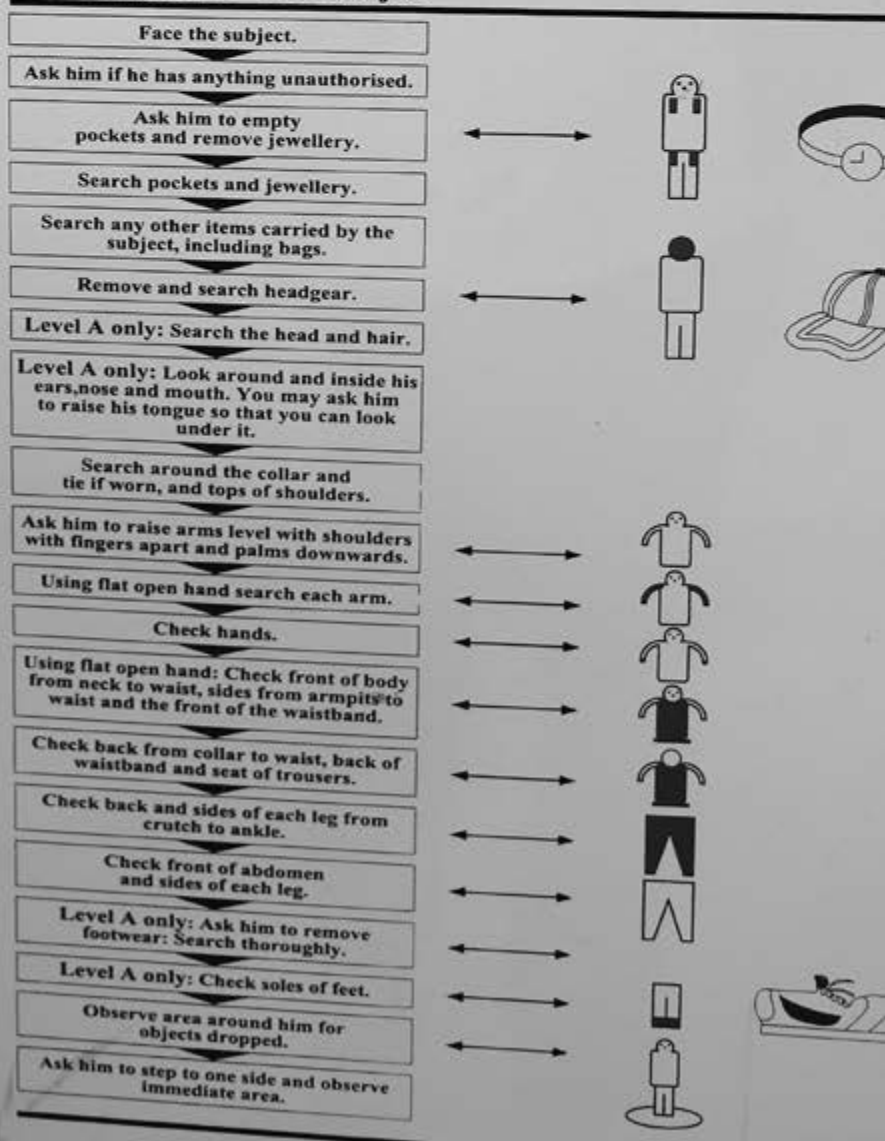
You can put in an application to see us (look for our brown boxes on the wings). We come into Pentonville every Wednesday afternoon. Or you can speak to us when you see us walking around the prison. We all wear badges with the IMB logo on.

See our leaflets for more details. Unless it's urgent or confidential, please try and use the Requests and Complaints procedure before you put in an application to see us.

ALL PRISONERS ARE TO BE SEARCHED ON EXIT FROM DAYCARE
NO EXCEPTIONS
NO ITEMS ARE TO BE TAKEN OUT WITHOUT PRIOR PERMISSION

EASY REFERENCE

Rub down search - male subject



Many prisoners on ACCTs were locked in their cells for long periods with nothing to occupy them. We have consistently highlighted the role of segregation in heightening the risk of self-harm. The most severe methods of restraint (such as segregation, special accommodation, strip clothing and body belts) should only be used on prisoners who have been identified as at risk of self-harm or suicide in the most exceptional circumstances – for the obvious reasons that such measures are likely to increase an individual's distress. However, despite this, we have repeatedly found prisoners on ACCTs held in segregation units with no exceptional reasons to justify this – at Buckley Hall, Dartmoor, Elmley, Forest Bank, Isle of Wight, Lincoln, Norwich, Portland and Stocken.

We also found inappropriate use of 'special accommodation' (unfurnished cells in segregation units used as a last resort for violent or refractory prisoners) for prisoners on ACCTs in Forest Bank, Isle of Wight, Northumberland, Norwich, Wakefield and Woodhill, as well as the extreme measure of removal of prisoners' clothing to prevent self-harm, also used at Forest Bank, Northumberland, Norwich, Stocken and Wakefield.

Substance misuse services

Responsibility for substance misuse services moved from NOMS to NHS England, with commissioning responsibility coming into effect from April 2013. Under the new arrangement, all substance misuse services will be fully integrated. We saw a welcome move towards more integrated treatment provision and a positive focus on recovery, including examples of active peer support and service user engagement.

A fully integrated substance misuse team ran a wide range of group work courses on both units, which had substance misuse nurses and recovery workers, and peer mentors were also actively involved. Forest Bank

The integrated drug treatment system (IDTS) improved treatment for opiate-dependent prisoners, but also resulted in some high-dose and long-term methadone prescribing, which was insufficiently managed. While the government's 2010 drug strategy focuses on recovery and abstinence as the ultimate goal of drug treatment, an expert treatment review (National Treatment Agency for Substance Misuse, 2012) cites 'compelling evidence for effective opiate substitution treatment' to support recovery. We recognise that abstinence is not realistic for everyone, and look for personalised treatment plans and care when inspecting this area.

We saw evidence under the integrated drug treatment system (IDTS) of good clinical management based on individual need, provided by a specialist team and reviewed regularly. Currently, 64 prisoners were prescribed opiate substitutes, with 70% on reduction regimes. Onley

In several prisons, there was poor clinical management, ranging from long-term maintenance prescribing without regular reviews to forced reduction without sufficient patient involvement, combined with inadequate support.

Prescribing practice had recently changed to encourage reduction rather than maintenance regimes, and to restrict the number of prisoners on Subutex (there was evidence of diversion). Prisoners engaged in reduction regimes had increased from 20% to 40%, but there was a lack of prisoner involvement and consultation in the process. We spoke to several prisoners who had relapsed following detoxification and now used substances illegally. Birmingham

> An average of 20% of new arrivals required opiate substitute treatment… 117 prisoners were prescribed methadone or Subutex, mainly on a maintenance basis, with only 17 reducing their dosage. We were concerned to see several examples of considerable increases in dosage… The clinical team was overstretched and unable to conduct regular multidisciplinary treatment reviews. Lincoln

In contrast, prescribing at some prisons was flexible and recovery-focused.

Since the introduction of IDTS, there has been a significant reduction in the illicit use of heroin in prisons. However, there has been a steady increase in the reported abuse of prescribed medication, where medication is 'diverted' by someone for whom it was not prescribed. Prisoners might sell their own medication or have it taken from them through theft or bullying.

The risks of diverted medication include bullying, drug debts, unexpected drug interactions and overdose. Medication commonly diverted includes certain painkillers, sedatives and psychiatric medication. Many of these medications cannot be detected by mandatory drug testing (MDT), or there are no legal powers to do so, and consequently, as highlighted in our 2010–11 report, MDT is no longer an accurate measure of drug use in British prisons. We also found that suspicion drug testing – which could detect some diverted medication – was not adequately completed at a third of the prisons we visited.

Since 2012, our survey has asked adult prisoners if they have developed a problem with diverted medication in their current prison. An average of 7% of prisoners across all types of prisons said they had.

In many prisons inspected, several factors contributed to medication diversion – high levels of prescribing of medications liable to abuse; divertible medication inappropriately given to prisoners in possession; poor supervision of medication queues; and a lack of secure in-cell storage for medications. In several prisons, the strategic approach to the problem was poor.

> Ninety-four per cent of medicines were supplied in possession… Most prisoners did not have lockable storage in their cells to keep medicines safely… There were opportunities for diversion and theft of medication… There were high levels of prescribing of medicines liable to abuse, often in-possession, although there were some procedures to reduce this. Highpoint

Some prisons attempted to prevent the diversion of Subutex (an effective licensed opiate substitute) by not offering it as an option for opiate-dependent prisoners. However, patients should be offered the clinically most appropriate medication for their treatment to be effective, and establishments should manage the diversion risk through more suitable mechanisms.

There were a few examples of good practice, including effective supervision of medication queues, new approaches to pain management to reduce inappropriate prescribing, and adequate resourcing to ensure all suspicion drug tests were completed on time.

> The Beacon Practice had developed some helpful protocols related to diverted medication and 'prized medication' (tradable medication)… All new prescriptions for these medications were agreed via a weekly prescribers meeting and prisoners already on opiates (strong pain relief) were systematically reviewed to ensure clinical appropriateness alongside adequate pain management. Isle of Wight

In the coming year we will be producing a thematic report on this area, looking at the extent and implications of medication diversion and measures to tackle it.

Respect indicators reasonably good

This section draws on 37 full inspections and 11 short follow-up inspections of adult male prisons.

- Treatment and conditions for prisoners were reasonably good for most prisoners, but the number of exceptions remained too high. Outcomes were assessed as 'good' in only one prison.
- Staff-prisoner relationships were usually positive, but in some prisons a few rogue staff had a disproportionately negative impact.
- Residential staff were not active enough in supporting prisoner rehabilitation.
- There was a failure to understand and address the needs of specific minority groups. The growing awareness of the needs of older prisoners was not yet matched by strategies for provision.
- Health care facilities had improved, but there were still long waiting times and a lack of mental health provision.
- Prisoners disliked the food, and delays in access to the prison shop could lead to debt for new arrivals.

We expect that prisoners are treated with respect for their human dignity in the accommodation in which they live, their treatment from staff, equality of provision (whatever their background, faith or religious beliefs), and with services to support their legal rights, health care and daily food and other needs.

Respect outcomes for prisoners remained good or reasonably good in 73% of the prisons we fully inspected, about the same as last year, and we found that nearly all of the establishments which received short follow-up inspections were making sufficient progress in this area. Given the financial and staffing pressures on prisons during the year this was a positive achievement.

However, this generally positive picture was less marked in local prisons, where only 58% received good or reasonably good assessments. The pressures on local prisons were more acute, with often a fine balance between managing a challenging and changing population and having the physical and staff resources to ensure prisoners were treated decently and respectfully.

Figure 5: Respect outcomes in adult male establishments – full inspections

	Good	Reasonably good	Not sufficiently good	Poor
Locals	0	7	4	1
Trainers	1	11	4	1
Open	0	3	1	0
High security	0	1	0	0
Foreign national	0	2	0	0
Young adults	0	1	0	0
Total	**1**	**25**	**9**	**2**

Figure 6: Respect outcomes in adult male establishments – short follow-up inspections

	Sufficient progress	Insufficient progress
Locals	2	1
Trainers	2	0
Open	2	1
Young adults	3	0
Total	**9**	**2**

Overcrowding remains

As in 2011–12, 60% of the prisons we inspected were overcrowded, with many prisoners sharing cells designed for one and insufficient activity and other resources to match the size of the population. The prisons with the most significant overcrowding problems were Dorchester, operating at 175% of its correct capacity, Preston (160%), and Durham and Lincoln (both 155%). The degree of overcrowding was reflected in the wider concerns we had about all of these prisons.

Few prisons we inspected had adequately screened toilets, and these were frequently dirty and required descaling. Most prisoners were required to eat their meals in their cells next to the toilet. Some cells did not have sufficient furnishings for two people. Communal showers were also poor, with some that were dirty, in need of repair and lacking sufficient privacy screening, although prisoners could usually have a daily shower and they had the basics to keep themselves clean and decent. Most prisons had policies about the display of offensive materials but these were applied inconsistently. Physical conditions were better in modern prisons built relatively recently, such as Littlehey, where cells were adequately furnished, clean and in good order, with a lockable cupboard, curtains and appropriately screened toilets.

Staff-prisoner relationships

Interactions between staff and prisoners were usually professional and positive. In our surveys, 77% of prisoners said that most staff treated them with respect. Good relationships usually resulted from a staff group who were willing to engage positively with prisoners, take an interest in their circumstances and be willing to listen to their concerns.

> Prisoners said that relationships with staff were generally positive, and most said they could always turn to an officer for support… We saw positive staff-prisoner relationships in all areas of the prison. Staff were polite and good humoured, interacted with prisoners during association, and used prisoners' preferred names. Onley

However, in some prisons staff were passive and disengaged, with too many wing staff reluctant to challenge prisoners about low-level poor behaviour or motivate them to address their offending behaviour; wing staff too often left this to safer custody teams or offender management units. For example, at Wolds we found that relationships between staff and prisoners were friendly but poor behaviour was often not challenged.

> We noted some prisoners shouting out of cell windows without challenge, particularly at night and on A and B units, which was a concern as B unit housed the segregation and induction units. Wolds

In Northumberland, prison staff were friendly but did not engage with prisoners' progress in their sentence:

> Personal officers made regular entries in prisoners' files, but many were brief and most limited to wing behaviour. There was little evidence of a focus on the personal circumstances of prisoners or on the support they required to achieve sentence progression. Northumberland

Individual staff who deliberately treated prisoners unfairly or who were abusive had a very damaging effect on staff-prisoner relationships as a whole.

Many prisoners complained about the attitude and behaviour of a small number of uniformed staff whom they considered, at best, too strict in the application of rules and, at worst, abusive. The local independent monitoring board had also identified this issue and had raised it with senior managers. We considered these concerns were credible and in need of investigation. Bullingdon

However, where staff-prisoner relationships were positive, and there was good consultation, the prison was safer and prisoners felt the benefit of this and were more productive. In Ford open prison, for example, previously poor relationships had been transformed following action taken after serious disturbances in the prison in January 2011. Ford recognised that it could not provide a meaningful personal officer scheme – allocating named individual officers to each prisoner – due to staffing levels and instead emphasised training for all staff to respond to prisoner needs effectively. It also introduced exemplary prisoner consultation.

An active and sophisticated prisoner council… met monthly and it was clear from minutes of meetings and council members that issues raised were taken seriously and progressed appropriately. Council members communicated effectively with prisoners to understand their concerns and inform them about progress on issues. Council members had been given access to prison departments so that they could advocate on behalf of individuals to resolve difficulties or conflict. Ford

An accessible and fair complaints system allows prisoners' individual concerns to be addressed, as well as providing a legitimate mechanism to deal with individual grievances, which is important for the good order of the prison. While most responses to complaints were prompt and to the point, we identified examples where responses were dismissive, delayed and answered by the person who was the subject of the complaint. These faults damaged the credibility of the system as a whole. Prisoners frequently lacked confidence in the complaints system. In our surveys, 38% of prisoners who had made a complaint told us they did not believe complaints were dealt with fairly.

Addressing diversity

Prisoners from minority groups were consistently more negative about their experience in prison than the majority population (see Appendix 5).

Overall, prisoners who considered themselves to have a disability expressed more negative views than non-disabled prisoners in 43 out of 58 of our survey questions. Black and minority ethnic and Muslim prisoners were more negative than white and non-Muslim prisoners in 39 out of 58 questions, and foreign nationals were more negative than British prisoners in 27 of the questions. There is some overlap between these groups.

However, older prisoners (aged 50 or over) were an exception to this pattern, being broadly more positive about their experiences than prisoners under 50. This is likely to be affected by factors other than age – for example, older prisoners were predominantly white.

Negative perceptions covered the full range of prison experience (except for respect for religious belief and access to religious leaders). (See Appendix 6 for survey diversity analysis.)

Prisons did not do enough to understand and address these negative perceptions. Consultation with prisoners covered by protected characteristics was very poor. Nearly all prisons analysed data on equality outcomes, but they mainly focused on ethnicity and few looked at all the minority groups. In many cases, outcomes for

black and minority ethnic prisoners were poorer, particularly in the application of disciplinary procedures and, in open prisons, in access to release on temporary licence, but scrutiny of these unequal outcomes varied. At Norwich we reported some good work and action taken, but this was the exception rather than the rule. In inspections of 13 establishments, we reported cross-deployment of specialist diversity staff to fit alongside generic officer duties or violence reduction responsibilities, and staff who were allocated too few hours to complete their diversity work. In other prisons, there were indications that the staff resource, including specialist posts, was insufficient.

All of the equality officers were subject to considerable redeployment, which had a detrimental effect on their ability to develop provision. Littlehey

Investigations into discrimination complaints (DIRFs) were thorough and timely in many prisons, but at others, such as Durham, they were poor or lacked rigour. In Ranby, we found two cases where the subject of the complaint had been asked to conduct the investigation. However, a few prisons involved prisoners in reviewing a percentage of discrimination complaints, which increased confidence in the system.

All DIRFs were quality checked by the equality manager and governor, and a percentage were robustly scrutinised quarterly by a panel consisting of prisoner representatives and prison and Independent Monitoring Board staff from prisons across the area. Hatfield

Gypsy, Roma and Traveller prisoners are a significant but often unrecognised minority in many prisons. In some cases they were over-represented in disciplinary processes, and little was done to address their offending behaviour or meet their specific resettlement needs. At Gloucester, our survey indicated that 11% of the population were from that background, but there was no provision or support for them. In contrast, Northumberland supported these prisoners well through the diversity manager, an outreach worker and group support meetings.

In most prisons, we found foreign national prisoners who had been detained beyond the end of their sentence. We were told this was either because their levels of risk precluded a move to an immigration removal centre (IRC), or that a place was not available. This was particularly the case for detainees who had previously been convicted of sexual or violent offences. Where the working relationship between the prison and the Home Office (previously through the United Kingdom Border Agency, UKBA) was not well developed, foreign national prisoners were at greater risk of being detained for a significant period beyond the end of their sentence. Many were detained for more than six months after their sentence had ended and at Lincoln we found the most extreme example.

Support from the United Kingdom Border Agency (UKBA) was intermittent and its lack of action in a number of cases was a cause of great concern. We found one prisoner who had been detained for nine years after his sentence had ended and was still awaiting a decision on his future. Lincoln

Links with the Home Office varied significantly between prisons. In some, designated as 'hubs' to hold foreign national prisoners, there were effective on-site teams:

> Overall, there were good structures to support foreign nationals, with good joint working between the foreign nationals' officer and on-site UKBA officer… The UKBA officer had a particularly valuable role as he had direct access to the immigration casework information database and could give prisoners quick answers to immigration-related questions. Manchester

Other prisons did not have on-site teams but there were regular surgeries, such as those at Wakefield, provided by visiting Home Office staff, to progress cases, or designated prison administrative staff, like those at Stocken and Wolds, who liaised with the Home Office.

However, in some prisons the relationship with the Home Office was poor or non-existent and foreign national prisoners had difficulty in progressing their cases or even knowing where they stood in relation to deportation. In Northumberland and in Stocken there were ad hoc arrangements with the Home Office, and in Buckley Hall the Home Office did not visit the prison.

General services for foreign national prisoners varied greatly, even in designated foreign national prisons or where high numbers were held.

> The number of foreign nationals had decreased… but at 230 still equated to nearly 40% of the population. Provision for them consisted almost solely of a free five-minute telephone call, which was only allowed if the prisoner did not receive any visits, and a few newspapers in the library. The role of foreign nationals liaison officer had ceased and there were no meetings, and there was no evidence of any understanding of their issues. Verne

Most prisons did not support foreign nationals in maintaining family ties, although Wolds was an exception, and free telephone calls to family abroad were often provided if the prisoner did not receive domestic visits.

We made more recommendations about disability than for any other protected characteristic. Identification of prisoners with disabilities was much too inconsistent. For example, Canterbury had identified 11 prisoners with disabilities but our survey suggested that the figure was three times higher. In contrast, Birmingham had good initial work with prisoners with disabilities through self-referral on reception.

Some prisons had made significant adaptations to their accommodation, and prisoners were used as paid carers and wheelchair pushers at Northumberland and Whatton (where 35 prisoners had been trained as wheelchair handlers).

In contrast, at Winchester we found two older, severely disabled men who spent all day together in a small dark cell, who had not been able to shower for months, and who faced problems that staff were unaware of.

Neither man was able to work so they spent 23.5 hours a day in their cell. Although there was a shower on the landing, it had not been adapted for use by people with disabilities and so they were unable to use it. Neither had had a shower for months but did their best to wash in their cell. They relied on other prisoners for help with tasks such as collecting meals. Wing staff were unaware of these problems when we brought them to their attention. Winchester

Planning for older prisoners

Older prisoners are a growing percentage of the overall prison population and this will need to be reflected in the focus of prisoner governors and future service provision.

In March 2013, we submitted written evidence on the needs of older prisoners to the Justice Committee, and the Chief Inspector gave oral evidence in April 2013.

In our evidence, we said that:

- because older prisoners are a largely compliant population, their specific needs may be overlooked in a system geared towards managing the much larger proportion of younger men
- the needs of older prisoners and a supporting framework to meet these needs have not been clearly defined by a national NOMS strategy, resulting in a significant variation in service provision for them across the prison estate.

We went on to call for a national NOMS strategy on older prisoners to set out a clear framework for delivery, defining the responsibilities of prisons and other agencies involved and with a common system for assessing the needs of older prisoners. We said that the strategy should address the shortage of suitable accommodation in prisons for those with mobility problems, and include plans to engage social care agencies in the community in providing care packages to prisoners and on release, as well as developing provision to meet their needs.

We found examples of such provision in one prison inspected in 2012–13.

The Lobster Pot, a day care centre run by the Resettlement and Care for Older Ex-offenders and Prisoners for the over 50s population, was an excellent resource. The various activities on offer, which attracted approximately two-thirds of over 50s, included training and allowed staff to conduct a dynamic assessment of needs. As a result, the provision was evolving accordingly. Leyhill

With the ageing of the population, more prisoners will die of natural causes while they are still in prison. Most prisons inspected had good end-of-life care with enlightened approaches to family visits. Some used the best practice care framework or were seeking accreditation with Macmillan cancer care.

Palliative care arrangements, including links with local hospice services, were excellent and the new unit was a positive development but lacked sustainable staffing. Before the unit had been built, a prisoner had been successfully cared for on a residential wing over the last year, involving positive collaboration between health care and prison staff to ensure high quality care and a dignified death. Leyhill

Health services – changes on the way

During the reporting year, there was much uncertainty about the forthcoming changes to the NHS and, in particular, how health services for prisoners would be affected. The year 2012–13 was the last in which prison health care was commissioned by primary care trusts (PCTs), commonly via regional consortia. From April 2013, there was a new oversight body, NHS England, with 27 area teams, of which 10 took the lead for the commissioning of offender health services. Health care is a devolved responsibility in Wales.

Many health services providers in the prisons we inspected were unclear about future arrangements, and this uncertainty affected services. While almost all prisons had carried out a health needs analysis of their prisoners, more analyses than usual had become out of date awaiting the outcomes of tendering exercises for health services.

There had been no assessment of the health care needs of prisoners for over three years, which meant that there was no action plan or workforce plan by which to monitor and develop services as required by the prison population. Verne

Tendering out of services often had unfavourable consequences, with services unable to develop or recruit staff to keep pace with need, due to the protracted processes involved. We noted the re-emergence of chronic difficulties in recruiting staff, particularly in Greater London and the South East.

There were several vacancies, and long-term agency staff were used. Thameside

The recent change in the health service provider had resulted in staff shortages and a considerable reduction in services, with limited external scrutiny of those provided. Wolds

Half the prisons we inspected had benefited from refurbishment of health care facilities, and all had adopted NHS-standard approaches to infection control measures and had compliance plans. We observed a trend to place automated external defibrillators in the main wing offices, which made them more accessible.

We saw good care for patients with lifelong conditions, and more nurses had received dedicated training. A few prisons, such as Hatfield and Isle of Wight, had introduced pain clinics to assist patients and reduce the range of their medications, with an associated reduction in the risk of medication diversion. This was a welcome innovation.

The management of long-term conditions mirrored the community model and prisoners had access to information and follow-up care aligned with national frameworks. Leeds

Prisoners had better access to wing-based nurse triage and GPs, but there were still long waiting times for other health professionals, such as dentists and opticians, at several prisons.

Pharmacy services were generally good, although some prisons had no pharmacy-led clinics. A minority of prisons had nurse prescribers or made good use of patient group directions (enabling nurses and other health professionals to supply and administer prescription-only medicine) to improve prisoner access to medications for prisoners.

In our surveys, 29% of prisoners reported having an emotional well-being or mental health issue. Many prisons had developed integrated mental health services, but others lacked provision at primary care level. Some benefited from access to forensic psychology, speech and language therapy and a few from IAPT (improving access to psychological therapies) services. Counselling services, such as those offered by Birmingham, Thorn Cross and Stocken, were valued by prisoners, and there were weekly support meetings for prisoners at Buckley Hall and a weekly support group for prisoners at risk at Gloucester. Wolds had introduced a therapeutic 'pat dog'. However, there was not always enough provision to meet need.

> Mental health care was provided by a team of four mental health nurses, and the service was valued highly by prisoners and staff. The team had also developed skills in delivering qualified counselling services… The service was also involved with developing peer mentors who provided additional support on the wings to prisoners with mental health issues. There was an open referral system with just over half the patients having self-referred. Prisoners were also discussed at protection and safeguarding meetings. A psychiatrist visited weekly.
> Buckley Hall

Transfers of patients to NHS secure mental health beds had generally improved but there were still some long waiting times, in particular for some specialised NHS secure services. We were pleased to see that many prisons had received and considered the Department of Health guidance on services for offenders with personality disorders.

Food and shop services

The average cost for food allocated per prisoner was £2.26 a day in the year ending March 2012 and reduced further to £1.96 in 2013. Prisoner perceptions of food were poor in many prisons we inspected, and only 26% of prisoners surveyed said the food was good. Black and minority ethnic prisoners were even less favourable about the food. We found that the quality of food varied greatly, with some establishments providing a reasonable standard, despite the low budget, while others offered meals that were inadequate, cold and unappetising.

Breakfast packs were still distributed to prisoners the day before they were to be eaten in most prisons, with the result that most were eaten then rather than the following morning. Where this was not the case, for example at Gloucester and Canterbury, prisoners had much better perceptions about the food. Meal times in most prisons continued to be too early (before noon and 5pm), particularly at weekends. Many prisoners still continued to eat meals in their cell – often alongside unscreened toilets – rather than dine in association with other prisoners.

Forty-four per cent of prisoners surveyed said that the prison shop provision (enabling prisoners to buy a range of products for their day-to-day living) did not meet their needs, and this rose to most black and minority ethnic prisoners. We were also concerned that many new arrivals could wait up to 10 days to receive their first shop order, which exposed them to potential debt and problems with other prisoners.

Too much time locked up, and too little to do

This section draws on 37 full inspections and 11 short follow-up inspections of adult male prisons.

- Activity outcomes were poor and falling.
- Too many prisoners spent too long locked in their cells, and evening association was increasingly curtailed.
- There were too few activity places, and low take-up of what was available, often disrupted by poor attendance and punctuality, prison routines and other activities.
- The impact of new learning and skills contracts was not yet clear, and quality assurance and use of data needed to improve.
- Achievement of qualifications was good for those who took them, but too few employability skills were recognised.
- Employment and training outcomes for released prisoners were not measured, links with local employers were still underdeveloped, and there was poor skills development to prepare prisoners for release.

We expect that prisons will provide prisoners with sufficient time out of their cell each day to take part in the activities on offer, associate with each other, take exercise and have 'domestic' time to look after their rooms and make contact with their families. Prisoners should have access to activities that are purposeful, benefit them and increase their chances of working on release.

We found that purposeful activity outcomes for prisoners were particularly weak this year. In 2012–13, we found that they were not sufficiently good or poor in over half of all prisons fully inspected, the worst outcome for six years. Most striking was the situation in local prisons, where we assessed 11 of the 12 as providing outcomes that were not sufficiently good or poor.

Figure 7: Purposeful activity outcomes in adult male establishments – full inspections

	Good	Reasonably good	Not sufficiently good	Poor
Locals	0	1	6	5
Trainers	1	6	7	3
Open	1	3	0	0
High security	0	1	0	0
Foreign national	2	0	0	0
Young adults	1	0	0	0
Total	**5**	**11**	**13**	**8**

Figure 8: Purposeful activity outcomes in adult male establishments – short follow-up inspections

	Sufficient progress	Insufficient progress
Locals	3	0
Trainers	1	1
Open	3	0
Young adults	3	0
Total	**10**	**1**

Time out of cell

Too many prisoners were locked up for too long every day, and their time out of cell had reduced. Only 17% of prisoners surveyed in category C training prisons and 15% in category B training prisons said they spent 10 hours out of cell on a weekday.

Figure 9: How long do you spend out of your cell on a weekday?

	Spend more than 10 hours out of cell (weekday) (%)	Spend less than two hours out of cell (weekday) (%)
Locals	9	22
Category B trainers	15	8
Category C trainers	17	10
High security	12	7
Young adults	15	11
Open	50	2

In our random roll checks during the working day, we found far too many prisoners locked in their cells – at least a third in local prisons, with as many as 57% in Gloucester. The average number of prisoners locked up in the category B local prisons we inspected was 40%. In category C prisons the figure ranged from no prisoners to 25% locked in their cells during the core day, with an average of 14% across all the prisons we inspected.

Prisoners engaged in working, training or education generally had the most time unlocked, with approximately nine hours on a weekday. But there were exceptions to this – at Lewes and Lincoln, unlock time was less than six hours, even for a fully employed prisoner.

Many prisoners not fully employed spent less than four hours out of their cells on a weekday. There was a discernible difference between the amount of time an unemployed prisoner could spend out of their cell at local or category C prisons. In local prisons unemployed prisoners received between two and four hours unlocked (with the exception of Forest Bank, which offered six hours); at category C prisons they received between three and nine hours (with the exception of The Verne where unemployed prisoners were unlocked all day).

Although the number of association periods offered to prisoners each week was similar to last year, the length of the evening association had reduced significantly in some prisons, with prisoners locked up for the night before 7pm. The provision of association was also unpredictable.

> Evening association periods were short and prisoners were locked up too early, at 6.45pm on Monday to Thursday and at 4.45pm on Friday and at weekends. Highpoint

The impact of such limited time unlocked on prisoners was significant.

> Unemployed prisoners could experience less than three hours out of cell during the week. Evening association periods were short, and some prisoners got only an hour when we observed late unlock for meals. This affected prisoners' ability to do everything they needed, such as eat their meal, make telephone calls and get a shower. Buckley Hall

However, there were exceptions to this pattern, showing that some prisons are able to offer their prisoners far more opportunities to spend time out of their cells to associate with others, take exercise and keep in touch with their families.

> Prisoners were not locked in their cells and had considerable freedom of movement, time out of cell and time in the open air… Association and outdoor exercise were scheduled daily and rarely cancelled. Verne

Activity places

In half the establishments, there were not enough activity places for the population – particularly in local prisons. For example, the local prison at Winchester had only enough purposeful activity places for just over half the population. But even in training prisons we found a shortage of places – with only enough places to employ 80% of prisoners at Stocken and Channings Wood.

To compound this shortfall, there was a widespread and unacceptable failure to fill the places available. Half of all prisons failed to use their available places effectively, leaving prisoners unnecessarily without work or training.

In addition, prisoners' chances of making the most of learning opportunities and the working day were frequently undermined by prison routines – particularly in local prisons where a variety of assessments, detoxification and legal processes required prisoners to have many appointments away from their activity place, and also where the number of remand prisoners led to disruption. However, much of this disruption was avoidable and a result of insufficient management attention and poor timetabling.

> The regime was plagued with daily disruptions that led to prisoners being unlocked late. Lincoln

Learning was also disrupted by prisoners going to recreational PE instead.

> Some prisoners were allowed to attend the gym during their working hours which disrupted learning and reinforced a poor work ethic. Dartmoor

Some disruptions were closely linked to staff shortages. In some cases, weak contractual arrangements meant there was no cover for supervisor or trainer vacancies, sickness or leave.

> Both libraries [had frequent closures] which occurred because no officers were available to escort prisoners there. These closures primarily affected evening and weekend library access, and over 100 sessions had been cancelled in recent months. This impacted severely on prisoners on vocational training programmes. Littlehey

Physical education remained a popular activity and there was much excellent provision, including specialist provision for groups with specific needs and, increasingly, imaginative health promotion strategies.

The quality of learning, skills and work

New contractual arrangements for the provision of learning and skills and work in prisons came into force in August 2012. The aim was to make provision more relevant to the local employment and college market, give governors more influence over delivery, and enable more outcome-based provision – with payment by results for prisoner achievements. However, we have yet to see evidence of improvements in prisoner outcomes. As payment by results does not extend to measuring the successful resettlement of prisoners into work or training, prisons do not know how many go into employment or training on release.

We have also seen little progress in making prisons places of realistic preparation for work. For example, there was too little relevant employment-related work and insufficient attention given to time-keeping and attendance. Few prisons offered realistic working days and hours. However, Highpoint and Ranby focused on employability and had good links with employers, and prisoners worked extended days (including night shifts at Ranby) in some high-quality workshops.

The range and quality of learning and skills provision required improvement. We found too little emphasis on vocational and employment-related work. Opportunities for prisoners to obtain work that could lead to employment were generally good in open prisons, such as Ford, Leyhill and Hatfield, and were supported by release for paid work in the community. There were also good commercial quality workshops and vocational training areas in some training prisons.

Resources for vocational training and industry workshops were very good with much commercial standard machinery. Many of the commercial workshops promoted realistic work environments through successful initiatives, such as contractual and production targets. Most areas offered employment-related training, and effective links with employers, such as Trackwork Ltd, supported successful entry to employment on release. Ranby

Release on temporary licence (ROTL) potentially provided prisoners with opportunities to prepare for release and aid reintegration within communities by enabling them to attend training courses, undertake voluntary work and gain paid employment. Unfortunately, with the exception of open prisons, it was infrequently used, even for category D prisoners.

In many training prisons, too little vocational training was available. A decent proportion of prisoners should have been able to attend vocational training courses and work in areas where vocational skills were accredited, giving them recognised skills to use on release. However we often found too little vocational work or training available and in the majority of prisons it was not sufficiently linked to skills shortages in local areas and communities. In Wolds, for example, only 42 prisoners (12% of the population) were working towards nationally recognised qualifications.

Too much prison work was mundane and repetitive, and many prisoners did not have enough to occupy them throughout the day. In the best cases well-planned prison work allowed prisoners to work to commercial standards and develop a good work ethic. However, we found large numbers in most prisons working in low skilled wing cleaning jobs which usually only took a few hours a day to complete. At Stocken we found around 30% of prisoners in wing jobs that did not fully occupy them. Prisoners in workshops routinely undertook tedious and monotonous work and work contracts often ran out, leaving prisoners with nothing to do.

Leadership and management of learning and skills and work activities were inadequate in a fifth of the prisons inspected, and good in only 38% of them. We rarely found consistently good quality assurance systems with a focus on improving learning in the prison. In most cases, management data were not used sufficiently well to identify trends and set targets for improvement, particularly for attendance and punctuality.

The standard of teaching, learning and assessment had, however, improved, and over half of the prisons we inspected were judged as good in this area. Improvements had also been made in vocational training, where there was good coaching in most cases. For those prisoners who took qualifications, success rates were good in over 60% of our inspections. Unfortunately there were often too few opportunities for prisoners to progress in their learning. Most accredited qualifications in prisons were at level 1 with fewer at level 2. Opportunities for level 3 qualifications were rare.

Too many prisons also failed to recognise or record the good employability skills developed by prisoners, which meant they had no evidence of their skills to show potential employers on release.

Prisoners in the kitchen developed good catering skills, although these were not accredited. There were also missed opportunities to offer prisoners qualifications or recognise skills in other areas, such as the gym, recycling, waste management and gardens. Lewes

Unequal participation

Our survey findings have revealed that minority groups of prisoners have more negative perceptions of their access to purposeful activity.

- Black and minority ethnic respondents to our survey were less likely than white prisoners to report having at least 10 hours a day out of their cell and less likely to be working, but more likely to use the library and the gym.
- Fewer Muslim than non-Muslim respondents said they were in work at the prison.
- The perceptions of prisoners who considered they had a disability were overwhelmingly negative. Survey responses indicated they were less likely to be working or attending education or vocational training, and fewer reported access to the library, gym, exercise, association or time out of their cell.
- There was little data collected by establishments concerning the participation of Gypsy, Roma or Traveller prisoners or those who were gay or bisexual in any aspect of the regime, including activities.

There had been no thorough investigation into the under-representation of black and minority ethnic prisoners across some activity areas, and there was no understanding of the reasons for this, and no action plan to address the issue. Standford Hill

Resettlement outcomes need to improve

This section draws on 37 full inspections and 11 short follow-up inspections of adult male prisons.

- Offender management and resettlement work were not given sufficient priority and were not seen as a whole-prison objective.
- There continued to be little custody planning for prisoners on remand or short sentences.
- There were gaps in understanding prisoners' offending behaviour needs and little provision to address these, notably for sex offenders.
- Release on temporary licence was inconsistent.

Prisoner resettlement is important both for prisoners and the safety of the public. Prisoners need to be prepared for their release back into the community, and given effective help to reduce their likelihood of reoffending. However, throughout the year we saw considerable variations in the extent and emphasis of resettlement work, and we repeated many of our concerns from previous years – such as variations in strategic direction, delays in the completions of assessments, limited support for lower risk prisoners, and variable provision for those serving less than 12 months.

These concerns are central to the issues the government says it wishes to address in its Transforming Rehabilitation strategy. Our findings this year reveal the scale of the problem which needs to be addressed.

Transforming rehabilitation strategy

The government consulted on plans to transform the rehabilitation process in January 2013 and published its conclusions in May 2013. Key elements of the agreed proposals were:

- the creation of a new national probation service
- extending statutory supervision to those who serve less than 12 months in custody
- developing a new nationwide 'through-the-gate' service and ensuring most prisoners end their sentence in a designated 'resettlement prison' for the area into which they will be released
- opening up the market for resettlement service providers to the private and voluntary sectors
- introducing payment by results linked to providers' success in reducing reoffending.

In response to the consultation we argued:

- the needs of prisoners who are released from a non-resettlement prison should be addressed
- arrangements should be made to respond to the dynamic and changing nature of the risks some offenders pose
- the role of the voluntary and community sector is essential – especially in supporting prisoners' families who play a key role in the resettlement process
- the work of resettlement providers needs to be integrated with the work of the prison as a whole
- some functions should only be provided by properly accredited and trained staff with a duty of candour
- the role of HM Chief Inspector of Probation will be crucial
- resettlement services should meet the needs of women, foreign national prisoners and those with complex needs due to their health or age.

The published strategy is available at:
www.justice.gov.uk/transforming-rehabilitation

Resettlement outcomes for prisoners were assessed as good or reasonably good in only 64% of all prisons inspected this year. This was the lowest level for six years.

Figure 10: Resettlement outcomes in adult male establishments – full inspections

	Good	Reasonably good	Not sufficiently good	Poor
Locals	1	7	4	0
Trainers	0	10	7	0
Open	0	2	2	0
High security	0	0	1	0
Foreign national	0	0	1	1
Young adults	1	0	0	0
Total	**2**	**19**	**15**	**1**

Figure 11: Resettlement outcomes in adult male establishments – short follow-up inspections

	Sufficient progress	Insufficient progress
Locals	3	0
Trainers	0	2
Open	3	0
Young adults	3	0
Total	**9**	**2**

Offender management and resettlement

Offender management was generally given a low priority in many prisons, with backlogs of the assessments necessary for sentence planning and inconsistent staffing of offender management units (OMUs).

All prisoners serving over 12 months should have the risk of harm they pose and the factors that led to their offending assessed through the offender assessment system (OASys) and a sentence plan developed to address them. The sentence plan should usually be overseen by a community-based offender manager, and an offender supervisor in the establishment should work with the prisoner to ensure it is achieved.

There continued to be backlogs in assessments and sentence plans at many prisons inspected – including 16 of 31 adult prisons that had full inspections. In addition, while prisoners assessed as high or very high risk of harm remained the overall responsibility of community-based offender managers, it was relatively rare for sentence plans to include contributions from prison departments outside the OMU, undermining a whole-prison approach to offender management.

Most OMUs were staffed by a combination of offender supervisors seconded from local probation trusts and those recruited from officer grades in the establishment. The use and management of these staff varied considerably – in some prisons, they all shared the work but in others probation staff were more likely to be allocated high risk cases and indeterminate sentence prisoners.

In virtually all prisons inspected, the role of offender supervisors, beyond completing OASys and sentence planning, remained undefined and variable. At Highpoint, Isle of Wight and Winchester contact with prisoners was infrequent and had little focus, while at Durham officer offender supervisors also undertook general wing duties, and contact was often limited to passing engagement during this time.

> Officer offender supervisors had little and/or infrequent engagement, and there was little evidence that contact was oriented to addressing identified risk factors. Durham

While probation staff usually received regular supervision, uniformed staff did not. Casework management and supervision was rare and quality assurance beyond OASys was usually missing.

The quality of sentence plans was also a concern. Those managed by uniformed offender supervisors were of lower quality than those developed by probation service offender managers. This was the case at Ranby, where uniformed offender supervisors expressed a lack of confidence in undertaking such work. At some other prisons, including Dartmoor and Gloucester, there was a lack of focus on articulating the actual risk of harm in sentence planning documents. A notable exception was the innovative model being developed at Buckley Hall, where the security department and OMU had been brought together and the head of offender management was the senior risk manager.

> The model was a positive approach and reflected recent national directions regarding offender management. There were some initial indications that the changes were having a positive impact on prisoner engagement. Buckley Hall

In Bullingdon and Forest Bank, the role of offender management in integrated offender management schemes was particularly effective. At Forest Bank, over 240 prisoners were being managed in joint prison and community projects across Greater Manchester, and they had good pre-release planning with regular monthly surgeries.

A 'whole-prison' approach to offender management

In July 2012, we published, jointly with HM Inspectorate of Probation, the second aggregate prison offender management report.[7] This found that:

- many prisons paid good attention to the resettlement needs of prisoners, but this needed to be underpinned by work to sustain changes in their attitude and behaviour
- there were still not enough places on accredited programmes, notably for sex offenders, to change prisoner behaviour before release
- many offender management staff were committed but were deployed to other duties, had insufficient guidance, and limited professional supervision and training
- the standard of public and child protection work was not sufficient
- other prison staff had little appreciation of offender management unit work
- sentence plans were generally inadequate and based on interventions that were available rather than those required, masking the true level of need across the prison estate.

The report's recommendations included the need for:

- offender management and resettlement to be a 'whole-prison' responsibility
- prisoners to be able to access programmes to address their offending behaviour
- all prisoners to have an outcome-focused sentence plan
- clarity of the role of offender supervisors.

Support for short stay and remand prisoners

There continued to be a lack of planning and provision for short-term prisoners – those serving sentences of less than a year. We found considerable variations in practice and effectiveness, particularly at local establishments holding remand prisoners. Liverpool and Gloucester had no custody planning for this group, Birmingham screened them against resettlement pathways but did not use the information to support them, and at Norwich, the OMU had no contact with these prisoners.

> Prisoners on remand or serving less than 12 months (40% of the population) had no contact with the OMU, and no one else had responsibility to support them in meeting any identified objectives. Norwich

Durham screened all prisoners on remand, but this model had not been used long enough to evaluate fully. However, at Lewes, resettlement staff or peer advisers, and pathway leads where necessary, saw all new arrivals; this approach worked well.

> All new arrivals were seen by one of three officers and/or seven peer advisers, along with resettlement pathway representatives… Where specific resettlement issues were identified, prisoners were signposted to appropriate service provision. Lewes

7 www.justice.gov.uk/downloads/publications/inspectorate-reports/hmiprobation/adult-inspection-reports/omi2/omi2-aggregate-report.pdf

Addressing offending behaviour

While planning was better for longer-term prisoners, there were still not enough essential interventions to address prisoners' behaviour – especially sex offenders.

Even where an analysis had shown a need for offender behaviour programmes, these were not always provided. This was often compounded by difficulties in transferring prisoners to suitable alternative establishments.

No sex offender treatment programmes (SOTPs) were delivered at the establishment, hindering prisoners' progress. Of the 41 prisoners waiting to transfer to do a SOTP at the time of the inspection, at least 14 of them would be released within the next five months without being offered a place. Moorland

The vast majority of sexual offenders were in denial of their offending but there was no strategy and almost no provision. Others convicted of a sexual offence were awaiting transfer to complete a SOTP but some of these were running out of time to complete it prior to release. Lincoln

Some prisons that did offer programmes did not have enough of them or had long waiting lists. Most prisoners arriving at Thorn Cross (an open establishment for prisoners coming up for release) were convicted of a violent offence and should already have completed relevant offending behaviour work, yet many were undertaking the thinking skills programme (TSP), suggesting no previous appropriate work.

The prison's annual TSP target was 80 starts and 63 completions, which it appeared likely to exceed. Nevertheless this was a high target for such a small population, and raised questions about why so many prisoners arrived at Thorn Cross with a need to undertake such work. Thorn Cross

We also found a lack of provision for foreign nationals. Canterbury and Bullwood Hall – which specialised in holding foreign national prisoners before their closures were announced in 2013 – had no offending behaviour programmes or resettlement provision, even though there were some significant needs. It was assumed that there was no need to provide these for prisoners who were to be deported, which was irresponsible and inaccurate. In Canterbury, about 10% of prisoners were released into the UK, and an additional unknown number were later released after transfer to immigration removal centres.

To fill capacity, the prison's reception criteria for prisoners had expanded to those with up to 27 months left to serve, but there were few opportunities for them to address their offending behaviour during this period. As a result, there was little evidence of risk reduction on release or removal. Only one prisoner had been transferred in 2012 to attend a course elsewhere. Canterbury

However, some prisons did attempt to find alternative approaches to offending behaviour work.

Some interesting initiatives were available. Remedi delivered a victim awareness course to a large number of prisoners each year, with some progressing to meetings with victims. 'Men Talking' was a programme that had potential to target bullying behaviour. Moorland

Although all young adults and adult prisoners serving sentences of over 12 months have some community supervision on release, NOMS does not routinely follow up their engagement after release to assess what provision in custody is most useful and likely to reduce reoffending.

Release on temporary licence

Release on temporary licence (ROTL) can be a useful tool in helping prisoners resettle into work and the community, but continued to be implemented inconsistently.

Open establishments, including Hatfield, Leyhill and Standford Hill, were more likely to use it effectively to develop employability skills through work outside the prison, and in maintaining family ties. But in other prisons, the numbers released on licence were often very low, or restricted almost exclusively to category D prisoners – although there was very little granted to the significant category D population at Lewes.

Elmley was an example of how even local establishments could use ROTL effectively, and had avoided the risk-averse approach that we saw in most prisons.

Release on temporary licence (ROTL) was used well to support resettlement for category C prisoners, who also saw it as a chance to show their readiness for progression to the open estate. This was impressive for a local prison. In the previous six months, 37 applications for ROTL had been approved for participation in the Bedgebury Project, which undertook work with the Forestry Commission and enabled prisoners to undertake unpaid charitable work. A few resettlement day release and overnight release applications had also been approved. Elmley

Provision for family support and resettlement

Provision for prisoners against resettlement pathways was inconsistent and in some prisons, assessed as inadequate. In some cases the identification of resettlement needs for prisoners was poor. At Whatton this was compounded by the fact that resettlement officers' links with offender supervisors were underdeveloped. This meant that information was not shared and some work was duplicated. In some cases services were not provided despite indentified need.

There was no debt management or advice available, although 40% of respondents to the prison's needs analysis indicated they had had debt before coming into custody. Gloucester

For most prisoners family support while in custody is extremely important, yet provision across establishments varied considerably. At Wolds considerable effort had been made to support family contacts and the range and quality of support for parenting and relationships was a creative response to assessed need. This was in stark contrast to The Verne where there were no parenting courses, core family visits days were only available four times a year and many prisoners appeared not to receive visits due to their geographical distance from families.

Key developments

This section draws on two full inspections and two short follow-up inspections of women's prisons.

- Support for strategic changes to women's prisons had grown.
- There were generally good outcomes in the small number of women's prisons inspected during the year.
- The number of self-harm incidents in women's prisons had continued to decline but remained disproportionately high.

Moves in strategy for women in prison

2012 marked the fifth anniversary of Baroness Corston's groundbreaking review of women with particular vulnerabilities in the criminal justice system. Women make up just 5% of the adult prison population and, as Baroness Corston found, too often their specific needs are not met in a system focused on the majority male population.

It was appropriate, therefore, that the year saw two major reviews of provision for women offenders.

- The Justice Select Committee inquiry into women offenders commenced in December 2012 and took written and oral evidence from the Inspectorate. The Chief Inspector gave oral evidence on 5 March 2013.
- On 22 March 2013, the government published its strategy for women prisoners, Strategic Objectives for Female Offenders.[8] These strategic objectives will be led by Helen Grant MP, the under secretary of state for justice, supported by a Ministerial Advisory Board. The Inspectorate has observer status on the Board. Two major pieces of work will be a review of the women's custodial estate and ensuring that the 'transforming rehabilitation' programme meets the needs of women offenders.

A focus of women in prison

In our evidence to the Justice Select Committee inquiry into women offenders we said:

- The level of need in women's prisons is visibly greater than in the male estate. Despite improvement, the women's prison estate is still not configured to manage the women it holds in the best way.
- In our inspections of women's prisons, we have found evidence that the Corston report has resulted in an improvement in the experience of women in prison, but the governance and leadership problems that the report raised remain almost untouched.
- Without addressing these problems and fully appreciating the different needs and circumstances of women in prison, further improvements will be difficult, if not impossible, to achieve.

2012–13 inspections

In 2012–13, we conducted two full inspections of women's prisons, at New Hall and East Sutton Park, and two short follow-ups, at Eastwood Park and Foston Hall.

8 Strategic Priorities for Female Offenders is available at: www.justice.gov.uk/publications/policy/moj/strategic-objectives-for-female-offenders

Figure 12: Outcomes in full inspections of women's prisons

	Safety	Respect	Purposeful activity	Resettlement
East Sutton Park (open)	Good	Reasonably good	Good	Good
New Hall	Reasonably good	Reasonably good	Good	Good

Our short follow-up inspections of Eastwood Park and Foston Hall assessed them as making sufficient progress against our previous recommendations in all areas except safety at Eastwood Park and resettlement at Foston Hall.

In a number of respects, these inspections highlighted the issues a review of women's custody will need to address.

Caring for women with complex needs

The number of self-harm incidents among women prisoners was 6,317 in 2012–13, a fall of 22% since the last year and 45% in the last two years. Despite the welcome decrease in the incidence of self-harm overall, there was still scope to improve the quality of self-harm monitoring documents.

There had been a significant decrease in the number of incidents of self-harm and the number of ACCT documents opened. Throughout 2011, there were on average 54 self-harm incidents every month, involving 27 women, which was lower than the average of 38 women each month at our last inspection. In the last six months of 2011, an average of 6% of the population was subject to ACCT procedures – half of what was reported in 2008. New Hall

At New Hall, we found good investment in mental health awareness training for staff, and the mental health team was supporting about a third of the population, but staff sometimes struggled to maintain an appropriate balance between discipline and care of the vulnerable. The result was an excessively punitive approach to the management of some prisoners with very complex needs.

There was still a conflict between some processes involved in managing troublesome but vulnerable women; some were placed on the basic level of the incentives and earned privileges scheme or in segregation without proper consideration of whether this was consistent with appropriate care. New Hall

In one case at New Hall, a new arrival who refused to hand over open-toed sandals and a strappy top (clothing allowed at her sending prison but not at New Hall) was restrained, put in the segregation unit and had her clothes cut off as she was forcibly strip searched. By contrast, Eastwood Park, which held a similar population, had no segregation unit at all, and we question whether such units are appropriate in women's prisons.

Women held on remand

The Inspectorate's short thematic review of Remand Prisoners, published in August 2012, found that: 'Overall, a higher proportion of the women's prison population are held on remand than for men. In March 2012, the proportion of women in prison on remand was 16% of the total number of women in prison; for men it was 14%. In 2009, women on remand spent an average of four to six weeks in prison and of these women over half did not go on to receive a custodial sentence.'

It also found that, compared with men on remand, women remand prisoners had a higher self-reported incidence of housing problems, money worries and health concerns when they arrived in prison, and were more likely to report problems with ensuring dependants were being looked after.

Identifying the specific needs of women in commissioning processes

Transport: A continuing concern is the transport of women in the same prison escort vans as men. The escort contract permits this provided the vehicles are partitioned.

Staffing: Women's prisons should have both male and female staff but the ratio between them should be sufficient to ensure there is always a female member of staff readily available to provide support if needed. The mother and baby unit at New Hall was a good facility – although underused – but we did not think it appropriate that a male officer was sometimes left in sole charge of the unit at night. Even the most highly trained and sympathetic male officer cannot provide the support and reassurance required by women in prison caring for small children.

Families: Helping women prisoners to maintain contact with their children and families is important to reduce the levels of distress among the women and to mitigate the effects of their imprisonment on their children. We found insufficient strategic direction and inadequate provision to assist women prisoners to maintain contact with their children and families, although there were some good approaches at New Hall.

Despite our repeated recommendations to employ family support workers, develop welcoming visitors' centres and ensure efficient visits booking processes, there seemed to be a reluctance to meet the specific needs of women prisoners to maintain contact with their families. Although New Hall had a trained family support worker who did excellent work with families, funding for this worker service was under threat. Foston Hall had no family support worker.

Telephone calls are very important for many women, especially those for whom the emotional trauma of separation from their children was intense, but we found unnecessary restrictions on their access to make calls. As prisons reduce evening association to make efficiency savings, prisoners have less access to telephones at times when their families are most likely to be available.

In none of the prisons inspected this year was it possible for women to receive incoming calls, even though this service has been available at Askham Grange open prison for women for some years. We also found an anomaly at East Sutton Park, where women released each day to attend work or education placements were allowed to use mobile telephones while out on release, but had to surrender them as soon as they returned to the prison (in line with NOMS policy).

The cost of prison telephone calls is a further barrier, as they exceed rates in the community.

Foreign national women prisoners have specific needs to access telephones to keep in touch with their families, who might be many thousands of miles away. They can find the costs of international telephone calls particularly difficult.

Women from the South West, Wales and the West Midlands were often held far from their homes because of the lack of prison places in these areas. For some families, particularly those with children, excessively long journey times restricted their ability to visit. However, prisons do not regularly monitor whether a woman uses her visits entitlements, or her distance from home, and cannot provide any assurance that women who do not receive visits are helped to maintain contact.

While New Hall held six family days a year, there were fewer at Foston Hall, and at Eastwood Park only women who had completed a two-day course (about the value of play in child development) could participate. At New Hall, there was good provision for standard visits.

> The visits hall was a large, bright, well decorated room with soft furnishings. The play area was staffed during each session by play workers from New Hall Kidz, who provided structured play activities. There was also a teenage room for older children. Women could join their children in the play area. Refreshments were provided and there were also vending machines. New Hall

However, at New Hall we also saw final pre-adoption separation visits taking place in the main visits hall without sufficient privacy.

What works

In many respects, East Sutton Park epitomised what a good women's prison should be, albeit in a very small, carefully selected population. We judged outcomes as good across all four of our expectation areas.

In the coming year, we will be developing a separate set of Expectations for women prisoners. The aim is to help improve outcomes for women prisoners, and to make sure our inspections focus on their specific needs.

Fewer young people in custody

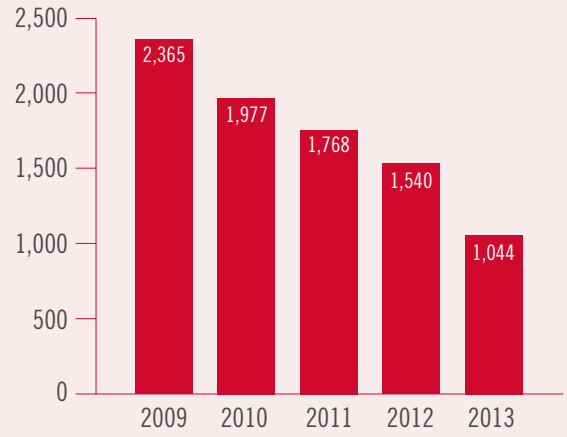
This section draws on five full inspections and one short follow-up inspection of young offender institutions (YOIs) holding children and young people aged 15 to 18 and, jointly with Ofsted, one inspection of a secure training centre (STC) holding young people aged 12 to 15.

- The number of young people held in custody fell sharply during the year.
- The smaller population included some of the most troubled young people, with complex needs.
- There was a high level of violence and bullying in YOIs, and low staff expectations sometimes affected young people's behaviour.
- Young people continued to be affected by being held far from their home.
- We began a new joint programme of inspecting STCs with Ofsted.

Fewer young people held

The size of the children and young people's custodial population reduced significantly from March 2012, when 1,540 were held, to 1,044 in March 2013 – a fall of 32%.[9] This follows significant falls in previous years as well.

Figure 13: Numbers of 15-18 year olds in YOIs (in March of that year)



Apart from Ashfield, where plans were introduced in January 2013 to decant the children and young people's population, there were no closures or beds decommissioned during the year.

We welcome the reduction in the number of children and young people held in custody. The fall in the numbers held, the high costs of individual places and high reoffending rates are significant factors in the government's decision to review the youth custody estate: the consultation, *Transforming Youth Custody: Putting education at the heart of detention*, was announced in February 2013. We submitted evidence to the review, welcomed the proposed greater emphasis on education and training but highlighted the need to ensure that, as the estate contracts, young people are held as close to their home as possible in settings that can still provide the range and level of services to meet the needs of young people with a greater concentration of high levels of need.

9 Figures supplied by Youth Justice Board.

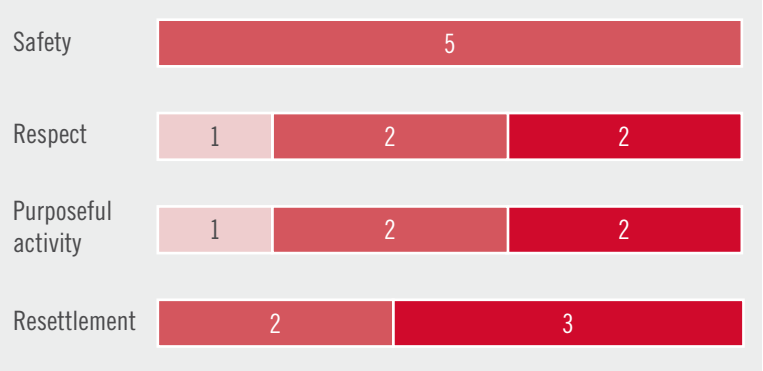
YOIs reasonably good overall

In 2012–13, our inspection findings showed a reasonably good picture, reflected in our healthy prison assessments in the full inspections we carried out.

Figure 14: Outcomes in full inspections of YOIs

	Safety	Respect	Purposeful activity	Resettlement
Cookham Wood	Reasonably good	Reasonably good	Reasonably good	Reasonably good
Mary Carpenter Unit	Reasonably good	Good	Good	Good
Parc	Reasonably good	Good	Good	Reasonably good
Werrington	Reasonably good	Not sufficiently good	Not sufficiently good	Good
Wetherby	Reasonably good	Reasonably good	Reasonably good	Good

Children and young people (5)



Key

Our short follow-up inspection of the Keppel Unit found that it was making sufficient progress on our previous recommendations in all four healthy prison areas.

From July 2012, these outcomes were assessed against the second revised edition of our Expectations for Children and Young People in Prison Custody. The new Expectations are more focused on the outcomes we expect establishments to achieve, and we hope they will support them in making improvements.

Safety

In our surveys of young people in 2012–13,[10] 30% of young men said they had felt unsafe in their establishment, and just over a fifth (22%) said they had been victimised by other young men.

Bullying was evident at all the boys' YOIs we inspected, and there continued to be high numbers of fights. At Werrington, there had been over 100 violent incidents in the six months before our inspection, and Parc had recorded 16 fights and 36 assaults between January and May 2012. Although most fights in these establishments were minor and did not result in injuries, some were serious. At most sites this problem was managed well, especially where there was an integrated staff approach and commitment to dealing with violent behaviour. Managing poor behaviour was not so successful where there was a reliance on specialist staff to handle it.

Shouting abuse from windows was widespread and we saw opportunities for bullying in many areas.

10 Children and Young People in Custody 2012–13 (due to be published November/December 2013)

‘Sometimes bullying occurs to vulnerable young people through the windows.’

‘When you’re in your pad you get people shouting around and you feel unsafe’. Young people surveyed at Werrington

At Werrington we also saw one young person who was afraid to leave his cell during association and who said he would not attend education because he felt unsafe.

As well as name calling through doors, bullying took other forms.

Other concerns were the organisation of fight clubs, with some young people trying to persuade others to fight, and threats to young people to buy items from the canteen. Young people also told us that personal telephone calls were a potential source of bullying with some young people forcing others to finish their calls before they were ready to do so. Cookham Wood

In some cases, establishments took measures to reduce opportunities for bullying – such as delivering shop orders directly to young people in their cells, marking goods and tracking stock levels – and staff engaged with them to detect problems.

Staff regularly sat with young people at meals and during association to talk informally and to pick up on undercurrents that might indicate a potential problem between young people. They were quick to notice young people who were reluctant to leave their cells for association or other group activities and find out why. Parc

Little bullying took place on the girls’ unit we inspected. The very high staff-to-prisoner ratio and excellent interaction between them meant there was a supportive environment for young women. Where bullying did occur, it tended to consist of low-level name calling, and staff were quick to intervene to mediate between those involved.

Three establishments we inspected used care and separation units extensively to deal with disruptive or violent young people. Cookham Wood had a well-run facility with an orderly environment, where each young person benefited from multidisciplinary input and had their own care plan. At Werrington the regime in the care and separation unit was adequate and purposeful but the living conditions were poor. The unit at Wetherby was bleak and young people spent most of their time locked in their cell.

There were no self-inflicted deaths in the juvenile estate during the year. Young people at risk of suicide and self-harm were well cared for at all the establishments we inspected, and most provided multidisciplinary support effectively.

The ACCT [self-harm monitoring] process had been adapted to try to maximise the involvement of staff without disrupting the young women’s educational experience. Mary Carpenter Unit

Contrary to our expectations, all newly admitted young people were routinely strip searched (apart from at the girls' unit). At Parc, routine strip searching had been reintroduced to comply with a Prison Service Instruction. An analysis of the data at Cookham Wood in October 2011 identified only two finds resulting from 729 strip searches. Routine strip searching of young people in custody is unnecessary, and we welcome the fact that NOMS has begun three month pilots of a risk-based approach at Werrington and Parc YOIs which will be evaluated on completion.

Staff in some establishments had high expectations of how young people should behave. Where residential staff were clear and confident about their role, they would not hesitate to challenge unacceptable behaviour, and in these cases there were often personal officers who had good knowledge about the young people they were responsible for. This gave young people a sense that staff were interested and cared about them.

In contrast, at Werrington some staff did not seem clear about when to intervene during particularly boisterous behaviour.

> We observed a number of low-level incidents between young people which were not appropriately challenged and had the potential to escalate. Young people said that in many situations staff just looked on rather than intervened. Staff expectations of young people were too low and there was too much tolerance of unacceptable behaviour. Werrington

In many cases, the quality of investigations into alleged violence was poor and we were not certain that young people had the confidence to report incidents to staff. Tellingly, only 17% of young people surveyed at Werrington said they would tell staff if they were being bullied, against the comparator of 50%.

Time out of cell

Only two of the establishments offered young people 10 hours a day out of cell. Although most young people could get adequate time out of their cell on weekdays, in a few establishments a small number of young people subject to disciplinary measures were unlocked for only two or three hours a day. In Werrington, no time was scheduled for young people to exercise outdoors.

> Only 5% of young people against the comparator of 50% said they could go outside for exercise every day, and the core day during the week did not include provision for time outside. Young people raised this as an issue in focus groups and, as reported at the previous inspection, it was not surprising that young people took their time walking to education and other activities when they had the rare opportunity to be outside. Werrington

Most young people undertook some education or training. In our surveys over the year,[11] 90% of all the young men said that they were involved in some kind of purposeful activity at the time of the survey – 79% said they were in education, 28% had a job in the establishment, and 18% were in vocational or skills training The standard of the provision varied – the quality of education and training was good at Parc and Cookham Wood but vocational input was poor at Werrington, where workshops were often cancelled, and the range of provision at the Mary Carpenter Unit had narrowed.

11 Ibid.

Preparing for release

The planning arrangements to help young people prepare for their release were sound at all the establishments we inspected. For example:

> Lead members of staff had been appointed for the resettlement pathways. Some innovative work was being carried out by the YOT [youth offending team] manager and a member of the psychology department who examined ASSET [assessment] scores pre and post release to track the progress of young people after they had left the establishment. Cookham Wood

However, obtaining suitable accommodation for young people on release continued to be a major problem.

> We were told that no young person had been discharged with no fixed accommodation since the previous inspection, but some individuals had been placed in unsatisfactory settings, such as bed and breakfast accommodation. Wetherby

> It was not unusual for accommodation to be finalised at the last minute, particularly for looked-after children. Cookham Wood

However, Wetherby also worked in partnership with a community organisation providing support to young people from a looked-after care background who were leaving custody and potentially homeless. This included a six-bedded unit in Leeds and support from social care staff.

Release on temporary licence (ROTL) can enable young people to gain work experience outside the prison and other opportunities to help them resettle successfully. While no young person had been released from Parc on ROTL during 2012–13, its use at Wetherby had doubled since the previous inspection.

> ROTL was used for a range of purposes, including work placements, community visits and college interviews. We observed young people going out on ROTL being escorted to the gate by an officer who checked that they were properly prepared, including having a packed lunch, and encouraged them to do well. Wetherby

The impact on young people of being located in prisons far from their home continued to be a significant problem, particularly at Mary Carpenter Unit, Wetherby and Keppel. Young people there told us about the difficulty in visiting for family and friends – both in the time and costs of travelling.

Although facilities for visits were mostly good, there was little evidence of establishments mitigating the effects on young people of their distance from home. Family days were not frequent (apart from at Cookham Wood), and were sometimes restricted to young people on the higher levels of the rewards scheme.

At some establishments, staff knowledge about which young people did not receive visits was patchy. However, at Cookham Wood:

> … the establishment had found that 11% of young people did not receive visits. Caseworkers had been tasked with working with young people who did not receive visits and their family to establish appropriate contact. Cookham Wood

Moving on to adult prisons

Transitions: An inspection of the transition arrangements from youth to adult services in the criminal justice system was a joint thematic with HM Inspectorate of Probation, the Care Quality Commission (CQC), Ofsted, Healthcare Inspectorate Wales (HIW) and Estyn, published in October 2012, which looked at the progress of young people who turn 18 while in custody on to an adult prison. It found that while most young adults said their transfer had been discussed in advance, they were given little notice of the date or the establishment for their transfer.

Young adults reported feeling ready for the transfer, but those who moved from a site that only held children and young people felt less prepared than those in establishments holding both adults and children and young people (separately). Offender supervisors in the receiving prison often struggled to make contact with YOT or probation workers. One young adult we met had still not met his probation offender manager 151 days after his transfer to the prison.

We also found disruption to some young adults' education, training and employment work, and they told us they had not been able to continue with courses begun at their children and young people's establishment. Overall, we found insufficient forward planning and communication, which led to a hiatus in sentence planning and delivery of interventions.

Young people who sexually offend

Examining Multi-agency Responses to Children and Young People who Sexually Offend, a thematic conducted jointly with HM Inspectorate of Probation, Care and Social Services Inspectorate Wales, CQC, Estyn, HIW, HM Inspectorate of Constabulary and Ofsted and published in February 2013, looked at children and young people who commit sexual offences. It found that they respond to interventions from YOTs and can be rehabilitated before entrenched patterns of behaviour develop. However, they were not being identified and picked up by the system quickly enough and there was often poor communication between the relevant agencies.

STCs – a new area

The 2008 Independent Review of Restraint in Secure Settings recommended that 'Ofsted and HM Inspectorate of Prisons should consider establishing a joint unit which should specialise in the inspection of restraint regimes and practices'. In 2012 we worked with colleagues from Ofsted and the CQC to develop a new methodology for a joint inspection programme of the four secure training centres (STCs). Following a pilot, we started our inspection programme at Medway STC in November 2012 and inspected all the STCs under the new joint arrangements by March 2013.

Only the report of the Medway STC inspection has been published in this reporting year, although many of the findings in the other STCs we subsequently inspected were similar.

We found that the overall effectiveness of the Medway STC was good, with good outcomes for young people in the core areas of safety, behaviour, welfare and resettlement, although it was only adequate in the provision of activities.

Staff know young people well and have positive and constructive relationships with them. The number of physical control in care (PCC) incidents continue to reduce and inspectors witnessed staff very effectively de-escalating incidents to prevent and minimise the use of restraint. Medway STC

Young people are effectively engaged through educational, leisure and enrichment activities during the day and in the evenings. Teachers and care staff work well in partnership to manage behaviour. However, too many lessons are insufficiently challenging for the more able learners, who do not always make the progress they should. Medway STC

Justice Committee report on youth justice

In March 2013, the Justice Committee published its report on youth justice.[12] We welcomed the committee's conclusion that youth custody should only be used as a final resort, and shared its concerns that young people who have been looked after by local authorities, rather than in family homes, are being drawn into the criminal justice system.

We also shared the Justice Committee's serious concern that: 'despite the fact that the use of force in restraining young offenders has now been definitively linked to the death of at least one young person in custody, the use of restraint rose considerably across the secure estate last year'.[13] We welcomed the new approach to restraint, with its emphasis on restraint minimisation and de-escalation. However, we do not agree with the inclusion of 'pain-compliance' techniques as an appropriate procedure in some circumstances. 'Minimising and managing physical restraint' began to be rolled out across STCs and YOIs holding children and young people towards the end of the year under review. It is still too early to assess the implementation and impact of the new policy but we will respond to the Committee's recommendation that we do so in our next annual report and by a more detailed specific thematic inspection.

12 Youth Justice, Seventh Report of Session 2012–13, Vol 1.I
13 ibid.

4 IMMIGRATION DETENTION

Safe, but degrading for some

This section draws on two full inspections and two short follow-up inspections of of immigration removal centres, the first inspection of the Cedars pre-departure accommodation, and inspections of eight short-term holding facilities and one overseas escort.

- There was slow progress on some immigration detention casework and, as a consequence, some detainees were detained for far too long.
- Detention facilities were reasonably safe, but transfer and escort arrangements were unsatisfactory.
- Mental health services had improved but were insufficient, and some detainees with poor mental health had suffered degrading treatment.
- Outcomes for people detained in short-term holding facilities were reasonably good.
- Treatment of detainees on overseas escorts had improved, but staff had not been trained in using force on board flights.

2012–13 inspections

Figure 15: Outcomes in full inspections of IRCs, 2012–13

	Safety	Respect	Purposeful activity	Preparation for release
Harmondsworth	Reasonably good	Not sufficiently good	Not sufficiently good	Reasonably good
Tinsley House	Good	Reasonably good	Good	Good

Our short follow-up inspections of Dover and Dungavel House assessed both centres as making sufficient progress against our previous recommendations in all areas except preparation for release.

Reasonably safe detention

Safety outcomes were at least reasonably good at all immigration removal centres (IRCs) inspected, with generally good reception arrangements, evidence of dealing with violence or bullying, and effective care for those at risk of self-harm. However, as in previous years, too many detainees underwent exhausting and disruptive night-time transfers between centres without any obvious need. It was also inappropriate that nearly all detainees were handcuffed for outside appointments as a result of risk-averse practices. Force was generally used proportionately, but separation was too frequent, although usually for short periods. We were not assured that strip searching, an extreme and exceptional measure, was always necessary, and were particularly concerned to see high use of this and poor governance at Dover.

Access to legal representation was generally good in Dungavel in Scotland but less so in the centres in England; most detainees could access limited free legal advice through detention duty advice surgeries, but there were not enough surgeries at Harmondsworth and many detainees interviewed for our joint thematic inspection (page 66) complained of difficulties in accessing good quality legal advice.

Immigration detention casework

In 2012 we published a joint thematic report, *The Effectiveness and Impact of Immigration Detention Casework*, with the Independent Chief Inspectorate of Borders and Immigration. We found that the initial decision to detain was generally in accordance with the law and published policy, but a recognised victim of trafficking was inappropriately detained. The fact that the detainee was a victim of trafficking should have been recorded with the decision to detain. Only in very exceptional circumstances should the victim have been held, and these too should have been recorded on file.

We were concerned to find insufficient progress as a result of inefficient work by immigration staff in a quarter of cases we examined. Not enough was done to resolve ex-prisoners' cases before the end of their custodial sentences, and not all relevant facts were considered when detention was reviewed – this meant that people experienced the severe and expensive measure of detention unnecessarily.

Decisions to detain were made by relatively junior Home Office staff, while the decision to release ex-prisoners could only be made by very senior staff. This sat uneasily with the presumption in favour of release. Difficulties in obtaining travel documents and deciding asylum claims caused lengthy detention. The former were sometimes outside the control of the Home Office, but the latter were not.

In many cases, caseworkers accused detainees of not cooperating with the re-documentation process. If detainees are non-compliant, the Home Office has the power to prosecute and put them before a court – however, this power was very rarely used; instead, caseworkers relied on open-ended and costly detention, effectively waiting for detainees to 'give in'. There was little evidence of a strategic approach to managing the most complex cases beyond use of extended detention.

Detention centre accommodation

Detainees are not held because they have been charged with a criminal offence, and Home Office detention centre rules require accommodation that is relaxed and allows as much freedom of movement and association as possible. While the management of the IRCs we inspected was generally good, we found some concerning variance in environment and procedures – some of which were more prison-like.

Of particular concern was the new and austere category B prison-standard accommodation at Harmondsworth, which was inappropriate for a population held for administrative purposes. This contrasted with the much more appropriate accommodation at Tinsley House and Dungavel IRCs. Tinsley House had made good progress to reduce the institutional feel of the building. However, at Dover, the preponderance of razor wire was disproportionate to the security required for the population.

> The newer prison style units were in a good state of repair, but remained austere and inappropriate environments for a detainee population. Harmondsworth

Treatment of detainees with mental illness

We found improvements to primary and secondary mental health services in IRCs, but provision was generally insufficient to meet need. Health care staff had been trained in how to recognise and treat signs of torture at Dover, but not at Dungavel or Harmondsworth. Some staff at Tinsley had received relevant awareness training.

Between 2011 and 2012, there were four separate cases in which the High Court found that detainees suffering from mental illnesses were subject to inhuman and degrading treatment in breach of article three of the European Convention of Human Rights. Two had been held at Harmondsworth IRC shortly before our inspection in November 2011.

At our inspection of Harmondsworth we found that detainees' mental health needs were under-identified, and staff described the inpatients department as a 'forgotten world'. There had been no mental health needs assessment, no staff training in mental health awareness and there was no counselling service, despite increasing numbers of detainees with high anxiety and low-level depression.

However, at Dover, registered mental health nurses delivered primary care counselling and there was support for detainees unable to cope with life in detention. At Dungavel, although a third of frontline staff had undergone mental health awareness training, there had been no training to identify and treat torture survivors.

Rule 35 of the detention centre rules and chapter 55.10 of UKBA's enforcement instructions and guidance should ensure that those suffering from mental illnesses are only detained in very exceptional circumstances. We found that rule 35 reports written by medical practitioners generally did not provide clinical findings and did not help caseworkers make informed decisions on whether to release – although at Tinsley some reports included diagnostic findings and all were reviewed by a doctor. Responses from caseworkers were often dismissive and none of those we reviewed led to release.

In one report a doctor recorded and documented stab wounds, cigarette burns and gunshot wounds. The report included body maps and the doctor concluded: 'Injuries are consistent with torture'. Despite this, the caseworker maintained detention and noted: 'We do not find any of your allegations of torture or for asylum credible (sic)'. Tinsley House

Facilities for families

In 2012, for the first time, we inspected Cedars pre-departure accommodation, where families are detained for up to a week before removal.

Cedars was a very good detention facility, with many practices that should be replicated in other places of detention. Centre staff had a large amount of information about families, which helped prepare for their arrival, families' needs were identified early, and support plans were individualised and effective. Accommodation was exceptionally good and designed around the needs of children and families. Barnardo's staff provided effective assistance and helped ensure that family needs were kept at the forefront of the centre's work. Parents said that they would rather be held at Cedars for a short time than taken straight to an airport, as it allowed them time to apply for judicial review and settle their children.

However, we had significant concerns about aspects of family detention, especially on the initial arrest, the point of removal and the use of force to effect removal. These were times of stress and upset for all family members, generating complaints about the behaviour of arrest teams. Although there was evidence of efforts to avoid force at the point of removal, it had nevertheless been used against six of the 39 families who had gone through Cedars by the time of our inspection. We were especially concerned that substantial force had been used to effect removal of a pregnant woman.

The woman was not moved using approved techniques. She was placed in a wheelchair to assist her to the departures area. When she resisted, it was tipped up with staff holding her feet. At one point she slipped down from the chair and the risk of injury to the unborn child was significant. There is no safe way to use force against a pregnant woman, and to initiate it for the purpose of removal is to take an unacceptable risk. Cedars

Short-term holding facilities

There are two types of short-term holding facilities (STHFs). Non-residential facilities are found at ports and reporting centres, and hold detainees for up to 24 hours before transfer to an IRC, removal or entry into the UK. Residential facilities normally hold detainees for up to five days, or seven if removal directions have been served.

We found that stays in STHFs were generally not excessive, but three detainees were held at Larne House for more than seven days, which was potentially unlawful. Staff in all STHFs were polite, courteous, and made great efforts to reassure and assist detainees. Detainees had good access to telephones and faxes, but only at Larne House could they freely access the internet or receive visits, although in limited privacy.

Detainees arriving at STHFs were often routinely handcuffed without an individual risk assessment, but use of force was otherwise rare and generally appropriate. The exception was at Cayley House, where staff had used an unapproved pain compliance technique to restrain a detainee.

Some accommodation was shabby and lacked natural light. Only Larne House had an outside exercise area, but it was enclosed and under a metal grid. It was inappropriate that men and women were often held in the same facility. We were pleased to see the facility at Electric House had been extended to allow for separation. Children were not held during any of our STHF inspections, and staff reported that since the implementation of a new family returns process children were no longer held.

Overseas escorts

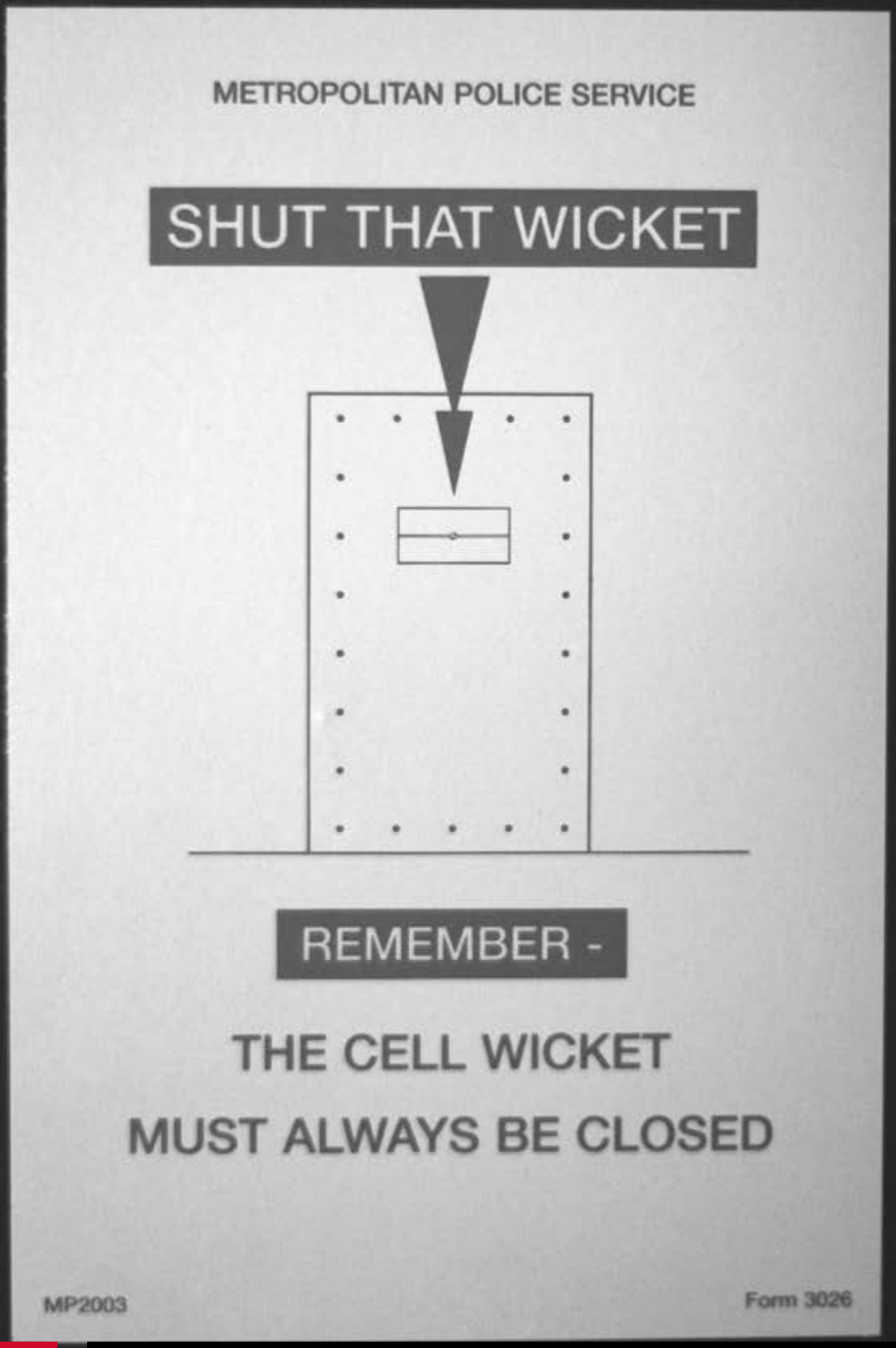
Inspectors accompanied a charter flight to Kabul, Afghanistan, during our third overseas escort inspection. We found some improvements on previous escorts. The removal was well planned and efficiently managed. Unlike our previous inspections, the staff-to-detainee ratio was proportionate.

Relationships between staff and detainees were polite and reasonably relaxed, and we heard no inappropriate language. Staff used handcuffs proportionately – although documentation for other flights to Afghanistan showed that restraints were not always removed as soon as possible. Light-touch restraint (where detainees were gripped by the elbow) was used unnecessarily in secure areas. On collecting detainees at one IRC:

> … the coach commander insisted on grasping the shoulder of each detainee as he introduced himself and shook their hands. This alienated at least two detainees who clearly interpreted this as a form of physical intimidation; one subsequently refused to cooperate with the rub-down search.
> Afghanistan overseas escort

We were concerned that there was no accredited training for use of force on board an aircraft. Indeed, some staff used ad hoc and unaccredited techniques, such as interlocking aircraft seat belts with handcuffs.

Detainees could not use toilets in privacy, and were not offered hot drinks, blankets or pillows. Interpretation was not used, despite the fact that many detainees spoke little English.



5 POLICE CUSTODY

More vigilance needed

This section draws on inspections of police custody suites in 12 counties or boroughs.

- Risk management was sometimes unsatisfactory, and there was poor analysis of use of force.
- Alternatives to arrest and detention have become more of a focus.
- There were too many mental health detainees in police custody.
- The treatment of 17-year-olds looks set to change.

Our inspections of police custody in England and Wales are conducted jointly with HM Inspectorate of Constabulary.

There were consistent themes across all inspections. These included unsatisfactory risk management, poor recording and analysis of use of force in custody, and use of alternatives to arrest. Forces were sometimes unable to provide important information about the number of immigration detainees held in custody, and the authorisation and incidence of strip searches and use of force; we were consequently not assured that those forces could identify and manage related risks or concerns.

However, our inspection of Norfolk and Suffolk found a 'benchmark' for the quality of provision, showing what was possible:

> Strong and consistent management, with a sustained attention to detail, to quality assurance, to effective handovers and to individual staff roles, had ensured a remarkable degree of consistency and uniformity in the custody processes, and consequently in custody outcomes. Norfolk and Suffolk

An emerging theme was the use of video-enabled courts to minimise stay in police custody, although there have been some mixed experiences.

Finding appropriate alternatives to custody for people with mental health needs remained a significant concern. We began work on a thematic report on the issue at the end of the year, and shared our inspection findings with other inquiries into the interactions between police and people with mental health problems.

Risk management

In some forces, custody staff were unclear about the frequency with which they should be checking detainees. In Bromley and in Staffordshire, so many detainees were on 30-minute observations that it had undermined the value of such observations, which should focus the attention of staff on detainees with particular risks.

> Custody staff had been given instructions to place all detainees on a minimum of 30-minute observations. Some staff were unclear about what purpose this served and did not regard it as proportionate in all circumstances. Greater Manchester

The use of strip clothing was excessive in some forces, and far in excess of what we normally find. At Belle Vale in Merseyside, about half the detainees in the suite were in strip clothing – including a man with mental health problems but no prior history of self-harm whose behaviour was judged 'unpredictable', and a 15-year-old girl who was too intoxicated for a risk assessment.

Many detainees had to suffer the indignity of attending consultation with legal advisers and health care personnel while dressed in their smocks. Nottinghamshire

Person escort records: sharing information and understanding its use

In October 2012, we published a report produced for the Ministerial Board on Deaths in Custody about the recording of risk of self-harm in person escort records (PERs). This presented data on the extent to which information about the risk of self-harm obtained during an individual's detention in police custody was accurately recorded and likely to be useful in subsequent care planning.

The report highlighted several concerns, including: incomplete and/or illegible records; details about risk of self-harm that were vague; inconsistency between the PER and other sources of information; and information on the PER not being shared or used to inform proper care planning for individuals at risk.

The report made 12 recommendations to police forces, NOMS and the Ministerial Board, which were agreed by the Board. These included that: the PER should be redesigned and made available electronically; police forces should undertake better quality assurance of completed PERs; there should be regional multi-agency forums to train staff and improve the quality of information sharing about risk of self-harm; and prisons should review how they use information about self-harm in caring for vulnerable people.

Analysis of use of force

Few forces monitored their use of force adequately, so they could not examine data to identify trends. The need for such analysis was demonstrated by the tremendous variability in the use of handcuffing and strip searching.

[Metropolitan Police Service, MPS] data showed that… 21% of detainees at Ilford had been strip-searched, which was a far higher figure than in some comparable MPS boroughs. Our custody record analysis showed that this was even higher, with 27% of detainees being strip-searched. London Borough of Redbridge

In Bromley, there were no central records of the use of force, which was recorded only in the custody record and in officers' notebooks. In Staffordshire, data were collected but there was no monitoring of trends. In the City of London, although trends were not monitored, officers were expected to justify any use of handcuffs, and this was noted in the custody record.

Alternatives to arrest and detention

There continued to be reasonable exploration by custody officers of the necessity to arrest and detain individuals, but more work was needed in some forces on the use of alternative approaches to arresting detainees. In Merseyside, we were told that 'there was a presumption in favour of arrest and that they usually authorised detention'. However, in Gwent operational officers were not sufficiently aware of the 'necessity criteria' (the reasons why an individual needed to be detained rather than given an alternative to custody or an appointment to attend for an interview), and the MPS borough operational command units inspected (Bromley, Lewisham, Redbridge and Waltham Forest) needed to be more focused on alternatives to detention.

14 www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/per-thematic.pdf

We observed custody sergeants checking the circumstances of the offence and arrest to determine if detention was appropriate. However, most custody sergeants had little focus on the necessity test and could recall only a few occasions when they had refused to detain. Waltham Forest

In November 2012, the revised Police and Criminal Evidence Act (PACE) code G was introduced, requiring officers to give consideration to the necessity criteria and, in particular, alternatives to custody. As we began our 2013–14 inspection programme, there were some encouraging signs that this revision to PACE code G was having an impact and focusing police forces more on alternatives to detention. This would bring more forces into line with the approach we found in one inspection.

Detention was not overused, and the close working with the co-located investigation units enabled it to be used efficiently. Norfolk and Suffolk

Mental health detainees in police custody

We found that police access to advice from mental health professionals was not systematic, and in some places was absent or by telephone only. This was unsatisfactory. However, we saw some assertive mental health in-reach services in police custody, and a commitment to experiment with mental health assessment before arrest.

In Liverpool, Merseycare was piloting a diversion-from-custody scheme, to divert people with mental illness away from the criminal justice system... In the four months since the pilot started, 30 detainees had been diverted into hospital care from police custody and the courts, compared with 24 in the previous full year. Merseyside

In the London boroughs and some other areas there was good access to NHS facilities for detainees under section 136 of the Mental Health Act, which enables a police officer to remove someone from a public place and take them to a place of safety. However this was not the situation in many areas and too many detainees held under section 136 found themselves in police custody suites. Data collected by the Association of Chief Police Officers for the year to March 2012 showed that 9,378 people were taken directly to a police station as a place of safety. Our inspections in 2012–13 continued to find similar inappropriate use of police custody.

Police custody suites were used frequently for detainees subject to section 136 of the Mental Health Act – 286 times a year, on average, in the three years to December 2012... The police and NHS partners were in the process of ratifying a revised section 136 protocol. Custody officers said that custody suites were used inappropriately as places of safety because of disputes about levels of intoxication and because NHS facilities were full or understaffed. Essex

Treatment of 17-year olds

Our inspection reports have consistently highlighted the anomaly that 17-year-olds – treated as children in all other aspects of UK law – are treated as adults under PACE, and therefore denied access to 'appropriate adults' to assist them while in custody. We have made repeated recommendations calling for appropriate adults to be made available to 17-year-olds in police custody.

The High Court ruled in April 2013 that the PACE definition was incompatible with human rights law, and the government announced that it would accept this judgment. We welcome this move, and it was encouraging to see 17-year-olds being afforded the rights of young people in subsequent inspections. However, we will continue to monitor this until there is a change in the law.

6 COURT CUSTODY

A new area of inspection

This section draws on two court area inspections covering court custody facilities in five counties.

- Her Majesty's Courts and Tribunals Service managers needed to be more active in how their custody facilities were run, but court times were flexible and contractor staff treated detainees with courtesy.
- Risk assessments and handling of vulnerable detainees lacked consistency.
- Cells in some courts were in poor condition.
- Health services were rudimentary and emergency equipment was often absent.

In 2012–13 we began a programme of inspections of custody facilities in Crown, magistrates' and other courts. We published the reports of the first two inspections during the year – of courts in Cleveland, Durham and Northumberland, inspected in August 2012, and of those in Merseyside and Cheshire, inspected in October. The number of courts covered totalled seven Crown courts, 21 magistrates' courts, a community justice centre and a youth court.

Although it is too soon to pinpoint trends, some early common concerns and themes have emerged.

Management of individual detainees

We found that courts were diligent in checking that they had the necessary authority to detain, but there was inconsistency in how warrants were executed, with detainees who presented themselves to the court directed to attend the police station and then detained there before they were taken back to the court cells.

There were also several instances where detainees were transported from prison to the court too early in the day, as well as delays – sometimes up to five hours – while prisoners released by the courts were held in court cells until the prison confirmed they could be released.

However, court cut-off times – the latest time they would receive a detainee – were improving, enabling detainees to be brought from police custody to some courts as late as 3pm. The later that courts accept detainees the better their chances of avoiding a night in police custody.

Vulnerable people in court custody

Children and young people (aged 10–17) have little specific provision while they are in court custody, with no named person to care for them during this time. Even though court custody staff, rather than escort contractors, are now responsible for the care of children and young people from secure training centres and local authority secure accommodation while they are in court custody, they had little awareness of local safeguarding procedures for vulnerable

detainees and had received no child protection training. They treated children and young people no differently to the adult detainees in court custody.

While in the custody suite, juveniles were not supported by a named member of staff, other than under the same system as for adults. Staff had not received any training in safeguarding children and vulnerable adults. They indicated that, when necessary, they would informally approach staff from the Probation Service or YOTs to seek additional support for detainees. Cheshire and Merseyside; Cleveland, Durham and Northumbria

The lack of systematic risk assessment of detainees was a common feature in the courts we inspected. We observed some good practice, as well as a lack of care for some vulnerable detainees.

Court custody staff rarely explored information in person escort records (PERs), even when there were recent incidents of self-harm. While staff were diligent in their observations of detainees, they rarely interacted with them.

The approach of a few custody staff was, as one put it, 'All I'm bothered about is that no one dies and no one escapes'. At Newcastle Crown Court, we saw staff going to a cell to speak to a detainee who had self-harm warning markers on the PER. The risk assessment was basic, consisting of two questions: 'are you all right today' and 'you're not going to hurt yourself are you?'. Cleveland, Durham and Northumbria

If court staff had significant concerns about a detainee, they liaised with probation service staff where necessary, completed self-harm warning forms and notified prison establishments.

Handcuffing

Detainees were routinely handcuffed to and from cellular vehicles, in the cell area corridors and on the route to the courtrooms – even though all these locations were within the secure envelope of the custody suite. The routine use of handcuffing was often disproportionate and unnecessary. However, following our recommendations, the contractors GEOAmey have changed their policy to allow staff some discretion in handcuffing, providing there has been a risk assessment.

Conditions in cells

While the physical conditions in some court cells were good, with efforts to maintain cleanliness and remove graffiti, some were dirty and unacceptable. There was widespread graffiti in the suites at Liverpool, Newton Aycliffe, Hartlepool and Crewe magistrates' courts, some of it dating back many years, and including offensive words and symbols, such as swastikas. At Newcastle Crown court, toilet paper that had been thrown at and stuck to the walls had simply been painted over. In Newcastle magistrates' court, cells had damp and rot, and some toilets did not flush properly.

There continued to be disagreements between HMCTS and the contractor about who was responsible for improving the cleanliness of some cells. There were no mattresses or provision to make detainees who were older, had disabilities or were pregnant more comfortable.

Health services

Health services in court custody were rudimentary. Although courts could request the assistance of a drug worker or sometimes a mental health worker, it was rare for any health professionals to visit. Courts did have access to a telephone helpline and NHS emergency services.

There were first aid kits but the contents varied. Surprisingly, we found a complete absence of automated external defibrillators. Detainees were assisted to self-administer prescribed medications, although some storage facilities for their medications were unsatisfactory.

Inspecting armed forces facilities

The Inspectorate has inspected the Military Corrective Training Centre (MCTC) in Colchester since 2004.

At our inspection in January 2012, published in June 2012, we reported that conditions in this unique national facility to hold detainees from the three armed services were now impressive, and that the centre was a very safe and positive place, with some aspects that were a model to other custodial institutions.

In 2013–14, the Inspectorate will begin inspecting conditions and treatment of detainees in armed forces service custody facilities in Great Britain, bringing these within the coverage of the UK's National Preventive Mechanism.[15]

15 The independent bodies that monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

7 APPENDICES

Inspection reports published 1 April 2012 to 31 March 2013

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Larne House STHF	Unannounced	2 April 2012
Drumkeen House STHF	Unannounced	2 April 2012
Dartmoor	Full announced	4 April 2012
Harmondsworth IRC	Full follow-up	11 April 2012
Durham	Full announced	17 April 2012
Cookham Wood	Full announced	18 April 2012
Littlehey	Full follow-up	25 April 2012
East Sutton Park	Full announced	27 April 2012
Hollesley Bay	Short follow-up	3 May 2012
Liverpool	Full follow-up	4 May 2012
Standford Hill	Full announced	8 May 2012
Humberside police custody suites	Unannounced	9 May 2012
Redbridge police custody suites	Announced	16 May 2012
Waltham Forest custody suites	Announced	22 May 2012
Whatton	Full announced	12 June 2012
Norwich	Full follow-up	13 June 2012
Military Corrective Training Centre	Announced	20 June 2012
Birmingham	Full announced	21 June 2012
Woodhill	Full announced	22 June 2012
Hull	Short follow-up	27 June 2012
Eastwood Park	Short follow-up	4 July 2012
Thorn Cross	Full announced	6 July 2012
Spring Hill	Short follow-up	13 July 2012
Stoke Heath	Full follow-up	18 July 2012
Ranby	Full announced	25 July 2012
Elmley	Full announced	27 July 2012
Portland	Short follow-up	1 August 2012
Wetherby	Full announced	3 August 2012
Wetherby (Keppel Unit)	Short follow-up	3 August 2012
Norfolk and Suffolk police custody suites	Unannounced	14 August 2011
Dover IRC	Short follow-up	15 August 2012
Buckley Hall	Full announced	21 August 2012
Wolds	Full follow-up	22 August 2012
Everthorpe	Short follow-up	28 August 2012
New Hall	Full follow-up	29 August 2012
Preston	Short follow-up	4 September 2012
Greater Manchester police custody suites	Unannounced	5 September 2012
Garth	Short follow-up	6 September 2012
North Sea Camp	Short follow-up	7 September 2012
Bromley police custody suites	Unannounced	18 September 2012
Lewisham police custody suites	Unannounced	18 September 2012
Reading	Short follow-up	20 September 2012
Vulcan House STHF	Unannounced follow-up	25 September 2012
Capital Building STHF	Unannounced	25 September 2012
Staffordshire police custody suites	Unannounced	27 September 2012

Inspection reports published 1 April 2012 to 31 March 2013 *(Continued)*

ESTABLISHMENT	TYPE OF INSPECTION	DATE PUBLISHED
Leyhill	Full announced	3 October 2012
Wakefield	Full follow-up	12 October 2012
Isle of Wight	Announced full follow-up	16 October 2012
Cedars pre-departure accommodation	Full announced	23 October 2012
Afghanistan overseas escort	Unannounced	24 October 2012
Cayley House STHF	Unannounced follow-up	26 October 2012
Electric House STHF	Unannounced follow-up	30 October 2012
Lunar House STHF	Unannounced follow-up	30 October 2012
Dorchester	Short follow-up	1 November 2012
City of London police custody suites	Unannounced	2 November 2012
Northumberland	Full unannounced	6 November 2012
Onley	Full announced	7 November 2012
Canterbury	Full announced	14 November 2012
Gloucester	Full unannounced	21 November 2012
Stocken	Full follow-up	27 November 2012
Bullingdon	Full unannounced	30 November 2012
Avon and Somerset police custody suites	Unannounced follow-up	4 December 2012
Dungavel IRC	Short follow-up	5 December 2012
Lincoln	Full unannounced	11 December 2012
Ford	Announced full follow-up	13 December 2012
Maghaberry	Full announced	17 December 2012
Sandford House STHF	Unannounced	18 December 2012
Parc	Full announced	21 December 2012
Cleveland, Durham and Northumbria court custody	Announced	8 January 2013
Bullwood Hall	Full announced	11 January 2013
Highpoint	Full announced	16 January 2013
Gwent police custody suites	Unannounced	22 January 2013
Glen Parva	Short follow-up	23 January 2013
Eastwood Park (Mary Carpenter Unit)	Full follow-up	1 February 2013
Cayman Islands Prison	Announced	5 February 2013
Cayman Islands police and courts custody	Announced	5 February 2013
Hatfield	Announced full follow-up	6 February 2013
Channings Wood	Full announced	12 February 2013
Medway Secure Training Centre	Unannounced	14 February 2013
The Verne	Full announced	19 February 2013
Mersey and Cheshire court custody	Announced	21 February 2013
Tinsley House IRC	Announced full follow-up	27 February 2013
Merseyside police custody suites	Unannounced	1 March 2013
Forest Bank	Full unannounced	6 March 2013
Werrington	Full follow-up	12 March 2013
Foston Hall	Short follow-up	19 March 2013
Winchester	Full announced	20 March 2013
Lewes	Full unannounced	27 March 2013

Other publications – 1 April 2012 to 31 March 2013

TITLE	DATE PUBLISHED
Children and young people's Expectations 3rd edition	11 June 2012
Corporate Plan 2012/13 to 2014/15	April 2012
Court custody Expectations	June 2012
POMI Aggregate report	20 July 2012
Remand prisoners	2 August 2012
Facing up to offending: Use of restorative justice in the criminal justice system (HMI Constabulary (lead), HMI Probation, HM Crown Prosecution Service Inspectorate, HMI Prisons)	18 September 2012
Transitions: An inspection of the transitions arrangements from youth to adult services in the criminal justice system (HMI Probation (lead), HMI Prisons, Care Quality Commission, Ofsted, Health Inspectorate Wales, Estyn)	11 October 2012
HM Chief Inspector of Prisons for England and Wales Annual Report 2011–12	17 October 2012
The use of the person escort record with detainees at risk of self-harm	22 October 2012
Immigration detention Expectations 3rd edition	October 2012
Border Force Expectations	December 2012
Children and young people in custody 2011–12	7 December 2012
The effectiveness and impact of immigration detention casework (HMI Prisons with the Independent Chief Inspector of Borders and Immigration)	12 December 2012
Examining multi-agency responses to children and young people who sexually offend (HMI Probation (lead), Care and Social Services Inspectorate Wales, Care Quality Commission, Estyn, Healthcare Inspectorate Wales, HMI Constabulary, HMI Prisons, Ofsted)	7 February 2013
Monitoring places of detention: Third annual report of the UK NPM, 2011–12	26 February 2013

Healthy prison and establishment assessments 2012–13

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
LOCAL PRISONS					
Birmingham	FA	3	3	2	2
Bullingdon	FU	3	2	2	3
Durham	FA	2	3	3	3
Elmley	FA	3	3	2	3
Forest Bank	FU	3	3	2	4
Gloucester	FU	3	2	1	2
Lewes	FU	3	3	2	3
Lincoln	FU	1	2	1	3
Liverpool	FFU	2	3	2	2
Norwich	FFU	2	2	1	3
Winchester – main site	FA	2	1	1	2
Woodhill	FU	2	3	1	3
Dorchester	SFU	1	2	2	2
Hull	SFU	2	1	2	2
Preston	SFU	2	2	2	2
TRAINER					
Buckley Hall	FA	3	3	4	3
Channings Wood	FA	3	3	2	3
Dartmoor	FA	3	2	2	3
Highpoint	FA	3	3	3	2
Isle of Wight – Albany	FFU	3	3	3	2
Isle of Wight – Camp Hill	FFU	2	3	1	2
Isle of Wight – Parkhurst	FFU	2	3	1	2
Littlehey	FFU	4	3	3	3
Northumberland	FU	3	3	2	2
Onley	FA	4	3	3	3
Ranby	FA	2	2	3	3
Stocken	FFU	3	3	2	3
Stoke Heath	FFU	3	3	2	3
Verne	FA	3	2	2	2
Whatton	FA	4	4	3	3
Winchester – West Hill	FA	3	1	2	2
Wolds	FFU	3	2	1	3
Everthorpe	SFU	2	2	1	1
Garth	SFU	2	2	2	1
OPEN					
Ford	FFU	4	3	3	2
Hatfield	FFU	3	2	3	3
Leyhill	FA	4	3	4	3
Standford Hill	FA	3	3	3	2
Hollesley Bay	SFU	2	2	2	2
North Sea Camp	SFU	2	1	2	2
Spring Hill	SFU	2	2	2	2

Healthy prison and establishment assessments 2012–13 *(Continued)*

PRISON/ESTABLISHMENT	TYPE OF INSPECTION	HEALTHY PRISON / ESTABLISHMENT ASSESSMENTS			
		SAFETY	RESPECT	PURPOSEFUL ACTIVITY	RESETTLEMENT
HIGH SECURITY					
Wakefield	FFU	3	3	3	2
WOMEN					
East Sutton Park (open)	FA	4	3	4	4
New Hall	FA	3	3	4	4
Eastwood Park	SFU	1	2	2	2
Foston Hall	SFU	2	2	2	1
FOREIGN NATIONALS					
Bullwood Hall	FA	4	3	4	2
Canterbury	FA	4	3	4	1
YOUNG ADULTS					
Thorn Cross	FA	4	3	4	4
Glen Parva	SFU	2	2	2	2
Portland	SFU	1	2	2	2
Reading	SFU	2	2	2	2
CHILDREN AND YOUNG PEOPLE					
Cookham Wood	FA	3	3	3	3
Mary Carpenter Unit	FA	3	4	4	4
Parc	FA	3	4	4	3
Werrington	FFU	3	2	2	4
Wetherby	FA	3	3	3	4
Keppel	SFU	2	2	2	2
EXTRA-JURISDICTION					
Cayman Islands – Northward	FA	1	1	1	1
Cayman Islands – Fairbanks	FA	2	1	1	1
Maghaberry – Northern Ireland	FA	2	2	2	3
IMMIGRATION REMOVAL CENTRES					
Harmondsworth	FFU	3	2	2	3
Tinsley House	FFU	4	3	4	4
Dover	SFU	2	2	2	1
Dungavel	SFU	2	2	2	1
MILITARY					
Military Corrective Training Centre	FA	4	4	4	4

KEY TO TABLE

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

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

Recommendations accepted in full inspection reports 2012–13

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant)	ACCEPTED	PARTIALLY ACCEPTED	REJECTED
LOCALS				
Birmingham	89	71	17	1
Bullingdon	78	52	22	4
Durham	110	83	23	4
Elmley	92	71	15	6
Forest Bank	47	38	6	3
Gloucester	-	-	-	-
Lewes	-	-	-	-
Lincoln	-	-	-	-
Winchester	-	-	-	-
Woodhill	99	83	15	1
Total	**515**	**360 (70%)**	**98 (19%)**	**19 (4%)**
TRAINERS				
Buckley Hall	83	71	4	8
Channings Wood	-	-	-	-
Dartmoor	118	93	23	2
High Point	65	55	7	3
Northumberland	81	67	11	3
Onley	66	57	3	6
Ranby	93	71	16	6
The Verne	-	-	-	-
Whatton	71	57	13	1
Total	**577**	**471 (82%)**	**77 (13%)**	**29 (5%)**
FOREIGN NATIONALS				
Bullwood Hall	-	-	-	-
Canterbury (now closed)	-	-	-	-
Total	-	-	-	-
OPEN				
Leyhill	61	43	12	6
Standford Hill	105	85	18	2
Total	**166**	**128 (77%)**	**30 (18%)**	**8 (5%)**
YOUNG ADULTS				
Thorn Cross	63	57	4	2
Total	**63**	**57 (90%)**	**4 (6%)**	**2 (3%)**
CHILDREN AND YOUNG PEOPLE				
Cookham Wood	75	63	10	2
Parc	63	50	10	3
Wetherby	62	56	6	0
Total	**200**	**169 (85%)**	**26 (13%)**	**5 (3%)**

Recommendations accepted in full inspection reports 2012–13 *(Continued)*

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant)	ACCEPTED	PARTIALLY ACCEPTED	REJECTED
WOMEN				
East Sutton Park	53	47	5	1
Total	**53**	**47 (89%)**	**5 (9%)**	**1 (2%)**
PRISON TOTAL	1,574	1,232 (78%)	240 (15%)	51 (4%)
SHORT-TERM HOLDING FACILITIES				
Cedars pre-departure accommodation	27	16	7	4
Drumkeen House	9	5	2	2
Larne House	15	8	4	3
Liverpool Capital Building	10	7	2	1
Total	**61**	**36 (59%)**	**15 (25%)**	**10 (16%)**
ESCORTS				
Afghanistan	19	6	12	1
Total	**19**	**6 (31%)**	**12 (63%)**	**1 (5%)**
IMMIGRATION TOTAL	80	42 (53%)	27 (34%)	11 (14%)
EXTRA-JURISDICTION				
Cayman Islands	-	-	-	-
Maghaberry	-	-	-	-
Total	-	-	-	-
MILITARY				
MCTC	-	-	-	-
Total	-	-	-	-
OVERALL TOTAL	1,654	1,274 (77%)	267 (16%)	75 (5%)

KEY TO TABLE

Hyphen (-) – Indicates that outstanding action plans were not returned within the deadline.

Recommendations achieved in follow-up inspection reports 2012–13

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant)	ACHIEVED	PARTIALLY ACHIEVED	NOT ACHIEVED
LOCAL				
Dorchester	123	65	18	40
Hull	174	85	29	60
Liverpool	162	46	33	83
Norwich	199	89	34	76
Preston	154	89	17	48
Total	**812**	**374 (46%)**	**131 (16%)**	**307 (38%)**
TRAINERS				
Everthorpe	137	70	15	52
Garth (category B)	119	55	21	43
Isle of Wight (cluster)	204	88	45	71
Littlehey	112	43	28	41
Stocken	109	63	18	28
Stoke Heath	243	130	48	65
Wolds	192	95	34	63
Total	**1,116**	**544 (49%)**	**209 (19%)**	**363 (33%)**
HIGH SECURITY				
Wakefield	174	85	29	60
Total	**174**	**85 (49%)**	**29 (17%)**	**60 (34%)**
YOUNG ADULT				
Glen Parva	145	75	32	38
Portland	151	69	36	46
Reading	142	51	50	41
Total	**438**	**195 (45%)**	**118 (27%)**	**125 (29%)**
CHILDREN AND YOUNG PEOPLE				
Keppel Unit	98	60	19	19
Mary Carpenter Unit	52	33	8	11
Werrington	85	30	14	41
Total	**235**	**123 (52%)**	**41 (17%)**	**71 (30%)**
WOMEN				
Eastwood Park	191	84	33	74
Foston Hall	148	66	27	55
New Hall	192	104	28	60
Total	**531**	**254 (48%)**	**88 (17%)**	**189 (36%)**
PRISON TOTAL	**3,306**	**1,575 (48%)**	**616 (19%)**	**1,115 (34%)**

Recommendations achieved in follow-up inspection reports 2012–13 *(Continued)*

ESTABLISHMENT	RECOMMENDATIONS (excluding recommendations no longer relevant)	ACHIEVED	PARTIALLY ACHIEVED	NOT ACHIEVED
IMMIGRATION REMOVAL CENTRES				
Dover	119	44	31	44
Dungavel	44	26	4	14
Harmondsworth	192	73	43	76
Tinsley House	59	20	16	23
Total	**414**	**163 (39%)**	**94 (23%)**	**157 (38%)**
SHORT-TERM HOLDING FACILITIES				
Cayley House	38	8	5	25
Electric House	36	12	14	10
Lunar House	42	13	6	23
Sandford House	4	1	1	2
Vulcan House	40	18	6	16
Total	**160**	**52 (33%)**	**32 (20%)**	**76 (48%)**
IMMIGRATION TOTAL	574	215 (37%)	126 (22%)	233 (41%)
OVERALL TOTAL	3,880	1,790 (46%)	742 (19%)	1,348 (35%)

Prisoner survey responses across all functional types: diversity analysis – ethnicity/religion/nationality/disability/age

		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners	Catholic prisoners	Non-Catholic prisoners	Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50
	Number of completed questionnaires returned	1,442	4,911	562	5,823	657	5,661	1,183	5,135	1,237	5,139	936	5,516
		%	%	%	%	%	%	%	%	%	%	%	%
1.3	Are you sentenced?	86	88	80	88	85	88	88	88	86	88	94	87
1.5	Are you a foreign national?	19	6			17	8	13	8	8	9	9	9
1.6	Do you understand spoken English?	99	99	93	100	98	99	99	99	99	99	100	99
1.7	Do you understand written English?	97	99	88	99	96	99	97	99	96	99	98	98
1.8	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories.)			47	20	89	15	11	25	14	25	11	24
1.9	Do you consider yourself to be Gypsy/Romany/Traveller?	3	5	10	4	2	5	11	3	8	4	3	5
1.1	Are you Muslim?	42	2	20	10					5	12	3	12
1.12	Do you consider yourself to have a disability?	12	22	18	20	10	21	21	20			36	17
1.13	Are you a veteran (ex-armed services)?	2	7	9	6	3	7	6	6	11	5	20	4
1.14	Is this your first time in prison?	42	35	57	35	44	36	33	38	34	38	51	35
2.6	Were you treated well/very well by the escort staff?	65	74	68	72	60	73	71	72	69	73	79	71
2.7	Before you arrived here were you told that you were coming here?	55	68	54	66	57	66	65	65	65	65	70	64
3.2	When you were searched in reception, was this carried out in a respectful way?	75	84	75	83	70	84	83	82	79	83	87	81
3.3	Were you treated well/very well in reception?	61	72	67	70	58	71	67	70	69	70	79	68
3.4	Did you have any problems when you first arrived?	66	63	66	64	69	63	66	63	84	59	62	64
3.7	Did you have access to someone from health care when you first arrived here?	69	73	68	72	67	72	73	72	70	72	70	72
3.9	Did you feel safe on your first night here?	75	83	72	82	74	82	83	81	71	84	81	81
3.10	Have you been on an induction course?	89	87	85	88	90	87	88	88	83	89	87	88
4.1	Is it easy/very easy to communicate with your solicitor or legal representative?	44	48	41	48	43	48	46	48	43	48	56	46
4.4	Are you normally offered enough clean, suitable clothes for the week?	60	64	67	63	57	65	61	64	63	64	82	61
4.4	Are you normally able to have a shower every day?	87	88	89	88	84	88	88	88	85	88	91	87
4.4	Is your cell call bell normally answered within five minutes?	36	37	41	36	35	37	38	37	36	37	46	35
4.5	Is the food in this prison good/very good?	20	28	26	26	18	27	25	26	24	27	36	24
4.6	Does the shop/canteen sell a wide enough range of goods to meet your needs?	33	48	44	45	32	46	44	45	43	45	51	44
4.7	Are you able to speak to a Listener at any time, if you want to?	50	63	53	61	47	62	61	60	62	60	72	58
4.8	Do you feel your religious beliefs are respected?	58	51	64	51	61	51	71	48	52	52	65	50
4.9	Are you able to speak to a religious leader of your faith in private if you want to?	60	58	61	58	66	57	72	55	57	58	65	57
5.1	Is it easy to make an application?	79	86	81	85	75	86	84	85	79	86	90	84
5.3	Is it easy to make a complaint?	58	63	58	62	60	62	62	62	62	62	66	61
6.1	Do you feel you have been treated fairly in your experience of the IEP scheme?	38	56	39	53	35	54	50	52	47	53	59	51
6.2	Do the different levels of the IEP scheme encourage you to change your behaviour?	43	46	39	46	45	46	45	46	42	46	44	46
6.3	In the last six months have any members of staff physically restrained you (C&R)?	7	6	7	6	8	6	8	6	8	6	2	7
7.1	Do most staff, in this prison, treat you with respect?	71	79	74	78	64	79	77	77	76	78	88	76
7.2	Is there a member of staff you can turn to for help if you have a problem in this prison?	71	78	76	76	68	77	76	77	76	77	86	75
7.3	Do staff normally speak to you at least most of the time during association time? (Most/all of the time)	16	22	16	21	15	21	21	20	21	20	31	19
7.4	Do you have a personal officer?	63	63	62	63	60	63	61	64	64	63	76	61

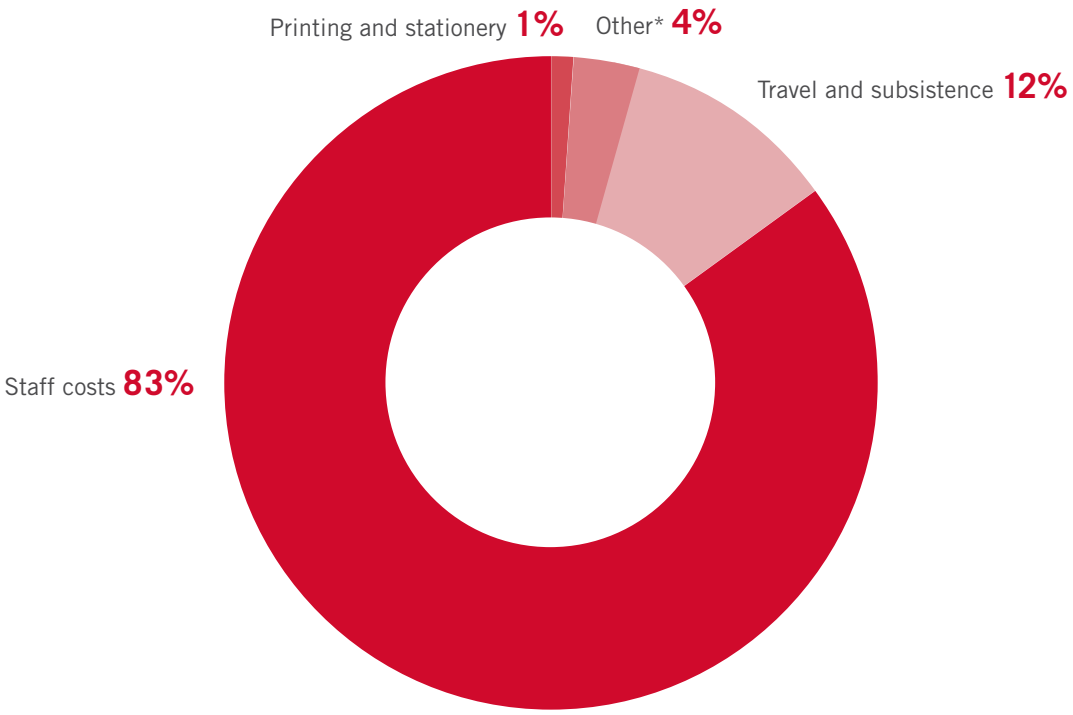
Prisoner survey responses across all functional types: diversity analysis – ethnicity/religion/nationality/disability/age

		Black and minority ethnic prisoners	White prisoners	Foreign national prisoners	British prisoners	Muslim prisoners	Non-Muslim prisoners	Catholic prisoners	Non-Catholic prisoners	Consider themselves to have a disability	Do not consider themselves to have a disability	Prisoners aged 50 and over	Prisoners under the age of 50
	Number of completed questionnaires returned	1,938	4,265	899	5,262	760	5,352	1,938	4,265	899	5,262	760	5,352
		%	%	%	%	%	%	%	%	%	%	%	%
8.1	Have you ever felt unsafe here?	38	32	37	33	42	33	33	34	50	30	30	34
8.2	Do you feel unsafe now?	18	13	19	13	21	13	14	14	22	12	10	14
8.3	Have you been victimised by other prisoners?	23	23	25	23	25	23	21	24	39	19	23	23
8.5	Have you ever felt threatened or intimidated by other prisoners here?	13	14	12	14	14	14	13	14	23	12	13	14
8.5	Have you been victimised because of your race or ethnic origin since you have been here? (By prisoners)	7	2	8	3	7	2	3	3	4	3	3	3
8.5	Have you been victimised because of your religion/religious beliefs? (By prisoners)	4	2	3	2	8	2	1	3	4	2	1	3
8.5	Have you been victimised because of your nationality? (By prisoners)	4	2	8	2	4	2	3	2	3	2	2	2
8.5	Have you been victimised because of your age? (By prisoners)	2	2	3	2	1	2	2	2	5	2	6	2
8.5	Have you been victimised because you have a disability? (By prisoners)	3	3	3	3	2	3	3	3	12	1	5	3
8.6	Have you been victimised by a member of staff?	34	26	27	28	41	26	31	27	41	25	22	29
8.7	Have you ever felt threatened or intimidated by staff here?	16	12	9	13	18	12	13	13	20	11	11	13
8.7	Have you been victimised because of your race or ethnic origin since you have been here? (By staff)	12	2	8	4	14	3	4	4	4	4	2	4
8.7	Have you been victimised because of your religion/ religious beliefs? (By staff)	7	2	3	3	13	2	1	3	4	3	2	3
8.7	Have you been victimised because of your nationality? (By staff)	5	2	8	2	9	2	3	2	2	2	2	3
8.7	Have you been victimised because of your age? (By staff)	2	2	3	2	2	2	2	2	3	2	3	2
8.7	Have you been victimised because you have a disability? (By staff)	2	3	2	3	1	2	2	2	10	0	4	2
9.1	Is it easy/very easy to see the doctor?	29	32	33	31	24	32	31	31	31	31	43	29
9.1	Is it easy/very easy to see the nurse?	50	56	50	54	49	55	55	54	58	53	65	52
9.4	Are you currently taking medication?	39	53	42	51	38	52	52	50	80	43	74	46
9.6	Do you feel you have any emotional well being/mental health issues?	20	31	26	29	22	30	31	28	58	21	23	30
10.3	Is it easy/very easy to get illegal drugs in this prison?	22	31	16	30	26	29	31	28	33	28	19	30
11.2	Are you currently working in the prison?	51	56	52	55	47	56	53	55	50	56	60	54
11.2	Are you currently undertaking vocational or skills training?	13	13	15	13	12	13	12	13	11	13	11	13
11.2	Are you currently in education (including basic skills)?	34	26	44	26	32	27	27	28	25	28	26	28
11.2	Are you currently taking part in an offending behaviour programme?	7	10	8	10	7	10	10	9	8	10	9	10
11.4	Do you go to the library at least once a week?	47	42	48	42	42	43	43	43	41	44	49	42
11.6	Do you go to the gym three or more times a week?	46	34	38	36	43	36	39	36	22	40	19	39
11.7	Do you go outside for exercise three or more times a week?	39	40	38	40	38	40	41	39	33	41	42	39
11.8	On average, do you go on association more than five times each week?	61	65	55	65	62	64	60	65	59	65	64	64
11.9	Do you spend 10 or more hours out of your cell on a weekday? (This includes hours at education, at work, etc)	14	16	12	16	14	16	15	16	14	17	22	15
12.2	Have you had any problems sending or receiving mail?	48	44	39	46	47	45	51	44	49	44	33	47
12.3	Have you had any problems getting access to the telephones?	33	26	25	28	36	27	29	28	30	27	19	29

KEY TO TABLE

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

Expenditure 1 April 2012 to 31 March 2013



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

PURPOSE	EXPENDITURE (£)
Staff costs[1]	3,814,605
Travel and subsistence	564,866
Printing and stationery	54,022
Information technology and telecommunications	32,244
Translators	8,376
Meetings and refreshments	37,560
Recruitment[2]	28,400
Conferences	8,084
Training and development	62,269
Total	4,610,426

1 Includes fee-paid inspectors, secondees and joint inspection/partner organisations costs, for example, General Pharmaceutical Council and contribution to secretariat support of the Joint Criminal Justice Inspection Chief Inspectors Group.

2 Includes cost of recruiting consultancy for recruitment of two specialist team leaders and external advertising for both posts.

Inspectorate staff – 1 April 2012 to 31 March 2013

The Inspectorate staff come from a range of professional backgrounds. While many have experience of working in prisons, others have expertise in social work, probation, law, youth justice, health care and drug treatment, social research and policy. The majority of staff are permanent, but the Inspectorate also takes inspectors on secondment from NOMS and other organisations. Currently, 10 staff are seconded from NOMS and one from Greater Manchester West Mental Health NHS Foundation Trust. Their experience and familiarity with current practice is invaluable.

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

	Nick Hardwick	Chief Inspector
	Martin Lomas	Deputy Chief Inspector
	Barbara Buchanan	Senior Personal Secretary to the Chief Inspector
	Joan Nash	Personal Secretary to the Deputy Chief Inspector
A TEAM (adult males)	Alison Perry	Team Leader
	Sandra Fieldhouse	Inspector
	Andrew Rooke	Inspector
	Paul Rowlands	Inspector
O TEAM (women)	Sean Sullivan	Team Leader
	Rosemarie Bugdale	Inspector
	Joss Crosbie	Inspector
	Paul Fenning	Inspector
	Jeanette Hall	Inspector
N TEAM (young adults)	Kieron Taylor	Team Leader
	Andrew Lund	Inspector
	Keith McInnis	Inspector
	Kevin Parkinson	Inspector
	Kellie Reeve	Inspector
J TEAM (juveniles)	Ian Macfadyen	Team Leader
	Angela Johnson	Inspector
	Ian Thomson	Inspector
I TEAM (immigration detention)	Hindpal Singh Bhui	Team Leader
	Beverley Alden	Inspector
	Colin Carroll	Inspector

(continued on next page)

P TEAM (police custody)	Maneer Afsar	Team Leader
	Gary Boughen	Inspector
	Peter Dunn	Inspector
	Vinnett Pearcy	Inspector
FEE-PAID INSPECTORS	Fay Deadman	Inspector (sessional)
	Karen Dillon	Inspector (sessional)
	Francesca Gordon	Inspector (sessional)
	Deri Hughes-Roberts	Inspector (sessional)
	Martin Kettle	Inspector (sessional)
	Gordon Riach	Inspector (sessional)
	Fiona Shearlaw	Inspector (sessional)
HEALTH SERVICES TEAM	Elizabeth Tysoe	Head of Health Services Inspection
	Paul Tarbuck	Deputy Head of Health Services Inspection
	Majella Pearce	Health Inspector
	Michael Bowen	Health Inspector (sessional)
	Helen Carter	Health Inspector (sessional)
	Nicola Rabjohns	Health Inspector (sessional)
	Sigrid Engelen	Drugs and Alcohol Inspector (sessional)
	Paul Roberts	Drugs and Alcohol Inspector (sessional)
RESEARCH, DEVELOPMENT AND THEMATICS	Catherine Shaw	Head of Research, Development and Thematics
	Samantha Booth	Senior Researcher
	Hayley Cripps	Acting Senior Researcher
	Laura Nettleingham	Senior Researcher
	Danielle Pearson	Policy Officer
	Annie Crowley	Researcher
	Ewan Kennedy	Researcher
	Rachel Murray	Researcher
	Helen Ranns	Researcher
	Alissa Redmond	Researcher
	Alice Reid	Researcher
	Joe Simmonds	Researcher
	Caroline Elwood	Research trainee
	Amy Radford	Research trainee
INSPECTION SUPPORT	Lesley Young	Head of Finance, HR and Inspection Support
	Stephen Seago	Administration Manager
	Francette Montgry	Administration Officer
	Francesca Hands	Administration Officer (fee-paid)
	Tamsin Williamson	Publications Manager (part-time)
	Brenda Kirsch	Acting Publications Manager (part-time)
	Jennifer Kim	Publications Assistant
	Jane Parsons	Press and Media Relations Manager (part-time)
EDITORS (fee-paid)	Anne Fragniere	
	Brenda Kirsch	
	Adrienne Penfield	
	Yasmin Prabhudas	

STAFF WHO LEFT SINCE THE LAST ANNUAL REPORT	Jessica Broughton	Chloe Flint	Martin Owens
	Michael Calvert	Olayinka Macauley	Laura Paton
	Sandra Charlton	Stephanie Moor	Nalini Sharma

Her Majesty's Inspectorate of Prisons
First Floor
Ashley House
2 Monck Street
London SW1P 2BQ

Telephone: 020 7035 2136
Fax: 020 7035 2141
Press enquiries: 020 7035 2123
General enquiries: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

Chief Inspector of Prisons
Nick Hardwick CBE

Published by TSO (The Stationery Office)
and available from:

Online
www.tsoshop.co.uk

Mail, telephone, fax & email
TSO, PO Box 29, Norwich, NR3 1GN
Telephone orders/general enquiries: 0870 600 5522
Order through the Parliamentary Hotline
Lo-call: 0845 7 023474
Fax orders: 0870 600 5533
Email: customer.services@tso.co.uk
Textphone: 0870 240 3701

The Houses of Parliament Shop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/general enquiries: 020 7219 3890
Fax orders: 020 7219 3866
Email: shop@parliament.uk
Internet: www.shop.parliament.uk

TSO@Blackwell and other Accredited Agents

ISBN 978-0-10-298692-1