REPORT ON

A FULL ANNOUNCED INSPECTION

OF

HM PRISON LONG LARTIN

14TH – 19TH JULY 2003

BY

HM CHIEF INSPECTOR OF PRISONS

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INTRODUCTION

Long Lartin is one of the five dispersal prisons in England, holding some of the most serious offenders in the prison system. Earlier this year, the prison began to hold remanded, as well as convicted, Category A prisoners.

There were many good aspects to the environment at Long Lartin. The inspection found that it was overall a safe place, in spite of the kind of prisoners it held. Suicide and self-harm policies were well-developed. The segregation unit, the largest in the dispersal estate, had better staff-prisoner relationships than other high security segregation units we have recently inspected; however, we found little effective work to return prisoners to normal location and take them out of the 'merry-go-round' that some of those in high security segregation experience. Staff-prisoner relationships were generally relaxed and respectful, though staff interaction with prisoners was sometimes limited. Prisoners were able to cook for themselves, and had regular time out of cell.

However, this relatively relaxed atmosphere masked some serious deficiencies. The most serious was the absence of sufficient activity, and the failure to make full use of what there was. This is something that we criticised in 1999 and 2002 and which has failed to improve. At its full capacity, the prison had activity spaces for only around half its prisoners. At the time of the inspection, two wings were closed and this in theory meant that 87% of prisoners could access jobs or education. In practice, though, this was far from true. In the month before the inspection, the prison managed to fill only a quarter of available spaces: so that many prisoners who should have been working were locked up. Some of this was due to the refurbishment programme; but it also reflected the poor management of staff and resources. Even when prisoners had access to work or education, they often failed to provide the necessary skills. Only one in ten of those in employment were involved in any training that led to qualifications; the prison was failing to meet its education targets for level 1 basic skills; and classes were constantly being closed. These are deficits

we would criticise in a hard-pressed local prison; they are difficult to excuse in the best-resourced and most stable part of the prison estate.

Another failing was the absence of proper reception, first night and induction procedures - in spite of the fact that Long Lartin was now receiving remand prisoners direct from court, who could be particularly vulnerable. One in four prisoners said that they had not felt safe on the first night; only 4% were able to make a phone call (compared with 35% in other dispersal prisons); and only 8% (compared to 43%) were given the induction information that they needed about the prison - most got it from other prisoners. 78% of prisoners said that they had difficulty accessing their property, and this gave rise to a steady stream of complaints and applications, and considerable dissatisfaction with the outcomes.

The prison ran an excellent drug treatment programme, Focus, for twenty prisoners a year. However, we had serious concerns about the rest of the prison's drug strategy. It was considerably out of date, and did not appear to have tackled problems either of supply or demand. The drug team was overloaded, understaffed and unable to run treatment groups. Though mandatory drug tests were relatively low, there was a significant refusal rate and a high proportion of positive tests revealed opiates: 80% of prisoners told us that it was easy to get hold of drugs, particularly opiates.

For the last three years, around 28% of Long Lartin's prisoners had been from black and ethnic minority communities. There had been some recent activity in relation to race, with the appointment of a new Race Relations Liaison Officer, who had succeeded in reducing the complaints backlog from 100 to 25, and the very recent establishment of assistant officers on the wings. Some complaints were handled well, others inadequately; monitoring data were unreliable. Overall, there was no clear direction or strategy, and there should be: we detected underlying tensions among prisoners, and a lack of confidence among staff and managers, which could lead to serious problems if left unattended..

In contrast to other dispersal prisons we have inspected, probation officers were carrying out some good reintegration work, as well as public protection work, with prisoners about to be released directly from Long Lartin. Offending behaviour

programmes continued to be excellent. However, resettlement work within the prison as a whole lacked drive, largely because the remit of the resettlement committee was unfocused. There was a considerable, and unquantifiable, backlog of sentence plans dating back several months; and the targets set were often unrealistic, requiring participation in offending behaviour programmes which were over-subscribed. The majority of life sentenced prisoners' reports were not completed on time; and the information booklet for them had been printed five years ago and was out of date.

Overall, Long Lartin was certainly a safe and comfortable prison for its staff and most of its prisoners, which is no mean achievement, given the nature of its prisoner population; and there were pockets of excellent work with those prisoners who could access treatment programmes. However, there were considerable gaps and deficits. Long Lartin could deliver a great deal more for its prisoners, and managers need to ensure that it does.

Anne Owers
HM Chief Inspector of Prisons **September 2003**

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Task of the establishment

To contribute to Prison Service objectives by providing a highly secure and controlled environment in which the throughcare of prisoners is based on assessment of risk and individual needs.

Area organisation

Directorate of High Security Prisons.

Number held

430.

Certified normal accommodation

599.

Operational capacity

442.

Last inspection

Last full inspection: October 1998.

Follow-up visit: January 2002.

Brief history

Built on the site of a former War Department Ordnance Depot six miles east of Evesham in Worcestershire, Long Lartin opened in 1971 as a category C training prison. Security was up-graded to dispersal level in 1972. Further upgrades took place between 1995 and 1997 as a result of the Woodcock and Learmont reports. Following the High Security Estate Review, Long Lartin now holds category A remand prisoners.

Description of residential units

There are six main residential wings: A, B, C, E and Perrie Red and Blue. In additional to these, there is a residential rehabilitation unit for up to 18 prisoners, a small health care centre and a segregation unit (known locally as the security, care and control unit - SCCU).

A and B Wings accommodate up to 77 prisoners each and are mainstream 'dispersal' wings that include 'high risk' category A prisoners within their populations. C Wing is an enhanced wing for up to 77 prisoners. It has an anti-smoking policy and plays an integral part in the drug strategy policy, as does E Wing, which offers specific support to prisoners in relation to drug misuse.

Perrie Wing is split into two spurs (Blue and Red) that accommodate up to 120 prisoners, including potential category A remands and prisoners on the basic level of privileges, both of which integrate in the wing regime.

Perrie, the SCCU, health care and the rehabilitation unit have integral sanitation, whereas A, B, C and E Wings have an electronic night sanitation system.

HEALTHY PRISON SUMMARY

Introduction

HP.01 All inspection reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern,* published in 1999. The criteria are:

- **Safety:** prisoners are held in safety.
- **Respect:** prisoners are treated with respect as individuals.
- **Purposeful activity:** prisoners are fully and purposefully occupied.
- **Resettlement:** prisoners are prepared for their release and resettlement into the community with the aim of reducing the likelihood of their re-offending.

Safety

HP.02 Long Lartin was a safe prison, which was a considerable achievement given the nature of prisoners held there. There was, however, room for improvement to some of the systems in operation and a need to remain vigilant to issues of safety and security, given that our prisoner survey indicated that 45% of prisoners had felt unsafe at some time during their stay.

HP.03 The reception area was large and welcoming. Prisoners were processed quickly and staff had a good rapport with those prisoners moving through the unit. Prisoners who were non-smokers did not receive a special reception pack and there were delays for all prisoners in accessing property stored in reception as a result of the frequent redeployment of staff to other areas of the prison at weekends.

HP.04 There were, in effect, no first night arrangements in place. Long Lartin had begun to hold category A remand prisoners who would need first night arrangements. Equally, many of those moving to Long Lartin would be experiencing a dispersal prison environment for the first time and effective first night arrangements for these prisoners would also be important. In our prisoner survey, a quarter of all prisoners stated that they had not felt safe on their first night and 4% said they had been able to

make a phone call on their first night, compared with 43% in the high security estate generally.

HP.05 The two-week induction programme was also not working effectively. Some prisoners were missing out on it entirely and there was little available for any prisoners undertaking it whose first language was not English. Overall, half of all prisoners who undertook induction at Long Lartin claimed that its content did not provide them with the information they needed.

HP.06 The segregation unit, called the security, care and control unit, held some very difficult prisoners. These prisoners were being managed well and in general there were good relationships between them and staff in the unit. Some prisoners were held in the unit for a very long time (one had been there for over a year at the time of our inspection) and there was little effective planning in place to return many of these prisoners to normal location. In addition, there was little activity in the unit: prisoners did not have access to the gymnasium or to work and, although education was said to be available on demand, no prisoners were undertaking any courses at the time of our inspection.

HP.07 A good anti-bullying policy was in place and staff were alert to issues of bullying within the prison. The anti-bullying policy outlined three stages of intervention and 70 prisoners had been placed on stage 1 since the beginning of the year; few prisoners, however, moved on to stages 2 and 3. Despite some good identification and monitoring of prisoners, no programmes were in place to support victims of bullying or to challenge bullies. It was also clear that some staff with responsibility for the anti-bullying policy were not as aware as we would have expected of the potential for more sophisticated forms of bullying that could take place in an environment such as that at Long Lartin.

HP.08 Good systems were in place for the management of those prisoners at risk of suicide or self-harm. Although F2052SH (self-harm booklet) entries were of variable quality, there were good systems in place for monitoring these and frequent management checks. Overall, there was a high level of staff training in suicide and self-harm matters and a good level of staff awareness. Sixteen listeners were in place

at the time of our inspection and there was weekly contact between this group and the Samaritans. Crisis suites were, however, poor and did not provide a welcoming or calming environment for prisoners.

HP.09 The incentives and earned privileges scheme was operated in a fair and transparent way. The system was based on points allocated weekly to each prisoner reflecting his behaviour during the week. The appeals process also operated fairly and effectively. Over half of all prisoners at Long Lartin were on the enhanced level of the scheme; 3% were on the basic level.

Respect

HP.10 Long Lartin provided a respectful environment underpinned by good relationships between staff and prisoners. This was supported by the relatively sparing use of force. However, race matters required closer attention.

HP.11 Long Lartin provided a generally clean environment for prisoners, although some areas awaiting refurbishment were shabby. Prisoners had access to clean clothing, a weekly change of sheets and daily showers. There were sufficient telephones for those prisoners who wished to use them during the regular periods of association. The standard of food was acceptable and prisoners were also able to cook for themselves in residential areas. Half of all prisoners responding to our survey said that they had problems sending and receiving mail and a major area of complaint was the delay in exchanging and receiving property.

HP.12 At night, prisoners wishing to use the wing toilets were unlocked electronically for a maximum of 12 minutes each time. This system led to some queuing and resulted in some prisoners throwing parcels of excrement from their cell windows into the prison grounds.

HP.13 The complaints system was used freely by prisoners. The system was properly tracked and monitored, and the confidential access system allowing prisoners to write directly to the Governor was effective and frequently used. Replies were generally respectful and to the point. However, in our survey, 75% of prisoners said that complaints were not sorted out fairly, which may in part have been due to the fact that

many complaints were about property and visits, both areas in which there had been longstanding unresolved difficulties.

HP.14 A full-time race relations liaison officer had been appointed in November primarily to deal with a backlog of complaints. At the time of this inspection, the number of outstanding complaints had been reduced to 25. The response to reported racist incidents was patchy: some were dealt with swiftly and effectively, while others were not. The appointment of assistant RRLOs on the units offered an opportunity for a more active approach, but they would need effective direction and support. As a result of the RRLO's commitment to clearing the complaints backlog, the race relations liaison officer had not undertaken much other work. Although the race relations management team met bi-monthly under the direction of the Governor, it was not following a clear action plan. There was also insufficient interrogation of monitoring data, some aspects of which were a cause of concern. Overall, given that 28% of Long Lartin's population identified themselves as being from minority ethnic groups, insufficient attention was being paid to this area and the promotion of diversity was lacking.

HP.15 Almost 15% of Long Lartin's prisoners were also foreign nationals of 29 different nationalities. There was some foreign language material about the prison and a foreign nationals group had been held recently, although this was its first meeting in about a year. Although some work was being undertaken with this group of prisoners, there remained a need for clearer strategic direction, and management responsibility.

HP.16 The chaplaincy team was offering a good service to prisoners of all faiths. There were good facilities for prisoners and the chaplaincy team saw the prison as its parish, visiting all areas regularly.

HP.17 There was safe delivery of health care at Long Lartin with generally good access for prisoners. However, staffing shortages and the recent loss of managers had impacted on the delivery of care, including the cancellation of many nurse-led clinics and other new initiatives. This situation was not helped by the fact that nurses were frequently required to undertake routine administrative duties. Despite this, over two-

thirds of respondents to our survey said that the treatment they received from nurses was good. Prisoners in the in-patient unit, however, received very little in the way of a regime and, although a psychiatrist visited weekly, no mental health in-reach team was working at the prison. Many of those in the in-patient unit were poor copers who had been inappropriately located there. The greatest concern for many prisoners was the long waiting list for dental treatment caused by the illness of both the regular and the stand-in dentists. In addition to increasing staffing levels, there was a need for an experienced clinical manager to give direction to the provision of health care at Long Lartin.

Purposeful activity

HP.18 As in our reports of 1999 and 2002, there was insufficient activity for prisoners at Long Lartin. Although some changes had taken place, this area of work had not improved significantly and it had not been well managed.

HP.19 About 87% of all prisoners were allocated jobs, although this figure was based on the number of prisoners at the time of our inspection when two of the residential units were closed for refurbishment; at its operating capacity, there would have been jobs for only 54%. There were also excessive closures of workshops and education: in the last month, only a quarter of all available prisoner work and education hours had been fully utilised. This resulted in many prisoners being locked up and paid for doing nothing.

HP.20 Over a third of all prisoners were involved in education, but there were frequent failures in provision: in June, for example, a third of all basic skills and information technology classes had been cancelled. Teaching throughout was rated as satisfactory or better and there was a good range of subjects. The prison was meeting its key performance targets for basic skills at level 2, but not at level 1. The prison library provided a very good service with appropriate access for all prisoners.

HP.21 There was very little vocational training available, with only 11% of all prisoners involved in any training leading to such qualifications (this included those prisoners allocated to one workshop that had been closed for a very long time due to staff sickness). There were also some difficulties with internal verification, which had

resulted in some prisoners' qualifications being invalidated. Basic skills information about prisoners was not being passed on to workshops. However, a good range of quality products was being produced in the workshops and some skills on the part of prisoners were evident. Overall, there was no real understanding of vocational training and there was a need for a more coherent and cohesive approach to education and training based on an analysis of the needs of the population.

HP.22 The physical education department offered a wide range of courses and recreational activity. Special needs groups were also invited into the prison. Over 60% of all prisoners made use of the gymnasium, but physical education staff felt that they were both geographically and operationally isolated. In particular, the department had been involved in recent rehabilitation work, but had not been systematically involved in other key strategies in the prison such as anti-bullying or suicide and self-harm work.

Resettlement

HP.23 The resettlement policy and committee in place during this inspection were not driving work in this area and developments were not based on a needs analysis of the population. Although some good work was being undertaken in some areas, key work in others was not being delivered. There was no clear resettlement focus for the committee, which operated as a catch-all safer custody committee, with elements of resettlement added.

HP.24 There was a considerable backlog of uncompleted sentence plans. No member of staff or manager was able to indicate to us the extent of this, but it dated back at least to February 2003. Targets being set for prisoners were generally satisfactory, but there was a heavy emphasis on offending behaviour programmes that the prison could not meet. When sentence plans were completed, they were generally of a high standard, but the backlog was also delaying re-categorisation decisions.

HP.25 The prison offered Enhanced Thinking Skills (53 completions a year) and Controlling Anger and Learning to Manage it (29 completions a year). These courses were delivered in excellent facilities by a dedicated and competent group of staff.

HP.26 As with the sentence planning, there was a backlog of life-sentenced prisoner reports. Again, exact figures were not available, but we were informed that reports on approximately 130 of the 200 life-sentenced prisoners at Long Lartin were not completed on time. When reviews were completed, however, the quality was generally satisfactory. There was, in effect, nothing specific in place for life-sentenced prisoners: there were no life-sentenced prisoner forums, no life-sentenced prisoner days and life-sentenced prisoners claimed not to have any contact with staff designated to work in this area. A booklet for life-sentenced prisoners was available, but this had been printed in 1998 and was out of date.

HP.27 Up to 24 prisoners were discharged into the community each year, some of them from the security, care and control unit. All prisoners were seen six months before release in order to begin working on matters of housing, jobs and the receipt of benefits. This work was good, but it was not linked into sentence planning. Public protection systems at the prison were also well managed and effective, with visits and other staff being well aware of their responsibilities.

HP.28 The drug strategy was out of date and there was no drug strategy committee. The mandatory drug testing positive rate was running at about 6%, but in some months there was also a refusal rate of an additional 10%. This, along with other security information available, requests by prisoners for heroin detoxification and the fact that 80% of respondents to our survey said that it was easy to get drugs, indicated that the mandatory drug testing positive rate might not be a true indicator of the amount of drugs, particularly opiates, available in the prison. Focus, a good programme for dealing with drug users was in place, but it was very selective. The counselling, assessment, referral, advice and throughcare (CARAT) service was overloaded and no groups were being run. Of the five staff funded for this work, only two were in post. Detoxification for prisoners was under review and the provision of Subutex was being considered. It would be necessary to ensure that appropriate conditions were in place before the introduction of Subutex to ensure its safe administration.

HP.29 Some visitors were experiencing very long delays in getting into visits. When coupled with the difficulties many had in booking a visit through the dedicated visits

booking line, this was proving to be a source of considerable frustration for prisoners and their visitors. When visits took place, however, they did so in a generally good environment with appropriate levels of supervision. All-day visits were available on two days each week. There was also a monthly scheme for family visits for those prisoners on the enhanced privilege level, which allowed prisoners to mix with their partners and children in a relaxed environment with discreet supervision.

Conclusion

HP.30 Long Lartin provided a safe and respectful environment for prisoners. However, the needs of the quarter of its prisoners who were from black and minority ethnic backgrounds were not receiving all the attention they deserved. Within the resettlement work of the prison, reintegration planning for the 24 or so prisoners who would be released directly into the community each year was effective. Sentence planning and work with life-sentenced prisoners required closer attention.

HP.31 The major area of deficit, however, was in terms of purposeful activity for prisoners. As highlighted in our reports of 1999 and 2002, this was an area that still required significant improvement if Long Lartin were to move closer towards being a healthy prison.

Main recommendations

HP.32 **There should be effective first night systems and a consistently delivered induction programme.**

HP.33 **Work should be undertaken with segregated prisoners to ensure they are returned to normal location whenever possible.**

HP.34 **Race relations matters should be reviewed and an action plan for improvement should be implemented.**

HP.35 **All prisoners should engage in education and meaningful work on a daily basis.**

HP.36 **Accreditation of courses and training opportunities should be increased.**

HP.37 **A drug strategy based on the needs of the population, and an action plan resulting from this, should be produced.**

HP.38 **A resettlement needs analysis of the population should be undertaken and an action plan implemented to meet identified need.**

CHAPTER ONE

ARRIVAL IN CUSTODY

Courts and transfers

Expected outcomes

The expected outcomes for courts and transfers procedures are:

Safety: Prisoners travel in safe conditions to and from court and between establishments

Safety: Prisoners are safe in crown court cells and other holding areas

Respect: Prisoners are held in decent conditions in escort vehicles and at court

Respect: Prisoners are provided with opportunities for refreshment, toilet and washing facilities at reasonable time intervals

Respect: The individual needs of prisoners during escort and while at court are given proper attention

1.01 Although Long Lartin was a training prison, it had recently also taken on responsibility for holding remanded Category A prisoners, as part of the restructuring of the high security estate. This increased the throughput of prisoners arriving and leaving. The escort contractors were Group 4 and Premier but Long Lartin staff escorted remand prisoners to and from court. Relationships between escort staff and reception were good.

1.02 On one day of our inspection, a group of six prisoners arrived: three for Long Lartin and three who were going on to Bristol Prison. The three who were in transit were allowed off the van to use the toilet. The documents of the three Long Lartin prisoners showed that they had been provided with packed meals. All the documentation was in order. As smoking was not allowed on the journey, one prisoner had been abusive to a member of the escort staff; this had been recorded and reception staff were notified. Generally, prisoners said that they had been treated well by escort staff.

Conclusion

1.03 Relationships between escort staff and reception were good. Prisoners were treated well by escort staff.

Reception, first night and induction

Expected outcomes

The expected outcomes for arrival in custody procedures (reception, first night and induction) are:

Safety: Everything reasonable is done to help prisoners feel safe on their reception into prison; prisoners' needs are identified, including physical and mental health care, in order that they may be cared for and supported by competent trained staff

Respect: The way in which entry procedures are conducted and the approach of competent staff preserves the personal identity of prisoners, respects their privacy and dignity and is responsive to their individual needs

Respect: Prisoners are made aware of prison routines, how to access available services and cope with imprisonment

Purposeful activity: Prisoners are constructively occupied during their first days in prison, preferably as part of a comprehensive induction programme

Resettlement and reducing re-offending: Prisoners' welfare needs are identified and appropriate help offered to deal with them

Reception

1.04 The reception area was in a large and airy warehouse, most of which was taken up with prisoners' stored property. Staffing levels were one principal officer and three officers during the week and two officers at weekends. Two officer support grades also worked in reception and dealt with parcels, registered mail and catalogue orders. In the period from 1 April to 15 July 2003, 92 prisoners had arrived and 187 had departed through reception.

1.05 We observed the reception procedures of three prisoners who had arrived from Garth Prison. They were processed individually. Each one was searched in a small

curtained area and a cell-sharing risk assessment form was completed. There was no shower or telephone for prisoners' use and prisoners were seen by health care in the health care centre. Prisoners were allowed to take essential permitted items from their sealed property bags with the intention that they would return in the next day or so to go through their property in detail and enter each item on their property cards. All three prisoners spoke English but reception also held a good range of prisoner information booklets in several languages. Prisoners were kept in reception for no more than 20 minutes. A tobacco reception pack to the value of £5 was available for smokers but there was no equivalent for non-smokers. Prisoners were treated well by reception staff and the process was informal and relaxed.

1.06 Prisoners were encouraged to hand out unwanted and non-permitted items during visits. Any remaining property was stored in clear bags that were sealed and placed in a large cardboard box. When this became full, prisoners were given 28 days in which to dispose of their property, after which the box was sent to the main warehouse at Branston.

1.07 Property could not be handed in on visits but prisoners could apply for items to be sent in through the post. A major prisoner complaint was the difficulty in getting to reception to exchange goods (one for one) and to collect recorded delivery items. Residential wings varied as to whether prisoners had to go to reception to collect property or whether staff would collect it for them. As reception was not in the same compound as residential wings, there were additional difficulties in escorting category A prisoners there.

1.08 Staff processed prisoners' applications for property at weekends. When we inspected reception, there were 11 outstanding applications, the oldest of which had been there for two weeks. Staff told us that they were often redeployed at weekends. In the period from 1 April to 15 July 2003, 29 (48%) of the 60 half-days at weekends had required staff to work elsewhere.

1.09 Prisoners also complained about the delays in processing and receiving catalogue items. The complex and time-consuming process involved the reception officer support grades, staff in the prisoner monies section and the cashier, and

required authorisation from managers. No written information about the process was available to prisoners and the assumption was that it would be explained to them by wing staff. We encountered a lot of frustration over catalogue orders, both from prisoners and from the various departments involved in the process.

Conclusion

1.10 Prisoners were treated well in reception and the process was informal and relaxed. There was no reception pack for non-smokers and prisoners' property was not itemised before they went to a residential unit. Regular redeployment of reception staff at weekends led to delays in dealing with property applications. The processes for catalogue orders were not publicised to prisoners or staff.

Recommendations

1.11 **Reception staff should not be redeployed if this means delaying prisoners' applications regarding property in reception.**

1.12 **Prisoners and staff should be provided with information about the placing and processing of mail order items.**

1.13 **A reception pack should be provided for non-smokers.**

1.14 **Alternative options should be found for prisoners to authorise the destruction of their property without having to go to reception.**

1.15 **There should be clear, consistent and effective procedures for the collection and exchange of items from reception.**

First night

1.16 There were no specific arrangements for prisoners spending their first night in Long Lartin. Apart from remand prisoners, who went to Perrie Wing, all prisoners were located wherever there was a space. Despite the fact that all prisoner accommodation was in single cells, cell-sharing risk assessments were still completed in reception and followed the prisoner onto the wing.

1.17 Provided they arrived on the wing before 6.30pm, prisoners could have a shower but were not given a free telephone call. They had to wait until any PIN telephone credits, or the equivalent value held on 'phone cards, had been transferred to their account. This could take several days but staff would telephone a prisoner's family if the message was important. The high security prison average for prisoners able to make a telephone call on their first day was 35%, compared to 4% at Long Lartin.

1.18 The little information given to prisoners in their first few days consisted of one piece of paper entitled 'Guide to new receptions for first 24-48 hours'. Depending on whether they arrived during or after normal hours, this told prisoners what would happen to them. The information was cursory to say the least:

'Come in via reception.
Be certified as fit by health care centre.
Go to wing.
You will be allocated a personal officer.
All requests and applications to be made via personal officer.
You will be taken to reception as soon as practicable.
Inductions will start either the following Monday or the Monday after that.
Inductions will be held in the programme's shop, go with labour move.'

1.19 The high security prison average for prisoners who were given written or spoken information about what was going to happen to them on their first night was 43%; at Long Lartin it was 8%.

Conclusion

1.20 There were no specific first night arrangements for prisoners. They could not use the telephone and initial information was inadequate. Twenty-seven per cent of respondents to our survey said that they did not feel safe on their first night. Existing arrangements did not recognise the needs of remand prisoners or the levels of stress for prisoners entering a high security prison.

Recommendations

1.21 **There should be specific first night procedures for all new prisoners during their first few days at Long Lartin.**

1.22 **All prisoners should be offered a free telephone call on their first night.**

1.23 **Sufficient information should be provided to prisoners to enable them to understand daily routines and what will be provided during their first week.**

Induction

1.24 Until a few months prior to this inspection, a regular and properly organised induction programme for prisoners had been delivered by a team of induction staff on Perrie Wing, the then designated induction wing. Following this induction, however, many prisoners resisted relocation to other wings knowing they were going to poor accommodation with no in-cell sanitation. A decision was taken, therefore, to house new prisoners wherever there were spaces and to deliver induction in a separate classroom. At the time of this inspection, induction was delivered in a classroom in the woodcraft shop. The dedicated team of induction staff had been disbanded and any officer on Perrie Wing willing to do so could deliver induction.

1.25 In theory, induction was a two-week rolling programme: the first week providing information on the services available within the prison and the second week being a generic preparation for work. In practice, delivery of the first week depended on staff availability and whether the woodcraft shop was open (instructors were sometimes sick or on leave). Quite often, the generic preparation for work section was delivered before the core induction modules. There was no provision for prisoners whose first language was not English. In our survey, 68% of respondents said that they had received induction more than one week after arrival and 50% said that it did not cover what they needed to know about the prison.

1.26 The current deficiencies of induction had already been recognised by senior managers, who intended to transfer responsibility for its delivery to the resettlement unit. Caseworkers would deal with certain aspects of induction with input from the various departments across the prison.

Conclusion

1.27 The arrangements to induct new prisoners were in disarray. Whether prisoners received induction depended on staff availability and on the woodcraft shop being open at the time. The arrangements were being reviewed and responsibility for induction was being transferred to the resettlement unit.

Recommendations

1.28 **All prisoners should receive proper induction within their first few weeks at the prison.**

1.29 **There should be a review of the induction course to ensure that it meets the needs of prisoners arriving at Long Lartin.**

CHAPTER TWO

RESIDENTIAL UNITS

Expected outcomes

The expected outcomes for accommodation and facilities, clothing and possessions, and hygiene are:

- **Safety:** Prisoners live in a safe and hygienic environment
- **Safety:** Prisoners are risk and needs assessed before being placed with other prisoners in shared cells
- **Respect:** Prisoners have their dignity and privacy of life respected while in prison
- **Respect:** Prisoners are encouraged, enabled and expected to maintain an acceptable level of personal hygiene in appropriate, decent residential accommodation
- **Purposeful activity:** Suitable space and facilities on residential units are available and used to permit association activities that meet prisoners' needs

Accommodation and facilities

2.01 Apart from those in the security, care and control unit and the health care centre, prisoners were accommodated in one of nine residential locations. As part of an ongoing programme of refurbishment and upgrading of prisoner living accommodation, two of the residential wings were out of commission at the time of our inspection. This reduced the prison's certified normal accommodation from 599 to 442.

2.02 Built in the late 1960s, the wings in the main part of the prison were not well designed, particularly for supervisory purposes. Each wing held 76 or 77 prisoners. Cells were located on the ground, first and second floors. Each landing had a recess area with showers and a bath. On A and B Wings, which did not provide in-cell sanitation, this area also included communal toilets (see section on hygiene). The newer wings, Perrie Red and Blue, provided accommodation in an L-shape, open plan layout joined to a central core of offices. Perrie Red had 74 cells and Perrie Blue had

42, both on two landings. All wings had their own outdoor exercise areas and association facilities that included pool or table tennis, Sky television and dartboards.

2.03 In general, the residential wings were well appointed, clean and reasonably decorated. The main exceptions to this were A and B Wings, which we found to be grubby and poorly maintained, particularly in the toilet and shower areas. It appeared that the short-term maintenance needs of these wings had been forgotten or overlooked while they awaited closure for refurbishment. During the refurbishment of C Wing, the only cellular accommodation suitable for wheelchair users had been removed.

2.04 All prisoners were in single cell accommodation and most had courtesy keys to offer some individual privacy and allow for the safekeeping of possessions. Most of the cells we saw were kept clean and tidy with no evidence of graffiti or inappropriate material on display. Up to 10 cleaners were employed on each wing to maintain communal areas and prisoners had ready access to cleaning materials. All wings provided an adequate range of staff offices and interview rooms, although the furniture and décor in some of these was poor. Prisoners had open access to laundry and ironing facilities. A communal kitchen where prisoners could prepare their own food was a well used and highly valued resource. Flip-down tables allowed prisoners to dine in association.

2.05 The interactions that we observed between staff and prisoners were generally relaxed and respectful, with many addressing each other by their first name. Some prisoners complained to us that staff attitudes were poor and that staff used security considerations as an excuse for not engaging with prisoners. On a number of occasions, we noted staff based in the office rather than being available on the wing; they told us that this was due to the large and varied demands being made of them, including paperwork and constantly ringing telephones. Use of the cell bell system was not excessive during the day and we observed staff responding to calls. However, only 49% of prisoners felt that their cell bell was answered promptly, compared to the high security prison average of 66%.

Conclusion

2.06 The living accommodation was being upgraded and refurbished. Where this had taken place, the standard of the accommodation was good. Areas awaiting refurbishment were being allowed to deteriorate further for want of routine maintenance. Prisoners had open access to a range of facilities, including being able to prepare their own food. Staff/prisoner exchanges were generally polite and respectful, although there was some evidence that staff were not spending a lot of time on the wings simply interacting with prisoners.

Recommendations

2.07 **The prison's capability for managing prisoners with disabilities, especially wheelchair users, should be clarified.**

2.08 **Pending closure for refurbishment, A and B Wings should maintain an acceptable level of presentation and cleanliness.**

Personal officers

Expected outcomes

The expected outcomes for key workers (personal officers) are:

- **Safety:** Key workers provide a first line level of care promoting safety in the prison environment
- **Respect:** Prisoners experience relationships with their key workers that are based on mutual respect, high expectations and affirmation
- **Respect:** Prisoners know that their key worker will support them fully in their involvement in the prison system and throughout the progress of their sentence, based on sound knowledge of the prisoner, including any special needs
- **Purposeful activity:** Key workers encourage the best use of their prisoners' time out-of-cell
- **Resettlement and reducing offending**: Key workers ensure that prisoners start and maintain the process of resettlement from the beginning of the sentence and in each new location

2.09 The personal officer scheme that we commended at our last inspection was still in operation. Each residential officer was allocated up to four prisoners on an individual basis rather than according to cell location. Three or four personal officers worked together as a team with one designated leader and were expected to cover for each other's absence. Although no-one could produce any specific written instructions or guidance on the personal officer role, all of the officers to whom we spoke could describe what was required of them; this tended to focus on maintaining regular contact with the prisoner and preparing reports.

2.10 According to our survey, 82% of prisoners had a personal officer; this compared favourably with the high security prison average of 67%. However, only 34% had met the officer within the first week, compared to the average of 52%. Over half of those prisoners who had a personal officer described them as helpful or very helpful but more than a third (36%) said their personal officer was not helpful.

2.11 Contact between the personal officer and prisoner was recorded in the prisoner's wing history file. A monthly contact monitoring sheet provided a routine summary of events and significant events and was supposed to be signed by both the officer and prisoner. We sampled a number of wing files in five of the main residential units and found the content and quality of entries to be variable. In some cases, entries were limited to recording the prisoner's weekly incentives and earned privileges score. We found some evidence of monthly monitoring sheets having been completed but this did not happen routinely. From the sample we saw, the most consistent and detailed entries were completed by officers on Perrie Wing. Staff told us that structured personal officer work was often the first task to be dropped when other work demands took priority.

Conclusion

2.12 Most prisoners had a personal officer and staff shared a common understanding of what the role entailed. Records of contact between staff and prisoners varied in both quantity and quality. According to staff, personal officer work was not always designated as a priority task.

Recommendations

2.13 **Clear written guidance should be produced on the role of the personal officer.**

2.14 **The content and quality of written records and reports prepared by personal officers should be standardised and subject to regular quality control.**

Clothing and possessions

2.15 Prisoners were allowed to wear their own clothing. The clothing they were allowed to have in their possession was defined in the in-possessions facility list and was linked to the incentives and earned privileges scheme. Those who chose to could wear prison clothing. Prisoners who had prison clothing told us that it could be changed on demand and that the correct size was always available. This was confirmed by our own observations and 90% of respondents to our survey said that they were normally offered enough clean, suitable clothes for the week.

2.16 The published in-possessions list had last been up-dated in June 2003. The list was long, running to 15 pages, and set out how each item could be obtained, what level of the incentives and earned privileges scheme a prisoner needed to be on to have the item and the maximum value the prison would be prepared to pay in the event of a claim against it. The list was comprehensive and sufficient to accommodate the needs of a long-term population.

2.17 Volumetric control was in operation and prisoners could apply to have items from their stored property in their possession (see section on reception).

Conclusion

2.18 Prisoners could wear either their own or prison clothing. Prison clothing was in good condition and easily available. The in-possessions list was comprehensive.

Hygiene

2.19 Every wing landing had communal toilets, showers and a bath, and prisoners could take showers during any or all of the three association periods each day. There were no problems with getting cleaning materials for their cells. Bedding was

satisfactory and was changed every week, although some prisoners said that getting replacement mattresses proved difficult.

2.20 Apart from those on Perrie Red and Blue Wings, the major drawback for prisoners was the electronic unlocking for night sanitation. This meant that, during the 12-hour period when prisoners were locked in-cell, one prisoner per landing could use the toilet for 10 minutes or so up to three times a night; duration times varied depending on which member of staff we spoke to. Night sanitation was also suspended when night staff conducted checks every hour on landings that housed category A prisoners. Although calls to use the lavatory were placed in a queue to ensure a fair system of unlocking, prisoners told us that they had to wait a long time to use the toilet at night and regularly threw excreta parcels out of their cell windows. Yard orderlies had also complained about this distasteful aspect of their work and were understandably reluctant to do it.

Conclusion

2.21 General hygiene arrangements were satisfactory but night sanitation was a continuing source of grievance for prisoners.

Recommendations

2.22 **Prisoners should have access to night sanitation when they need it and this should be included in any redesign of the residential unit.**

2.23 **Mattresses for cell beds should be replaced as required.**

CHAPTER THREE

DUTY OF CARE

Anti-bullying

Expected outcomes

The expected outcomes for creating an environment safe from bullying are:

- **Safety:** Prisoners are as safe as possible from bullying behaviour and bullied prisoners are always given full support in any bullying incident
- **Respect:** Neither staff nor prisoner uses their position or power to bully others
- **Respect:** Bullying and bullied prisoners are treated fairly and are aware of the systems that operate to prevent bullying behaviour
- **Purposeful activity:** Activities take place to develop self-esteem within an environment which discourages bullying and assists those who are or might be bullied
- **Resettlement and reducing offending:** Street and prison cultures are challenged through effective anti-bullying measures and programmes for all who are involved

3.01 The anti-bullying strategy had last been reviewed in December 2002. Posters in all areas of the prison set out the prison's policy on bullying.

3.02 The policy was supported by an anti-bullying committee that, according to the policy document, should have been chaired by a residential governor. The minutes showed, however, that the meetings were chaired either by the principal officer who was the anti-bullying co-ordinator or by a senior officer. The committee was multidisciplinary and was well attended. It reviewed each wing for bullying behaviour and discussed individual prisoners who were subject to anti-bullying measures. The minutes showed that the committee was attempting to form links between suicide prevention work and anti-bullying but did not demonstrate any knowledge or action of the more sophisticated and organised bullying that was likely to take place in a long-term dispersal prison.

3.03 The strategy for dealing with bullying was a three-stage process. Any prisoner thought to be bullying would be placed on stage 1. An entry would be made in the wing observation book detailing why he had been placed on stage 1 and the anti-bullying co-ordinator would place him on the central anti-bullying log. The prisoner would be closely monitored for seven days without his knowledge, with comments noted on specific monitoring sheets. The sheets of those prisoners currently on stage 1 showed that they had been carefully observed throughout the day. All prisoners subject to stage 1 measures were discussed at the daily residential morning meeting. All the staff to whom we spoke were aware of any prisoners on stage 1 measures on their wing and of the other elements of the strategy. After seven days, or earlier if it was evident that bullying was taking place, a residential governor, the wing manager and the anti-bullying co-ordinator would review the prisoner's behaviour: if there was no evidence of bullying, the anti-bullying measures would stop; if a further period of observation was required, a further seven days on stage 1 would commence; if there was evidence that bullying was taking place, the prisoner would be placed on stage 2.

3.04 Any prisoner placed on stage 2 of the strategy was located on Perrie Wing for 28 days. He would then be placed on the basic regime of the incentives and earned privileges scheme (see section on incentives and earned privileges). He would be informed by his wing manager of the reasons for this move and advised of his avenues of appeal. He would also be told that when he was ready to return to normal location he would not return to his current wing. Other than being placed on the basic regime, there were no interventions to challenge or change his bullying behaviour. He would be reviewed after 28 days. If he had conformed to the regime and there was no evidence of further bullying, he would be returned to normal location, staff on his new wing would be informed of his circumstances and his behaviour would be monitored informally for a month. If he had continued to be a bully, he would be considered for a further period on basic regime or moved to stage 3.

3.05 Stage 3 meant being placed in the security, care and control unit on Rule 45 by the Governor for the good order and discipline of the prison. The prisoner would be allowed back onto normal location only after satisfying the Governor that he would

change his behaviour. He would be assessed by the psychology department, probation or wing managers.

3.06 Since the beginning of the year, 70 prisoners had been placed on stage 1, only10 had progressed to stage 2 and one to stage 3. At the time of our inspection, four prisoners were on stage 1. The documentation showed that they had been observed for any signs of bullying. Staff were aware of the location of prisoners subject to anti-bullying measures.

3.07 The policy provided for victims of bullying to be referred to the probation department for support. However, we could find no evidence that this had taken place.

Conclusion

3.08 An anti-bullying policy and committee were in place but the committee was not chaired by a governor grade. While bullying was reviewed at meetings, there was no pro-active approach to identifying any form of sophisticated or organised bullying. The strategy was understood and fairly applied by staff. There were no interventions to challenge or change bullying behaviour. The support mechanism for victims had lapsed.

Recommendations

3.09 **A residential governor should chair the anti-bullying committee meetings.**

3.10 **The committee should set in place systems to check for methods of sophisticated or organised bullying.**

3.11 **Interventions should be put in place to challenge and change the behaviour of identified bullies.**

3.12 **The policy's interventions for victims of bullying should be re-introduced and regularly monitored by the anti-bullying committee.**

Preventing self-harm and suicide

Expected outcomes

The expected outcomes for preventing self-harm and suicide are:

Safety: Prisoners are held in an environment in which all reasonable steps are taken to protect prisoners from self-harm and suicide and honouring the prison's duty of care to every prisoner

Safety: Significant information about individual prisoners at risk of self-harm or suicide is communicated effectively by those who hold it to those who need it and integrated into the support plan

Respect: Prisoners know where to find help and access it in times of crisis or need

Respect: Raising and maintaining prisoners' self esteem, especially in times of transition or change, should be inherent in the prison's culture, management, regimes and activity

Respect: The treatment of those at risk of self-harm or suicide shall always maintain confidentiality, preserve or enhance the dignity of the prisoner and shall not itself be dehumanising

Purposeful activity: Those prisoners at risk of self-harm or suicide are encouraged to participate in appropriate purposeful activities including specific programmes for their needs in this respect

3.13 The suicide and self-harm policy was up to date. A suicide prevention committee met bi-monthly chaired by a senior manager; minutes showed that it was well attended by representatives from all areas of the prison. Each wing had a designated suicide prevention officer.

3.14 All prisoners who were being monitored using the suicide and self-harm booklet (F2052SH) were reviewed at a daily meeting chaired by the suicide prevention officer, a principal officer, and attended by staff from the residential units and other departments. The documentation was reviewed by the principal officer, who checked the quality of entries made and the appropriateness of the care plans. Further arrangements were also made for case reviews at this time. The document was also quality checked by the duty principal officer each evening and a further

independent check was made by a member of the administrative staff when the document was 'closed'.

3.15 Six prisoners were subject to suicide and self-harm measures, three of whom were residing in the health care centre. The entries made by staff in the F2052SHs were variable both in quality and in terms of how much they reported interactions with prisoners.

3.16 A total of 55 F2052SHs had been opened since the beginning of the calendar year and there had been12 incidents of self-harm in the same timeframe.

3.17 Long Lartin had 16 trained listeners who worked to a rota compiled by the suicide prevention officer. Two listeners were available at any one time with two more held 'in reserve'. The Samaritans visited the prison on a Wednesday evening to 'debrief' the listeners. Each listener had a minimum of six months stay at Long Lartin. Any telephone for use by prisoners had access to the Samaritans helpline. Listeners presented a module on the prisoner induction programme to explain their work and how to access their services.

3.18 There were two crisis suites, both located in Perrie Wing. Each consisted of two adjoining cells with a gate between the two cells. These cells were not fitted with comfortable furniture, were spartan in décor and provided a poor environment for prisoners in crisis. There were two anti-ligature cells: one in the health care centre and one in the security, care and control unit.

3.19 A total of 365 staff, all of whom had regular prisoner contact, had been trained in suicide awareness, including how to react to a prisoner found hanging.

3.20 We found sealed anti-suicide kits with see-through lids on each residential unit. All were equipped with anti-ligature scissors. However, not all staff questioned were aware of the location of these kits.

Conclusion

3.21 There was an active suicide and self-harm policy in place. F2052SHs were regularly monitored and quality checked. Entries in F2052SHs were variable. A good listeners scheme was in place. The crisis suites were not comfortably furnished. There was a high level of staff training but not all staff knew the location of anti-suicide kits.

Recommendations

3.22 **The crisis suite cells should be made more suitable for their purpose.**

3.23 **Staff should be reminded of the need to record interactions with prisoners.**

3.24 **Staff should be aware of the location of all emergency equipment.**

Race relations

Expected outcomes

The expected outcomes for race relations are:

- **Safety:** Prisoners live in an environment in which they are safe from physical, verbal or emotional abuse, intimidation or victimisation or any discrimination on the grounds of race or culture
- **Respect:** Prisoners experience a culture that values diversity and actively promotes, maintains and monitors good practice in race relations
- **Respect:** Foreign nationals and those for whom English is not their first language are enabled to understand and communicate successfully
- **Respect:** Prisoners, regardless of their ethnic cultural background, have equal access to all appropriate facilities and activities within the establishment. Eligibility for benefits and privileges, e.g. risk assessments, are made without regard for race, ethnicity or culture
- **Purposeful activity:** Prisoners and staff are able to recognise and acknowledge the cultural diversity of the prison population

3.25 For the three years prior to this inspection, the proportion of minority ethnic prisoners at Long Lartin had remained static at around 28%. From our discussions with prisoners, we detected underlying tensions and unresolved issues: some minority ethnic prisoners believed their needs were not understood or respected, while some white prisoners felt that black prisoners in particular were treated more favourably.

3.26 Earlier in 2003, a prison officer had been dismissed for using racist language, which may have created or reinforced anxieties among staff. Although large numbers of staff had received race relations or diversity training in the previous three years, there was a general lack of confidence among staff and managers in dealing with issues of diversity.

3.27 The Governor chaired the bi-monthly meetings of the diversity action team (DAT), which was formerly the race relations management team and had retained broadly the same agenda. Representation on the team was good, covering all departments and operational areas within the prison. In common with many other prisons, Long Lartin had experienced difficulties in securing regular attendance from community-based agencies, although some input had been provided by the Worcester Race Equality Council and the Race Hate Crime department of West Mercia police.

3.28 The DAT had not developed a clear strategic framework for itself, which meant that matters were being dealt with in a somewhat piecemeal and opportunistic way. A prisoner survey had been completed and was awaiting analysis but a staff survey had not yet been timetabled.

3.29 Based on the notes of the last three meetings, it was clear that action points were not always allocated to a specific member of the team nor routinely followed up at the next meeting.

3.30 The race relations liaison officer compiled the monitoring statistics for the DAT, including range settings and using a traffic light system to highlight areas that required attention or action. Ethnic monitoring was provided from up to 15 areas, including closed visits, incentives and earned privileges, accommodation and prisoner

activities. The provision of this data was unreliable. In May 2003, for example, no monitoring information was provided on the use of control and restraint, the drug testing programme, release on temporary licence, adjudications, the security, care and control unit and the gymnasium. The DAT meeting therefore had to commission investigation into some of these areas.

3.31 No prisoner representatives attended the meeting. A previous prisoner forum, set up as a sub-committee of the race relations management team, had been disbanded. According to the notes of the DAT meetings, the black prisoners' forum proposals had been postponed due to lack of time (January 2003) and no information being presented (March 2003). By May 2003, assistant race relations liaison officers had been agreed for each residential unit. They were to meet with minority ethnic prisoners and feed back issues to the main DAT. This was a relatively new arrangement and it was too early to comment on how well it was working.

3.32 The race relations liaison officer post (currently held at principal officer level) had been increased to full-time in November 2002, mainly to deal with a backlog of over 100 racial incident complaints. By the time of our inspection, the backlog stood at 25 but still accounted for most of the race relations liaison officer's time, leaving little opportunity for developmental work. We read a number of completed inquiries and found that roughly an equal number of complaint forms had been submitted by staff and prisoners. Those from staff tended to refer to allegations of racist behaviour or language from prisoners; those from prisoners referred mainly to alleged racial discrimination by staff. There were no complaints by prisoners against other prisoners.

3.33 A significant proportion of complaints had not resulted in full inquiries, usually because of lack of evidence. However, we found some good examples of where completed inquiries had resulted in changes to operational practice. An under-representation of black prisoners in wing cleaner posts, for example, had led to centralised allocation of these jobs and clear guidance had been issued when it was found that the allowance of days off work for religious observance had 'not been consistent across the residential function'. In two cases where prisoners had reported

racist graffiti on their cell doors, the response had been that staff would monitor the situation. This was inadequate.

Foreign national prisoners

3.34 On average, foreign national prisoners accounted for 15% of the prisoner population. Jamaican and Irish prisoners made up the largest groups; between 25 and 30 other nationalities were usually represented in single numbers. For many years, a probation officer in the prison had taken responsibility for convening foreign national meetings. These had lapsed in 2002 due to other work pressures on the probation department but had been restarted in 2003. The meetings were organised on an ad hoc basis, depending on the availability of a suitable venue and a guest speaker. Between 40% and 50% of foreign national prisoners attended the meetings, which normally lasted a couple of hours. The probation officer always attended the meeting and dealt with any queries but told us that he had limited contact with foreign national prisoners outside the meetings. No-one in the senior management team had overall responsibility for foreign national prisoners and, as with minority ethnic prisoners, there was no strategy or action plan for responding to their specific needs.

3.35 While we were told that most foreign national prisoners were able to communicate adequately in English by the time they reached Long Lartin, we found one Chinese prisoner who communicated mainly by sign language and 13 prisoners were on an 'English for speakers of other languages' course run by the education department.

3.36 The prison had a contract with a translation company and we were told that most of the annual expenditure in this area was to meet the security needs of the prison rather than prisoner needs.

3.37 The issues raised with us by foreign national prisoners were similar to those we have encountered in other prisons: the choice of food, the cost of telephone calls and arrangements for visits. In addition, foreign national prisoners at Long Lartin complained about the lack of consistency in their treatment and entitlements within the high security estate.

Conclusion

3.38 Both staff and prisoners lacked confidence in the current race relations policy. While most of the necessary components were in place, Long Lartin did not have strategies and accompanying action plans for its work with minority ethnic or foreign national prisoners. There was no prisoner representation on the diversity action team. The activity that was taking place was piecemeal and staff and prisoners were not routinely kept informed of what was being done. Ethnic monitoring data was not consistently available, making it difficult for the diversity action team to identify trends or areas requiring attention. Apart from occasional meetings, no specific provision was made for foreign national prisoners.

Recommendations

3.39 **The diversity action team should have clear strategies and action plans for minority ethnic and foreign national prisoners, and these should be published to staff and prisoners.**

3.40 **The action plan should contain an early intervention to increase both staff and prisoners' confidence in the work of the diversity action team.**

3.41 **There should be prisoner representatives on the diversity action team.**

3.42 **Proven acts of discrimination or intimidation should be responded to decisively.**

3.43 **The availability of ethnic monitoring data should be consistently produced, reliable and acted on.**

3.44 **A senior manager should take responsibility for foreign national prisoners.**

3.45 **The notes of the diversity action team should specify who is responsible for progressing action points and ensure that these are followed up fully at subsequent meetings.**

Substance use

Expected outcomes

The expected outcomes for substance use are:

Safety: All prisoners are as safe as possible from exposure to and the effects of substance use whilst in custody

Respect: Prisoners with substance related needs are identified at reception and throughout their time in custody

Purposeful activity: All prisoners receive effective drug and alcohol education interventions to meet their needs

Resettlement and reducing offending: Prisoners, according to their individually assessed needs, are provided with the necessary support and treatment both in prison and after release to maintain healthy lifestyles and avoid the harmful effects of drug use

3.46 Long Lartin did not have a drug strategy co-ordinator at the time of this inspection. The head of residence had taken temporary responsibility for this area in the short-term.

3.47 While a policy document with targets and performance indicators existed, an annual review had not taken place and the drug strategy implementation plan was out of date. The absence of a current action plan had gone unnoticed. There was no drug strategy committee. In the absence of dedicated meetings, demand and supply reduction issues were not being addressed in a strategic and integrated manner.

3.48 A drug strategy principal officer, who co-ordinated mandatory and voluntary drug testing, was responsible for the rehabilitation unit, acted as programme manager for the Focus programme and was in charge of the voluntary drug testing unit on E Wing. The supply/reduction remit was split between three principal officers (security, dog section and operations).

3.49 Treatment provision consisted of the counselling, assessment, referral, advice and throughcare (CARAT) service, detoxification and health care services, and a rehabilitation unit that hosted the Focus programme.

3.50 CARAT resources were stretched. A full CARATs staff complement of a team leader and three drug workers from Compass drug services had never been in place due to recruitment problems. A variation of the contract with Compass had been agreed to remedy the long-term staff shortage. One Compass worker and a dedicated prison CARAT officer carried a caseload of 76 and were supported by an administrator.

3.51 The team had stopped delivering their induction package due to time constraints, but the high number of self-referrals showed that the service was accessible to prisoners.

3.52 The prison exceeded its key performance target of 30 initial assessments per year, worked within the required timeframe and had contributed to 25 transfer reports and to 17 sentence plans/life-sentenced prisoner boards since April 2003.

3.53 Workers attended case conferences, release and parole boards, and meetings of the Focus board (the Compass drug worker also tutored on the Focus course). The CARAT officer was trained in auricular acupuncture and delivered drug awareness training to staff on a bi-monthly basis.

3.54 A group work programme had been developed but could not run due to staff shortages.

3.55 Focus was an accredited cognitive behavioural drug and alcohol treatment programme designed for long-term offenders whose substance problem had been linked to their criminal behaviour. Selection included an IQ assessment and a psychopathy checklist. It had a tri-partite management structure including a programme manager, a treatment manager (forensic psychologist) and a throughcare manager (the rehabilitation unit principal officer). Prison officers, a psychology

assistant, a forensic psychologist and a CARATs worker had been trained as course tutors. Ten prisoners out of 30 to 40 referrals were accepted onto the programme, which ran twice a year over 22 weeks. Prisoners on this programme were held on a designated rehabilitation unit, which could cater for 18 in single cell accommodation.

3.56 The weekly regime consisted of four Focus sessions, one education session and a mixture of exercise, relaxation groups and association. The unit's own gymnasium was due to open shortly. Frequent voluntary drug testing was carried out by the unit officers.

3.57 The current course was close to completion and had retained all 10 participants. Prisoners commented on the usefulness of the programme and saw it as part of their sentence plan to address offending behaviour rather than as a voluntary undertaking.

3.58 The need to run Focus as a residential programme was questioned by staff because the majority of participants wanted to stay on normal location.

3.59 Prisoners requiring detoxification from heroin underwent a CARAT assessment before being prescribed Lofexidine on an emergency basis. Protocols were also in place for alcohol detoxification. Medication was dispensed at the health care centre and blood pressure was monitored regularly. Prisoners did not find that Lofexidine effectively alleviated their withdrawal symptoms, and one had to discontinue the regime after only two days due to low blood pressure. The health care acting clinical manager thought that less than 10 opiate detoxifications had taken place since his arrival last November. In the absence of a needs assessment, demand could not be gauged accurately. Discussions had begun about introducing Subutex as a more effective treatment for heroin users; the health care acting clinical manager possessed specialist experience in this area.

3.60 Voluntary drug testing could take place anywhere within the establishment. All enhanced prisoners on C Wing had signed a separate frequent testing compact. In June, 262 voluntary drug testing compacts were in operation compared to a target of 230. Prisoners testing positive were referred to CARATs. E Wing was the designated

voluntary drug testing unit where officers aimed to offer a supportive regime, including the provision of auricular acupuncture twice a week.

3.61 Mandatory drug testing facilities were satisfactory. The 10% target of random testing was met, including weekends. The year-to-date figure for positives stood at 5.3%, although refusals could be as high as 10% in any month. The low mandatory drug testing rate contrasted with available intelligence about drugs in the prison, especially heroin, and staff had concerns about prisoners invalidating samples. In our survey, 80% of prisoners thought that it was 'easy' or 'very easy' to get illegal drugs in the prison.

3.62 The other security measures for drug detection included a PIN telephone system, closed-circuit television and searches in visits, active and passive drug dogs, x-raying mail, target searches and police liaison.

Conclusion

3.63 The drug strategy did not appear to enjoy a high profile within the establishment. The absence of dedicated team meetings and an up-to-date action plan meant that supply reduction efforts were fragmented and gaps in treatment provision had not been addressed coherently. While random mandatory drug testing positives ran at only 5.3%, both staff and prisoners indicated the availability of heroin within the prison.

3.64 Appropriate detoxification policies and procedures were not in place and there was no structured support offered to drug-using prisoners.

Recommendations

3.65 **A multi-disciplinary drug strategy team should meet separately and on a regular basis to address supply and demand reduction issues.**

3.66 **A needs assessment should be undertaken to establish demand for detoxification.**

3.67 **An action plan with specific targets and performance measures for the current year should be developed in consultation with drug strategy team members.**

3.68 **A structured group work programme should be implemented.**

3.69 **The staff shortage within the CARATs team should be addressed**

Maintaining contact with family and friends

Expected outcomes

The expected outcomes for maintaining contact with family and friends are:

- **Safety:** Prisoners and visitors feel safe in their time together on visits and visitors feel safe within the establishment
- **Respect:** The rights of prisoners to maintain contact with family and friends are upheld and practical arrangements are in place to provide for their visitors, with special consideration being given to children and partners
- **Respect:** Visitors are welcome to the establishment, supported within the prison and recognised as free members of society in order that they may contribute positively to the prisoners' progress
- **Resettlement and reducing re-offending:** Prisoners are encouraged to build and maintain family and social networks and relationships that contribute to their well-being and help reintegrate them into the community

3.70 Social visits took place on Mondays, Fridays, Saturdays and Sundays between 2pm and 4.30pm, and on Tuesdays and Thursdays between 9.30am and 11.30am and 2pm and 4.30pm. There were no visits on Wednesdays.

3.71 Mondays were reserved for family visits where the aim was to provide quality time for the family, with play activities for fathers to share with their children. Prisoners had to make a separate application for family visits and were concerned about the time it took to be accepted for these visits.

3.72 There were all day visits on Tuesdays and Thursdays when a visitor could use one visiting order to visit in both the morning and afternoon. Many visitors travelled long distances and all day visits made the journey worthwhile.

3.73 Depending on which level of the incentives and earned privileges scheme a prisoner was on, it was possible to have a maximum of five visits each month; the minimum number was two.

3.74 Prisoners applied for visiting orders, which were then sent out to the visitors. The date of a visit had to be booked by the visitor by telephone. The one telephone booking line was open from 9am to noon and from 2pm to 4pm on weekdays and from 9am to noon at weekends. The operator had other work to do as well as answering the visits booking line. At the weekend, the booking line was operated by a prison officer. All the visitors to whom we spoke complained that it was very difficult to get through on weekdays but said that once they did get to speak with the operator they were well treated and were confident that their booking had been taken. By contrast, they had no confidence in booking at weekends. They said that it was almost impossible to get through and even if their call was answered they would often find that the visit had not been booked when they arrived to visit. We phoned the booking line five times and managed to get through only once.

3.75 Visitors waited in a visitors' centre outside the prison. The building was large, with comfortable seating and tables, a play area for children and good toilet facilities. Volunteers staffing the centre served refreshments and a probation service officer spent part of her time in the centre. A useful booklet was placed on tables giving information about visiting procedures. Visitors praised the work done by the volunteers and the probation service officer. They said that prison officers mainly treated them reasonably and that if they visited regularly and got to know the staff they were well treated. Everyone complained about the failure to start visits on time, with delays of about half an hour being normal. This was confirmed by both staff and our own observations.

3.76 The searching procedures for visitors were completed thoroughly but with respect. Prisoners arriving for visits were treated in the same way.

3.77 The visits room was large and airy with a play area for children and a refreshments machine. There were usually between 20 and 30 visits at each session and the tables were arranged so that people could talk in private. The staff supervising visits did so unobtrusively. They were also well informed on matters of public protection. The closed visits boxes were out of sight of the main visits room and private.

Conclusion

3.78 The amount of visits a prisoner could have each month was generous. Family and all day visits were good initiatives. The booked visits system was not working properly. The visitors' centre was a good facility. There were delays in starting visits at the published time. Prison staff treated visitors reasonably and supervision in the visits room was conducted sensitively.

Recommendations

3.79 **The telephone system for booking visits should be reviewed to ensure a quick response for people calling the line.**

3.80 **Visits should start at the published time.**

Good practice

3.81 *Family visits took place on Monday and all-day visits were possible on Tuesdays and Thursdays.*

Applications and complaints

Expected outcomes

The expected outcomes for applications, requests and complaints are:

- **Safety:** Prisoners are safe from repercussions or recrimination in making any application or request or complaint
- **Respect:** Prisoners know and are given appropriate help to exercise their right of access both to applications, and requests and complaints; they receive a prompt, courteous and fair response from staff

- **Purposeful activity:** Applications are used to enable access to activities
- **Resettlement and reducing re-offending:** Sentence plans are normally implemented without a prisoner needing to use applications or request and complaints

3.82 An applications system operated on all wings. Whenever they were out of their cells, prisoners could obtain an application form (there were individual forms for each department or main type of request) from the wing office. In our survey, 92% of respondents said that it was easy or very easy to get an application form.

3.83 Completed forms were handed in to the wing office. They were not recorded or tracked, although informal applications on B Wing were entered onto a computer so that progress could be monitored if there were any delays in responding to the application.

3.84 Prisoners did not regard the complaints system as satisfactory. Although 87% of respondents to our survey said that forms were easy or very easy to obtain, 76% claimed that resolution of complaints was not prompt and 77% said that complaints were not sorted out fairly.

3.85 Complaints were posted in yellow boxes on the wings. Wing senior officers opened these boxes and the forms were taken to the daily meeting chaired by the head of residence. They were then handed to the complaints clerk who gave them a unique reference number. Complaints relating to wing matters were handed back to the senior officer to resolve and those for other departments were forwarded to them by the complaints clerk. Any forms for confidential access to the Governor, the Independent Monitoring Board or the Area Manager were placed inside a sealed envelope by the prisoner and remained unopened until they reached the addressee.

3.86 In the period from 1 April to 30 June 2003, there had been 528 complaint forms, many of which were about property in reception and visits. The Prison Service target of 95% for replies to prisoners within three days of making an initial complaint was not being met, with the prison averaging 86% in the sample period. We looked at

some completed forms where replies had been sent to the complainant: most replies were handwritten but legible; all were courteous and answered the question. Replies emanating from residential staff were usually resolved at officer grade, which meant that staff were responsible, accountable and involved.

Conclusion

3.87 We found delays in responding to some complaints but replies to prisoners were courteous and relevant to the problems raised.

Recommendations

3.88 **Wing applications should be recorded and tracked.**

3.89 **All complaints should be replied to within the target dates set by the Prison Service.**

CHAPTER FOUR

HEALTH CARE

Expected outcomes

Inspectors will make judgements about health care against the following outcomes:

- Prisoners receive a full range of primary health care, health promotion and disease prevention services in an environment that is clean, safe and conforms with the standards that operate in the NHS
- NHS and prisoner records are available to those responsible for the care of the patient
- Prisoners receive health care from appropriately trained staff and support and care in meeting their health needs from all prison staff**.** Their right to refuse treatment is recognised
- Prisoners with physical or mental health problems are identified and assessed promptly, receive appropriate treatment and care and, where appropriate, are referred without delay to appropriate secondary care providers
- Prisoners' access to health promotion in primary care is equivalent to that in the community
- Prisoners are encouraged to maintain healthy lifestyles while in prison and on release and are linked to community services including GPs prior to release
- Prisoners receive in-patient health care that meets NHS standards in an environment that is clean, safe and meets NHS standards
- In-patients receive purposeful, therapeutic occupation according to their assessed needs and care plan
- Patients requiring specialist health care are identified promptly and referred to visiting specialists or the NHS
- Continuity of treatment and care is not impeded by transfer between prison and the NHS or by inappropriate security precautions

Environment

4.01 The health care centre (HCC) was located at the centre of the prison and occupied the first floor of a two-storey building. It was well situated in terms of prisoner access and the overall impression was one of a clean and well maintained department.

4.02 The HCC was entered through a gated area, which doubled as a foyer and waiting area. There was bench seating for prisoners waiting for treatment but only a limited amount of health promotion and health centre information was on view.

4.03 The HCC was divided into two distinct departments: out-patients and in-patients.

4.04 The out-patient area was accessed through the waiting area and consisted of various offices, consulting rooms, the medical records office, the dental surgery, the x-ray room, the nurses' station, a treatment room and storage rooms. A security hatch through which medicines were administered opened onto the corridor outside. Emergency equipment was to be found within one of the store cupboards.

4.05 The nurses station was small and well equipped. The staff had access to standard prison IT systems but there was no link to the NHS internet or local PCT.

4.06 Overall, the dental surgery was equipped to a high standard. Sterilization of instruments was by means of an autoclave and the surgery appeared to meet current cross-infection guidelines. The flooring met current guidelines but staff reported that standards had slipped since its cleaning had become part of the 'cleaning contract'. We were unable to confirm whether the compressor and autoclave had been inspected by the appropriate authorities. Ionising radiation equipment was currently certificated by the National Radiological Protection Board and local rules were displayed.

4.07 The in-patient area was accessed through a solid locked metal door. There were nine single cells including an anti-ligature cell. All cells had in-cell sanitation with a washing area but no screens. Prisoners had their own televisions and radios,

and most cells were furnished with an easy chair. In contrast to the cells in the main prison, these cells were a reasonable size and were generally in a good state of repair.

4.08 The whole area was bright with a lot of natural light. There was a reasonably well equipped kitchen with a cooker, microwave and fridge that was used by the prisoners some of the time. There was access to a PIN telephone in the main corridor.

4.09 The ward office was well equipped and had a large glassed area that looked out onto the main corridor, allowing observation of the whole area.

4.10 The clean and tidy ablutions area contained a bath and shower. Next to the bathroom was a small 'association room' with board games and comfortable seating.

Records

4.11 Inmate medical records (IMRs) were located in a small office at the end of the out-patient area. They were in lockable filing cabinets accessed only by authorised HCC staff. A random check of IMRs confirmed that they were well maintained. Old IMRs were retained in the prison.

4.12 The prescription sheets for all prisoners were kept in the treatment room; the majority were well maintained and correct. However, two had not been completed for the last three days and there was no recorded explanation for this omission.

4.13 There was a very limited stock of controlled drugs. All were stored correctly. The register appeared to be fully and correctly maintained. Orders or prescriptions for controlled drugs were faxed to the pharmacy in the same way as other prescriptions. This was unlawful practice.

4.14 The dental records appeared well maintained and were held securely in locked cabinets within the surgery. Given the split responsibilities of the prison authority and the contracted dental service provider, the required documentation was not readily available for inspection.

Staffing

4.15 The deputy governor was responsible for overseeing the HCC but the day-to-day management of the department was delegated to the Head of Health Care who normally attended the senior management team meetings.

4.16 At the time of the inspection, there was no Head of Health Care in post as the previous incumbent had left very recently. A Principal Officer (Discipline) was acting into the role supported by an F grade Registered Mental Nurse (RMN) acting up into a G grade post providing the clinical lead for the nursing team.

4.17 In addition to the Head of Health Care post, which was an I Grade, there should have been 16.5 whole time equivalents (WTE) in post. In fact, 9.5 WTE E and F grade nurses were in post, one of whom was on maternity leave while another was undertaking administrative duties only as she was pregnant. Agency nurses were regularly employed on day and night duty from the local Abacus agency. A Grade B health care assistant was also employed on a full-time basis.

4.18 Due to the severe staff shortages, three prison officers working on contract hours were attached to the HCC and were based in the in-patient area covering shifts between 7.30am and 7.30pm from Monday to Friday. A further two prison officers were deployed to the out-patients area to supervise the collection and discipline management of prisoners attending for treatments.

4.19 There was a full-time administrative officer who told us that he was mainly responsible for the HCC budget.

4.20 Medical officer cover was provided by trained GPs from the local De Montfort practice in Evesham. Two doctors provided 1.5 sessions a day, covering the HCC from 9am to 5pm every weekday. Out-of-hours was covered from the De Montford surgery.

4.21 Dental services were provided under a private contract between the prison authorities and the primary care trust through the local dental committee. We

understood that the contract made provision for a range of dental treatments similar to those available within the NHS. The usual dentist, who normally attended for four sessions per week, had been on long-term sick leave and only a reduced service had been possible during this time.

4.22 A physiotherapist, podiatrist and radiographer all attended regularly, as did two consultant psychiatrists and a psychosexual counsellor. A range of visiting Consultants from the local acute hospital also carried out sessions at the prison.

4.23 The pharmaceutical service was provided by Forensic Pharmaceutical Services, which supplied the prison from Liverpool

Delivery of care

4.24 The HCC was a type 3 health care facility providing 24-hour nursing cover and a primary care service.

4.25 The HCC was unable to provide a fully comprehensive health service due to its severe staffing problems. Some of the nurse-led clinics had been suspended to ensure that prisoners received essential services. Overall, a safe and respectful service was being maintained.

4.26 New arrivals to the prison were processed through reception before being taken to the HCC where they were health assessed and screened by a nurse prior to examination by the doctor.

4.27 A patient information booklet was made available, although many of the prisoners claimed not to have seen one. The booklet outlined the surgery timetable and the services available to prisoners, including specialist clinics and visiting health care professionals.

4.28 The doctor's surgery commenced each morning at 9am. Prisoners wishing to see the doctor completed an application form, which was placed in a dedicated HCC box on the wings. This was collected each night by the night nurse and appointments were made generally within four to seven days.

4.29 Prisoners reporting special sick would see the wing staff and, following consultation with the HCC, would be called to the HCC, triaged by a nurse and, if necessary, seen by the doctor. A record of any treatment either by the doctor or nurse would be recorded in the IMR.

4.30 Although two of the nurses had been trained in nurse triage, they were unable to implement it properly due to staff shortages.

4.31 Treatments were carried out in the HCC at 8.15am, noon and 6pm. The evening treatment time was busiest and prisoners were brought to the HCC by wing allocation. Medicines were given through the hatch from the treatment room.

4.32 In-possession medications were given for up to 28 days following a risk assessment of the prisoners. There was no written in-possession policy or written prescribing formulary. No over-the-counter medicines were available nor were there any patient group directives.

4.33 The prescription/administration form was not of the standard format, which meant that it was not suitable for faxing to Liverpool. Consequently, as well as prescribing on the prescription form, the doctor also filled out an order/prescription form to be faxed to Liverpool. Orders that were faxed by 12.30pm were received back at Long Lartin on average three days later. On the majority of occasions, prescriptions were not returned for up to two days and often those prescriptions written on a Thursday would not reach the prison until the following Monday. Very urgent supplies had to be purchased locally in Evesham.

4.34 There was very little contact by the pharmacist despite the fact that the contract with Forensic Pharmaceutical Services specified that a pharmacist should visit the prison fortnightly. The pharmacist visited about once a month. There did not appear to be any contact between the pharmacist and prisoners, or indeed any contribution to health promotion programmes in the prison. Forensic Pharmaceutical Services had sub-contracted a pharmacist to attend the prison for two hours every fortnight to undertake clinical audit activities.

4.35 The medicines and therapeutic committee had met intermittently. The last meeting was held in March 2003.

4.36 The dental service had been problematical due to the sickness of both the regular and stand-in dentists. The waiting list, which had previously been under control, was now increasing, with 65 patients waiting for appointments. We understood that self-referral was the main route to access the dental services, although routine screening on admission had been discussed.

4.37 Any prisoner requiring specialist out-patient consultation would be referred to the appropriate specialist consultant at one of the local hospitals.

4.38 The physiotherapist, podiatrist and radiographer all attended regularly and there were no lengthy waits for these specialities.

4.39 The radiologist carried out x-rays on Thursday mornings and these were usually reported on by Worcestershire Hospital within 48 hours.

4.40 Although suspended at the time of the inspection, there was evidence that nurse-led clinics were available. When staffing levels permitted, nurses ran asthma, Well Man, hepatitis B and HIV counselling and testing clinics.

4.41 The manual chronic disease register was rudimentary and out of date.

4.42 A successful 'quit smoking' programme had been completed recently and more funding from the primary care trust had been secured to start a second programme in September.

4.43 Pathology requests were dealt with by a local hospital and two of the nursing staff were able to carry out venepuncture.

4.44 At the time of the inspection, there were seven prisoners in the hospital; five could be considered non-medical and were there because they were felt to be vulnerable if accommodated on the main prison wings.

4.45 The in-patient area provided access to nursing care 24 hours a day. A nurse was delegated to that area every day, although current staffing problems meant that one was not always present. A registered nurse was on duty every night with an officer support grade.

4.46 Prisoners were seen twice weekly by the doctor or more frequently if necessary. Those prisoners 'lodging' on the HCC were seen on request. Prisoners had a named nurse, a practice that worked well and was appreciated by them. Time out-of-cell for prisoners was good and they were able use the exercise area once a day. Education was available and there were good relationships with the education department, but other than this there was little in the way of constructive activity.

4.47 Prisoners in the security, care and control unit were routinely seen in their cells by the doctor on Monday, Wednesday and Friday and in between times if required.

4.48 Mental health services were provided by two visiting psychiatrists who visited weekly from the Raeside Medium Secure Unit in Birmingham. The mental health in-reach team was still in the process of being set up. There was no forensic clinical psychologist, although a visiting registered nurse was also a psychosexual counsellor.

4.49 There were sufficient HCC staff with a specialist psychiatric qualification, although they were unable to operate effectively due to the overall staffing problems. They did have a limited case load but it was difficult to keep up with the demand for one-to-one counselling. There was also some concern from RMN staff having to undertake general nursing duties for the majority of their shifts.

4.50 All prisoners were seen before their release and a letter was sent to their GP if known.

4.51 Relationships between health care staff and other areas of the prison were good and staff were arranging a meeting with the physical education instructors to look at ways of working together to improve prisoners' general and mental health problems.

4.52 External relationships appeared to be good and amalgamation with the primary care trust was progressing very well. Both the chief executive and the director of nursing visited the prison during the inspection and it was clear that there was much support on offer.

4.53 Clinical supervision had also suffered as a result of the loss of senior nurse managers but current staff were very aware of its priorities and implications.

4.54 Health care protocols were located in the treatment room but they were incomplete, out of date and in some cases irrelevant.

4.55 Professional training was well supported by the Governor and it was felt that there would also be opportunities within the primary care trust for the training and exchange of staff. The current staffing situation precluded any attendance at courses for the immediate future.

4.56 Daily staff meetings took place following the Governor's morning meetings and this provided the platform to relay information to staff. Regular HCC staff meetings had been initiated and took place fortnightly. These were well supported and allowed staff to participate in business and professional discussion.

4.57 The administrative system was under pressure and did not appear to manage proper clinical or administrative audit. Records and statistics were unavailable and nursing staff appeared to be undertaking unnecessary administrative duties at a time when clinical expertise was at a premium.

Conclusion

4.58 Clinical staff were stretched but nonetheless were maintaining a satisfactory service to both in- and out-patients. The facilities and accommodation were good and

well looked after. The lack of clinical leadership was apparent but the overall management of the acting Head of Health Care was competent.

4.59 Many of the clinical initiatives started since the last inspection were suspended for the foreseeable future and staff felt frustrated that they could not provide the service they would wish.

4.60 Prisoners were very conscious of staffing problems and sympathetic to them. Dental services were under pressure and the pharmacy service was not felt to be meeting expectations.

Recommendations

4.61 **A skill mix review and training needs analysis should be undertaken to determine the requirement of both professional and administrative staff.**

4.62 **The emergency medical equipment should be located in a more central position to enable rapid access in an emergency.**

4.63 **The medicines and therapeutic committee should meet at least quarterly and undertake a full review of pharmacy services in association with the primary care trust. It should draw up a prescribing formulary and policies for in-possession and special sick medication. All documents should be reviewed regularly.**

4.64 **The pharmacist should visit the prison fortnightly to provide guidance and advice for both patients and staff. The subcontracted pharmacist should visit as contracted.**

4.65 **Any prescriptions for controlled drugs (and not faxes) must be forwarded to Forensic Pharmaceutical Services for dispensing.**

4.66 **A comprehensive chronic disease register should be maintained to enable chronic disease management clinics to be undertaken.**

4.67 **The Head of Health Care should consult with the Director of Dental Services of the local PCT to ensure that the appropriate documentation is in place.**

4.68 **Dental patients who need pain relief should receive timely treatment, including out-of-hours emergencies.**

4.69 **The dental treatment requirements of all new prisoners should be established on admission and a range and standard of care equal to that available in the NHS should be provided.**

4.70 **A dental recall system should be established to enable continual care for long-stay prisoners.**

4.71 **Hygienists and dental health educators, should be included within the dental team.**

4.72 **Independent clinical monitoring of the dental services provided should be established.**

4.73 **Appropriate IT links with the local PCT and NHS Intranet should be made.**

4.74 **Venepuncture training programmes should be held to increase the number of nursing staff able to take blood.**

4.75 **Health care protocols should be fully revised in order to ensure that they are evidence based so that they can be used to include clinical care and management.**

CHAPTER FIVE

ACTIVITIES

Management of activities

5.01 The head of resettlement and regimes was the senior manager responsible for sentence management, education, library, industries' workshops, physical education regimes, resettlement and probation. The head of estates was responsible for health and hygiene, prisoners' catering, gardens and waste management. Both reported directly to the Governor.

5.02 There were 303 workplace spaces available. During the week of our inspection, 87% of prisoners were allocated to work and education activities. However, two residential units were closed for refurbishment and, had the prison been running at its full capacity, the percentage of available workplace spaces would have fallen to 54%.

5.03 Unfortunately, allocation to an activity did not necessarily mean that the prisoner was occupied. On several days during the inspection, we found large numbers of prisoners locked in their cells due to the cancellation of activities. In the month prior to our inspection, only a quarter of all available prisoner work and education hours had been fully utilised. This meant that, rather than being purposefully employed, many prisoners were being paid to do nothing.

5.04 New management monitoring reports were effective in giving clear data for analysis and evaluation. These showed that while disruption caused by the refurbishment work accounted for a large proportion of the workshop closures, this was by no means the only problem. Insufficient prison officers were being allocated to workshop security duties, which also significantly hampered the effective management of the activities.

5.05 A structured activities allocation process had been introduced some five weeks prior to the inspection. This provided central control and co-ordination over the allocation of places and aimed to improve equality of opportunities. For example, responsibility for allocating wing cleaners had been transferred from wing staff to the allocation board when ethnic monitoring data had shown that few black prisoners were working as wing cleaners.

Conclusion

5.06 The management of prisoner activities was divided between two senior managers. While there appeared to be sufficient activity places for the current population, many prisoners spent most of their time locked up. This was mainly because either the workplace supervisor was not on duty or there were insufficient prison officers to supervise the workplaces. Allocation to activities appeared to be working well.

Recommendation

5.07 **A review of activities should be completed in order to keep activities open.**

Employment

Expected outcomes

The expected outcomes for prisoner employment are:

Safety: Prisoners work in a safe, suitable environment

Respect: The range, type and availability of work activity meets the needs of the prison population and prisoners are treated fairly in all aspects of their work, its allocation and pay

Purposeful activity: Prisoners are engaged in well-organised employment; work programmes are integrated fully with residential units and other departments

Resettlement and reducing re-offending: Prisoners are occupied in realistic work that prepares them for employment on release and helps to reduce re-offending

5.08 There was work available in eight workshops, the gardens, yards, stores, as cleaners, painters and orderlies. The graphics and time workshops had opportunities for accredited learning and some other workshops gave prisoners in-house certificates

to recognise skills learned. Basic skills support was available to prisoners in two workshops provided by education staff. Work in the other prison areas did not lead to accredited awards. Prisoners produced good work to industrial standards and received effective training from well-qualified and experienced instructors. Some instructors held assessor and internal verifier awards from previous years when vocational qualifications had been offered to prisoners. However some of these were out of date and therefore invalidated some of the awards being gained by prisoners.

5.09 The contracts workshop and laundry, which had 51 work places, were rarely affected by closures. Management prioritised these to be kept open as they had deadlines to meet with outside organisations. Prisoners in these workshops were not allowed to attend part-time education classes or go to the gymnasium during the working week. They were given priority at evening gymnasium sessions.

5.10 There were 150 work places available in the other workshops. These were also involved with outside parties, such as charities, colleges, schools and the general public, but were frequently disrupted by closures. The prisoners had a variety of work choices, including metalwork, woodwork, graphics and computers. Two workshops offered basic skills support and two vocational qualifications. There were 102 prisoners working in the other employment areas of the prison. The prisoners were allowed to attend two gymnasium sessions and two part-time education classes a week while being allocated to employment.

5.11 We saw safety equipment not being used by prisoners in three workshops, including prisoners not wearing safety boots and goggles. The prison provided the safety equipment but instructors told us that it was difficult to enforce its use.

Conclusion

5.12 There were good standards of prisoners' work and effective training. There was good use of outside organisations in providing work for prisoners. Qualifications were not being offered to prisoners where they could have been. Health and safety was not enforced in all workshops.

Recommendations

5.13 **The prison should match qualifications to work activities and introduce them across the establishment.**

5.14 **Improvements should be made to the monitoring of workshop health and safety practices.**

Education and work skills training

Expected outcomes

The expected outcomes for education are:

Safety: Prisoners receive education and work skills training in a safe, suitable environment in which they are enabled to participate fully

Respect: Prisoners are offered opportunities in education and work skills training that meet their identified needs and different levels of ability, and promote and respect personal responsibility; education is facilitated and valued by the establishment and reflects a sensitivity to equality of opportunities issues

Purposeful activity: Prisoners have the opportunity to engage in a range of education and work skills training that provides constructive and meaningful activity and potential for self-expression

Resettlement and reducing re-offending: Prisoners are involved in education and work skills training specifically to enhance their employment opportunities

Work skills/vocational qualifications

5.15 Eleven per cent of prisoners were allocated to vocational qualifications in four areas of the prison. The graphics workshop, which offered qualifications for 12 prisoners, had been closed for some time due to the instructor being ill and the prisoners involved had been given the opportunity to transfer to other activities. This meant that, in reality, only 8% of the prisoners were participating in vocational training at the time of this inspection. There had been no skills needs analysis completed in order to provide a coherent approach to providing relevant skills to prisoners.

5.16 Five prisoners were taking physical education qualifications and 12 were undertaking distance learning/cell study for clinical nutrition diplomas. Fifteen prisoners worked in the kitchens, including eight prisoners who had just started a national vocational qualification (NVQ) at level 1 in food preparation. One prisoner had compiled a portfolio for a NVQ level 2 award. All prisoners working in the kitchen took basic food hygiene awards. All prisoners took essential food hygiene awards while on the prison induction programme. An education department basic skills tutor was supporting 10 prisoners in the time workshop to complete Open College Network level 1 woodwork award portfolios.

5.17 The staff in all these areas were very enthusiastic about vocational training qualifications. They were well qualified and experienced in their specialist occupational areas but many had insufficient knowledge of the management requirements for the awards. There were no qualified internal verifiers in the physical education department and the kitchen. In addition, the kitchen did not have qualified assessors, although two members of staff were working towards the assessor award. The external organisations providing internal verification services were not visiting the prison very often to support the prison staff and the prison staff did not have written feedback to help them improve their provision. The physical education staff were unable to offer the range of qualifications they had available because they did not have enough staff to use all their facilities simultaneously.

Conclusion

5.18 Very few prisoners were undertaking work that led to them gaining qualifications. Those who were taking qualifications were supported by enthusiastic staff. There was a lack of qualified internal verifiers and those in place did not get sufficient support from external verifiers. There was potential to provide more qualifications in the physical education department.

Recommendation

5.19 **Consideration should be given to providing the physical education department with sufficient staff to offer more qualifications**.

Education

5.20 The education provision was sub-contracted to Evesham and Malvern Hills College. This was their only prison education contract. There were five full-time and 17 part-time staff. Education classes operated nine sessions for 22.5 hours a week throughout the year. In 2002/03, key performance targets at entry level and level 2 were met but fell short at level 1. A good range of subjects was taught, including basic skills, English for speakers of other languages, parentcraft, art, computers and GCSEs. Twelve prisoners were studying for Open University degrees. Education staff were also working in two workshops and the health care unit. They provided education support to prisoners in the security, care and control unit on request.

5.21 Only 36% of prisoners were involved in education. Thirty-three were full-time students and 119 attended one or two classes a week, most being employed in the prison at other times. Retention and achievement data was not kept in a way that could identify trends or effectively inform teachers or managers.

5.22 Prisoners' progress was disrupted by class closures and late arrival at classes. The reasons for these disruptions over the last three months had been recorded and many could have been avoided with effective planning. Closures were also affecting outreach basic skills teaching in the workshops by education staff. These closures were impacting on classroom efficiency targets.

5.23 Teaching of basic skills was satisfactory but there was an over-reliance on worksheets and paper-based materials and a lack of stimulating activities. There was a good range of taster courses that were taught well, using a variety of teaching methods and resources. There was little sharing of good practice between staff and not all teachers had been observed teaching in accordance with the college's quality assurance procedures.

5.24 Education staff were responsible for the initial assessments of prisoners' literacy and numeracy. They did not, however, tell the instructors and work supervisors about the literacy and numeracy abilities of the prisoners allocated to their work areas, which meant that supervisors did not know if a prisoner could read safety

notices, work instructions or carry out numerical calculations. We found one prisoner who had been in the workshops for about six months who was still being communicated with by hand-signals due to his lack of English.

5.25 Prisoners were often put onto computer courses that were inappropriate for their skills and abilities, and had to be changed to appropriate groups later on. The two computer suites were good. While there were insufficient resources to enable prisoners to complete one qualification, these had been ordered prior to the inspection.

Conclusion

5.26 A good range of subjects was offered to prisoners and some outreach education was provided. There were constant class closures and disruptions. The quality of teaching was satisfactory. Information about prisoners' numeracy and literacy ability was not being passed to other departments.

Recommendations

5.27 **More outreach education should be offered.**

5.28 **The reasons for constant class closures and disruptions should be investigated and remedied.**

5.29 **Information about prisoners' numeracy and literacy should be shared with other departments.**

Library

5.30 Sub-contracted to Worcestershire County Library Services, the library was staffed by two prison officers, two prisoner orderlies and one qualified librarian who also taught part-time in the education department. Located in a central and easily accessible position, the library was well used and valued by prisoners. Eighty-seven per cent of prisoners were registered as library users and approximately 40% used the library every week. In our survey, only 12% of prisoners said they were able to access the library less than once a week or never.

5.31 Each residential wing, including the health care centre, had scheduled access to the library for one hour a week. In addition, prisoners could attend by application or call at any time during its opening hours: Monday to Friday 10.15am to 11.30am and 2.15pm to 4.45pm. An introduction session to the library was supposed to be included in the induction programme but we were told that there had been occasional difficulties in achieving this. A small stock of books was kept in the security, care and control unit; we have commented in previous reports on the poor quality of this provision and we found no noticeable improvement during this inspection.

5.32 The library was well stocked with some 8,000 publications, including the required reference and legal textbooks, books in 14 languages and a good variety of CDs on subjects such as history, Asian and world music. There was a long-standing subscription to another library service for Asian books. Newspapers were provided in English, Arabic, Russian and Turkish, and prisoners could order their own choice of newspaper or magazine. Good links with the education department enabled the librarian to stock books needed to support the curriculum and she was very responsive to requests from staff and prisoners for books to support their interests. For example, she had ordered vocational catering books requested by kitchen staff.

Conclusion

5.33 The library was easily accessible and well used by both staff and prisoners. It was well-stocked and provided books for all cultures. The staff were pro-active in helping anyone who visited the library.

Physical education

Expected outcomes

The expected outcomes for physical education are:

Safety: Prisoners are safe during physical education activities

Respect: The range, type and availability of physical education activities meet the needs of the prison population; prisoners are treated fairly in all aspects of physical education

Respect: Physical education is part of the provision of a healthy lifestyle in promoting personal health, fitness and co-operative and team skills

Purposeful activity: Prisoners are engaged in suitable physical education programmes that are fully integrated with other purposeful activities

5.34 The gymnasium was geographically isolated from other activities and, indeed, much of the prison. It was accessed via an enclosed secure outdoor corridor, which had a number of no-visibility spots but was not covered by security cameras. Neither physical education staff nor prison officers supervised groups of up to 40 prisoners as they moved through this corridor from the gymnasium to the main building. Physical education staff were aware that this area was one in which 'scores were settled'.

5.35 The gymnasium itself provided a clean, welcoming and professional environment. Good quality facilities included an excellent sports hall, a weights room and an outside sports pitch that was used only on Saturdays. The shower room was of a high quality, providing adequate changing and showering facilities. However, the gymnasium did not have its own laundry. The staff team of one physical education senior officer and eight physical education officers were enthusiastic and dealt with prisoners respectfully and politely.

5.36 The department ran a full and varied programme seven days a week. This included recreational physical education, courses and special sessions for groups such as prisoners on the rehabilitation unit, those aged over 40 and those requiring remedial physical education. The department had links with three community groups for people with learning difficulties; these groups used the gymnasium regularly with the assistance and support of staff and prisoners. Attendance figures indicated that over 60% of the prisoner population regularly used the gymnasium. In our survey, 61% of respondents said that they were able to use the gymnasium three times or more a week; this was far above the 36% average for high security prisons. Physical education staff told us that population management procedures required prisoners to apply in advance for most of the sessions held in the gymnasium. There was no provision for filling spare spaces at the last minute, which meant that some sessions did not run at full capacity.

5.37 Aside from the work with the drugs rehabilitation unit, the department was not being used to support other key strategies within the prison. With appropriate risk assessment, some physical education activity could be provided to prisoners in the security, care and control unit, especially those who might spend long periods there. There was also potential to develop appropriate activities to support those at risk of self-harm or victims of bullying. Such initiatives would depend on closer integration between physical education and other relevant departments within the prison.

Conclusion

5.38 The physical education department provided a wide range of activities in a good environment. With closer linkages with other departments or strategic initiatives, there was potential for the department to enhance the contribution it made to the work of the prison and the lives of prisoners. At present, the department was both geographically and operationally isolated from the rest of the establishment.

Recommendations

5.39 **The supervision of prisoners in the gymnasium corridor should be improved.**

5.40 **Allocation of prisoners to physical education activities should enable all available spaces to be filled.**

5.41 **Physical education staff should contribute to key strategic initiatives.**

Faith and religious activity

Expected outcomes

The expected outcomes for faith and religious activity are:

Safety: Prisoners can safely take part in spiritual activities

Respect: Prisoners of all faiths are able to practise their faith in suitable accommodation with sufficient appropriate facilities

Purposeful activity: Prisoners have ready access to a range of appropriate spiritual activities

Resettlement and reducing re-offending: Prisoners and groups of prisoners are able to be involved with their faith ministers from the community

5.42 The chaplain was a full-time Anglican priest and his assistant was also Anglican. The other main faiths in the prison, Roman Catholic, Muslim, Sikh and Buddhist, all had leaders who visited the prison regularly. In addition, a Free Church and Greek Orthodox minister did sessional work to support the chaplaincy.

5.43 The chaplain met all new prisoners within 24 hours of their arrival. As well as verbal information, they were given a pamphlet called 'Introducing the chaplaincy' that explained the various services and other activities available, such as the Wednesday bible class.

5.44 The facilities for the various faiths were very good and all were situated together within the education area. There was a Church of England chapel, a Roman Catholic chapel, a prayer room and a Sikh temple. There was also a Buddhist garden within the prison. The times of services and prayers were published around the prison.

5.45 Prisoners could make an application to see a chaplain or simply stop one and make an appointment. Any applications were dealt with within 24 hours.

5.46 One member of the chaplaincy visited the security, care and control unit each day. The chaplaincy's intention was to try to offer a parish service to the prison. A member of the chaplaincy walked all the areas of the prison each day to offer pastoral care.

5.47 The chaplain was immediately contacted when a prisoner had to be informed of an illness, death or other bad news and was consulted about the best way to deal with the situation.

5.48 The chaplaincy team enjoyed good relations with the prison staff and the chaplain had direct access to the Governor whenever necessary.

Conclusion

5.49 There was a pro-active team of ministers working in good facilities who tried to provide pastoral support and care for the prisoners

Time out-of-cell

Expected outcomes

The expected outcomes for time out-of-cell, including hours unlocked, association and exercise, are:

Safety: Prisoners are safe when participating in out-of-cell activities

Respect: All prisoners have fair access to out-of-cell activities, opportunities for which meet the needs of the prison population

Purposeful activity: Varied and appropriate activities are supported by well-run wing routines and staff involvement

5.50 All prisoners could have time in the fresh air every day. There was a 45-minute session from 11.30am to 12.15pm and, during the summer months, another hour from 5.45pm to 6.45pm. There were three periods of association on weekdays, from 8am to 9am and 5pm to 7pm. At weekends, these times were slightly different, being 9.40am to11.40am, 2.20pm to 4pm and 5pm to 7pm.

5.51 During these times, prisoners could take a shower, use the telephone, clean their cells and associate with other prisoners on the wing. They could also cook meals in their separate prisoners' kitchen on the ground floor of the wing.

5.52 While association arrangements were good, prisoners who were not in employment or other purposeful activity spent 5.5 hours in-cell during each working day with nothing to do.

5.53 We observed evening association taking place. All wings were unlocked for association. Prisoners' cell doors remained unlocked and they could move about freely on the wing. The atmosphere was relaxed and leisure equipment such as table tennis and pool tables was available. Staff on the main wings were not actively

engaging with prisoners and were mainly in wing offices. This was markedly different, however, on Perrie Wing where staff were out and about on the wing and engaging with prisoners.

Conclusion

5.54 Prisoners had plenty of time out-of-cell when they were not at work or education. However, given the number of prisoners who were not engaged in an activity, many spent much of each day locked in their cells.

Recommendation

5.55 **Staff should be encouraged to engage with prisoners on association.**

CHAPTER SIX

GOOD ORDER

Expected outcomes

The expected outcomes for good order are:

Safety: Prisoners' safety is protected by clear rules necessary for the maintenance of good order and discipline and enforced by the properly exercised authority of prison staff

Respect: Prisoners understand the rules of the establishment and are treated fairly; they are able to appeal against decisions

Respect: Segregation, the use of force and application of category and status are used for their proper purposes and not as punishments

Respect: Every opportunity is taken to encourage good behaviour even when enforcing boundaries of control

Purposeful activity: Good order is supported through activities for prisoners which are challenging and well-organised

Security and rules of the establishment

6.01 In January 2003, Long Lartin had achieved an overall grade of 'good' from the Standards Audit Unit for its work in the area of security. Security was a key feature of the work of the prison, as would be expected in any establishment in the high security estate.

6.02 The management of security was a central element of the work of the deputy governor and two other governors in the prison, along with a principal officer and four senior officers. The prison also had a dedicated searching team that conducted targeted searching and the searching of category A prisoners and their cells.

6.03 Security intelligence was well managed and was co-ordinated by an intelligence analyst. Approximately 4000 security information reports were received from staff each year, although these were of varying quality. A monthly security

assessment was published, which highlighted the security reports received and detailed other important security information. This was available to all staff.

6.04 Searching targets were being met and managers were aware of the qualitative differences sometimes found between cell searches carried out by residential staff and those done by the dedicated searching team. The latter had responsibility for all category A searches, while residential staff conducted other routine residential searches.

6.05 Prisoners to whom we spoke were aware of the rules of the prison and were prepared to challenge those they did not think to be appropriate. However, as a result of the regular failure of the induction programme to operate and impact on all new prisoners, some were learning about the workings of the prison from other prisoners rather than from members of staff.

6.06 Key components of dynamic security were in place at Long Lartin: there were good relationships between staff and prisoners, good information was provided to the security department on the basis of this and many staff took an interest in the prisoners for whom they were responsible. The principles of dynamic security were lacking, however, in the failure to provide prisoners with sufficient amounts of purposeful activity, as discussed elsewhere in this report.

Conclusion

6.07 Security was well managed at Long Lartin and this played a significant part in creating a safe environment within the prison. The principles of dynamic security were, however, undermined by the lack of purposeful activity for prisoners.

Segregation unit (security, care and control unit)

6.08 The segregation unit had been renamed the security, care and control unit. It was located in a purpose-built block along a secure corridor adjacent to Perrie Wing. The unit was on two levels and contained spaces for 40 prisoners, with one cell furnished as a safe cell with anti-ligature fittings. Eight high control cells at the far end of the unit on the ground floor could hold prisoners on close supervision. There

were four showers on the upper floor and one on the ground floor. Two special cells were also located on the ground floor.

6.09 During the course of this inspection, two prisoners were housed in high control cells and most of the other cells were in use during the week. Those prisoners held in the unit were there for justifiable reasons, with three prisoners held for their own protection. Over time, the unit had held some prisoners who were extremely dangerous and difficult to manage. Prisoners had been located in the unit from various parts of the prison and historically the locations from which prisoners were sent to the unit was representative of the state of order and control throughout the prison. A and B Wings had been the source of most prisoners in the unit in the past, but this had now changed to Perrie Wing.

6.10 Some prisoners spent a very long time in the unit. At the time of this inspection, one prisoner had been located in the unit for over a year and two others had been there for over six months. Monthly reviews were conducted on all prisoners, although unit staff could not initially find records of these for the last six months; they were eventually recovered. There was insufficient attention paid in them, however, to developing and implementing strategies to return prisoners to normal location as quickly as possible.

6.11 There were usually regular entries in unit records of prisoner behaviour, but these were not made on a daily basis for all prisoners; one prisoner had not had an entry made for approximately four months.

6.12 Despite this, relationships between staff and prisoners were generally good and staff conducted themselves in a professional manner, sometimes in difficult and trying circumstances. Most staff were on first name terms with the prisoners in the unit and only one of the prisoners to whom we spoke claimed to have any serious difficulties with staff.

6.13 Prisoners had daily access to showers, exercise and telephones if they requested them on the daily application form. There was, however, a dearth of purposeful activity: there was no physical exercise or work, and education, which was

offered on demand, was not being delivered at the time of our inspection. Visits were offered in the main visits room after a risk assessment of the prisoner concerned had been undertaken; others were allowed visits in the high-risk visits area adjacent to the main visits room. Prisoners were not allowed to attend religious services, but a member of the chaplaincy team visited the unit daily. The duty governor, the doctor and the Independent Monitoring Board also made regular visits to the unit.

Conclusion

6.14 Staff in the security, care and control unit managed some difficult and dangerous prisoners well. There were, however, insufficient steps taken to return prisoners quickly to normal location. The regime for those held in the unit was lacking in activity, although all prisoners were receiving their basic entitlements.

Recommendations

6.15 **Plans should be developed for all prisoners to ensure that they are returned to normal accommodation as soon as possible.**

6.16 **Prisoners should be offered work, physical exercise and education where security factors allow.**

6.17 **Daily entries should be made in unit records detailing the mental, emotional and physical health of all prisoners.**

Use of force

6.18 Documents recording the use of force were accurately kept in the security, care and control unit and in the security department. Force was used relatively infrequently and this may have been accounted for by the good relationships between staff and prisoners that were witnessed during this inspection.

6.19 Force was recorded in the security, care and control unit as having been used whenever prisoners were handcuffed, even though this was not always linked to the formal use of control and restraint techniques. Additionally, force was always used when prisoners were located in the special cells.

6.20 In the period from January to March 2003, force not involving the use of the special cells was recorded as having been used 14 times, but on only four of those occasions were control and restraint techniques used; in the other 10 instances, prisoners had walked to the security, care and control unit after handcuffs had been applied.

6.21 In addition to this, however, the special cells had been used and prisoners had been located there following the use of force. In the period from January to March, the special cells had been used 11 times.

6.22 In total, then, control and restraint techniques had been used 15 times in the first quarter of 2003, and prisoners had been taken to the security, care and control unit in handcuffs on an additional 10 occasions.

6.23 There was a commitment to keep prisoners in the special cells for the minimum period possible, but records showed that some had stayed in for lengthy periods. On further examination, this was accounted for by some prisoners being unwilling to leave special cell conditions and the decision being taken not to employ force to secure their removal.

6.24 It was clear from this that there was an emphasis on de-escalation at Long Lartin and that prisoners were only held in special cell conditions for as long as was necessary; records indicated that force was only used legitimately and as a last resort.

Conclusion

6.25 The use of force was not excessive. Records indicated that force was used legitimately and as a last resort.

Disciplinary procedures

6.26 Adjudications were conducted in a room on the second floor of the security, care and control unit. The room was appropriate for its purpose, with prisoners being seated at one end facing the adjudicating governor and with prison offices at either side.

6.27 Prisoners were placed on charges for a variety of reasons, all of which resulted from alleged significant breaches of prison rules. Checks were made to ensure that prisoners understood the charges they faced and they were given the opportunity to seek legal advice when they requested this.

6.28 The proceedings were clear, fair and open; prisoners were given the opportunity to call witnesses when appropriate and adjudicating governors gave appropriate time to ensure that adjudications were conducted thoroughly. All prisoners were made aware of the evidence against them and were given opportunities to question the officer laying the charge.

6.29 Findings of guilt were based on the evidence presented to the adjudicating governor after proper process. The resulting awards were fair, consistent and not excessive: punishments were based on a tariff, which was adjusted according to the circumstances of the offence and the individual who had been charged.

Conclusion

6.30 Adjudications were conducted in a fair and open manner. Findings of guilt were made after proper process. Awards were consistent and not excessive.

Incentives and earned privileges scheme

Expected outcomes

The expected outcomes for incentives and earned privileges are:

Respect: Prisoners understand the rules of the establishment and are treated fairly; they are able to appeal against decisions

Respect: Every opportunity is taken to encourage good behaviour even when enforcing boundaries of control

6.31 The policy on incentives and earned privileges (IEP) was based on the same points system that we commended in 2002. The three levels of basic, standard and enhanced were being used and prisoners arriving at Long Lartin would be placed on standard level unless there was evidence that they had achieved enhanced status at their previous prison.

6.32 Around 55% of prisoners were on enhanced level, 42% were on standard level and 3% were on basic level. Prisoners on basic level were primarily to be found on Perrie Blue Wing and were located close to the small number of remand prisoners there.

6.33 In our survey, 44% of respondents said they did not understand how IEP worked and 61% said they felt they had not been fairly treated within the scheme. A points system was in place and prisoners were scored on their behaviour, cleanliness and attitude. The scheme was properly structured and prisoners' performances were assessed every week. IEP levels were reviewed after four weeks so that trends in behaviour, rather than individual incidents or an unsatisfactory week, reflected overall performance. Prisoners received written notification of their points every week and received a written warning when a weekly score was 32 points or less. Prisoners had recourse to appeal at any stage of the IEP process, firstly by using an IEP appeal form and then through the complaints system.

6.34 Prisoners on basic regime were assessed every day. Basic regime was not unduly punitive and prisoners on it were not deprived of exercise, work, showers or use of the telephone. They could not have in-cell television and association time (including exercise) was limited to three hours a day. Their weekly cash allowance was £3.00, compared to £12.30 for standard and £20.00 for enhanced; the amount they could transfer to their spending account was limited to £25, as opposed to £100 for standard and £150 for enhanced prisoners.

Conclusion

6.35 The IEP system continued to provide a fair and open assessment of prisoners' behaviour and compliance with prison rules. We could find no objective grounds to support prisoners' complaints about the system.

CHAPTER SEVEN

RESETTLEMENT

Expected outcomes

The expected outcomes for resettlement are:

Safety: Prisoners are able to trust staff to deal with details of their offending and personal circumstances responsibly

Respect: Sentence planning, offending behaviour and substance use programmes and reintegration planning are effective and meet prisoners' assessed needs

Respect: The approach of all staff encourages responsible behaviour and supports prisoners working on their offending, substance use and other problems and preparing for release

Purposeful activity: Access and allocation to purposeful activity is linked to prisoners' assessed needs and their planned targets

Resettlement and reducing re-offending: Prisoners address their offending behaviour and related problems and prepare for release while in custody

Management of resettlement

7.01 A resettlement policy and committee were in place. The policy document did not clearly set out what and how Long Lartin intended to deliver on resettlement and was not based on any analysis of the population. Instead it contained lists of information on various aspects of the prison, including, for example, how to report a racist incident, prisoners with disabilities, prisoner induction, prisoners' pay structure, access to the regime and workshop criteria. The policy appeared to be a collection of information about activities and processes in Long Lartin.

7.02 The committee, which met monthly, was multidisciplinary and was well attended. After examining the minutes of the last three meetings, it was our view that the committee was not working as a resettlement committee but more like a catch-all safer custody committee with some elements of resettlement interspersed. There was

no monitoring of all the various elements of resettlement such as sentence planning. The committee did not drive or direct resettlement work in the prison.

7.03 Resettlement had recently been moved from the residential function and a new post of head of resettlement and activities had been created. The post-holder recognised the shortcomings of the policy and the need for fundamental change.

Reintegration planning

7.04 The probation department was responsible for re-integration planning, which was split into the two elements of need and risk. All prisoners due to be released were interviewed by a probation service officer six months in advance. The probation service officer worked to a structured interview, which was designed to elicit any concerns the prisoner may have had about his release. It picked up on specific areas of need such as housing, employment and benefits. The probation service officer then began to work on the issues for the prisoner and kept in touch with him up until his release.

7.05 At the same time, the senior probation officer dealt with the risk factors. Many of the prisoners released from Long Lartin were on the dangerous prisoners panel and subject to public protection measures. The prison had good systems in place for identifying and administering public protection. The senior probation officer liaised with all the internal and external agencies to ensure that prisoners were released with proper release plans. When a prisoner was not subject to public protection measures, the senior probation officer organised case conferences and ensured that the home probation officer attended.

7.06 We spoke with the two prisoners who would be released within the next two months. Both had been interviewed by the probation service officer, who had done work on their behalf and had kept them informed of progress.

Sentence planning

7.07 Sentence planning was completed in the residential support unit. The unit consisted of administration grades who prepared the plans and casework officers who completed them. There was a backlog of sentence plan reviews, although it was not

possible to ascertain the exact number. The best we could determine was that the casework officers were still working on some reviews from February.

7.08 Prisoners were reviewed three months after arrival and then every 12 months. A clerk was responsible for gathering written information from contributors and preparing the sentence plan reviews. The list of contributors did not include education. When a prisoner was due for a review, the clerk passed the documents to the caseworkers regardless of whether or not all the written contributions had been obtained. Many of the reviews we examined did not have all the written contributions that they should have had.

7.09 The review board consisted of the caseworker, a probation officer and the prisoner. The prisoner's home probation officer was invited to attend but it was rare that this happened. The head of residence signed off each review.

7.10 The reviews were carefully completed by the casework officers and it was clear that the prisoner was encouraged to engage in the process. The written contributions from personal officers were variable. Many started with the words 'I do not have a lot of contact with this prisoner' but then went on to offer views that were important to that prisoner's future. The targets set nearly always contained Enhanced Thinking Skills (ETS), Controlling Anger and Learning to Manage it (CALM) or CARATs. As far as Enhanced Thinking Skills and CALM were concerned, the targets were mainly meaningless as the prison could achieve only 82 completions for both. Some looked at other areas the prisoner could work at but there was little recognition that education, physical education and work could also be used as risk reducers.

Offending behaviour programmes

7.11 There was a dedicated unit for delivering offending behaviour programmes: ETS and CALM. The prison had targets of 53 completions for ETS and 29 for CALM. These were the same as last year when the prison had achieved 100% Intermediate Quality Rating for ETS and 95% for CALM.

7.12 The facilities were excellent. There were two classrooms that were soundproofed and well equipped, and sufficient offices for the staff to do their work. There was a programme manager for both courses and a treatment manager who worked in the unit. The tutor group consisted of four prison officers, two psychological assistants and a part-time psychologist. All were knowledgeable about their subjects and enthusiastic about their work.

Conclusion

7.13 The resettlement policy document was not focussed on the elements of resettlement or based on an analysis of the population. The committee did not focus on resettlement, monitor properly the elements of resettlement, drive or direct the policy. Re-integration planning was done thoroughly. Sentence planning was not up to date and no one knew the extent of the backlog. Sentence plan reviews were carefully completed but the targets mainly related to CALM, ETS and CARATs. There was little evidence that the caseworkers looked beyond these programmes for activities that would help reduce risk. The offending behaviour programmes were delivered in excellent facilities by highly motivated staff.

Recommendations

7.14 **The resettlement policy should be reviewed and should be based on an analysis of the resettlement needs of this population.**

7.15 **The committee should concern itself only with resettlement issues and monitor, direct and drive the policy.**

7.16 **The backlog of sentence plan reviews should be quantified and eliminated.**

7.17 **There should be a system put in place to track sentence plan reviews to ensure that all documentation is available at the review.**

7.18 **Casework officers should be trained to identify sentence planning targets other than offending behaviour programmes that help to reduce risk.**

7.19 **The offending behaviour programmes unit should identify referrals for programmes and only make programmes a sentence plan target when a prisoner is able to take part within the appropriate time frame.**

Life-sentenced prisoners

Expected outcomes

The expected outcomes for life-sentenced prisoners are:

Safety: Life-sentenced prisoners trust that details of their offences and personal circumstances are treated responsibly by staff

Safety: Potential life-sentenced prisoners on first entering custody, and newly-sentenced life-sentenced prisoners returning from court, are given close attention and support from trained staff

Respect: All life-sentenced prisoners are able to address their risk factors and prepare for release within the timescale of their tariffs

Respect: Recalled life-sentenced prisoners and licence revokees are dealt with promptly, openly, consistently and fairly and a regime provided for them

Respect: Staff working with life-sentenced prisoners understand the life-sentenced prisoner system and encourage life-sentenced prisoners to maintain a positive approach to their sentence and work towards their eventual release

Purposeful activity: Life-sentenced prisoners experience balanced regimes with opportunities for work, education, leisure and social interaction, which afford them choice and require them to take increasing responsibility for themselves

Resettlement and reducing offending: Life-sentenced prisoners are able to access help which assists them in coming to terms with their sentence and to take responsibility for their offending

Resettlement and reducing offending: Life-sentenced prisoners experience a phased reintegration into the community supported by a resettlement team in the discharging prison which includes input from the home probation officer

7.20 Long Lartin could hold a maximum of 220 life-sentenced prisoners and 200 were in the prison at the time of this inspection. The prison acted as a first stage centre for life-sentenced prisoners, but it also held others who had not made

progressive moves elsewhere or who had been transferred to Long Lartin from less secure conditions, usually for disciplinary reasons.

7.21 The management of life sentence reporting procedures was similar to that found in relation to the management of sentence plans for determinate-sentenced prisoners. There was a backlog of uncompleted reports, but no member of staff was able to give us an accurate account of how great this was; the most informed speculation was that 130 of the 200 life-sentenced prisoners were not having reports completed on them on time. This was unacceptable.

7.22 In addition to the failing arrangements for the completion of reports on life-sentenced prisoners, there were no special arrangements in place for this group. This was not as a result of a deliberate decision to treat these prisoners in the same way as determinate-sentenced prisoners, but was rather the result of the failure to ensure appropriate arrangements were in place. There were no forums for life-sentenced prisoners and no life-sentenced prisoner days. Even the booklet that had been produced to introduce life-sentenced prisoners to the prison was long out of date and inaccurate.

7.23 Steps had been taken to ensure that a module for life-sentenced prisoners was included on the induction programme, but this programme was not being delivered consistently, as described elsewhere in this report.

7.24 In short, life-sentenced prisoners were not having their specific needs met effectively.

Conclusion

7.25 There were 200 life-sentenced prisoners at Long Lartin at the time of this inspection. There were significant backlogs in the completion of reports for this group of prisoners and there were no effective arrangements in place to meet their specific needs.

Recommendations

7.26 **Reports on life-sentenced prisoners should be completed on time.**

7.27 **There should be a review of current provision for life-sentenced prisoners and an action plan should be developed, implemented and monitored.**

Categorisation and allocation

Expected outcomes

The expected outcomes for categorisation are:

Safety: Prisoners are held in accommodation which is appropriate for their own and others' safety

Respect: Prisoners are located in an establishment that is as close to home as possible and able to meet their identified needs

Respect: Criteria for determining security categorisation and allocation procedures are clear, open and fair, and rules governing transfer arrangements are fairly and consistently applied without discrimination

Purposeful activity: Security conditions do not unnecessarily restrict prisoners' access to purposeful activity

7.28 Categorisation reviews were scheduled to take place on an annual basis to link in with each prisoner's sentence plan review. This reduced the need for unnecessary duplication of effort in information gathering and ensured that key decisions about the prisoner took place in a co-ordinated way. As sentence reviews were not being completed on time (see section on sentence planning), this automatically led to a delay to the categorisation review.

7.29 Prisoners were informed of the intended date of their review. Very few reviews occurred in response to prisoner application; it was evident from talking to prisoners that they knew what needed to happen to make them eligible for re-categorisation and had realistic expectations of when this would happen. Reviews would be brought forward if exceptional circumstances indicated a clear change in risk factor. Cases involving re-categorisation from category A to B were dealt with by staff external to the prison.

7.30 Once the categorisation decision had been made, a copy of the decision form (page 5 of form RC1) was sent to the prisoner as notification. We saw several such copies filed in prisoner wing history sheets. Appeal against the decision was handled through the complaints system by a governor other than the one who had been involved in the categorisation review.

7.31 At the time of the inspection, around a quarter of the population were category A prisoners. We found no evidence of unnecessary security restrictions impacting on the regime for prisoners or preventing their access to activities. The sentence profile of the prisoner population meant that most moves from Long Lartin were progressive transfers to a category B establishment. Prisoners could apply for transfers. These were dealt with by a tactical management officer located in reception who told us that 16 prisoners were awaiting transfer to category B or C establishments; the latter could normally be achieved in a matter of weeks.

Conclusion

7.32 A clear, structured process was in place. Although categorisation reviews should have taken place annually, delays in sentence plan reviews were preventing this. Prisoners were informed throughout the process.

CHAPTER EIGHT

SERVICES

Catering

Expected outcomes

The expected outcomes for catering are:

Safety: Prisoners' food is prepared and served safely in accordance with Environmental Health regulations and religious requirements

Respect: Prisoners receive a fair portion of healthy, balanced, nutritious and varied meals to meet their physical, gender, health, religious, ethnic and medical needs

Respect: Prisoners have a choice and are encouraged to eat healthily to help them create and maintain healthy lifestyles

8.01 The catering department employed a principal officer and seven officer/civilian caterers. The kitchen also employed 15 prisoners. Menu choice was based on a three-week cycle and accommodated dietary restrictions such as vegetarian, vegan and religious diets. The catering budget was £1.50 per prisoner per day.

8.02 Meal times were breakfast at 8am, lunch at 11.30/11.45am and a tea meal at 4.30/4.45pm. Some prisoners chose to cook their own meals in the wing kitchen. In our survey, the ratings for food quality, choice, portion size and dietary needs were generally good or very good, although a significant proportion was also neither good nor bad.

8.03 There was no catering committee with prisoner representation but two food surveys were conducted every year. One had just been completed in June but the response rate was very low. Prisoners did raise two points with us that, in our view, should have been resolved by the catering department. The first was the inability to get semi-skimmed or skimmed milk without the doctor's approval; the second was to have baguettes without any margarine or butter spread. Kitchen staff said that prison

farms did not provide different milk other than in the very small packs and that if they provided plain baguettes for some prisoners then 'they would all be asking for them'.

8.04 Wing serveries held food registers that recorded daily temperatures of food trolleys, hot plates and food at the time of serving. Although food hygiene standards on the wings were monitored by a hygiene coordinator, a recent Prison Service Standards Audit found deficiencies. When we inspected food areas on the wings, we found the small kitchens used by prisoners to be untidy and dirty and utensils and food trays used by prisoners were left unwashed overnight. There was no accounting of the number of food trays returned to the kitchen and in one wing office we found an almost empty food tray with the remains of a pasta meal that had been there at least overnight if not longer.

8.05 All prisoners took essential food hygiene awards while on prison induction and 12 prisoners were engaged in distance learning/cell study for clinical nutrition diplomas. All prisoners working in the kitchen took basic food hygiene awards. Eight prisoners had just started a national vocational qualification (NVQ) at level 1 in food preparation and one had completed a portfolio for a NVQ level 2 award. There were links with the library and the librarian ordered vocational catering books requested by kitchen staff.

8.06 Staff were very enthusiastic about vocational training qualifications. They had produced learning materials themselves and had set up a classroom with computers adjacent to the kitchen, providing a staff mentor and one session a week to each NVQ learner. Staff were well qualified and experienced in their specialist occupational areas, but many had insufficient knowledge about the management requirements for the awards. There were no qualified internal verifiers in the kitchen, neither were there any qualified assessors, although two were working towards the assessor award. External organisations were providing internal verification services. However, they were not visiting the prison very often to support prison staff and prison staff did not have written feedback to help them improve their provision.

Conclusion

8.07 The catering department provided an acceptable service to prisoners and many prisoners chose to cook their own food in the small kitchen on each wing. Standards of cleanliness in wing kitchens were poor. As part of induction, all prisoners took essential food hygiene awards. Catering staff worked hard to provide qualifications for prisoners but few were taking vocational qualifications.

Recommendations

8.08 **NVQ recommendations are contained in the separate Adult Learning Inspectorate report.**

8.09 **The provision of semi-skimmed or skimmed milk to prisoners should not require medical approval.**

8.10 **Wing cleaning schedules should ensure that prisoners' kitchens are cleaned after every main meal and before night patrol state.**

Good practice

8.11 *All prisoners took essential food hygiene awards as part of the general prison induction.*

Prison shop

Expected outcomes

The expected outcomes for the prison shop are:

Safety: Arrangements to enable prisoners to purchase goods minimise opportunities for bullying

Safety: Items held in the prison shop and store are stored and served according to the requirements of food safety, hygiene, religion and security

Respect: Prisoners have a suitable range of affordable goods available for purchase at reasonable prices to meet their ethnic, cultural and gender needs

8.12 Although the prison shop had been run by Eurest for some years, there had never been a formal contract between this company and the prison. Despite this,

quarterly review meetings were held and representatives of both parties described the working relationship as positive and productive. A specification to run the prison shop had gone out to tender earlier this year and it was anticipated that formal arrangements with the successful company would be completed by October 2003.

8.13 Although only 43% of prisoners surveyed said the shop sold a wide enough range of goods to meet their needs, the list of goods available was among the most extensive and varied we have seen. Managers regularly compared the shop list with others in the high secure estate and undertook a survey of all prisoners approximately every six months to identify the demand for new products. We saw the results of the February 2003 survey, which highlighted a potential 46 new items, including a significant proportion of ethnic food stuffs. Subject to negotiations with Eurest, the most popular of these would be added or substituted on the existing list.

8.14 Prisoners could order and receive goods each week. They completed an order form over the weekend, having received their pay slip and hence details of the amount they had available to spend on Friday morning. Eurest staff attended each wing on Friday afternoon and handed bagged goods direct to prisoners, using the wing servery as a distribution point. We were told that there were few wrong or incomplete orders but, as the Eurest store was located just outside the main gate, errors could be rectified promptly.

Conclusion

8.15 Prisoners had weekly access to a wide and suitable range of goods through the prison shop and regular surveys identified demand for new goods.

CHAPTER NINE

RECOMMENDATIONS AND GOOD PRACTICE

The following is a listing of recommendations, housekeeping points and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

To the Governor

Main recommendations

9.01 There should be effective first night systems and a consistently delivered induction programme. (HP.32)

9.02 Work should be undertaken with segregated prisoners to ensure they are returned to normal location whenever possible. (HP.33)

9.03 Race relations matters should be reviewed and an action plan for improvement should be implemented. (HP.34)

9.04 All prisoners should engage in education and meaningful work on a daily basis. (HP.35)

9.05 Accreditation of courses and training opportunities should be increased. (HP.36)

9.06 A drug strategy based on the needs of the population, and an action plan resulting from this, should be produced. (HP.37)

9.07 A resettlement needs analysis of the population should be undertaken and an action plan implemented to meet identified need. (HP.38)

Reception

9.08 Reception staff should not be redeployed if this means delaying prisoners' applications regarding property in reception. (1.11)

9.09 Prisoners and staff should be provided with information about the placing and processing of mail order items. (1.12)

9.10 A reception pack should be provided for non-smokers. (1.13)

9.11 Alternative options should be found for prisoners to authorise the destruction of their property without having to go to reception. (1.14)

9.12 There should be clear, consistent and effective procedures for the collection and exchange of items from reception. (1.15)

First night

9.13 There should be specific first night procedures for all new prisoners during their first few days at Long Lartin. (1.21)

9.14 All prisoners should be offered a free telephone call on their first night. (1.22)

9.15 Sufficient information should be provided to prisoners to enable them to understand daily routines and what will be provided during their first week. (1.23)

Induction

9.16 All prisoners should receive proper induction within their first few weeks at the prison. (1.28)

9.17 There should be a review of the induction course to ensure that it meets the needs of prisoners arriving at Long Lartin. (1.29)

Accommodation and facilities

9.18 The prison's capability for managing prisoners with disabilities, especially wheelchair users, should be clarified. (2.07)

9.19 Pending closure for refurbishment, A and B Wings should maintain an acceptable level of presentation and cleanliness. (2.08)

Personal officers

9.20 Clear written guidance should be produced on the role of the personal officer. (2.13)

9.21 The content and quality of written records and reports prepared by personal officers should be standardised and subject to regular quality control. (2.14)

Hygiene

9.22 Prisoners should have access to night sanitation when they need it and this should be included in any redesign of the residential unit. (2.22)

9.23 Mattresses for cell beds should be replaced as required. (2.23)

Anti-bullying

9.24 A residential governor should chair the anti-bullying committee meetings. (3.09)

9.25 The committee should set in place systems to check for methods of sophisticated or organised bullying. (3.10)

9.26 Interventions should be put in place to challenge and change the behaviour of identified bullies. (3.11)

9.27 The policy's interventions for victims of bullying should be re-introduced and regularly monitored by the anti-bullying committee. (3.12)

Preventing self-harm and suicide

9.28 The crisis suite cells should be made more suitable for their purpose. (3.22)

9.29 Staff should be reminded of the need to record interactions with prisoners. (3.23)

9.30 Staff should be aware of the location of all emergency equipment. (3.24)

Race relations

9.31 The diversity action team should have clear strategies and action plans for minority ethnic and foreign national prisoners, and these should be published to staff and prisoners. (3.39)

9.32 The action plan should contain an early intervention to increase both staff and prisoners' confidence in the work of the diversity action team. (3.40)

9.33 There should be prisoner representatives on the diversity action team. (3.41)

9.34 Proven acts of discrimination or intimidation should be responded to decisively. (3.42)

9.35 The availability of ethnic monitoring data should be consistently produced, reliable and acted on. (3.43)

9.36 A senior manager should take responsibility for foreign national prisoners. (3.44)

9.37 The notes of the diversity action team should specify who is responsible for progressing action points and ensure that these are followed up fully at subsequent meetings. (3.45)

Substance use

9.38 A multi-disciplinary drug strategy team should meet separately and on a regular basis to address supply and demand reduction issues. (3.65)

9.39 A needs assessment should be undertaken to establish demand for detoxification. (3.66)

9.40 An action plan with specific targets and performance measures for the current year should be developed in consultation with drug strategy team members. (3.67)

9.41 A structured group work programme should be implemented. (3.68)

9.42 The staff shortage within the CARATs team should be addressed. (3.69)

Maintaining contact with family and friends

9.43 The telephone system for booking visits should be reviewed to ensure a quick response for people calling the line. (3.79)

9.44 Visits should start at the published time. (3.80)

9.45 Wing applications should be recorded and tracked. (3.88)

9.46 All complaints should be replied to within the target dates set by the Prison Service. (3.89)

Health care

9.47 A skill mix review and training needs analysis should be undertaken to determine the requirement of both professional and administrative staff. (4.61)

9.48 The emergency medical equipment should be located in a more central position to enable rapid access in an emergency. (4.62)

9.49 The medicines and therapeutic committee should meet at least quarterly and undertake a full review of pharmacy services in association with the primary care trust. It should draw up a prescribing formulary and policies for in-possession and special sick medication. All documents should be reviewed regularly. (4.63)

9.50 The pharmacist should visit the prison fortnightly to provide guidance and advice for both patients and staff. The subcontracted pharmacist should visit as contracted. (4.64)

9.51 Any prescriptions for controlled drugs (and not faxes) must be forwarded to Forensic Pharmaceutical Services for dispensing. (4.65)

9.52 A chronic disease register should be maintained to enable a patient and medical audit to be undertaken (4.66)

9.53 The Head of Health Care should consult with the Director of Dental Services to ensure that the appropriate documentation is in place. (4.67)

9.54 Dental patients who need pain relief should receive timely treatment, including out-of-hours emergencies. (4.68)

9.55 The dental treatment requirements of all new prisoners should be established on admission and a range and standard of care equal to that available in the NHS should be provided. (4.69)

9.56 A dental recall system should be established to enable continual care for long-stay prisoners. (4.70)

9.57 Hygienists and dental health educators should be included within the dental team. (4.71)

9.58 Independent clinical monitoring of the dental services provided should be established. (4.72)

9.59 Appropriate IT links with the local PCT and NHS Intranet should be made. (4.73)

9.60 Venepuncture training programmes should be held to increase the number of nursing staff able to take blood. (4.74)

9.61 Health care protocols should be fully revised in order to ensure that they are evidence based so that they can be used to include clinical care and management. (4.75)

Management of activities

9.62 A review of activities should be completed in order to keep activities open. (5.07)

Employment

9.63 The prison should match qualifications to work activities and introduce them across the establishment. (5.13)

9.64 Improvements should be made to the monitoring of workshop health and safety practices. (5.14)

Work skills/vocational qualifications

9.65 Consideration should be given to providing the physical education department with sufficient staff to offer more qualifications. (5.19)

Education

9.66 More outreach education should be offered. (5.27)

9.67 The reasons for constant class closures and disruptions should be investigated and remedied. (5.28)

9.68 Information about prisoners' numeracy and literacy should be shared with other departments. (5.29)

Physical education

9.69 The supervision of prisoners in the gymnasium corridor should be improved. (5.39)

9.70 Allocation of prisoners to physical education activities should enable all available spaces to be filled. (5.40)

9.71 Physical education staff should contribute to key strategic initiatives. (5.41)

Time out-of-cell

9.72 Staff should be encouraged to engage with prisoners on association. (5.55)

Segregation unit (security, care and control unit)

9.73 Plans should be developed for all prisoners to ensure that they are returned to normal accommodation as soon as possible. (6.15)

9.74 Prisoners should be offered work, physical exercise and education where security factors allow. (6.16)

9.75 Daily entries should be made in unit records detailing the mental, emotional and physical health of all prisoners. (6.17)

Resettlement

9.76 The resettlement policy should be reviewed and should be based on an analysis of the resettlement needs of this population. (7.14)

9.77 The committee should concern itself only with resettlement issues and monitor, direct and drive the policy. (7.15)

9.78 The backlog of sentence plan reviews should be quantified and eliminated. (7.16)

9.79 There should be a system put in place to track sentence plan reviews to ensure that all documentation is available at the review. (7.17)

9.80 Casework officers should be trained to identify sentence planning targets other then offending behaviour programmes that help to reduce risk. (7.18)

9.81 The offending behaviour programmes unit should identify referrals for programmes and only make programmes a sentence plan target when a prisoner is about to take part in one. (7.19)

Life-sentenced prisoners

9.82 Reports on life-sentenced prisoners should be completed on time. (7.26)

9.83 There should be a review of current provision for life-sentenced prisoners and an action plan should be developed, implemented and monitored. (7.27)

Catering

9.84 NVQ recommendations are contained in the separate Adult Learning Inspectorate report. (8.08)

9.85 The provision of semi-skimmed or skimmed milk to prisoners should not require medical approval. (8.09)

9.86 Wing cleaning schedules should ensure that prisoners' kitchens are cleaned after every main meal and before night patrol state. (8.10)

Examples of good practice

Maintaining contact with family and friends

9.87 Family visits took place on Monday and all-day visits were possible on Tuesdays and Thursdays. (3.81)

Catering

9.88 All prisoners took essential food hygiene awards as part of the general prison induction. (8.11)