

Report on an unannounced short follow-  
up inspection of

# **HMP WOLDS**

17 – 19 September 2007

by HM Chief Inspector of Prisons

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# Introduction

HMP Wolds is a privately managed category C training prison run by GSL. When we previously inspected in 2004, we commended a number of aspects of the establishment, but were concerned by weaknesses in the quantity and quality of purposeful activity and by aspects of resettlement. This short follow-up inspection found that significant progress had been made and that the prison, as a result, was performing reasonably well across the board.

Wolds remained a reasonably safe establishment. First days in custody were managed well and there was little evidence of bullying or substance abuse. Suicide and self-harm prevention work was effective, although there was still no Listeners' suite. There was little recourse to use of force, adjudications were conducted appropriately and the segregation unit provided a reasonable environment, although some prisoners were spending too long there.

Residential units were generally satisfactory, but population pressures had led to the doubling of prisoners in inappropriate accommodation. Staff-prisoner relationships were good, supported by an imaginative incentives and earned privileges scheme. More work was needed to gain prisoner confidence in the applications and complaints systems. The management of race equality issues had improved significantly, although more work was needed to support foreign national prisoners. Health services remained reasonable.

Prisoners spent plenty of time out of cell and efforts had been made to improve both the quality and quantity of purposeful activity. Learning and skills was now better linked to employment opportunities in the community, and there was much greater emphasis on accredited training. The library, although small, had continued to improve.

The strategic management of resettlement had improved, although it was still not informed by a comprehensive analysis of the risks and needs of prisoners. Offender management had taken root, supported by access to the offender assessment system (OASys), and there was now an impressive array of resettlement and reintegration services. There was a need to develop work with life-sentenced prisoners.

Staff and managers at Wolds deserve considerable praise for building on the strengths that we identified in our previous inspection and for acting on those areas that we identified as requiring improvement. Inevitably, there is more to do, but this is a positive report on an improving establishment.

Anne Owers  
HM Chief Inspector of Prisons

December 2007



# Fact page

## **Task of the establishment**

Adult male category C training prison.

## **Brief history**

In 1991, Group 4 won the contract to manage the first private prison in Europe. Wolds opened in April 1992 as a remand centre and in 1994 re-rolled to become a local and category B training prison. GSL won the re-bid competition for a re-role category C prison for 10 years from January 2003.

## **Number held**

374

## **Certified normal accommodation**

300

## **Operational capacity**

380

## **Last full inspection**

15-19 November 2004

## **Description of residential units**

A unit = College	60 places
B unit = Normal location	60 places
C unit = Lifer unit	50 places
D unit = Normal location	60 places
E unit = Normal location	60 places
F unit = Normal location	60 places
G unit = Normal location	16 places
Induction unit = new admissions	14 places
Segregation unit = R45 and punishments	





# Section 1: Healthy prison assessment

## Introduction

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HP1 All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

<b>Safety</b>	prisoners, even the most vulnerable, are held safely
<b>Respect</b>	prisoners are treated with respect for their human dignity
<b>Purposeful activity</b>	prisoners are able, and expected, to engage in activity that is likely to benefit them
<b>Resettlement</b>	prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending.

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the National Offender Management Service.

**...performing well against this healthy prison test.**

There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

**...performing reasonably well against this healthy prison test.**

There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

**...not performing sufficiently well against this healthy prison test.**

There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

**...performing poorly against this healthy prison test.**

There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern

observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

## Safety

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- HP4 As at the last inspection, Wolds was providing a relaxed and safe environment. The wings were calm and well ordered and prisoners reported feeling safe. Positive relationships and respectful communication between staff and prisoners underpinned good dynamic security.
- HP5 First days in custody arrangements were good. The reception area was clean and welcoming and contained relevant information. Interviews took place in private and prisoners generally moved to the induction unit quickly. Prisoners were offered a shower, a free telephone call and access to a Listener, and were observed regularly during their first night. The induction programme was thorough and an updated induction booklet was available in various languages.
- HP6 There was little evidence of bullying and the anti-bullying strategy was thorough, although staff awareness of it was variable. Violence reduction meetings examined a wide range of relevant information, including injury and security information reports. Most staff were trained in assessment, care in custody and teamwork (ACCT) procedures and there were few self-harm incidents. The quality of care for prisoners at risk of self-harm and the recording in ACCT documents were very good. There were sufficient and easily accessible Listeners, but still no care suite.
- HP7 The segregation unit provided a reasonable environment and prisoners who had spent time there felt they had been treated appropriately. However, prisoners were routinely strip-searched on entry and were not moved to normal location as quickly as they should have been. The quality of history file entries was mixed and few demonstrated positive engagement by segregation unit staff.
- HP8 Adjudications were conducted fairly, but the tariff still included 100% stoppage of earnings for some charges, which was inappropriate. Some adjudication records were difficult to read and many lacked detail.
- HP9 The use of force was low and appropriately recorded. Staff reports were informative and injury report forms were completed every time. The use of unfurnished accommodation was not excessive, but had increased since the start of 2007. Reasons for its use were not always clear from documentation and strip conditions were used without risk assessment. Prisoners in unfurnished accommodation did not appear to be moved at the earliest opportunity.
- HP10 There was little evidence from prisoners or other sources of significant substance use. Positive mandatory drug tests were running at less than the target level. The drug strategy group met regularly and prisoner representatives attended. An alcohol policy had been developed and implemented.

- HP11 Of the 16 recommendations made under the area of safety at our last inspection, 14 had been achieved in whole or in part and two had not been achieved. We have made seven further recommendations.
- HP12 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

## Respect

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- HP13 The residential units were in good condition, but single cells were still inappropriately shared by two prisoners and toilet screening in many cells was inadequate or non-existent. Cells did not have lockable cupboards, which was particularly problematic for prisoners sharing cells. Arrangements for allocation to single cells meant prisoners already in single cells wanting to move wings had to return to a double cell and join a waiting list, which acted as a disincentive for prisoners to go to the education or lifer wings. Prisoners had good access to showers, cleaning materials and hygiene requisites.
- HP14 Staff-prisoner relationships were good. All staff wore name badges and generally used first names with prisoners. Staff were considered approachable and respectful. As at the last inspection, prisoners had little confidence in either the applications or complaints systems. Some applications were outstanding by several weeks. Most responses to complaints were courteous and helpful, but some were superficial, lacked detail and suggested poor investigation.
- HP15 The five-stage incentives and earned privileges scheme had an innovative range of incentives to motivate prisoners to attain the enhanced levels. The criteria for advancement to enhanced levels A and B were challenging, including a requirement for prisoners to make attempts to achieve literacy and numeracy levels 1 and 2. Prisoners placed on basic were not issued with meaningful personalised targets.
- HP16 Regular consultation meetings were held to discuss catering issues, food surveys were conducted and wing food comments books were answered promptly. Despite this, most prisoners we spoke to were extremely critical of the standard of the food.
- HP17 Senior managers provided clear leadership on the importance of race equality and prisoners expressed few concerns about racism. Quarterly diversity and race equality meetings were well attended, although prisoner representatives did not always attend and there were no external representatives. The meetings provided effective oversight and direction. Ethnic monitoring was discussed and any identified issues were investigated. Racist incident reports were generally well investigated and considered at each meeting. However, policy to address diversity or race equality was thin, with little to guide development, and we were not convinced that any single person had enough dedicated time to focus on race equality work. Prisoners with disabilities did not have comprehensive care plans and improvements were needed in their general care and management.
- HP18 Foreign national prisoners were allowed a free 10-minute international telephone call and there was some information in translation. However, there was little independent immigration advice and the foreign nationals policy needed updating in consultation with foreign national prisoners. There was little prisoner awareness of legal services.

- HP19 Health services were reasonable, but staff resources were spread thinly and only core work was being done. There was usually only one nurse detailed for work on any given day and a sickness absence could potentially compromise patient safety. Staff and prisoners were unable to see a pharmacist and there were delays in obtaining prescribed medication. There was no medicine and therapeutics committee. The refurbished dental surgery was a good facility.
- HP20 Of the 39 recommendations made under the area of respect at our last inspection, 30 had been achieved in whole or in part and nine had not been achieved. We have made 18 further recommendations.
- HP21 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

## Purposeful activity

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- HP22 There had been some significant improvements in the amount and quality of purposeful activity on offer.
- HP23 Partnerships with external education establishments had been developed and extended, and prisoners could undertake a range of qualifications linked to work. There were also good links with a number of external companies and vocational training opportunities now included the popular track work scheme linked to a qualification leading to good opportunities for full-time work on release. New courses were about to start. Take-up of courses in the kitchen and physical education was limited.
- HP24 A good range of higher-level programmes had been developed and delivered through distance learning and a new partnership with Hull University. IT resources had been obtained to support distance learning and a significant number of prisoners were able to participate in higher education qualifications through the Open University. The education manager and assistant manager now had enough time to manage the education department. Quality assurance processes were new and not yet embedded.
- HP25 The library had a designated quiet area and two prisoner computers, but the area was still too small. Book stock had been improved and was broadly linked to the training on offer. There was a good level of association and time out of cell.
- HP26 Of the 10 recommendations made under the area of purposeful activity at our last inspection, nine had been achieved in whole or in part and one had not been achieved. We have made three further recommendations.
- HP27 On the basis of this short follow-up inspection, we considered that the prison was now performing reasonably well against this healthy prison test.

## Resettlement

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- HP28 As at the last inspection, there was reasonable focus on resettlement and there had also been some improvements in strategic management. A thorough resettlement strategy was clearly linked to regional and local resettlement objectives and each pathway had an identified leader, but the strategy was not based on a needs analysis.

- HP29 Offender management had developed reasonably well in a short space of time and a well-staffed offender management unit had been established. The offender assessment system had been rolled out to most of the population despite some problems linking GSL's computer system to the Prison Service system.
- HP30 The resettlement unit included specialist housing and employment and training workers, as well as three resettlement orderlies. Prisoners reported good access to resettlement staff and services. A particular innovation was a new resettlement service for ex-servicemen, 'Operation Veteran', which had been developed by one of the lifers with charitable funding. Public protection arrangements were efficiently managed by the probation team. Communication and relationships between the different elements of the resettlement function were good.
- HP31 Enhanced thinking skills, anger management (CALM) and cognitive skills booster (CSB) courses were offered. Two CALM courses had recently started simultaneously and had absorbed lifers on the waiting list. Waiting times for programmes were not excessive, but there were not enough CSB programmes to meet the needs of the long-term population. The prison's capacity to run more programmes was shortly due to increase substantially as a new programmes unit with four well-equipped classrooms had been built.
- HP32 Lifers appreciated the help given by the lifer manager, and lifer groups and days were held regularly. The lifer population had increased from 48 to 60 and was continuing to rise. Many were transferred to Wolds to complete programmes, which were supplemented by some additional constructive activity, including the popular lifers' allotments. However, population pressures across the prison estate meant they were often unable to move on to the next programme or stage in a different establishment. The competing claims of determinate and indeterminate prisoners with shorter sentences or tariffs also caused some frustration. We met prisoners who had received little information about the consequences of being on indeterminate public protection sentences.
- HP33 It was a particular concern that lifers at an advanced stage of a long custodial sentence had to share cells and revert to less independent living. There was very limited opportunity for self-catering and an overall need for more and clearer information.
- HP34 The visits facilities were satisfactory. The attractive children's play area was now supervised, although not all the time. The number of closed visits was high for a category C population, but the evidence suggested that when such action was taken it was proportionate and subject to review. The range of work to support families was extremely good. A series of structured family visits aimed to reproduce some typical family circumstances and accredited courses were offered to help promote family life.
- HP35 Of the 21 recommendations made under the area of resettlement at our last inspection, 18 had been achieved in whole or in part and three had not been achieved. We have made six further recommendations.
- HP36 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.



## Section 2: Progress since the last report

The paragraph reference numbers at the end of each recommendation below refer to its location in the previous inspection report.

### Main recommendations

To the Chief Executive of NOMS

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- 2.1 **The offender assessment system (OASys) should be available to contracted out prisons. (HP47)**  
**Achieved.** OASys was rolled out in November 2006 and assessments had been completed on nearly all prisoners within scope apart from some lifers. However, attempts to link GSL's computer system to the Prison Service system had been unsuccessful. Five Quantum terminals linked to the Prison Service were now available, but were considered barely sufficient.

#### Further recommendation

- 2.2 More terminals should be available to staff completing OASys documents.

- 2.3 **Prisoners should not be required to share cells designed for one prisoner. (HP45)**  
**Not achieved.** With the exception of C wing, 10 single cells on each unit were shared by two prisoners. These cells were cramped, with space for only one chair and too little storage. Privacy screening, where it existed, comprised a shower curtain hanging from the ceiling, which was inadequate.  
**We repeat the recommendation.**

### Main recommendations

To the Director

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- 2.4 **Sufficient purposeful activity places should be provided to deliver an effective training prison regime. (HP42)**  
**Achieved.** There were enough purposeful activity places, with 120 full-time places in education, all of which were taken up, and 251 in work, of which 222 were taken up.
- 2.5 **Adjudications should be conducted and punishments awarded in accordance with published guidelines with the standard of adjudications subject to regular external monitoring. (HP43)**  
**Partially achieved.** The hearing we observed was conducted properly. The process was explained and the prisoner given every opportunity to explain his version of events and question the evidence. Nearly 11% of hearings in July and August 2007 had resulted either in charges not proceeded with or in not guilty findings. While this indicated that adjudications were conducted fairly, many written records of completed hearings showed that guilty pleas were accepted without investigation. Many were difficult to read and insufficiently detailed. The recently revised published tariff still inappropriately included a potential punishment of up to 100% stoppage of earnings for certain offences. There was no evidence of external monitoring.  
**We repeat the recommendation.**

- 2.6 **Unfurnished or partly furnished accommodation should be used only when authorised by the Home Office controllers. A full explanation of the reason for its use should be recorded and trends should be monitored by managers. (HP44)**  
**Partially achieved.** There was one special cell and three cells with no integral sanitation or running water. The correct documentation was completed whenever these cells were used to house prisoners in unfurnished accommodation, but did not always make clear why it was deemed necessary. Use of unfurnished accommodation had been approved 18 times in 2007 and correct authorisation had been obtained from the Home Office controller. Use was monitored by managers.

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**Further recommendation**

- 2.7 A full explanation of the reason for the use of unfurnished accommodation should be recorded.

- 2.8 **Effective systems to monitor and promote race equality should be put in place as a matter of urgency, supported by regular consultation with black and minority ethnic prisoners. (HP46)**

**Achieved.** Around 14% of prisoners, similar to 2004, were from black and minority ethnic backgrounds. The main forum for monitoring and promoting race equality was the quarterly race and diversity meeting. This was attended by managers and prisoner representatives, although attendance by the latter was erratic. Policy statements were displayed around the prison, including on race relations notice boards and in the visitors' centre. Regime and activities were monitored by a system similar to Prison Service ethnic monitoring (see also section on race equality).

- 2.9 **A resettlement strategy should be developed based on a needs assessment and with full account taken of the Prison Service's area strategy. (HP48)**

**Partially achieved.** The resettlement strategy had been re-written in February 2007. It was thorough and logically structured around nine resettlement pathways, all of which had been identified in the regional offender manager's commissioning plan. These included prolific and priority offenders and the contribution of the voluntary and community sector. The strategy clearly linked regional and local objectives and identified leaders for each pathway, but had not been informed by a local risk or needs analysis.

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**Further recommendation**

- 2.10 A local risk and needs analysis should inform a future review of the resettlement strategy.

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## Recommendations

To the Director

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### First days in custody

- 2.11 **The environment and comfort of the second admissions holding room should be improved and the room should be easily observed by staff. (1.27)**

**Achieved.** The second holding room had been redecorated, comfortable seating provided and reading material made freely available. Its location made direct supervision difficult, but an emergency bell had been fitted and the observation port in the door enlarged. Prisoners did not wait long in the room before moving to the induction unit.



- 2.12 **Prisoners should be allowed a free telephone call on arrival on the induction unit. (1.28)**  
**Achieved.** All new arrivals received a free three-minute telephone call and this was recorded on a locally-devised checklist.
- 2.13 **Information in the induction unit booklet should be updated and all prisoners should be given a copy on arrival. (1.29)**  
**Achieved.** The induction booklet had been revised in June 2006 and was up to date. A copy was provided in each of the cells on the induction unit. Prisoners were advised to read it and ask questions if necessary. The booklet was available in 12 languages other than English. Relevant information was also reinforced on wing notice boards.
- 2.14 **A comprehensive, structured and multidisciplinary induction programme that fully occupies prisoners and is delivered by trained staff should be introduced. (1.30)**  
**Achieved.** All members of staff who worked on the induction unit and presented the main part of the induction programme had been carefully selected and received 'shadowing' training from an experienced colleague. The programme included input from, among others, education, physical education, the counselling, assessment, referral, advice and throughcare service, health services and the chaplaincy. It was normally delivered over three days on a rolling basis and the content met prisoners' needs. There were periods when prisoners were not fully occupied, but they were able to remain unlocked, which helped them to settle in.

#### **Additional information**

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- 2.15 Delays in admissions were minimal as much of the process, including healthcare interviews, took place once the prisoner had moved to the induction unit, where new arrivals were allocated one of seven double cells. An eighth cell had been converted to accommodate a prisoner with disabilities. High-risk prisoners, identified through the cell-sharing risk assessment, were given a cell to themselves. Staff in the induction unit had devised a local checklist to ensure that each new arrival received all his entitlements, including a shower. The duty Listener saw all new arrivals and this was listed as a 'must happen' on the checklist. Prisoners who arrived during the inspection confirmed that they had received all of their entitlements and been treated well.

#### **Residential units**

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- 2.16 **Mattresses should be replaced once they have become compacted. (2.18)**  
**Achieved.** Prisoners could apply to have a soiled or compacted mattress replaced. If approved after inspection, an order was submitted and the details recorded in a work order book held on each unit. These books showed that replacement mattresses had been provided where appropriate.
- 2.17 **The furniture provided in each cell should be adequate for the number of occupants. (2.19)**  
**Not achieved.** See paragraph 2.3.  
**We repeat the recommendation.**
- 2.18 **Deodorant and shampoo should be supplied free on request. (2.20)**  
**Achieved.** New arrivals were issued with hygiene requisites, including deodorant and shampoo as necessary. The vast majority of prisoners bought their own toiletries from the prison shop, but each wing held a small stock for issue if requested.

## Additional information

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- 2.19 Privacy screening in shared single cells was inadequate and several cells had no screening at all. The work order book on A wing included a request dated 14 July 2007 for a privacy curtain and rail to be fitted, but this had not been done 11 weeks later. No lockable lockers had been provided where prisoners could secure their personal possessions and any in possession medication. Prisoners had courtesy keys to their cells, but those in some small doubles, particularly on B wing, had only one key between them.
- 2.20 Unless a prisoner was required to have a single cell because of his cell-sharing risk assessment, he was initially allocated to one of the small doubles. He would then probably progress to a large double before eventually qualifying for a single cell. However, he was then expected to start again in a small double if he moved wings, which was a disincentive to prisoners who wanted to move to one of the voluntary drug testing (VDT) units (A, B and C wings) or the education wing. Prisoners on other wings could sign up to a VDT compact, but would not have the support of other prisoners committed to the programme. (See also paragraph 2.145.)
- 2.21 The wings were calm and well ordered and prisoners reported feeling safe. Staff wore name badges and staff and prisoners used first names. Positive relationships and respectful communication between staff and prisoners underpinned good dynamic security.

### Further recommendations

- 2.22 All cells should be fitted with appropriate privacy screening as a priority.
- 2.23 Lockable lockers should be fitted in double cells so that prisoners can secure their personal possessions.
- 2.24 Prisoners in double occupancy cells should be issued with their own courtesy key.

## Duty of care

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### Bullying

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- 2.25 **Staff should be trained in responding to bullying behaviour as part of the violence reduction strategy. (3.7)**  
**Not achieved.** Staff said they followed a zero-tolerance approach to bullying, but most had not had anti-bullying training and none of those who had had received refresher training. Some unit staff were knowledgeable about the anti-bullying strategy, but most of those we spoke to were unaware of anti-bullying procedures or where to find relevant documentation.  
**We repeat the recommendation.**
- 2.26 **All suspected incidents of bullying should be investigated and the outcomes recorded. (3.8)**  
**Achieved.** The head of custody kept a register of bullying behaviour where all incidents and outcomes were recorded. There had been only three recorded incidents in 2006 and none to date in 2007. Written investigations were thorough and there was good cross-referencing of intelligence information indicating potential bullying.

## **Additional information**

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- 2.27 The anti-bullying strategy was thorough and prisoners believed there was little bullying. The low level of drug use (see section on substance misuse), and therefore minimal drug-related bullying, was considered one of the main reasons for this. Violence reduction meetings examined a wide range of relevant information, including injury and security information reports.

## **Self-harm and suicide**

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- 2.28 **The need for first night watches should be based on individual assessments. (3.24)**  
**Achieved.** All new arrivals spent their first night on the induction unit, where they were routinely checked about every hour through the night, which was proportionate, rather than six times an hour as in 2004. Their names and cell location were highlighted to night staff on a laminated roll board and in the wing handover book. Individual assessments had not been introduced, but we were satisfied that monitoring would be increased accordingly if a new arrival was identified as presenting a particular risk.
- 2.29 **Prisoners should be invited and encouraged to attend their F2052SH (self-harm monitoring) reviews. (3.25)**  
**Achieved.** Recently closed assessment, care in custody and teamwork (ACCT) documents showed that prisoners routinely attended their case reviews.
- 2.30 **Prisoners at risk of self-harm should not be held in bare cells or strip conditions except in exceptional circumstances. (3.26)**  
**Achieved.** Only 20 ACCT documents had been opened to date in 2007 and there had been nine incidents of self-harm. Prisoners considered at risk of self-harm were moved to the induction unit where they could be supported by Listeners and observed by staff (see paragraph 2.34). None of the closed ACCT documents we looked at indicated that the prisoner had been placed in strip conditions solely to prevent self-harm and none of the regular induction staff could recall this happening.
- 2.31 **A programme of self-harm and suicide refresher training should be developed. This should emphasise the need to verify prisoners' accounts of their problems and to understand that behaviour may be a rational response to distress. (3.27)**  
**Achieved.** A programme of refresher training had started following the implementation of ACCT procedures. Since the start of 2006, 125 staff had received this training, which was based on the foundation training module. The training covered all aspects of the module, including highlighting the signals that a prisoner may not be coping.
- 2.32 **The level of staffing at night should be reviewed to ensure that the prison can adequately respond to emergencies. (3.28)**  
**Achieved.** G wing had opened since the last inspection and the number of night staff had increased by one. This allowed much more flexibility to respond to incidents at night. The prison also had a list of staff prepared to attend at short notice. There had been several occasions when a prisoner had needed to go to hospital at night and the prison had been able to staff the escorts appropriately.

## **Additional information**

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- 2.33 There continued to be low levels of self-harm and there had been no deaths in custody since the last inspection. The safer custody committee met quarterly and was chaired by the head of custody. Meetings were well attended, including a representative from the Listeners and the local branch of Samaritans. ACCT documents were generally well completed and demonstrated multidisciplinary care of prisoners at risk. Initial assessor reports, case reviews and monitoring entries were all well completed and post-closure reports were routine. The head of custody monitored completed ACCT documents and provided meaningful feedback to unit and night managers.
- 2.34 There were 12 Listeners and prisoners had good access to them, but there was no care suite. Prisoners requiring the support of Listeners were temporarily moved to the induction unit, which was not ideal.

### **Further recommendation**

- 2.35 A care suite should be provided to support the work of Listeners.

## **Diversity**

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### **Additional information**

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- 2.36 The wider issues of diversity had been subsumed into the diversity and race equality meetings. The diversity policy was fairly skeletal, underlining commitment rather than detailing how the needs of minority groups would be met. Responsibility was shared among managers and unit staff and supported by recent training. The prison aimed to supplement and refresh training annually. The manager responsible for training, diversity and safer custody had attended external training and was due to receive further training on disability. Impact assessments were at an early stage.
- 2.37 There was a brief disability policy. Health services took the lead in looking after people with disabilities, which meant that the care plan was based on the healthcare remit rather than the prisoner's day-to-day life. A double amputee was located in a cell on the second floor of the block that housed healthcare. The block had a lift, his cell door had been widened for his wheelchair, new sanitary-ware had been bought, but was not yet installed and he had an adjustable bed. Some of his needs were addressed as they became apparent, but no care plan had been drawn up in consultation with him to anticipate and address all his needs. Unable to work, he was studying in his cell. He found it difficult to write and relied on another prisoner taking dictation and typing up his coursework on a computer in the education department, as he had no computer in his cell. He had no access to a shower or bath and staff were unsure how to evacuate him in the event of a fire. He did not fit the evacuation chair.

### **Further recommendations**

- 2.38 The prison's diversity policy should be informed by impact assessments and outline how the needs of minority groups will be met.

- 2.39 Prisoners with disabilities should have a comprehensive care plan, dealing with treatment and wider needs within the prison regime and drawn up in consultation with the prisoner.

## Race equality

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- 2.40 **The director or deputy director should chair the race relations management team (RRMT). The race relations liaison officers (RRLs) should have at least eight hours between them each week dedicated to their work. (3.39)**  
**Achieved.** Diversity and race equality meetings were held quarterly, chaired by the director or deputy director (sometimes both attended), and were well attended by functional heads. Responsibility for race relations was shared. The deputy director retained oversight, particularly for investigating racist incident reports. Reporting to him was an operational manager responsible for training, diversity and safer custody. Unit managers, each supervising two units, included managing diversity with all their other duties. Prisoners expressed few concerns about racism and managers set a tone of intolerance towards racist behaviour. However, the GSL contract did not provide for a full-time race equality officer and the thin spread of responsibility for this key area risked dispersing that focus, although managers tried to allay this with training and monitoring. After a period when it had been difficult for Wolds, as a private prison, to secure training to match the 2006 Prison Service Order on race equality, a two-day training had been delivered to nine managers, including unit managers. All staff received annual refresher training.
- 2.41 **The race relations management team (RRMT) should have at least one black and minority ethnic member from outside the prison and a prisoner representative from each residential unit. (3.40)**  
**Partially achieved.** Approaches to external bodies had failed to elicit sustained interest. A community representative from Hull had attended some diversity and race equality meetings, but had not appeared recently. The prison had invited another organisation to attend. Managers had also issued open invitations to black and minority ethnic prisoners to attend meetings. The aim was to have six prisoner representatives, but their attendance was erratic and none had come to the last meeting. Prisoners said it was not a popular task because anyone who did it had to put up with complaints from others if they did not achieve everything requested. Minutes of the meetings were posted on the wings.  
**We repeat the recommendation.**
- 2.42 **A black and minority ethnic prisoners' support group should be established to allow these prisoners to raise their concerns, to help effective consultation on matters relevant to race equality and to help promote good race relations in the prison. (3.41)**  
**Not achieved.** No prisoner support group had been organised.  
**We repeat the recommendation.**
- 2.43 **The race relations management team (RRMT) should actively promote positive race relations throughout the prison. (3.42)**  
**Achieved.** Positive race relations were promoted through staff training, the induction programme, race relations notice boards, diversity and race equality meetings, monitoring of activities, competent investigation of racist incidents and occasional planned events celebrating the history and culture of minority groups.
- 2.44 **Complaints that include racial issues passed on from the complaints clerk should be investigated as racist incidents and monitored as such. (3.43)**  
**Achieved.** The racist incident report form (RIRF) file included a number of standard complaints

that had been attached to an RIRF to be investigated as such because of a possible racist element.

- 2.45 All investigations should include an interview with the complainant and a written reply, and the complainant's satisfaction with the process should be monitored. (3.44)**  
**Partially achieved.** Investigations were prompt, thorough and usually completed within a couple of weeks. The complainant and other relevant parties were interviewed and detailed interview notes, usually typed, were filed. The outcome was explained to the complainant. Staff complainants saw the written report, but the response to prisoners was not always in writing. Several forms included a report on how the complainant reacted. Where any admonition or reiteration of policy was issued, a copy was kept with the report. All complaints were signed off by the director and reported to the quarterly diversity and race equality meetings. The deputy director kept a separate log of names that came up in reports to ensure that any further reports were collated. To date in 2007, 26 RIRFs had been logged. RIRFs were submitted by staff and prisoners, with some instigated on the advice of staff or by staff on behalf of prisoners. In the previous year, one prisoner had been responsible for a batch of complaints, all of which were referred to the Home Office controller for independent investigation.

#### Further recommendation

- 2.46** Complainants who instigate a racist incident report form should receive a written reply and their satisfaction with the process should be monitored.
- 2.47 Comprehensive racial monitoring should be conducted in accordance with Prison Service guidelines. This monitoring should be acted on by the race relations management team (RRMT) and made freely available to prisoners and staff. (3.45)**  
**Achieved.** The prison had developed an ethnic monitoring system similar to that used by the Prison Service. This incorporated range-setting for white and non-white prisoners, a breakdown using standard ethnic codes and traffic light warning or action signals. Monthly reports were produced and checked by the deputy director. Any divergence from the range was investigated and a comment attached to the monitoring sheets. These were presented and discussed at quarterly diversity and race equality meetings. The monitoring information was available to staff and prisoners through these meetings. Minutes were sent to attendees and the library, although when we asked in the library they could not be found. The information was also on the intranet. A high proportion of black and minority ethnic prisoners were in education and on enhanced status. The deputy director undertook monthly spot checks of movements between the incentives and earned privileges bands to ensure that these were appropriate.
- 2.48 Appropriate efforts should be made to recruit black and minority ethnic staff. (3.46)**  
**Partially achieved.** Only two operational staff were of a different nationality or from a minority ethnic background, but the minority ethnic population in the local area was also small. Recruitment advertisements had targeted minority ethnic groups, but staff turnover was relatively low.  
**We repeat the recommendation.**

## Foreign nationals

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- 2.49 There should be a written foreign nationals policy provided to all foreign national prisoners during induction. (3.51)**  
**Partially achieved.** There was a written foreign nationals strategy, but it was undated and in

need of updating and clarification in some areas, partly to reflect the frequent changes in immigration law and procedure. The policy was not widely known by staff or prisoners. The induction programme provided for extended briefing of foreign national prisoners or those with language difficulties.

#### Further recommendation

2.50 The foreign nationals policy should be updated.

2.51 **There should be a foreign nationals coordinator who is known to prisoners and who provides practical information and support to them individually and as a group, including advice about sources of help on immigration matters. (3.52)**

**Partially achieved.** A foreign nationals coordinator had been appointed and was known to some prisoners, but also had a number of other tasks. No foreign nationals group meetings were held to share information, air problems and offer peer support. Relevant issues were discussed at the diversity and race equality meetings. It was intended that three foreign nationals should come to these meetings, but attendance at the last meeting had been poor. The foreign nationals coordinator had written to all 23 foreign national prisoners asking if they would be interested in attending and three had agreed to do so. Some issues had been raised effectively in the previous year, including increasing the standard five-minute telephone call for foreign nationals without visits to 10 minutes.

2.52 There was a lot of confusion about status and some foreign national prisoners said it was difficult to get information and advice, but an officer from the Border and Immigration Agency had visited only once in recent months and there was no planned programme of visits. Immigration officers did not attend the prison. Foreign national prisoners said they relied instead on contacts outside to search for immigration advisers, who were in short supply and usually unwilling to take on cases unless detainees could pay privately.  
**We repeat the recommendation.**

#### Additional information

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2.53 There were several language identification charts and some translated material was available around the prison. Managers had also invested in translation software, but the results were sometimes erratic. Professional telephone interpreting services were used occasionally, including recently to explain Court of Appeal papers to a prisoner. The foreign national strategy included a list of people in the prison who spoke languages other than English, most of whom spoke other European languages.

#### Contact with the outside world

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2.54 **Visitors should be identified either by a wristband or ultra-violet stamp but not both. (3.68)**

**Achieved.** Visitors were issued with a wristband only.

2.55 **A closed visit should not be given on a single indication by a drug dog without any other intelligence. (3.69)**

**Achieved.** Index cards on all prisoners were kept in a locked cabinet and visits staff used these when the passive drug dog indicated a visitor to check whether there was any corroborative intelligence. If there was, a closed visit was offered; if there was not, the visitor was asked to join a second line to see if the dog indicated again, in which case a closed visit

was offered. Since April 2007, an average of 23 a month were on closed visits, with the number rising in recent months. While this appeared high, security staff were able to describe more than one strand of intelligence relating to prohibited items or substances, the sanction was subject to review at least monthly and managers were willing to use discretion, highlighting a number of instances when the decision had been revised to allow open visits for the benefit of families.

**2.56 The play area should be supervised at all times. (3.70)**

**Not achieved.** The play area was supervised by qualified child care workers on four afternoons. There was no supervision on the fifth afternoon or in the evenings. Finite funding was provided by the National Lottery in partnership with the Pre-School Learning Alliance. **We repeat the recommendation.**

**2.57 Alternative, more comfortable seating should be provided in the visits hall to allow better contact between prisoners and their visitors. (3.71)**

**Partially achieved.** Most of the furniture continued to be fixed plastic seating, but the prison was progressively increasing the amount of soft seating, currently still used only by enhanced level prisoners and their visitors. To replace all the seating required a slightly larger seating area and plans included altering a corner of the play area.

### **Additional information**

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2.58 The overall visits environment was welcoming and family-oriented, including an effort to transform the barred window in the visitors' centre by displaying toy animals climbing up and down the bars. The family learning coordinator, a qualified teacher, was taking forward some creative projects in collaboration with other staff and external partner organisations. Family learning courses, accredited by the national open college network (OCN), were linked with family days and attended by parents and children under five. Older children could occasionally attend following consultation with their schools. The course content included relationships, communication, money, parenting and preparing for release.

2.59 Prisoners who benefited from the accredited courses then explained the information to others and helped with the Storybook Dads scheme, recording DVDs to be sent home. This scheme included prisoners whose families could not visit and foreign national prisoners with families abroad. Not all foreign national prisoners' families had DVD players, in which case photographs were taken to be sent home with letters. Muslim prisoners were also specifically involved, with different texts and music being researched for inclusion on the recordings.

2.60 A 'kids visiting' group had been established involving prisoners, the visits manager and the family learning coordinator. This discussed problems, projects and fundraising plans. The team was bidding for additional funding to maintain the present work and progress further plans, such as family gym, cooking and eating together. When we met with prisoners in groups, the opportunity for creative family contact was cited as one of the most positive aspects of Wolds.

### **Good practice**

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2.61 *Staff and prisoners collaborated in creative family-oriented projects, including accredited courses for couples and parents and family days, as well as fundraising to maintain and develop this work.*



## Applications and complaints

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- 2.62 **Managers should find out why prisoners have a poor view of how applications are handled. (3.84)**  
**Not achieved.** Prisoners remained very negative about the application system and had little confidence in it. Prisoners submitted applications on standard forms and the details were recorded in application books held on each residential wing. The application was forwarded to the relevant department, answered, returned to the unit and the prisoner was informed of the reply. The application form, including the written response, was inserted in a prisoner's individual file and the date of response was recorded in the wing book. However, replies were often not received for several weeks, which was consistent with prisoner complaints.

### Further recommendation

- 2.63 All applications should be dealt with and responded to within three days or, in exceptional circumstances, 10 days.

### Additional information

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- 2.64 About 24 formal complaints were made each week. Complaint forms were freely available on the residential units and the secure boxes were emptied by the night manager. Most responses were helpful and courteous, but some were superficial, not fully investigated and lacked detail.

### Further recommendation

- 2.65 All formal complaints should be fully investigated and appropriately responded to.

## Legal rights

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- 2.66 **The legal services officer (LSO) should keep a record of each prisoner seen and any action taken. (3.92)**  
**Achieved.** The legal services officer recorded the applications she dealt with. There were only three entries for the year to date and seven for 2006, which might have been indicative of unmet need. The legal service was not widely advertised and some prisoners with legal queries did not know there was a legal services officer.

### Further recommendation

- 2.67 Legal services should be better advertised to prisoners.

## Substance use

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- 2.68 **The drug strategy group should meet more regularly to monitor the strategy more effectively. (8.80)**  
**Achieved.** The drug strategy group met bi-monthly. Attendance included representatives from

probation, programmes, the counselling, assessment, referral, advice and throughcare (CARAT) service, health services, security, the residential manager and the Independent Monitoring Board. A prisoner representative attended part of the meeting.

- 2.69 **The drug strategy group should develop an alcohol policy. (8.81)**  
**Achieved.** An alcohol policy had been developed and was available in hard copy and on the prison's intranet.
- 2.70 **The drug strategy group should formulate a plan for staff training and development. (8.82)**  
**Partially achieved.** A significant amount of substance use-related training had taken place, including input on the staff induction course and training related to the integrated drug treatment system (IDTS). All CARATs staff, two nurses and one of the GPs had completed the Royal College of General Practitioners RGP1 course. However, there was no plan for staff training and development in this area.  
**We repeat the recommendation.**
- 2.71 **The area drug coordinator should review the yearly key performance target (KPT) of 200 initial care assessments for the counselling, assessment, referral, advice and throughcare (CARAT) team. (8.83)**  
**Achieved.** The KPT of 200 initial care assessments for the CARAT team had been reviewed and amended. The KPT that 95% of prisoners requiring initial care assessments would be seen within 15 working days was being met.

### **Additional information**

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- 2.72 There was little evidence of significant substance use and positive mandatory drug tests were below target. The prison was preparing for the introduction of the IDTS, but pharmacy systems did not appear to be appropriate to support IDTS prescribing. There was no medicine and therapeutics committee and no named pharmacist regularly visited the prison. (See also section on health services.)

### **Further recommendation**

- 2.73 An appropriate pharmacy structure, including regular visits by a pharmacist, should be put in place before the introduction of the IDTS.

### **Health services**

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- 2.74 **The skill mix of nurses should be reviewed to ensure that the department is able to provide a comprehensive healthcare service to meet the needs of the population, rather than merely meeting minimum staffing requirements. (4.36)**  
**Not achieved.** No evidence of a skill mix review was available and healthcare staff were not aware that one had taken place. The staff skill mix was unchanged, with a head of healthcare, two registered mental health nurses (RMNs) and two registered general nurse (RGN) posts. One registered general nurse was in post and the second post had been offered, but the nurse was awaiting security clearance. The head of healthcare post was vacant and another member of the team was acting up on a temporary basis.  
**We repeat the recommendation.**

2.75 The prison should develop and implement a policy for sharing healthcare information. (4.37)

**Partially achieved.** There was an information-sharing protocol between healthcare, CARATs and the mental health in-reach team, but no formal information-sharing policy between health services and the wider prison.

**We repeat the recommendation.**

2.76 Triage algorithms should be developed to ensure consistency of advice and treatment. (4.38)

**Not achieved.** Triage algorithms were not used. Current staff shortages meant there was often only one trained member of staff on duty each day, and special sick clinics were often undertaken by a mental health-trained nurse or healthcare assistants.

**We repeat the recommendation.**

#### Further recommendation

2.77 Clinical work undertaken by healthcare assistants should be directly supervised and counter-signed by a qualified member of staff.

2.78 A formal, comprehensive chronic disease register should be established. (4.39)

**Achieved.** The primary care RGN maintained registers of all prisoners with life-long conditions. These were well maintained and up to date. Current staff shortages meant that routine clinics for these prisoners were not run and anyone wanting to discuss their condition had to make a request to see a doctor or nurse.

#### Further recommendation

2.79 Prisoners with life-long conditions should be able to attend appropriate clinics with appropriate staffing. Staff should have protected time to organise and run these clinics.

2.80 The medicine and therapeutics committee should undertake the following:

- The revision of stock lists and stock levels of medication held in the healthcare centre.
- The development of patient group directions for prescription-only medications to be administered by nurses without an individual patient prescription.
- The implementation of an audit procedure to reconcile usage of stock items against medication prescribed.
- The development of initiatives to allow prisoners a direct interface with a pharmacist or pharmacy technician. (4.40)

**Not achieved.** There was no medicine and therapeutics committee. Pharmacy services were provided from Bromborough (near Liverpool), which meant that patient-named medication prescribed, for example, at a Monday afternoon GP clinic was not available for collection before Wednesday teatime. The named pharmacist had recently left and staff did not know who had taken on responsibility for the prison. Monitoring of stock, ordering and date checking of medication were all undertaken by nursing staff. Prisoners did not have direct contact with a

pharmacist. (See also section on substance use.)  
**We repeat the recommendation.**

- 2.81 **All not in-possession medication should be dispensed on a named-patient basis. Stock items should only be used as a temporary measure until named-patient dispensed medication can be obtained. (4.41)**  
**Achieved.** Non-in possession medication was dispensed on a named-patient basis. If items were used from the limited stock, the patient was allocated his own box of medication and all such medication was dual-labelled.
- 2.82 **An audit of the dental sessions provided should be carried out to confirm value for money. (4.42)**  
**Not achieved.** No audit appeared to have taken place.  
**We repeat the recommendation.**
- 2.83 **A dental hygienist should be appointed to meet the dental needs of longer-term prisoners.**  
**Achieved.** A dental hygienist attended with a dental nurse once a month.
- 2.84 **The refurbishment of the dental surgery should not be delayed and should include the re-siting of the emergency alarm. (4.44)**  
**Achieved.** The dental surgery had been refurbished to a good standard and the emergency alarm had been removed rather than re-sited. The surgery was untidy and a number of boxes were stored on the floor.

#### Further recommendation

- 2.85 An emergency alarm should be fitted in the dental surgery.

#### Housekeeping point

- 2.86 Boxes should not be stored on the floor in clinical areas.

#### Additional information

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- 2.87 No senior member of staff was available during the inspection. The previous head of healthcare had recently taken up permanent employment at another establishment, the senior nurse who was acting head of healthcare was on leave and one staff nurse post was vacant. This meant that the service was dependent on only two staff nurses (one RGN and one RMN). Although the core work was delivered, the service was at full stretch. Should either staff nurse be unavailable for duty, it would impact on the care delivered to prisoners and compromise patient safety.
- 2.88 The mental health in-reach team welcomed open referral and did not restrict its service to those with severe and enduring mental illness. Resettlement links with the community appeared good, with care plan approach (CPA) reviews taking place before a prisoner's release. An information sheet outlining risk indicators for relapse was completed for prisoners on the in-reach caseload and shared with wing staff with the prisoner's consent.
- 2.89 Under a new arrangement for the provision of GP services, two GPs from a local practice attended the prison. GP clinics were available for one session each weekday with an

emergency/reception clinic on Saturdays. Outside these times, one of the doctors was on call to provide telephone advice and visit the prison if required. Prisoners, healthcare staff and the GPs were all positive about these new arrangements.

#### Further recommendation

- 2.90 The clinical staffing levels of the department should be addressed urgently.

## Learning and skills and work activities

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- 2.91 **The time and resources available to managers and staff to develop and quality assure the education provision should be increased. (5.12)**

**Partially achieved.** The education contract had been re-allocated to Global Solutions Ltd (GSL) in April 2006. An education manager and assistant manager now had enough time to manage the programmes. The establishment of a quality improvement framework had been slow. A new framework had recently been developed, but was not yet embedded. Staff had continued to review the quality of teaching and learning in the education department and had used questionnaires to evaluate prisoners' views. However, this information had not been formally evaluated or used to set improvement targets or to inform the self-assessment process. The framework did not extend to vocational training accredited courses.

#### Further recommendation

- 2.92 Quality assurance should be embedded in the education provision and extended to include all accredited vocational training.

- 2.93 **Courses beyond level two should be developed. (5.13)**

**Achieved.** Courses had been significantly expanded to offer prisoners the opportunity to gain higher-level university-recognised credit accumulation points from Open University and distance learning courses. Foundation degree courses in sociology and psychology were run in conjunction with Hull University. Most national vocational qualification (NVQ) courses were at level 2.

- 2.94 **Sufficient work opportunities, offering accredited qualifications, should be provided to meet the needs of the population. (5.25)**

**Partially achieved.** Work opportunities had been further developed and were now well linked to accredited training. Accredited qualifications were offered in almost all work areas, including the Braille workshop, production of glass fabrications, horticulture, cleaning, railway track work and safety, electrical engineering and information, advice and guidance (IAG). Many of these qualifications were delivered through effective partnerships with a number of colleges. NVQ training was also offered in the kitchens, but take-up was limited. An external contractor ran the kitchens and no annual targets for NVQ achievement had been negotiated with them.

#### Further recommendation

- 2.95 Accredited training opportunities in the kitchen should be further developed.

- 2.96 **Allocation to work and training should be linked to sentence plans and reintegration need. (5.26)**

**Partially achieved.** There was no system to review sentence planning and analyse the training and education needs of prisoners. The prison was aware that current processes were disparate and did not give a collective picture of overall need. However, sentence plans were reviewed and education and work were linked to reintegration need.

#### Further recommendation

2.97 Sentence planning and activities and work should be effectively linked and integrated.

2.98 **The prison should provide a quiet area for prisoners to undertake independent study. (5.14)**

**Partially achieved.** The library had a designated quiet area, but this was also the computer area and the space was too small for both. Plans to extend the library accommodation had not materialised.

**We repeat the recommendation.**

2.99 **The information technology provision in the library should be improved. (5.15)**

**Achieved.** The library had two computers without internet access.

2.100 **The range of non-fiction resources in the library should be developed and linked to vocational learning programmes and work. (5.16)**

**Achieved.** The non-fiction book stock had improved and was set to improve further with charity funding of £5,000. Textbooks that supported some vocational training were available.

### Physical education and health promotion

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2.101 **The equipment in the weight training room should be renewed. An outdoor sports activity area should be provided. (5.32)**

**Partially achieved.** The weight training equipment had been renewed, but there were no plans for an outdoor activity area due to limited space and health and safety factors.

2.102 **An appropriate vocational sports programme to give prisoners the skills and qualifications to work in the sports industry after release should be planned and implemented. (5.33)**

**Not achieved.** The range of qualifications offered by the physical education department was sufficient, but take-up was limited. No prisoners were undertaking accredited training, although 10 were due to start a boxercise course. In the previous 12 months, only 20 prisoners had started accredited programmes. The prison was establishing a partnership with an external education provider to extend the range and frequency of programmes.

**We repeat the recommendation.**

### Faith and religious activity

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2.103 **Food prepared for Muslim prisoners during Ramadan must be of adequate quality, quantity and variety. (5.42)**

**Achieved.** During the recent Ramadan, fasting Muslims had been given extra food to eat early and late, including two flasks of warm food for their evening meal when they broke the fast. A special menu had been drafted a few weeks in advance in consultation with the Muslim chaplain and, in turn, Muslim prisoners. The final menu reflected a compromise between what the catering manager believed was possible and what Muslim prisoners requested. Prisoners

said the provision was adequate, although they felt Muslim prisoners working in the kitchen should have had more say.

### **Additional information**

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- 2.104 There were 22 declared Muslim prisoners, the largest non-Christian group. The world faith room was too small to accommodate all of them, particularly during Ramadan when attendance at services increased. Plans to reorganise the main chapel to permit its use for a range of services had not yet been implemented.

#### **Further recommendation**

- 2.105 Plans for diverse services in the chapel should be implemented.

### **Discipline**

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- 2.106 **Trends in the use of force, not just control and restraint (C&R), should be monitored. (6.27)**  
**Achieved.** Trends in control and restraint incidents continued to be monitored and relevant data submitted to the security department for analysis. Violent acts such as fights and assaults and other indicators of violence were monitored and analysed by the violence reduction committee.

### **Additional information**

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- 2.107 Force had been used only 22 times to date in 2007. Use of force documentation was mostly well completed. Injury forms (F213s) were routinely completed and staff statements provided a good account of events leading up to the incident and their involvement in it. Unfurnished accommodation had been used 18 times over the same period. Prisoners held in unfurnished conditions were routinely held in strip clothing, which was unnecessary and inappropriate. In 13 cases, the prisoner had been held overnight. The average stay was over 14 hours, which was excessive and indicated that prisoners were not returned to normal location at the earliest opportunity. Monitoring entries in many cases showed that the prisoner had been compliant some hours before being relocated. The timing of many monitoring entries was predictable, which called into question their validity.

#### **Further recommendations**

- 2.108 Prisoners held in unfurnished or special accommodation should not routinely be issued with strip clothing.
- 2.109 Prisoners should be removed from unfurnished or special accommodation at the earliest opportunity.
- 2.110 Monitoring entries should reflect the exact time the check was carried out.

- 2.111 **The length of stay of prisoners in the segregation unit should be monitored and reduced, and prisoners in the unit for over a week should be encouraged to undertake cell work, cleaning or education. (6.28)**

**Not achieved.** Long stay in the segregation unit remained an issue. The unit was full, with six prisoners segregated in their own interest, eight under good order or discipline (GOOD) and one serving cellular confinement. One of those held under GOOD had been in the unit nearly seven weeks and one held in his own interest nearly three weeks. Managers tried to move prisoners out as quickly as they could, but monthly monitoring statistics clearly highlighted that this was an ongoing issue. Prisoners in the segregation unit could clean their cells daily, but no other work was available. In-cell education was possible, but this was not well promoted and take-up was low.

**We repeat the recommendation.**

**2.112 The excellent monitoring of the segregation unit should be used to inform prisoners' care. (6.29)**

**Achieved.** Monitoring of the segregation unit was still of a high standard. Findings were presented in a comprehensive quarterly report distributed to key personnel. The level of monitoring included measuring performance against related baselines and any non-compliance resulted in action points being identified. While the non-compliances identified were relatively minor, some of the resulting action points impacted directly on prisoner care.

**Additional information**

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**2.113** The segregation unit was impressively clean and presentable. Occupancy levels were high, mainly due to the problems moving prisoners on. The average occupancy since the start of 2007 was 11. Prisoners received on the unit were routinely strip-searched despite written instructions to the contrary. The regime was fairly basic, but was consistently provided, with prisoners having daily access to exercise, showers, cell cleaning and the telephone. Prisoners we spoke to had no complaints about their treatment. All requisite visitors attended each day. Staff made regular entries in wing history files, but the quality varied and few demonstrated positive engagement with prisoners.

**Further recommendations**

**2.114** Prisoners located on the segregation unit should be strip-searched only where the need has been identified through risk assessment.

**2.115** Entries in wing history files of segregated prisoners should demonstrate positive engagement by staff.

**Incentives and earned privileges**

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**2.116 Prisoners should receive written notification of warnings issued to them. (6.44)**

**Achieved.** Prisoners were advised of any formal warnings both verbally and in writing. A copy of the written warning was inserted in the prisoner's file.

**2.117 Officers should complete bi-monthly behaviour updates consistently and managers should monitor these. (6.45)**

**Achieved.** Bi-monthly behaviour updates were routinely completed by personal officers and submitted to the unit manager along with any recommendation for promotion or demotion within the incentives and earned privileges (IEP) scheme. Personal officers had to check whether the prisoner met the published criteria for movement within the scheme before



completing the reports. Completed reports were kept in the IEP section of each prisoner's personal file.

**2.118 Prisoners appealing against their conviction should not be prejudiced from applying for enhanced levels A and B of the incentives and earned privileges (IEP) scheme. (6.46)**  
**Achieved.** Prisoners appealing against conviction were eligible for advancement to enhanced levels A and B as long as they were addressing their offending behaviour and complying with sentence plan targets. Prisoners wanting to be considered for enhanced level A also had to attain level 1 in literacy and numeracy, while level B required them to reach level 2. The application form for these levels was sent to the education coordinator to check individual learning plans and report back. The form clearly stated, however, that any prisoner deemed to have tried his best but who was unlikely to achieve these levels could still qualify for advancement. One prisoner had been allowed to progress under these arrangements.

**2.119 Specific short-term interventions should be developed to help those on basic level to change their behaviour. (6.47)**  
**Not achieved.** There were no specific short-term interventions to help basic level prisoners modify their behaviour. Individual improvement targets were set, but many were meaningless and impersonal, such as 'be compliant with all unit rules and regimes' and 'remain warning and adjudication-free'. The wing files of the one current and previous basic level prisoners did not indicate that they had been offered any help to modify their behaviour.

#### Further recommendations

**2.120** Improvement targets should be specific to the individual, and objectives should be measurable and achievable.

**2.121** Staff should work with basic level prisoners to help them modify their behaviour and meet their targets. This should be evidenced in wing history files.

**2.122 Prisoners on basic level should be reviewed weekly. (6.48)**  
**Achieved.** Basic level prisoners were reviewed weekly by a board consisting of the unit manager and at least one other member of staff. The policy document had been amended to reflect this requirement.

**2.123 Prisoners should not be paid different wages for the same work. (6.49)**  
**Achieved.** Prisoners on the higher incentive levels no longer received higher rates of pay. Instead, enhanced level prisoners were given a 50 pence subsidy off the cost of their in-cell television. This was one of a range of innovative measures designed to motivate prisoners to advance within the scheme.

#### Additional information

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**2.124** The IEP scheme was being revised and prisoners had been invited to make suggestions. The scheme was fully explained at induction and in the information booklet. Nearly two-thirds of prisoners were on one of the enhanced levels and a third on standard. Only one was on basic. The incentives available for those on the normal enhanced level were motivational. With effort and good behaviour, prisoners could progress to enhanced A and B, where the range of innovative privileges included family meals, family photographs and better seating in visits.

#### Good practice

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- 2.125 *The incentives and earned privileges scheme was genuinely motivational and offered innovative privileges, including family meals and family photographs.*

## Catering

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- 2.126 **Efforts should be made to improve the quality of the food so that prisoners' level of satisfaction increases. (7.7)**  
**Partially achieved.** The daily catering allowance was £2.09 per prisoner, which was better than in some prisons. Staff ate the same food as prisoners. The food we saw and sampled was reasonable. Prisoners were routinely consulted (see paragraph 2.127), but opinion of the quality of food was not high.  
**We repeat the recommendation.**
- 2.127 **A food consultative committee involving prisoners from all units and those with specific dietary requirements should be established and food surveys should take place regularly. (7.8)**  
**Achieved.** A catering committee met monthly attended by the catering manager, another manager and prisoner representatives. Prisoners with special dietary requirements could meet the catering manager individually, either following referral by health services or on their own application. Many prisoners were on first name terms with the catering manager. Food comments books on the wings were well used and routinely checked. Entries were both positive and negative and the most recent had been made two weeks previously. The catering manager visited the wings fortnightly, collated comments from the books and entered her own written responses. Food surveys took place twice a year, with the majority opinion that food was fair to poor. Despite regular consultation, and some evidence that changes were made in response, prisoners said the food was often poor or at best variable.
- 2.128 **Prisoners working in the kitchen should have the opportunity to gain qualifications. (7.9)**  
**Achieved.** Some prisoners working in catering were able to gain NVQ levels one and two, and some other basic qualifications. Sixty NVQ units had been delivered in the year to date, exceeding the annual target of 55 units.
- 2.129 **Out of date and obsolete equipment in the kitchen should be replaced. (7.10)**  
**Achieved.** The obsolete equipment had been removed and some suitable new equipment installed, although the freezer was too small to meet the needs of the increased population.

### Further recommendation

- 2.130 The prison should have adequate freezer capacity to cater effectively for the needs of the population.

### Additional information

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- 2.131 Enhanced level prisoners were positive about the family meals. These took place one afternoon a fortnight in the staff canteen and enhanced level prisoners could invite close relatives. The catering manager produced English, Chinese, Asian and Mexican menus, and birthday cakes for children were also provided.

### Good practice

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- 2.132 *Enhanced level prisoners could take occasional meals with close relatives, when the staff canteen was set aside and the catering manager produced special menus.*

## Prison shop

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- 2.133 **Prisoners should be able to buy goods from the shop the day after their arrival. (7.20)**  
**Partially achieved.** The Aramark shop list was issued on Thursdays, collected on Fridays and goods were delivered on Mondays. Prisoners arriving at weekends with enough credit could place an order by Saturday evening and the goods were delivered in the usual way on the Monday. Anyone arriving after that time had to wait until the following Thursday to Monday ordering process. They were offered a smoker's or non-smoker's reception pack valued at £4.95 and repayable when they had money in their accounts.  
**We repeat the recommendation.**
- 2.134 **Managers should consult black and minority ethnic prisoners to identify suitable products for the prison shop. (7.21)**  
**Achieved.** Prisoners were routinely consulted through bi-monthly general consultative meetings, quarterly diversity and race equality meetings and annual surveys. Some changes were made to the shop list as a result, although prisoners still said the list was too short. According to Aramark's April 2007 survey, 67% of 182 respondents thought products suited their cultural needs (good, very good or excellent) and 47% rated the variety of products positively.

## Strategic management of resettlement

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- 2.135 **The resettlement and regimes committee should monitor resettlement activity. (8.7)**  
**Achieved.** The quarterly resettlement policy group meeting had recently been restructured to reflect the resettlement pathways and provided oversight of the major elements of resettlement activity in the prison.
- 2.136 **Outside agencies and the residential function should play a greater part in the development of resettlement policies. (8.8)**  
**Partially achieved.** The resettlement policy group was well attended and included prisoner representatives and staff from Shelter and Humbercare, the latter being the resettlement unit coordinator. A wide range of issues was discussed and progressed, but residential staff did not attend.

### Further recommendation

- 2.137 Residential staff should contribute to the resettlement policy group meetings.

## Offender management and planning

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- 2.138 **Subject to the prisoner's consent, his family should be invited to planning reviews. (8.16)**  
**Achieved.** Family members were routinely invited to programme and sentence planning reviews. Some had recently attended programme reviews, but none had attended sentence planning reviews.

- 2.139 Funding for the Sycamore Tree programme should be provided in such a way that the course is open to all prisoners with an identified need irrespective of faith. (8.27)**  
**Achieved.** The Sycamore Tree programme ran three times a year with 16 prisoners on each course. In 2005, GSL had agreed full funding for an initial period of three years so the chaplaincy coordinator no longer had to find voluntary donations. This funding was due to expire in March 2008, but there were plans to obtain a funding extension. In this more stable environment, there were no restrictions on entry to the course and the last intake had included three Muslim prisoners.

**Further recommendation**

- 2.140** The Sycamore Tree programme should continue to receive full funding.

- 2.141 Courses run by the resettlement team should be considered for accreditation as part of a preparation for work module. (8.41)**

**Achieved.** The resettlement team ran the track work course, which attracted level 2 accreditation, and the two-day Safety Passport course, which was a prerequisite for prisoners working in the building or construction industry. There was a general commitment to run accredited courses (see section on learning and skills and work activities).

- 2.142 A system should be developed to ensure that any resettlement needs identified after induction, either through sentence planning targets or other methods, are referred to the resettlement office for action. (8.42)**

**Achieved.** Communication between the different departments under the general resettlement umbrella was good. Staff from the offender management unit (OMU), probation and programmes, and residential staff, regularly telephoned each other to relay information. The relatively small size of the prison meant they were able to have regular face-to-face contact. The OMU used a formal referral form to send information to other departments and requested information on another form. Feedback from prisoners on communication with and between resettlement, OMU and probation staff was positive. On reception, an 'induction feedback form' was routinely completed and sent to the resettlement coordinator. The form included basic information on 'issues, needs and action' relating to accommodation, employment, training, debt, benefits and family ties.

- 2.143 There should be sufficient offending behaviour programmes and purposeful activity available for lifers. (8.55)**

**Partially achieved.** Two anger management (CALM) courses were running simultaneously and all participants on one and half on the other were lifers. However, some staff and prisoners were concerned that lifers coming up to parole reviews would not have enough time to complete cognitive skills booster (CSB) courses. The 2007-08 timetable included four CSB courses, double the number run during the previous year, but the last one had been in August and the next was not scheduled until January 2008, a considerable gap. In terms of purposeful activity, there were some useful courses, particularly the track work, Summit (computers) and Vulcan (windows) courses, and some lifers attended all of these. They also participated in other constructive activity, notably tending the impressive allotments.

**Further recommendation**

- 2.144** Sufficient cognitive skills booster programmes should be available for the long-term population.

**2.145 Lifers should not have to share a cell. (8.56)**

**Not achieved.** Life-sentenced prisoners routinely shared cells for at least part of the time. C wing was the main lifer unit, with 42 of the 49 prisoners serving life sentences. This wing had 26 single cells, none of which were doubled. Those not in single cells shared double cells, graduating to single cells as they became vacant. There were 18 lifers on other units, where they usually started in a double cell before moving up the waiting list for a single (see paragraph 2.20). Some lifers preferred to stay on these other units because either they had a better chance of getting a single cell on units with shorter-sentenced prisoners or they would end up at the bottom of the waiting list again if they moved to C wing. Staff on C wing were lifer trained and at least one officer on other wings was lifer trained to act as personal officer for any life-sentenced prisoners on that unit.

**We repeat the recommendation.**

**2.146 Lifer groups should be held. (8.57)**

**Achieved.** All lifers could attend meetings held in the chapel every few months and preceding lifer days, which were held twice a year.

**2.147 Lifers should be able to cook their own meals. (8.58)**

**Not achieved.** Meals for all prisoners were cooked in the main kitchen and sent to wing serveries. A feasibility study of access to cooking facilities had not suggested meeting this recommendation, referring to cost, fairness and equality. Part of the problem at the time of the study was that lifers were not all held together in a dedicated unit where facilities exclusive to them could be installed, although the population of C wing was now predominantly lifers (see paragraph 2.145). Lifers on C wing also grew organic vegetables in small allotments for their own use and the purchase of a greenhouse had been authorised.

**We repeat the recommendation.**

**Good practice**

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2.148 *Life-sentenced and some other long-term prisoners could grow their own vegetables on allotments at the back of C wing.*

**2.149 The child protection arrangements for visits should clearly identify children considered to be at risk from an identified prisoner. (8.64)**

**Achieved.** All new inductions were screened for public protection concerns and any issues were discussed at the monthly public protection meetings. Probation staff contacted social services about child visitors for any of these prisoners. Visits staff also attended these meetings and were made aware of any concerns, and minutes were routinely copied to the visits manager. In the visits hall, a daily staff briefing highlighted prisoners who were to be watched for any reason and a visits staff checklist included a requirement to collect information on possible public protection concerns. Cards on every prisoner were kept in the visits hall and contained relevant up-dated risk information. No identified prisoners had recently applied to have child visitors.

**Additional information**

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2.150 The resettlement department ran an innovative programme for prisoners who had once been in the armed forces, of whom there were 21. 'Operation Veteran' was organised by a lifer who had previously been in the forces himself and funding had been obtained from the Royal British Legion. The course provided support and assistance with various issues, including employment and accommodation, and was motivated by evidence showing that a large

number of ex-servicemen find it difficult to reintegrate into society following discharge from the army or prison and many are homeless.

- 2.151 The 2007-08 programmes timetable included four enhanced thinking skills (ETS) courses for up to 10 prisoners each, four CSB and three CALM courses, both for up to eight prisoners each. Most prisoners were assessed within two months of reception. The number of programmes on offer was sufficient for the general population, but there were plans to increase provision of CSB and CALM courses to meet the needs of lifers. The prison's capacity to run more programmes was shortly due to increase substantially as a new programmes unit with four well-equipped classrooms had been built.
- 2.152 Lifers were often unable to move on to the next programme or next stage in a different establishment because of population pressures in the prison estate. The competing claims of determinate and indeterminate prisoners with shorter sentences also caused some frustration. We met prisoners who had received little information about the consequences of being on indeterminate public protection sentences.
- 2.153 The mental health in-reach team had good community links and covered the neighbouring prisons, HMP Everthorpe and HMP Hull, to maintain contact with some prisoners on transfer and discharge and to coordinate their care.
- 2.154 Approximately 120 prisoners were in scope of offender management. The OMU had been set up in November 2006 and was well organised. There were six offender supervisors, a case administrator and an overall offender liaison manager. Offender supervisors were clear about their role and a number of prisoners described useful contact with them. The head of offender management was part of the Yorkshire and Humberside regional offender management steering group and had a clear understanding of the prison's roles and responsibilities within the offender management model. He had produced clear and accessible local documentation, including an end-to-end offender management flow chart explaining how offender management worked and the role of each member of staff within it.

### **Good practice**

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- 2.155 *The innovative resettlement programme for prisoners who had once been in the armed forces provided dedicated support and assistance to men identified as at particular risk of homelessness and isolation.*
- 2.156 *Staff were provided with clear and accessible local documentation, including a useful flow chart, to explain how offender management worked and the role of each member of staff within the process of end-to-end offender management.*

# Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

## Main recommendations to the Chief Executive of NOMS

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- 3.1 More terminals should be available to staff completing OASys documents. (2.2)
- 3.2 Prisoners should not be required to share cells designed for one prisoner. (2.3)

## Main recommendations to the Director

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- 3.3 Adjudications should be conducted and punishments awarded in accordance with published guidelines with the standard of adjudications subject to regular external monitoring. (2.5)
- 3.4 A full explanation of the reason for the use of unfurnished accommodation should be recorded. (2.7)
- 3.5 A local risk and needs analysis should inform a future review of the resettlement strategy. (2.10)

## Recommendations to the Director

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### **Residential units**

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- 3.6 The furniture provided in each cell should be adequate for the number of occupants. (2.17)
- 3.7 All cells should be fitted with appropriate privacy screening as a priority. (2.22)
- 3.8 Lockable lockers should be fitted in double cells so that prisoners can secure their personal possessions. (2.23)
- 3.9 Prisoners in double occupancy cells should be issued with their own courtesy key. (2.24)

### **Bullying**

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- 3.10 Staff should be trained in responding to bullying behaviour as part of the violence reduction strategy. (2.25)

### **Self-harm and suicide**

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- 3.11 A care suite should be provided to support the work of Listeners. (2.35)

## **Diversity**

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- 3.12 The prison's diversity policy should be informed by impact assessments and outline how the needs of minority groups will be met. (2.38)
- 3.13 Prisoners with disabilities should have a comprehensive care plan, dealing with treatment and wider needs within the prison regime and drawn up in consultation with the prisoner. (2.39)

## **Race equality**

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- 3.14 The race relations management team (RRMT) should have at least one black and minority ethnic member from outside the prison and a prisoner representative from each residential unit. (2.41)
- 3.15 A black and minority ethnic prisoners' support group should be established to allow these prisoners to raise their concerns, to help effective consultation on matters relevant to race equality and to help promote good race relations in the prison. (2.42)
- 3.16 Complainants who instigate a racist incident report form should receive a written reply and their satisfaction with the process should be monitored. (2.46)
- 3.17 Appropriate efforts should be made to recruit black and minority ethnic staff. (2.48)

## **Foreign nationals**

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- 3.18 The foreign nationals policy should be updated. (2.50)
- 3.19 There should be a foreign nationals coordinator who is known to prisoners and who provides practical information and support to them individually and as a group, including advice about sources of help on immigration matters. (2.51)

## **Contact with the outside world**

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- 3.20 The play area should be supervised at all times. (2.56)

## **Applications and complaints**

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- 3.21 All applications should be dealt with and responded to within three days or, in exceptional circumstances, 10 days. (2.63)
- 3.22 All formal complaints should be fully investigated and appropriately responded to. (2.65)

## **Legal services**

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- 3.23 Legal services should be better advertised to prisoners. (2.67)

## **Substance misuse**

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- 3.24 The drug strategy group should formulate a plan for staff training and development. (2.70)



- 3.25 An appropriate pharmacy structure, including regular visits by a pharmacist, should be put in place before the introduction of the integrated drug treatment system (IDTS). (2.73)

### **Health services**

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- 3.26 The skill mix of nurses should be reviewed to ensure that the department is able to provide a comprehensive healthcare service to meet the needs of the population, rather than merely meeting minimum staffing requirements. (2.74)
- 3.27 The prison should develop and implement a policy for sharing healthcare information. (2.75)
- 3.28 Triage algorithms should be developed to ensure consistency of advice and treatment. (2.76)
- 3.29 Clinical work undertaken by healthcare assistants should be directly supervised and counter-signed by a qualified member of staff. (2.77)
- 3.30 Prisoners with life-long conditions should be able to attend appropriate clinics with appropriate staffing. Staff should have protected time to organise and run these clinics. (2.79)
- 3.31 The medicine and therapeutics committee should undertake the following: the revision of stock lists and stock levels of medication held in the healthcare centre; the development of patient group directions for prescription-only medications to be administered by nurses without an individual patient prescription; the implementation of an audit procedure to reconcile usage of stock items against medication prescribed; the development of initiatives to allow prisoners a direct interface with a pharmacist or pharmacy technician. (2.80)
- 3.32 An audit of the dental sessions provided should be carried out to confirm value for money. (2.82)
- 3.33 An emergency alarm should be fitted in the dental surgery. (2.85)
- 3.34 The clinical staffing levels of the department should be addressed urgently. (2.90)

### **Learning and skills and work activities**

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- 3.35 Quality assurance should be embedded in the education provision and extended to include all accredited vocational training. (2.92)
- 3.36 Accredited training opportunities in the kitchen should be further developed. (2.95)
- 3.37 Sentence planning and activities and work should be effectively linked and integrated. (2.97)
- 3.38 The prison should provide a quiet area for prisoners to undertake independent study. (2.98)

### **Physical education and health promotion**

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- 3.39 An appropriate vocational sports programme to give prisoners the skills and qualifications to work in the sports industry after release should be planned and implemented. (2.102)

### **Faith and religious activity**

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- 3.40 Plans for diverse services in the chapel should be implemented. (2.105)

### **Discipline**

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- 3.41 Prisoners held in unfurnished or special accommodation should not routinely be issued with strip clothing. (2.108)
- 3.42 Prisoners should be removed from unfurnished or special accommodation at the earliest opportunity. (2.109)
- 3.43 Monitoring entries should reflect the exact time the check was carried out. (2.110)
- 3.44 The length of stay of prisoners in the segregation unit should be monitored and reduced, and prisoners in the unit for over a week should be encouraged to undertake cell work, cleaning or education. (2.111)
- 3.45 Prisoners located on the segregation unit should be strip-searched only where the need has been identified through risk assessment. (2.114)
- 3.46 Entries in wing history files of segregated prisoners should demonstrate positive engagement by staff. (2.115)

### **Incentives and earned privileges**

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- 3.47 Improvement targets should be specific to the individual, and objectives should be measurable and achievable. (2.120)
- 3.48 Staff should work with basic level prisoners to help them modify their behaviour and meet their targets. This should be evidenced in wing history files. (2.121)

### **Catering**

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- 3.49 Efforts should be made to improve the quality of the food so that prisoners' level of satisfaction increases. (2.126)
- 3.50 The prison should have adequate freezer capacity to cater effectively for the needs of the population. (2.130)

### **Prison shop**

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- 3.51 Prisoners should be able to buy goods from the shop the day after their arrival. (2.133)

### **Strategic management of resettlement**

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- 3.52 Residential staff should contribute to the resettlement policy group meetings. (2.137)

## **Offender management and planning**

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- 3.53 The Sycamore Tree programme should continue to receive full funding. (2.140)
- 3.54 Sufficient cognitive skills booster programmes should be available for the long-term population. (2.144)
- 3.55 Lifers should not have to share a cell. (2.145)
- 3.56 Lifers should be able to cook their own meals. (2.147)

## **Housekeeping point**

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- 3.57 Boxes should not be stored on the floor in clinical areas. (2.86)

## **Good practice**

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- 3.58 Staff and prisoners collaborated in creative family-oriented projects, including accredited courses for couples and parents and family days, as well as fundraising to maintain and develop this work. (2.61)
- 3.59 The incentives and earned privileges scheme was genuinely motivational and offered innovative privileges, including family meals and family photographs. (2.125)
- 3.60 Enhanced level prisoners could take occasional meals with close relatives, when the staff canteen was set aside and the catering manager produced special menus. (2.132)
- 3.61 Life-sentenced and some other long-term prisoners could grow their own vegetables on allotments at the back of C wing. (2.148)
- 3.62 The innovative resettlement programme for prisoners who had once been in the armed forces provided dedicated support and assistance to men identified as at particular risk of homelessness and isolation. (2.155)
- 3.63 Staff were provided with clear and accessible local documentation, including a useful flow chart, to explain how offender management worked and the role of each member of staff within the process of end-to-end offender management. (2.156)



## Appendix I - Inspection team

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Hindpal Singh Bhui	Team leader
Steve Moffatt	Inspector
Eileen Bye	Inspector
Mandy Whittingham	Health services inspector
Sheila Willis	Ofsted

## Appendix II - Prison population profile

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### Population breakdown by:

(i) Status	Number of prisoners	%
Sentenced	374	
Convicted but unsentenced	0	
Remand	0	
Civil prisoners	0	
Detainees (single power status)		
Detainees (dual power status)		
<b>Total</b>	<b>374</b>	

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	1	
6 months to less than 12 months	3	
12 months to less than 2 years	22	
2 years to less than 4 years	107	
4 years to less than 10 years	158	
10 years and over (not life)	28	
Life	55	
<b>Total</b>	<b>374</b>	

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month	Not available			
1 month to 3 months				
3 months to 6 months				
6 months to 1 year				
1 year to 2 years				
2 years to 4 years				
4 years or more				
<b>Total</b>				

(iv) Main offence	Number of prisoners	%
Violence against the person	105	
Sexual offences	1	
Burglary	61	
Robbery	45	
Theft & handling	9	
Fraud and forgery	0	
Drugs offences	61	
Other offences	92	
Civil offences	0	
Offence not recorded/holding warrant	0	
<b>Total</b>	<b>374</b>	

(v) Age	Number of prisoners	%
21 years to 29 years	177	
30 years to 39 years	126	
40 years to 49 years	50	
50 years to 59 years	17	
60 years to 69 years	4	
70 plus years	0	
Please state maximum age	61	
<b>Total</b>	<b>374</b>	

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	<b>Not available</b>	
Between 50 and 100 miles of the prison		
Over 100 miles from the prison		
Overseas		
NFA		
<b>Total</b>		

(vii) Nationality	Number of prisoners	%
British	351	
Foreign nationals	23	
<b>Total</b>	<b>374</b>	

(viii) Ethnicity	Number of prisoners	%
<i>White</i>		
British	318	
Irish	4	
Other White	7	
<i>Mixed</i>		
White and Black Caribbean	5	
White and Black African	1	
White and Asian	0	
Other Mixed	0	
<i>Asian or Asian British</i>		
Indian	4	
Pakistani	8	
Bangladeshi	0	
Other Asian	5	
<i>Black or Black British</i>		
Caribbean	11	
African	5	
Other Black	4	
<i>Chinese or other ethnic group</i>		
Chinese	1	
Other ethnic group	0	
<b>Total</b>	<b>373</b>	

(ix) Religion	Number of prisoners	%
Baptist	0	
Church of England	115	
Roman Catholic	57	
Other Christian denominations	4	
Muslim	22	
Sikh	1	



Hindu	0	
Buddhist	11	
Jewish	1	
Other	12	
No religion	151	
Total	374	

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