Report on an unannounced short follow-up inspection of

HMP Lincoln

3–5 May 2010

by HM Chief Inspector of Prisons

Printed and published by:
Her Majesty's Inspectorate of Prisons
1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

Contents

Introduction

The full unannounced inspection of HMP Lincoln took place in May this year before I took up my appointment. The inspection took place and the initial draft of this report was written during the tenure of my predecessor, Dame Anne Owers.

HMP Lincoln is a Victorian local or category B prison with capacity for 738 adult male remand and convicted prisoners and unsentenced young adult prisoners.

HMP Lincoln has had a troubled past. A serious riot in 2002 caused long-term damage to the fabric and morale of the prison. However, by the time of my predecessor's last inspection in 2008, the prison had returned to normality and was making progress although plenty of scope for improvement remained. This follow-up inspection shows that progress continues to be made – but too slowly.

The most striking conclusion to emerge from this inspection was the poor physical environment of the prison. The external environment was dirty and littered. Cells contained a large amount of graffiti as did too many communal areas. Prisoners shared cells designed for one that were too small for two sets of furniture. Most had only one table and chair so one prisoner had to eat his meals on his bed. Toilets in these small cells were not always screened. The segregation unit was dirty and the toilets and washing facilities within it were not clean. On a hot summer's day, inspectors described the temperature of the segregation unit, and especially the special accommodation cell, as unbearable.

In contrast to the poor physical conditions, staff-prisoner relationships remained reasonably good although inconsistent. Prisoners' views reflected this and were mixed. Formal processes were conducted fairly: the incentives and earned privileges scheme was used effectively and complaints were generally dealt with well. Measures for dealing with violence reduction had improved and these were understood by staff and acted on. There were regular effective safety surveys. There was good training for staff in anti-bullying and prisoners said bullying was rare. Staff in the segregation unit engaged well with prisoners and although the segregation regime was poor prisoners were usually only there for short periods.

It is pleasing to see that the coordination of a number of essential aspects of the prison regime has improved. Health services had improved and were better integrated into the management of the prison. There was better planning of training, education and employment activities. The quality of this provision was generally good and considerable progress had been made. The quality of learning and skills provision had improved but the quantity was still insufficient. There were still problems in making the best use of the available places. Time out of cell had improved since our last inspection but remained too low. An exception to the generally better coordination of activities was the position of the integrated drug treatment system (IDTS) team who were under-resourced and under-supported.

Resettlement activities were an area where already good outcomes had improved. There was a comprehensive resettlement strategy and good links with local agencies. Work with prisoners and their children and partners was excellent and innovative.

Nick Hardwick — September 2010
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Lincoln is a category B prison holding adult/young adult remand and convicted adult/young adult male sentenced prisoners, life-sentenced prisoners and prisoners serving indeterminate sentences for public protection. Lincoln currently has plans to move towards becoming a community prison.

Area organisation
East Midlands

Number held
634

Certified normal accommodation
436

Operational capacity
738

Last inspection
December 2007

Brief history
HMP Lincoln opened in 1872. Parts of the prison are Grade II listed buildings. It is a local prison serving the Crown Court of Lincoln, and the magistrates courts of Lincolnshire, Nottinghamshire and Humberside.

Description of residential units
There are four main residential units, three of which are of original Victorian design. The most recent wing (E) wing was opened in 1992.

A wing is the first night centre

B wing holds sentenced and convicted prisoners who are employed in the prison.

C wing holds prisoners participating in detoxification programmes, both convicted and remand prisoners.

D wing is the segregation unit, which also has a safer cell.

E wing is designated for vulnerable prisoners, predominantly sex offenders.

J wing is a small unit holding prisoners undertaking the short duration drugs programme.

The health care centre at present has inpatient facilities.

Section 1: Healthy prison assessment

Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2007 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. 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:

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

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.

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

- outcomes for prisoners are reasonably good 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. Procedures to safeguard outcomes are in place.

- outcomes for prisoners are not sufficiently good 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.

- outcomes for prisoners are poor 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

HP4 At our inspection in 2007, we found that in Lincoln, outcomes for prisoners were not sufficiently good against this healthy prison test. We made 37 recommendations in this area, of which 12 had been achieved, 11 partially achieved, 13 had not been achieved and one was no longer relevant. We have made a further 32 recommendations.

HP5 Prisoners reported a reasonable experience of transfers to the prison and most had travelled short distances from court. The reception environment remained poor and did not provide a confidential environment in which to carry out cell sharing risk assessments. There was no facility for the Listener or the Insider who worked in reception to speak to new prisoners privately.

HP6 Prisoners were usually able to have a shower and a one-to-one interview with staff when they arrived on A1, the designated first night accommodation. Arrangements for prisoners located elsewhere were less reliable. Cells on the first night centre were dirty and night staff had no clear responsibilities with regard to newly arrived prisoners. The first night landing was also used to accommodate some problematic and high-risk prisoners, and new arrivals were publicly identifiable on the A wing roll board.

HP7 Induction was reasonably comprehensive and swift. All prisoners had a custody passport completed, which included an assessment of resettlement needs.

HP8 Self-harm and suicide prevention arrangements were reasonable. The quality of care for those on assessment, care in custody and teamwork (ACCT) documents during the day was good but observations by night staff were predictable and did not include any interaction. There had been seven deaths in custody since the previous inspection, most of which had been self-inflicted. The action plans arising from deaths in custody were not monitored through the safer custody meeting but data analysis and follow-up of issues from it at this forum were good.

HP9 Measures for dealing with violence reduction had improved and were well understood and utilised by staff but prisoners were generally unaware of the policy. Regular safety surveys were conducted, analysed and acted on.

HP10 Security arrangements were sound and the level of security intelligence was good, although some action identified was not carried out promptly. Engagement at the security meeting was good and interdepartmental. Closed visits were imposed for illicit activity unrelated to visits.

HP11 The segregation unit remained an unsuitable environment. It was dirty and the toilets and sinks were grubby. The regime on the unit was poor but staff engaged well with prisoners, who stayed for relatively short periods and were mostly reintegrated back to the wings. Adjudications were of a good standard and quality assurance arrangements excellent.

HP12 Levels of use of force and use of special accommodation were reasonable and governance arrangements had improved, although there was not sufficient quality assurance following some incidents.

HP13 The clinical integrated drug treatment system (IDTS) team was severely understaffed. Prescribing regimes were flexible, but treatment did not start until the day after arrival, with only symptomatic relief available to opiate-dependent prisoners. C wing had become the IDTS unit, but it also accommodated other prisoners. The regime was unsupportive, the teams working with IDTS prisoners were not integrated, and some uniformed staff demonstrated an uncooperative and unhelpful attitude. The random mandatory drug testing (MDT) positive rate had reduced, and MDT data were analysed and discussed at both security and drug strategy committee meetings.

HP14 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still not sufficiently good against this healthy prison test.

Respect

HP15 At our previous inspection, we found that in Lincoln, outcomes for prisoners were reasonably good against this healthy prison test. We made 85 recommendations in this area, of which 31 had been achieved, 25 partially achieved, 28 had not been achieved and one was no longer relevant. We have made a further 56 recommendations.

HP16 The external environment was dirty and littered. Internal communal areas were clean but cells and other areas contained graffiti. Prisoners shared cells too small to contain furniture for two. Many toilets were unscreened or screened with bedding sheets. Communal showers and urinals did not afford any privacy.

HP17 There were issues around the timely processing of mail. Telephones were not all noise protected and several were out of order. Unemployed or part-time prisoners who had association in the afternoon were never able to telephone friends or families in the evening.

HP18 Although there were some inconsistencies in the way that the incentives and earned privileges scheme was managed, in general it was used effectively as a behaviour management tool. The incentives for being on the enhanced level were sufficiently motivational, but prisoners had to work to be considered for this status and there were insufficient employment opportunities.

HP19 Prisoners varied in their views about staff, but all were clear that they had someone they could go to with concerns. Some staff were proactive and knew the prisoners in their care well, while others were remote and sometimes dismissive. On association, some staff engaged actively with prisoners while others were withdrawn. There was some developing use of prisoner peer support.

HP20 Some prisoners reported no contact with their nominated personal officer, while others had good contact and were appreciative of him or her. Few personal officers introduced themselves and the scheme was cell based.

HP21 Catering and prison shop arrangements were reasonably good. There were no opportunities for prisoners to dine in association. Prisoners could wait as long as 13 days to receive shop goods and there were no emergency order arrangements.

HP22 There was no overarching diversity strategy and no provision for older, gay, bisexual and transgender prisoners. Arrangements for prisoners with a disability were underdeveloped. The Lincoln equality action team (LEAT) was proactive in race equality issues and provision in this area had improved. The new race equality officer had not been trained and was frequently redeployed. There was a consistently small number of racist incident report forms, which were subject to external quality analysis.

HP23 Support for foreign national prisoners had improved and monthly surgeries with the UK Border Agency were run and issues followed up. There were no links with specialist independent advice and voluntary sector organisations. There was good use of translated written material and interpreting services.

HP24 Faith provision was reasonable, although prisoners had to be approved by the security department to attend worship. Links with the community were underdeveloped and non-faith chaplaincy activities limited.

HP25 Not all wings had stocks of the different complaint forms but responses we saw were mainly respectful and addressed the issues raised. Complaints were monitored, trends analysed and action taken where required.

HP26 Arrangements to support prisoners in legal matters had improved and bail information staff offered a good service.

HP27 Health services had improved and were better integrated into the management of the prison. The reception screening template was reasonable and relevant referrals made but the secondary screening tool was inadequate and conducted by health care support workers. GP services were good but there were long waiting lists for the dentist and optometrist. The appointment system was efficient and supported by wing-based nursing. There were lead nurses in chronic disease management but their clinics were irregular due to staffing pressures. The management of medication posed a risk, particularly around prescription medication charts. The inpatient environment was unsuitable for people with acute needs. Mental health provision had improved. Transfers out under the Mental Health Act were managed proactively and within target timescales.

HP28 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still reasonably good against this healthy prison test.

Purposeful activity

HP29 At our previous inspection, we found that in Lincoln, outcomes for prisoners were not sufficiently good against this healthy prison test. We made 21 recommendations in this area, of which 13 had been achieved, four partially achieved and four not achieved. We have made a further 17 recommendations.

HP30 Time out of cell varied between around two and a quarter hours for unemployed and eight for full-time employed prisoners. Between 30% and 52% of the population was locked up on the residential units when we conducted our roll checks. Association and exercise were offered reliably but time in the open air was cancelled in inclement weather and nothing offered as an alternative.

HP31 There were not enough employment, education or training places for the population. Poor communication made allocation processes inefficient; too many prisoners were not in activities and there had not been sufficient management analysis of the use of activity places.

HP32 Opportunities for accredited vocational learning had improved, as had achievements of qualifications. Although accredited training was fairly basic, it was appropriate for the often short-term stay of many prisoners.

HP33 The careers information and advice service effectively identified learning needs during induction and ensured that those who had a need and wanted to engage were referred to appropriate courses.

HP34 The quality of teaching and vocational training had significantly improved and was now good, and education achievement rates had improved greatly. Attendance and punctuality had improved, aided by the changed movement arrangements.

HP35 The library was good, although provision for foreign national prisoners was not publicised sufficiently.

HP36 PE provision was also good. The number of accredited awards achieved in PE had significantly increased.

HP37 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still not sufficiently good against this healthy prison test.

Resettlement

HP38 At our previous inspection, we found that in Lincoln, outcomes for prisoners were reasonably good against this healthy prison test. We made 38 recommendations in this area, of which 15 had been achieved, 12 partially achieved, 10 had not been achieved and one was no longer relevant. We have made a further 21 recommendations.

HP39 There was a comprehensive resettlement strategy, based on a thorough needs analysis. The strategy focused on pathway provision. Ongoing changes were made to try to meet the needs of the population. Governance arrangements were good and monitored action against targets set. Resettlement staff formed a key part of prisoners' induction and were available subsequently to address new needs and follow-up referrals.

HP40 Prisoners in scope of offender management had up-to-date offender assessment system (OASys) assessments. Links with offender managers were good and many were relatively local. Three-quarters of the low- and medium-risk prisoners who fell outside the scope of offender management arrangements were waiting for an OASys assessment or review. There was no strategy to deal with this backlog, although

assessors prioritised medium- over low-risk cases. There was custody planning in the form of the prisoner passport for all prisoners, including those on remand and serving under 12 months.

HP41 The single lifer manager was part of the resettlement, rather than offender management, group. Arrangements for life- and indeterminate-sentenced prisoners had improved, with a dedicated event held the previous year to discuss relevant issues.

HP42 Public protection arrangements were reasonable. Weekly interdepartmental risk management meetings were effective and prisoners informed of any restrictions they faced and how to appeal against them. Residential staff members' awareness of public protection issues had improved, but they were not always confident of their role in monitoring and challenging potentially risky and dangerous behaviour.

HP43 Observation, classification and allocation work appeared up to date, despite recent somewhat chaotic staffing arrangements. We were unable to assess how many were waiting for transfers to category C prisons, as the statistics were unreliable. There was no strategy to ensure allocation according to sentence planning targets.

HP44 The prison had an effective partnership with Lincoln Action Trust. Comprehensive housing support was offered, although 11% of prisoners were recorded as leaving prison with no fixed abode. Finance, debt and benefit services had reduced with the loss of the debt counsellor. A budgeting course was available and Jobcentre Plus offered benefit services to those being released. Prisoners could not open bank accounts.

HP45 Education, training and employment pathway provision had improved. A range of pre-release support was provided and the work was supported by Jobcentre Plus staff.

HP46 Health care discharge planning was reasonable and appointments made for prisoners with GPs in the community where required.

HP47 There were throughcare links with local drug intervention programme (DIP) teams, and designated DIP link workers visited prisoners regularly. Counselling, assessment, referral, advice and throughcare (CARAT) work consisted of one-to-one sessions but did not engage with primary alcohol users. Alcoholics Anonymous support was available but there were no alcohol awareness modules or structured interventions. The short duration drugs programme (SDP) had been suspended for six months owing to staffing issues but had restarted in April 2010, in conjunction with HMP North Sea Camp.

HP48 The pathway for family and friends offered excellent work with prisoners and their children and partners. There was a proactive children's support worker and links with Play in Prison, which provided crèche facilities. There was limited waiting space for visitors, with poor facilities, and the visits area was noisy, especially for those on closed visits. There was graffiti in holding rooms and closed visits booths. Prisoners wore high-visibility bibs in visits, which detracted from the focus on families.

HP49 Other than the SDP, no accredited offending behaviour programmes were run but the range of non-accredited programmes had mainly been designed to address the need and short-term stay of the majority of the population. Thinking skills had been identified as an unmet need.

HP50 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 The reception area should be refurbished or replaced to provide a clean and welcoming environment that is fit for purpose. (HP56)

Not achieved. Reception remained in an unsuitable location and had not undergone any obvious refurbishment since the previous inspection. The three waiting rooms were poorly ventilated, dirty and bleak; there was evidence of them being swept by the reception cleaners but there was a considerable amount of dirt under the benches and around the windows. There had been some attempt to remove graffiti from the walls but this had led to the paint being removed, adding to the already poor environment. The waiting rooms were over-heated and the environment was stifling when several prisoners were held in them. There were no televisions in any of the waiting rooms, and at the time of the inspection there was no written information for prisoners or reading material available. The wheelchair lift on the outer steps was out of use and none of the staff on duty in reception knew how to operate it. There was insufficient appropriate interviewing space, resulting in prisoners being interviewed (including the cell sharing risk assessment) in the main thoroughfare, in the full hearing of the prisoners in one of the waiting rooms. There was no facility for the Listener or the Insider who worked in reception to speak to new prisoners privately, other than in the clothing store. Neither had a defined role to speak to all new prisoners and relied on being approached. There were plans for reception to be relocated to a new purpose-built unit within the ongoing building programme.

Further recommendations

2.2 The reception area should be clean and welcoming and provide a spacious, properly ventilated environment which is suitable for those with disabilities and where prisoners can be held safely, provided with relevant information and interviewed in private.

2.3 The Listeners and Insiders should introduce themselves to newly arrived prisoners and give information about the prison in a suitable venue, where prisoners can also express initial concerns and ask questions.

2.4 The role of E wing should be reviewed and its management, staffing and allocation arrangements overhauled. Each prisoner coming onto E wing should sign a compact accepting that they will behave respectfully to other prisoners on the wing, and the incentives and earned privileges (IEP) scheme should be used to ensure that the compact is used. (HP57)

Partially achieved. The role of E wing had been reviewed. The management structure of the wing was clear, with the residential manager based on the unit and supported by a team of regular senior officers and officers. There was no formal protocol for eligibility for allocation to E wing. In the six months before the inspection, prisoners who had originally been located on E wing because of debt had been reintegrated onto other residential wings. This had resolved

the conflict we had identified at the previous inspection between those on E wing because of the nature of their offence and those there because of escaping debt, and prisoners we spoke to there said that they felt safe and that bullying was not an issue. Although compacts specific to E wing were in place, few of these were evident in wing files, and in many cases where a copy was available, it was not signed by the prisoner. The IEP scheme was not used actively to ensure compliance with the compact on any residential wings.

Further recommendation

2.5 Each prisoner allocated to E wing should sign up to the standard of behaviour outlined in the compact, and their compliance with this should be monitored by personal officers and reflected in their place in the incentives and earned privileges (IEP) scheme.

2.6 The race equality policy should include a section on how the prison intends to engage actively with black and minority ethnic prisoners in its care, and relevant external organisations. (HP58)

Not achieved. The race equality policy did not include a specific section on how the prison intended to engage actively with the black and minority ethnic prisoners in its care, and relevant external organisations. There was evidence in the annual report that some progress had been made in engaging with community organisations, and an external member had been appointed to the equality action team, although it was not part of the race equality policy. We repeat the recommendation.

2.7 All areas used to deliver health services should be refurbished and made fit for purpose. (HP59)

Partially achieved. A programme of refurbishment had begun, with the upper corridor of the health care department now providing suitable office and consulting room space for general health care, the mental health team and the integrated drug treatment service (IDTS). The lower corridor was clean and freshly painted but the inpatient area was poor, with individual cells bleak and poorly decorated. There were plans to close the inpatient provision. Wing health care rooms on C and E wings had been refurbished. There was a triage/consulting room on E wing which was carpeted and had no hand-washing facilities. The health care room on A wing and the room used for secondary assessments on the ground floor of A wing were clean and in reasonable decorative order. The room used by health services staff on J wing for the administration of medication and consultations had no hand basin and had not been refurbished. There were plans to refurbish the association area in inpatients with funding from the King's Fund's Enhancing the Healing Environment Programme (see also recommendation 2.205).

Further recommendation

2.8 The inpatient residential area should be refurbished or taken out of commission. Hand-washing facilities should be introduced on E and J wings. The triage room on E wing should have the carpet removed and J wing should be refurbished.

2.9 There should be sufficient activity places to occupy the population purposefully during the core working day. (HP60)

Not achieved. There remained insufficient activity places to occupy all prisoners during the

core working day. Prison records showed that nearly 200 prisoners were not in activities. Only 90 prisoners were on remand and could therefore choose not to work. Sixty prisoners had yet to be allocated work and 65 were unemployed. There had been insufficient analysis about how activity places were used and management information did not adequately support decisions on how to improve provision.

Further recommendation

2.10 Prison managers should investigate the number and use of activity places to ensure that an appropriate range is offered to enable the population to be occupied appropriately and purposefully during the core working day.

2.11 Clear and effective strategies should be introduced for the development, management and coordination of learning and skills across the prison. This should be supported by a quality improvement system, including regular and rigorous self-assessment; observation of teaching and learning across all programmes; the collection and use of the views of prisoners; and rigorous monitoring of performance. (HP61)

Achieved. The prison had a clear strategic plan for learning and skills, with overall strategic objectives and a development plan identifying more detailed and specific actions to achieve them. Learning and skills were well coordinated across the prison. Quality improvement arrangements included the collection and analysis of data, regular performance meetings and an effective self-assessment process. The views of learners were gathered and used to inform the self-assessment report. Performance of all learning and skills activities was monitored by managers through the data and information trend meetings and quality improvement group (see also paragraph 2.273 and further recommendation 2.284).

2.12 The segregation unit should be renovated and the facilities updated to an acceptable standard, and the special unfurnished cell completely redesigned. (HP62)

Not achieved. The accommodation in the segregation unit was in a poor state. It was dirty, the toilets and sinks were grubby and there was graffiti on cell walls. The heat was unbearable in some cells, particularly the special accommodation, and this cell had not been changed since the previous inspection.
We repeat the recommendation.

2.13 A full comprehensive resettlement needs analysis should be carried out to ensure that the resettlement strategy meets the needs of the population. (HP63)

Achieved. A full and comprehensive needs analysis had been conducted in 2008 and used to inform the current reducing reoffending strategy. The establishment had conducted a further needs analysis in September 2009 which included prisoner surveys, as well as an analysis of 25% of prisoners' offender assessment system (OASys) assessments. The results of this were still in the process of being analysed. Both needs analyses had focused on the seven reducing reoffending pathways. Since the previous inspection, further interventions had been introduced, based on the analysis completed, in addition to the ongoing development of resettlement services. The needs of short-term sentenced prisoners (who made up 20% of the population at the time of the inspection) were now better addressed and they could access the short courses that would assist them in reducing their risk of offending. A full-time remand housing officer was now in post to provide better support to all remand prisoners who were deemed at high risk of losing their accommodation due to the uncertainty of their release, and they were now able to access all resettlement services (see section on resettlement).

Resources had also been allocated to providing more support to prisoners in establishing and maintaining contact with their families.

Recommendations

Courts, escorts and transfers

2.14 Prison and escort managers should work together to reduce the time that vans have to wait to enter the prison. (1.6)

Achieved. Of the four vehicles we observed entering the prison, the longest wait was 10 minutes. Gate staff told us that if more than one vehicle arrived at the same time, the wait was often considerably longer, as there was a policy of admitting only one escort vehicle at a time, because of space limitations. Escort vehicles were given priority access when carrying prisoners. No record was kept at the gate of the time at which vehicles arrived outside, only when they physically entered the gate lock. The gate book showed that there was usually a quick turnaround of vehicles.

Housekeeping point

2.15 A record should be kept of the time of arrival of vehicles.

2.16 Prisoners should arrive at the prison before 7pm. (1.7)

Partially achieved. Our analysis of prisoner escort records for the four months before the inspection showed a marked reduction in the number of prisoners arriving at the prison after 7pm, with only nine occasions where this had happened. These had involved 30 prisoners, arriving mainly from the Nottingham and Mansfield courts. HMP Nottingham currently held most prisoners dealt with by these courts, and it was reportedly only in times of full occupancy of HMP Nottingham that prisoners were redirected to Lincoln. The latest that any of the prisoners had been received into the prison during this period was 8.30pm, with most received into custody by 8pm.
We repeat the recommendation.

Additional information

2.17 The contractor for prisoner transfers was Global Solutions Limited. Prisoners in our groups and in reception reported being well treated by escort staff. All of the vans we saw were clean and carried refreshments. Journey times were mostly short and from local courts. Most prisoners we spoke to were returning remand prisoners from court appearances. Embarkation and disembarkation procedures were efficient and there was a good working relationship between prison and escort staff.

First days in custody

2.18 Procedures should be reviewed to ensure that prisoners spend as short a time as possible in reception. (1.20)

Not achieved. There was no evidence of a review of waiting times. Prisoners we spoke to said that they had had to wait around three hours from arrival to being located on the wing.

Prisoners on the vulnerable prisoners unit said that they had had to wait much longer. All newly arrived prisoners we observed remained in reception for no more than three hours. Reception staff said that prisoners returning from courts were prioritised to be processed and returned to their wings. Vulnerable prisoners were brought to reception first and returned to their unit last, once all other movements had been completed, although reception staff said that they occasionally escorted individual prisoners back to the wing.
We repeat the recommendation.

2.19 There should be regular, formal meetings of prisoner Insiders, where they can share and develop their knowledge and practice and receive appropriate support and guidance from a nominated member of staff. (1.21)

Partially achieved. There were two Insiders on each of the main wings. There had been only two meetings of the current Insiders, which had been chaired by the senior officer responsible for coordinating the Insider scheme. The Insider we spoke to said that they had met each other for the first time at the meetings, shared experiences and received training in personal skills.
We repeat the recommendation.

2.20 Prisoners should be able to have a shower before being locked up on their first night. (1.22)

Partially achieved. There was one shower in reception. This was used only for prisoners on long-term trials, who, because of escort timings, did not have the time or the facility to shower on their wing before going out of the prison or on returning from court in the evening. New prisoners could have a shower in the first night centre, C wing (for integrated drug treatment system (IDTS) prisoners) or E wing (the vulnerable prisoner unit) if they arrived before lock-up; if not, they were offered a shower the next morning. All of the prisoners we saw arriving were located on A or E wing by 6.30pm and offered a shower.
We repeat the recommendation.

2.21 Prisoners should be able to make one free telephone call, in private, on reception or in the first night centre, and this opportunity should be documented. (1.23)

Not achieved. There was no facility to make telephone calls in reception and prisoners were not usually afforded a free telephone call. The exceptions to this were prisoners returning from transfer or recall or newly sentenced with a P-NOMIS number, who, because of restrictions in the electronic records system could not be given a new PIN. Such prisoners had to wait for their old account to be activated the next day (at which point a £1 credit was applied, if required). When this was the case, the staff on the A1 first night centre landing made a call on the prisoner's behalf. All other prisoners were given a new PIN number with £1 credit, which was recoverable against future spends. There was no record of calls made on the unit and new prisoners who had been located on E wing reported not being offered a telephone call at all.
We repeat the recommendation.

Housekeeping point

2.22 A record should be kept of calls made on the first night centre, for managerial assurance that these are taking place.

2.23 Wherever possible, new prisoners should remain on A wing until they have completed their induction. (1.24)

Partially achieved. Most of the new prisoners who arrived during the inspection were located in the first night centre. The remainder were located on the vulnerable prisoner unit following requests for vulnerable prisoner status. Managers in the first night centre said that sometimes there was insufficient space to locate new prisoners on A1 because the landing was also used to locate some problematic high-risk prisoners and some with health issues. There were also plans to turn four cells on the unit into health care cells. This resulted in some prisoners not being able to complete their induction on A wing.
We repeat the recommendation.

Further recommendation

2.24 The first night centre should only be used for the purpose for which it was designed.

2.25 Prisoners located in units other than the first night centre should receive the same essential first night procedures and a full induction. (1.25)

Not achieved. New prisoners were interviewed individually by first night centre staff if they were located there early enough before lock-up. The unit was profiled to have enough staff to conduct these interviews after lock-up but staff were routinely reassigned to other duties at this time, preventing late arrivals from undergoing interview on the first night. Other prisoners (on C and E wings and in segregation) were not interviewed until the following day. The Insiders did not see new prisoners until the first session of induction, despite the policy stating that they would see all new prisoners on arrival. Prisoners and staff we spoke to were clear that the induction for new prisoners (particularly vulnerable prisoners) located away from the first night centre was inconsistent and did not mirror the main induction process.
We repeat the recommendation.

Further recommendation

2.26 Insiders should see all new prisoners on arrival.

Housekeeping point

2.27 The schedule of actual Insider activity should be reflected in the first night policy.

2.28 Procedures should be put in place to ensure that prisoners with poor use of English receive equivalent care to English speakers during their first days in custody. (1.26)

Achieved. Information was available in the first night centre in 20 languages (prioritised by empirical evidence), and there was also a software program that reportedly could be used to translate information into any language. However, there were some anomalies in the outcomes of translations (see paragraph 2.179 and housekeeping point 2.180). The Insider we interviewed said that when he was presented with someone who spoke no English at all, he was sometimes unable to identify the language spoken by the prisoner, but that once the language had been identified, almost any information could be provided in any language. The notable exception was the prison shop list. A professional telephone interpreting service was available and used in a coordinated way, with all relevant parties and the prisoner attending, to maximise the facility.

Housekeeping point

2.29 The language identification list should be widely available to Insiders and induction staff.

2.30 There should be regularly updated needs assessments of all young adult prisoners. (1.27)

Not achieved. At the time of the inspection, there were 42 young adult prisoners, of whom 10 were on remand. There was no evidence that there was any consideration of the levels of maturity or the needs of young prisoners, other than an attempt to ensure that they shared cells where possible. There were only 10 young persons' cells in the prison, nominally for convicted and sentenced young adults, and these were clearly identified.
We repeat the recommendation.

2.31 Induction information should be provided in a range of accessible formats. (1.28)

Achieved. A number of formats was used for delivering the information. There were one-to-one interviews with health services, probation, mental health in-reach and counselling, assessment, referral, advice and throughcare (CARAT) staff. Group presentations were delivered on legal services, general induction, the chaplaincy, the education department and the role of Insiders and Listeners. There was a range of written material, available in multiple languages, and PowerPoint and DVD/video presentations on health and safety and resettlement.

Additional information

2.32 Most of the cells on the first night centre were dirty and had graffiti on the walls, despite a recent painting programme.

2.33 Induction for mainstream prisoners started on the day after arrival and was delivered over a two-day period, and there were sufficient group rooms and interview rooms to deliver it. Induction for the prisoners on E wing took place at ad-hoc times over the course of a week. Staff on E wing reported a lack of support for their new prisoners from first night centre and induction staff.

2.34 There were no systems to identify new prisoners on wings other than A1, where the roll board indicated the arrival date of individual prisoners. As the A1 landing was used as an association area for the other landings, the obvious identification of newly arrived prisoners had the potential to put pressure on them, as they were assumed to have both tobacco and grocery goods, having just come from reception, and we observed prisoners congregating around the doors of new arrivals.

2.35 Individual prisoners' progress through the induction process was recorded in a passport document, which was held with wing files.

Further recommendations

2.36 Cells on the first night centre should be cleaned in preparation for new arrivals.

2.37 The roll boards should be maintained in an area accessible only to staff, to safeguard the identity and location of newly arrived prisoners.

Housekeeping point

2.38 There should be systems to identify new prisoners to staff on all residential units.

Residential units

2.39 All external areas should be kept clear of litter. (2.8)

Not achieved. The external areas immediately outside the wings, and the exercise yards, were dirty and littered. The exception was A wing, where the refurbishment had included the fitting of sealed unit windows. There were regular cleaning parties for the exercise yards but the area outside B wing remained dirty throughout the inspection.
We repeat the recommendation.

2.40 Prisoners should have an opportunity to clean their cells, and the locked door policy should not hinder this. (2.9)

Partially achieved. There was no consensus among staff as to when prisoners could clean their cells. Some said that the first period of the day following unlock was designated for cell cleaning, while others said that prisoners were allowed to have their doors unlocked for the first part of association time to clean their cells, if they asked an officer. Given that there was little time out of cell, cell cleaning was unlikely to be a priority for prisoners during association times, and the morning period out of cell varied from wing to wing. When asked how easy it was to clean their cells, prisoners were mixed in their responses; some reported using their own shower gel, as cleaning materials were hard to come by, and this was supported by wing cleaners, who said that they usually had access to the cleaning materials they needed for the wings but that it was limited for cell cleaning purposes.
We repeat the recommendation.

Housekeeping point

2.41 Prisoners should be able to access proper and sufficient cleaning materials.

2.42 The offensive display policy should be rewritten to clearly identify what constitutes acceptable items that can be retained in-cell and what can be displayed openly. (2.10)

Achieved. The offensive display policy had been rewritten and clearly identified what constituted acceptable material. There were additional expectations around what was acceptable for young adults. Prisoners we spoke to were aware of the policy and had signed compacts on arrival, agreeing not to display pornographic images. The policy was well policed and we saw no inappropriate material on display during the inspection.

2.43 Cell bells should be answered within five minutes. (2.11)

Partially achieved. Prisoners in our groups mostly expressed the view that staff were slow to respond to cell call bells. During the inspection, we observed that a few responses to call bells, predominantly on C wing, took beyond five, but no longer than 10, minutes. The prison was focused on the issue, and responsiveness to cell call bells was the subject of security and safer custody meetings. Occasions where response times had been longer than five minutes had been noted and wing managers alerted. The lack of responsiveness on C wing was of

particular concern, as when J wing was left unstaffed owing to staff redeployment (see section on time out of cell), C wing staff were expected to respond to any cell call bells on that wing. We repeat the recommendation.

2.44 Money sent in to prisoners should be made available without unnecessary delays, and agreed timescales should be published on all wings. (3.81)

Partially achieved. A notice to prisoners had been published to explain the timescales for the receipt of money. There were delays of up to 18 working days to receive cheques and some postal orders since the implementation of P-NOMIS. Unpredictable staffing in the mail room also resulted in delays in getting money to prisoners' accounts (see additional information).

Further recommendation

2.45 Under P-NOMIS, money sent in to prisoners should be made available within 48 hours.

2.46 An agreed and realistic mechanism for managing internal post should be established. (3.82)

Achieved. The management and delivery of internal mail had improved significantly.

2.47 All wings should have letter boxes of the same standard as on A wing. (3.79)

Achieved. All wings had secure letter boxes, accessible only by staff responsible for processing mail.

2.48 All prisoner telephones should have privacy hoods. (3.80)

Not achieved. Not all telephones had privacy hoods and many were out of order. We repeat the recommendation.

Housekeeping point

2.49 Out of order telephones should be repaired without delay.

2.50 Prisoners should be able to use telephones daily, and at times convenient to their families and friends. (3.83)

Partially achieved. While prisoners could use telephones every day, not all could use them at a suitable time for contacting their families. Unemployed prisoners were on association during the afternoon, which made it difficult for them to contact family members and friends who worked during the day.

Further recommendation

2.51 Prisoners should be able to use the telephones at times convenient to their families and friends.

Additional information

2.52 Internal communal areas were clean but cells contained a large amount of graffiti. Despite being recently decorated, one cleaner's cell on C wing had graffiti all over the ceiling. There was also graffiti in other areas such as the first night centre, closed visits booths, visits holding rooms, segregation unit and Listener suites (see sections on first days in custody, self-harm and suicide and resettlement). Too many prisoners shared cells designed for one and these cells were too small to contain sufficient furniture, so most had only one table and chair between two. This meant that one person had to eat dinner on his bed, as there was no dining in association. Although privacy curtains for the toilets had been installed, many were missing, leaving toilets unscreened or screened with bedding sheets.

2.53 Only remand and enhanced prisoners were allowed to wear their own clothes, and prisoners reported problems in obtaining their own clothes on first arrival, owing to delayed searching of property. Wing laundries were generally able to cope with the small amount of personal clothing being washed. Some washing machines and driers were out of action, restricting the amount of clothing that could be washed.

2.54 The communal showers on the wings did not afford any privacy, and the urinals at the front of the shower areas were open to the full view of the wing. There were problems with the temperature of the showers during the inspection, as major replacement of the heating and water systems was under way in order to meet health and safety requirements.

2.55 Mail was delivered daily (except Sundays) to the prison by 7.30am. Staff were detailed to sort incoming and outgoing mail from 9am, after it had been checked by the drug dogs and X-rayed.

2.56 During the inspection, there was at least one occasion when only one member of staff was on duty in the mail room, so mail could not be processed. Additionally, the mail room was not staffed on Saturdays, so any mail that was received on that day was not sorted and delivered until the following Monday. Outgoing mail was also subject to delays on Fridays, as this was not sent out until Monday. The outgoing mail boxes on the wings could be opened by mail room staff only.

2.57 There had been a number of formal complaints relating to money that had been sent in to prisoners but not received. A new system for dealing with monies sent in had been implemented, whereby prisoners no longer signed cash books to acknowledge receipt when money was sent in.

2.58 Rule 39 mail (legal and confidential access correspondence) from solicitors and legal representatives was handled appropriately.

Further recommendations

2.59 Cells should be checked daily for graffiti and remedial action taken where it is identified.

2.60 Cells designed for one should not be shared. Where cells are shared, there should be sufficient space and furniture for two prisoners.

2.61 All cell toilets should have privacy screening.

2.62 All showers should have privacy screening and urinals should not be open to the wing.

2.63 All prisoners on enhanced and standard levels of the incentives and earned privileges scheme should be allowed to wear their own clothes.

2.64 Staffing in the mail room should be increased and predictable, to ensure that incoming and outgoing mail is dealt with within 24 hours.

Housekeeping points

2.65 Out-of-order laundry facilities should be repaired without delay.

2.66 Prisoners should sign for all individual monies sent into the prison.

The vulnerable prisoners unit

2.67 Clear protocols should be drawn up to establish which prisoners should be admitted onto E wing. (2.16)

Not achieved. There were no protocols for the admission of prisoners onto E wing. The criteria considered by the manager allocating a prisoner to the wing concerned vulnerability and risk, but there was no formalised procedure.
We repeat the recommendation.

2.68 There should be regular staff on E wing. (2.17)

Partially achieved. There was a regular group of staff assigned to E wing and they had personal officer and other duties allocated to them. There were occasions when staffing requirements meant that staff were redeployed from E wing to other areas and from other areas to E wing.
We repeat the recommendation.

2.69 The personal officer scheme on E wing should be re-launched. (2.18)

Partially achieved. The personal officer scheme had not been re-launched but had been implemented on E wing as in the rest of the prison. Prisoners were all allocated personal officers on the basis of the cell in which they were placed (see section on personal officers).

Staff–prisoner relationships

No recommendations were made under this heading at the previous inspection.

Additional information

2.70 Prisoners in our groups varied in their views about staff but generally felt that the majority were respectful and that there was always someone they could approach. We observed mixed staff–prisoner interactions during the inspection, with some staff engaging well with prisoners during association and movement times, but others being distant and withdrawn. Staff had started to be deployed onto exercise areas rather than standing outside them.

2.71 Most staff were receptive to prisoners, both generally when out on the wings and also in response to requests and applications. Some staff were proactive and knew the prisoners in their care well, while others were remote and sometimes dismissive. Surnames were routinely used. Staff we spoke to were mixed in their view of their role, although most said that support for prisoners was the main element. Most staff were confident in reinforcing the standards of behaviour required and described a range of ways that they would achieve this, from informal warnings to placing prisoners on report, depending on the issue and how many times it had been raised.

2.72 There was evidence of some responsive consultation with prisoners, predominantly through wing, foreign national and diversity representatives (see also section on diversity). Attendance at the wing meetings was inconsistent and in the previous six months there had not been a meeting at which all wings were represented. Issues raised at meetings were followed up, although minutes did not always clearly specify outcomes.

Further recommendations

2.73 All supervising staff should engage with prisoners during their time out of cell.

2.74 Staff should refer to prisoners using their title or by their preferred name.

2.75 There should be wider consultation with prisoners than simply through peer representatives, and attendance at meetings should ensure as wide a representation as possible.

Housekeeping point

2.76 Minutes of wing representative meetings should include action points and outcomes.

Personal officers

2.77 The roll-out of the personal officer scheme should continue until the policy is fully and consistently in operation on all residential wings. (2.27)

Partially achieved. The policy for the personal officer scheme was the same throughout the prison and relatively consistent in its application across all residential wings. Where there was variation, it was in the way that personal officers operated the scheme, rather than between wings. Some personal officers were diligent in introducing themselves and completing the personal officer interview, while for others there was no record of initial contact. Paper records we sampled generally showed the fortnightly entries required by the policy, but the move to P-NOMIS seemed to have reduced the number of entries to monthly. It was not clear that many of these entries had involved engagement with the prisoner concerned, and most mentioned the prisoner impersonally, as 'this prisoner' or by surname. In our groups, some prisoners reported no contact with their nominated personal officer, while others had good contact and appreciated the efforts of their personal officer.

Further recommendation

2.78 All personal officers should introduce themselves to the prisoners for whom they are responsible and maintain weekly contact thereafter, ensuring that this is reflected in the individual's wing history sheet.

Housekeeping point

2.79 Wing file entries should refer to prisoners by their preferred name.

2.80 Personal officers should be consulted and provide input on all matters relating to their prisoners. (2.28)

Partially achieved. The policy for the personal officer scheme required personal officers to have input into parole reports, recategorisation, home detention curfew (HDC) and release on temporary licence (ROTL) applications, cell sharing risk assessments, and assessment, care in custody and teamwork (ACCT) and IEP reviews. While it appeared that personal officers completed contributions as requested, there was little evidence that they attended reviews or sentence planning boards, and the role laid out in the policy concerning links with the offender management unit (OMU) was not in evidence or well understood by personal officers we spoke to. Although passports were completed for prisoners on induction, personal officers we spoke to rarely made use of these beyond an initial read-through.
We repeat the recommendation.

2.81 There should be regular management checks of wing history files, and personal officers should be formally notified of inappropriate or inadequate entries. (2.29)

Partially achieved. There was reasonable evidence of regular management checks, both in the paper and electronic files. The policy required senior officers to conduct weekly checks of at least five prisoners. The quality of these checks was poor and their likelihood of improving practice limited. In one case, there had been only two entries in four months, but the senior officer check noted 'good entries'.

Further recommendation

2.82 Management checks of the personal officer scheme should include comments on the quantity and quality of the entries made by personal officers and ensure that any improvements needed are communicated to the member of staff concerned and acted on.

Additional information

2.83 The standard of engagement with the personal officer scheme varied. Staff and prisoners we spoke to knew what the role entailed but described different approaches. Few personal officers could identify personal issues for those on their caseload but most were aware of whether the prisoners for whom they were responsible were working and some were able to describe concerns about arrangements for release or transfer. The scheme was still cell based, meaning that a move of cell, even on the same wing, required a change of personal officer. One prisoner undergoing detoxification on E wing had had two personal officers in as many months.

2.84 There was little evidence that personal officers engaged with prisoners about resettlement issues, although most we spoke to knew to whom they would direct prisoners if they had such concerns. Staff were mixed in their view of the changes to their role with the advent of P-NOMIS; some said that it made recording contact more straightforward and offered better opportunities for non-residential staff to provide input, but many reported difficulty in accessing computers, particularly on C wing.

2.85 The personal officer scheme required personal officers to comment monthly on prisoners' IEP status. There was some evidence in files that this was done, although when there were entries, they were usually limited to describing the level that a prisoner was on, rather than whether or not this was appropriate. We saw some cases where a personal officer had recommended a move to enhanced.

Further recommendations

2.86 The allocation of personal officers should remain consistent on individual wings.

2.87 There should be sufficient access to computers in all residential areas to allow personal officers to make relevant entries on P-NOMIS.

2.88 Personal officers should be directly involved in determining the IEP status of the prisoners in their care, making a monthly assessment of whether the current level is appropriate.

Housekeeping point

2.89 Personal officers should record issues concerning the personal circumstances of the prisoners in their care and support contact with their families and friends.

Bullying and violence reduction

2.90 Staff should be trained in anti-bullying strategies. (3.7)

Achieved. There had been a significant drive to train staff in violence reduction and anti-bullying strategies. A total of 178 staff had been trained at the time of the inspection. Of these, there were 15 senior officers, 82 officers and 34 operational support grades; the remaining 47 were staff from other areas of the prison who had direct prisoner contact. The training had been suspended in the latter part of 2009 while the new strategy document was being approved and implemented. Since the beginning of December 2009, violence reduction training had featured at every training day, with an average of 10 staff being trained at each event.

2.91 The revised violence reduction strategy should be implemented as soon as possible. (3.8)

Achieved. The revised violence reduction strategy had been launched in December 2009 following a long consultation period. There was evidence that the strategy was applied across the prison, and the anti-bullying log demonstrated its application. Staff we spoke to on the wings were aware of the policy and were able to quote the appropriate actions to take in the event of bullying being reported to them. Prisoners we spoke to were not aware that there was such a policy, although they said that incidences of bullying were rare at the establishment.

Additional information

2.92 There had been a steady decrease in reported bullying at the establishment since the previous inspection: there had been 301 cases in 2008, 242 in 2009 and 76 in 2010 to date, which gave a projected annual figure of around 220 at the current rate of reporting.

2.93 There was a combined safer prisons meeting that considered both violence reduction and self-harm and suicide. Data were analysed, with clear actions being identified for nominated members of staff. These actions were followed up at subsequent meetings. A wide range of information was considered and acted on. A check was made in relation to the content of security information reports; where there were safety implications, a follow-up was carried out to ensure that supporting entries had been made in wing files, in addition to identifying any trends or hotspots of violence that had not been previously identified in other data. A snapshot survey was carried out monthly on cell call bell response times in all residential areas to identify areas and response times (se recommendation 2.43). An analysis of complaint data was carried out to ensure that all instances of anti-social behaviour were reported and acted on. The locations and number of prisoners identified as high risk on cell sharing risk assessments was monitored and considered in the light of any emerging trends or incidents.

2.94 There was a two-stage anti-bullying process. Stage one resulted in a written warning; stage two resulted in a demotion to the basic level of the IEP scheme. A support plan was initiated to address behaviour and consideration of the victim was made. If there was sufficient evidence to demonstrate a continued threat to the victim, the aggressor was placed in the segregation unit on good order or discipline. Prisoners on stage two of the strategy were reviewed at least every seven days.

2.95 There was no specific policy to support victims of bullying, although provision was made within the prison's vulnerable prisoners policy to manage and support victims.

2.96 An annual staff and prisoner anti-bullying survey was carried out, analysed and acted on. The survey for 2010 had been conducted in January, but the findings of the survey had not been published at the time of the inspection. Exit surveys were carried out regularly, although because it was conducted immediately before discharge, engagement was reported to be poor.

Housekeeping point

2.97 The anti-bullying exit survey should be carried out a few weeks before discharge.

Self-harm and suicide

2.98 The contributions and input of the health services staff at assessment care in custody and teamwork (ACCT) reviews should be clearly recorded for the benefit of all staff. (3.23)

Not achieved. In the ACCT review records we saw in which attendance was listed, it was not clear what input the health services staff had made or whether the contribution had been from general or mental health staff.
We repeat the recommendation.

Housekeeping point

2.99 The roles of staff attending reviews should be clearly stated.

2.100 A member of the mental health in-reach team should attend the safer prisons committee. (3.24)

Not achieved. Attendance at the last six safer prisons committee meetings before the inspection did not include a representative from the mental health in-reach team, and the in-reach team was not included in the terms of reference for the self-harm and suicide prevention policy or in the attendance list for the safer prisons committee. There was not always a representative from the health care department at the meeting.
We repeat the recommendation.

2.101 One of the Listener suites should have a secured area created to allow a Listener to operate safely if the prisoner involved has been assessed as high risk. (3.25)

Achieved. The self-harm and suicide prevention policy included the management of prisoners identified as high risk on cell sharing risk assessment. Interventions included the 'Listen' taking place in association areas in sight of staff (or the adjudications room for segregated prisoners) and the provision of a Samaritans telephone if the risk assessment negated Listener involvement.

Additional information

2.102 There had been seven deaths in custody since the previous inspection in 2007, only one of which was from natural causes. There was no reference to any of them in the minutes of recent meetings, and reviews of action plans were not included in the standing agenda. The safer custody manager was not aware of any action plans and there was no integration of the Prisons and Probation Ombudsman recommendations to inform policy or inclusion in the continual improvement plan.

2.103 A repeat recommendation had been made after the previous inspection about having prison staff first-aid trained. At the time of the inspection, none of the directly-employed night staff held a current first-aid qualification. There were two nursing staff on duty each night who were reported to be trained to intermediate life support standard, although training records were not available (see paragraph 2.210). Only 39 discipline staff held current first-aid certificates, of whom only four were senior officers. No directly employed staff were trained in the use of a defibrillator.

2.104 The safer prisons committee reviewed a variety of relevant data from across the prison in order better to inform policy and create as safe an environment as possible. The meeting included input from a range of departments, although attendance from some departments was inconsistent. A representative from the Samaritans attended regularly and prisoner Listeners attended part of the meeting. There were effective links to other strategies, further integrating the strategy into the prison.

2.105 There had been 473 ACCT documents opened in 2008, 399 in 2009 and 117 in 2010 to date, which projected to an annual figure of around 350, continuing the downward trend. At the time of the inspection, there were 17 prisoners on open ACCT documents and three on constant watches. ACCT documentation was mostly good, with high-quality entries made during the day but insufficient detail in entries made during the night, where the entries were predictable and repetitive, and made at minimum intervals. It was not always clear who had made entries, as illegible signatures were not always followed by the printed name and role. A recent instruction had been issued by the safer custody manager for staff to include their epaulette number (where applicable). There was evidence of the safer custody manager carrying out quality checks, but a noticeable absence of qualitative entries from other managers, other than a 'tick box' management check.

2.106 There were three Listener suites, one each on A, C and E wings. They consisted of two adjacent cells, having had the adjoining wall removed. The suite on A wing was being used as a store room at the beginning of the inspection. On the second day of the inspection, the stores had been removed and the furniture (a settee with a chair on each side) had been returned. There were no comfort facilities in the suite and there was graffiti on the walls. The C wing suite was dirty, bleak, contained graffiti and had no comfort facilities; some of the cushions had been removed from the suite, and although it had not been used as a Listener suite for some time, there was evidence of it being used as a smoking room. The E wing suite was clean but, although there was a kettle, there was only a bag of tea bags in the room.

2.107 There were 48 case managers and 19 ACCT assessors. Staff who had undergone foundation and refresher ACCT training included 249 contact staff. There were 98 others trained in ACCT foundation and refresher training, including administration staff, nurses, drug workers and operational support grades.

Further recommendations

2.108 The Prisons and Probation Ombudsman action plans should be reviewed at the safer prisons meeting and incorporated into ongoing monitoring.

2.109 Directly employed staff should be trained in the use of the defibrillator.

2.110 Managers should make qualitative entries in ACCT documents in addition to the pre-set management check stamp.

2.111 Listener suites should only be used for supporting prisoners in crisis and be maintained to provide a clean and supportive environment.

2.112 All contact staff should undergo foundation and refresher ACCT training.

Housekeeping points

2.113 Staff should be reminded of the type and quality of entry required in ACCT documentation.

2.114 Night-time observations should be at unpredictable intervals.

Applications and complaints

2.115 Prisoners' applications should be subject to tracking by managers to ensure that prisoners receive a timely and adequate response to their query. (3.94)

Not achieved. Prisoner applications were logged on each wing but not tracked to ensure that replies were received.
We repeat the recommendation.

2.116 Applications boxes should be secure and only accessible to prison staff. (3.95)

Achieved. There were secure applications boxes on all wings, accessible only by staff.

2.117 The replies to prisoners' complaints should be monitored by managers to check quality, and identify trends in complaints and the ethnicity of complainants. (3.96)

Achieved. Prisoner complaints were monitored and checked at the weekly performance meetings. This included identifying trends, monitoring by ethnicity, wing and subject, and taking action where required.

Additional information

2.118 Prisoners were able to make applications daily. Wing staff dealt with those relating to wing matters and others would be sent to the relevant departments. We were unable to ascertain if those that were sent off the wing were responded to within a reasonable time, if at all (see recommendation 2.115).

2.119 Not all wings had stocks of the different complaint forms. Prisoners had free access to complaint forms and posting boxes during association. All complaints were logged and most were answered within the stipulated timescales. The main subjects of complaints were property, visits and security. Of the complaints that we checked, most were answered respectfully and addressed the issue at hand. We found a few examples of responses in which prisoners were asked to resubmit their complaints to another person, rather than them being passed to that person to provide a response.

Housekeeping point

2.120 A stock of the various complaint forms should be available on all residential units.

Legal rights

2.121 There should be a full-time legal services officer, who should see all new receptions. (3.103)

Not achieved. The legal services officer post was not full time. Two staff provided limited back-up, mainly serving recall packs to enable prisoners to challenge the recall. All new receptions were provided with information about legal services on induction but they were not interviewed by legal services staff.
We repeat the recommendation.

2.122 Legal services should be advertised and promoted across the establishment. (3.104)

Not achieved. There were legal services notice boards in the first night centre and on B wing but not in any other locations around the prison. Prisoners we spoke to were not aware of how to obtain legal advice.
We repeat the recommendation.

2.123 Monitoring of the legal services should take place to identify trends, workload, training needs of the legal services officer and quality of the service provided. (3.105)

Not achieved. No monitoring of legal services had been undertaken.
We repeat the recommendation.

2.124 Resources in the legal services office should be improved and updated. (3.106)

Achieved. Legal services had been recently relocated to an office in the first night centre. It

was adequately equipped and held information about legal representatives and some law reference books.

Additional information

2.125 Prisoners were provided with stationery and free legal letters if they were involved in ongoing cases. They could also apply for free telephone calls to their legal representatives.

2.126 There were arrangements for legal visits but there were not sufficient private interview rooms. Legal interviews were sometimes held in the open visits area, which did not allow sufficient privacy.

2.127 There was a video-link court room and two private video-link interview rooms, which were all well used. The court link had been used, on average, more than 80 times a month.

2.128 Bail information services were provided by two Probation Service officers. They interviewed all new remand prisoners to assess their requirement for bail services. They provided liaison with legal representatives, checked addresses and liaised with probation offender managers. Over the previous 12 months, they had written 100 bail assessment reports for courts. Accommodation was available through ClearSprings and there had been 62 referrals, resulting in 20 releases, over this same period.

Further recommendation

2.129 There should be sufficient private interview rooms to accommodate all legal visits.

Faith and religious activity

2.130 Prisoners should not have to apply to attend corporate worship. (5.45)

Not achieved. Prisoners were seen on induction by the chaplaincy team and their faith identified. They were invited to attend corporate worship and those who expressed a wish to attend were assessed by the security department before being added to the list to be unlocked for worship. Prisoners who had not expressed a wish to attend at the induction interview had to make an application, which was then assessed by the security department. Prisoners who were refused access to corporate worship were offered individual access to chaplains for worship.
We repeat the recommendation.

2.131 A Buddhist chaplain should be appointed as soon as is practicable. (5.46)

Achieved. An approved Buddhist chaplain attended monthly.

2.132 Multi-faith facilities should be adequate to meet the needs of those faith groups using the facilities. (5.47)

Partially achieved. The chapel was designated as a multi-faith area. When used by other faiths, Christian artefacts were covered by a curtain. There was a small multi-faith room with washing facilities but this was closed at the time of the inspection due to an infection of the water supply.
We repeat the recommendation.

Additional information

2.133 The chaplaincy provided a range of faith leaders, who were able to conduct corporate worship for all the faiths and denominations represented in the prison. Mormon prisoners were not able to meet their faith leader, as he could only come to the prison on Sundays, when there were insufficient staff to admit him.

2.134 Sunday worship conflicted with exercise, which affected attendance on fine days. Access to the chapel for prisoners with a disability was poor and individual worship was provided for those who could not access the chapel.

2.135 As well as corporate worship, the chaplaincy provided Christian Bible study for vulnerable prisoners and the Alpha Course for those on main location. The Muslim chaplain provided a Muslim theology course. No other non-religious moral guidance courses, such as victim awareness, were provided.

2.136 Although they did not have structured links with a community chaplaincy programme, prisoners who requested it were put in touch with faith organisations in their release area. Prisoners who might present a risk to the public were referred to the probation department, to ensure that faith organisations were appropriately briefed.

2.137 The chaplaincy team was represented on an appropriate range of prison management groups and was consulted on licence applications, sentence planning and lifer boards.

Further recommendations

2.138 Prisoners attending corporate worship should be allowed to take exercise.

2.139 Disabled access to the chapel should be provided.

Housekeeping point

2.140 Corporate worship should be available for Mormon prisoners.

Substance use

2.141 The substance misuse team should be found appropriate accommodation that allows them to undertake assessments at the point of reception effectively. (3.116)

Not achieved. The reception area remained crowded. Due to the lack of facilities, the substance misuse team conducted assessments on the first night centre, but prisoners were often not fast-tracked from reception, and this caused undue delays.
We repeat the recommendation.

2.142 Psycho-social support should be provided to all prisoners receiving clinical support for substance misuse as part of the overall programme of provision. (3.117)

Not achieved. While CARAT workers provided a good level of one-to one support to prisoners receiving opiate substitute treatment, there was no structured programme of psychosocial support. Due to a lack of establishment support, IDTS group work modules were not yet

running, and the clinical substance misuse team was not sufficiently resourced to co-facilitate groups.
We repeat the recommendation.

2.143 Joint care planning should be undertaken between the counselling assessment referral advice and throughcare (CARAT) and the substance misuse teams to ensure continuity of provision for those on clinical support. (3.118)

Partially achieved. Under the IDTS, joint work between the CARAT and the substance misuse teams had improved but was still ad hoc; a designated CARAT worker liaised with substance misuse nurses daily, shared clients' care plans and helped to ensure continuity of treatment on release. However, the teams were not yet fully integrated and did not meet formally to discuss care coordination or co-facilitate group work modules.

Further recommendation

2.144 CARAT and clinical substance misuse services should be further integrated and undertake joint care plans and reviews.

2.145 The establishment should appoint a general practitioner with special interest to ensure both a flexible and consistent substance misuse programme. (3.119)

Achieved. All GPs working at the establishment had undertaken parts one and two of the Royal College of General Practitioners training. The substance misuse lead GP provided two sessions a week to assess and review clients; however, this was not sufficient to ensure regular reviews of all patients under the IDTS.

Further recommendation

2.146 The prison, in partnership with the clinical substance misuse provider, should ensure that all patients receive regular treatment reviews.

2.147 A voluntary testing and/or drug-free area should be identified within the establishment for prisoners to move to after completing a substance misuse programme, without requiring enhanced status. (3.120)

No longer relevant. The prison no longer had a voluntary drug testing/drug-free landing, and under the IDTS, the number of prisoners on methadone maintenance regimes had increased. C wing was now the designated IDTS unit. Voluntary drug testing was available to prisoners, irrespective of location or IEP status.

2.148 Management information regarding mandatory drug testing (MDT) should be collated separately from that supplied specifically for key performance target purposes and should include a detailed breakdown of information by wing. (3.121)

Achieved. MDT data were closely analysed by type of test (random, suspicion, frequent or risk testing), results, type of drug and wing, and discussed at both security and drug strategy committee meetings. Figures quoted at the time of the inspection had the random MDT positive rate averaging at 14.8% over the previous 12 months, against a target of 15%; as of April 2010, the target was set at 12.5%.

2.149 The management of suspicion testing should be reviewed to ensure that appropriate staffing levels are available and that testing is not undertaken on a predictable basis. (3.122)

Not achieved. While testing was not undertaken on a predictable basis and included weekends, figures quoted at the time of the inspection said that only 15 suspicion tests had been conducted between October 2009 and March 2010 and MDT remained a flexible task. The establishment did not monitor whether suspicion tests were always conducted within the required timeframe.

Further recommendation

2.150 The establishment should ensure that suspicion testing is conducted within the required timeframe.

Additional information

2.151 The establishment had implemented the IDTS in October 2009. The clinical IDTS team was severely understaffed and carried seven vacancies. During the inspection, 140 prisoners were receiving clinical support. While prescribing regimes were flexible, treatment did not start until the day after arrival at the prison, with only symptomatic relief available to opiate-dependent prisoners.

2.152 Alcohol and benzodiazepine detoxification began immediately after arrival, and prisoners experiencing severe withdrawal were admitted as inpatients. There were plans to close inpatient beds, since facilities on the first night centre and C wing did not allow for unrestricted monitoring.

2.153 C wing had become the prison's IDTS unit, but it also accommodated other prisoners. There was no designated landing and no supportive regime, and some officers demonstrated an uncooperative and unhelpful attitude.

Further recommendations

2.154 Opiate dependent prisoners should have access to effective first night treatment, and substitute prescribing regimes should start without delay.

2.155 The prison should ensure that prisoners undergoing severe withdrawal are managed safely.

2.156 The prison should provide a supportive regime to prisoners located on the integrated drug treatment system (IDTS) unit. All discipline staff working on C-wing should receive substance misuse awareness training, and unhelpful attitudes/behaviour should be challenged.

Diversity

2.157 The diversity strategy document should be broadened to include the policy towards elderly and openly homosexual prisoners, and these issues should be standing agenda items on the diversity committee. (3.32)

Not achieved. The prison did not have a current prisoner diversity strategy document.

Although there was no policy which addressed the needs of gay prisoners, they were able to access condoms (see paragraph 2.216) so that they could practice safe sex. The prison held 54 prisoners over the age of 50, the maximum age being 74. There was little special provision for older prisoners in their location, treatment, conditions or activities.

Further recommendation

2.158 The prison should develop a diversity strategy document, in consultation with prisoners, which addresses all strands of diversity.

Additional information

2.159 The prison had recently appointed a new diversity manager to replace the previous incumbent, who had been on sick leave for more than 12 months. The newly appointed diversity manager was fully committed to delivery of the short duration drugs programme and was due to be absent for five weeks at another establishment for training. He had not received training in diversity management.

Further recommendation

2.160 The diversity manager should receive formal training in his duties and his post should be ring fenced to enable him to cover his duties.

Race equality

2.161 Those staff in contact with prisoners should receive diversity training on appointment, and refresher training at least every three years. (3.45)

Not achieved. Initial training for operational staff included a component on diversity. The only diversity training for staff in post was the 'challenge it, change it' programme, which addressed staff diversity issues.

2.162 A deputy race equality officer (REO) should be appointed and trained. (3.46)

Not achieved. A member of staff had been nominated as relief race equality officer but he had not been confirmed in post and had not been trained.
We repeat the recommendation.

2.163 The quality of racist incident report forms (RIRF) should be externally assured. (3.47)

Achieved. RIRFs were audited by an external assessor, appointed in July 2008. She was the Lincoln Police equality adviser, and she reviewed a sample of 5% of RIRFs every six months. The reports she produced contained suggestions for improvement where appropriate.

2.164 An intervention should be developed to address racist behaviour and bullying. (3.48)

Not achieved. There was no structured intervention available for perpetrators of racist behaviour. When racist behaviour was identified in a RIRF, the perpetrator was provided with advice on his behaviour from the REO.
We repeat the recommendation.

2.165 Impact assessments should be brought up to date, and prisoners actively involved in their completion. (3.49)

Achieved. During 2009, six impact assessments had been completed and approved. A new system of impact assessments had been introduced which involved full prisoner consultation. The first of these had been to assess visiting arrangements, and the report reflected prisoner and visitor consultation. The findings of the report were insightful and the proposed actions were relevant. There was a programme for the year to complete a further 10 assessments.

2.166 Procedures should be developed to identify and make staff aware of prisoners with a history of racially motivated offending. (3.50)

Partially achieved. A database of prisoners with a history of racially motivated offending and those suspected of presenting a risk of racially motivated behaviour was compiled by the REO. She relied on cell sharing risk assessments completed on reception, information from the security department and RIRFs. The database was updated weekly and circulated to wing senior officers. Awareness of the database among senior officers we spoke to was inadequate and they did not make use of the information to ensure that all wing staff were aware of the risk.

Further recommendation

2.167 Information circulated about prisoners presenting a risk of racially motivated behaviour should be known by wing staff and used to support effective supervision of prisoners' behaviour.

2.168 A monthly black and minority ethnic prisoner consultation meeting should be run, and the issues raised discussed at the race equality action team (REAT) and other relevant prison committee meetings. (3.51)

Partially achieved. There were race equality prisoner representatives on each wing and they met staff wing representatives bi-monthly. Attendance by prisoners was poor. The meetings were minuted and action taken to address matters raised either by the REO or through the Lincoln equality action team (LEAT) committee.

Further recommendation

2.169 A monthly meeting, open to all black and minority ethnic prisoners, should be held and the issues raised discussed at the Lincoln equality action team (LEAT) meeting.

2.170 The establishment should organise events to celebrate racial, ethnic and cultural diversity, working collaboratively with external partner organisations. (3.52)

Achieved. There had been events for Black History Week in October 2009, and food from different cultural backgrounds offered on the prison menu. An event had also been held for Travellers. The events were publicised in prisoner publications.

Additional information

2.171 At the time of the inspection, there were 93 prisoners (15%) from a black and minority ethnic background at the prison. There was a newly appointed REO, who had not received formal

training. Since her appointment, she had frequently been redeployed to other duties and did not have sufficient time to fulfil her role. During the week of the inspection she was redeployed for six half-days.

2.172 Race equality was considered at the LEAT meeting, which was chaired by the governor or deputy governor. The LEAT considered ethnic monitoring at every meeting, and the indicators for black and minority ethnic prisoners were in range in all areas.

2.173 The number of RIRFs submitted each year was consistent: there had been 62 in 2008, 64 in 2009 and 20 in 2010 to date. Those we examined had been appropriately investigated and signed off by a senior manager. Staff challenged racist behaviour by prisoners and complaints were dealt with fairly. A complainant protection action plan had been completed where required. A small number had been inappropriately submitted by staff who had been accused of racism.

Further recommendation

2.174 The REO should receive formal training in her duties and her post should be ring fenced to enable her to cover her duties.

Foreign national prisoners

2.175 Work with foreign national prisoners should be covered by a dedicated prison committee meeting to which prisoners should be invited. (3.59)

Achieved. The foreign national committee met bi-monthly. It was chaired by the deputy head of residence and included relevant prison departments. UK Border Agency (UKBA) staff were invited but had not attended any of the last three meetings and there was no independent organisation represented.

Further recommendation

2.176 An independent immigration organisation and the UK Border Agency (UKBA) should be represented at meetings of the foreign national committee.

2.177 The foreign nationals liaison officer post should be ring fenced, with cross-deployment to other duties only taking place in emergency situations. The support offered to foreign national prisoners should be published to prisoners. (3.60)

Achieved. The foreign nationals liaison officer post was full time and ring fenced. In the previous 12 months he had been deployed to other duties, on average, only three half-days a month, except for November 2009, when his redeployment had risen to an unacceptable level. Foreign national prisoners were provided with information about services, in their own language, in the first night centre and there were informative notice boards in wing association areas.

2.178 Telephone translation services should be used routinely when new prisoners with little or no use of English arrive at the establishment, and when required at other times. (3.61)

Achieved. Evidence from invoices showed that there was extensive use of telephone interpreting services in the prison. In November and December 2009, they had been used on 33 and 39 occasions, respectively. We were told that this had included induction meetings with prison departments and adjudications.

2.179 A greater range of translated materials should be provided to prisoners, including key information about prison rules and regimes. (3.62)

Achieved. Both local and national prisoner information books were available in reception and in the first night centre in a range of appropriate languages. In the first night centre, staff had also translated prisoner compacts and health and safety notices. Staff were concerned that some translations were not entirely accurate, one example being a Russian handbook which had translated 'exercise yard' as 'execution yard'.

Housekeeping point

2.180 The accuracy of translated material should be verified.

2.181 A list of staff and prisoners able to speak languages other than English should be developed and kept up to date. (3.63)

Not achieved. A request for staff with a second language to provide interpreting services had not received a good response. Prisoners willing to interpret had signed up to a compact but there was no central list compiled and updated. The wing prisoner representatives provided some interpreting services and informal arrangements were facilitated.
We repeat the recommendation.

2.182 Foreign national prisoner wing representatives should be appointed and monthly consultation meetings held. (3.64)

Partially achieved. There were foreign national prisoner representatives on each wing. They met wing officer representatives approximately every two months but the attendance of prisoner representatives was poor. The quality of services was monitored through these meetings but there was no structured monitoring of outcomes through wider prisoner consultation or surveys.

Further recommendation

2.183 Foreign national prisoner wing representatives should attend all consultation meetings, and the outcomes for foreign national prisoners should be monitored annually by prisoner consultation and surveys.

2.184 Foreign national prisoners not receiving monthly visits should be provided with a credit to the value of a five-minute telephone call to their families and friends abroad. (3.65)

Achieved. Staff and prisoners told us that this system operated effectively, and a governor's notice to staff and prisoners outlined the system. It was described in the foreign national policy document but this was contradictory because one section stated that it was policy that prisoners with family in another country would be allowed free calls, regardless of whether they received visits. This would have spared prisoners the dilemma of choosing between a visit and a telephone call if they had family both in the UK and abroad.

Further recommendation

2.185 Prisoners with close family abroad should be given a free five-minute telephone call every month, regardless of whether they receive visits, as outlined in the foreign national policy document.

Additional information

2.186 Eighty-two people (13% of the population) were foreign national prisoners; 14 were detainees held beyond their sentence expiry date. Ten detainees had been sent to the prison following a disturbance at an immigration removal centre. A special surgery with UKBA had been organised within five days of their arrival.

2.187 There was a full-time foreign nationals coordinator but he did not have a deputy to provide cover when he was away from the prison. There were duties which required prompt action, especially when a foreign national prisoner was served with a deportation notice, which needed to be covered at all times.

2.188 Monthly surgeries were provided by UKBA. All detainees beyond the end of their sentence were referred and other prisoners could apply to attend. This meeting was publicised through wing representatives and notices on wing notice boards but one seen during the inspection was out of date

2.189 The foreign nationals coordinator provided information through written material and personal advice on the services of independent immigration services but the latter did not provide a service in the prison.

2.190 There was no staff training in awareness of the specific needs of foreign national prisoners.

Further recommendations

2.191 The duties of the foreign nationals coordinator should be covered by a deputy or competent staff in his absence.

2.192 An independent immigration advisory service should be available for foreign national prisoners.

2.193 Training in the specific needs of foreign national prisoners should be provided for all residential staff.

Housekeeping point

2.194 UKBA clinics should be accurately publicised on wing notice boards.

Older prisoners and disability

2.195 A disability liaison officer should be appointed with ring-fenced time to assess and meet the needs of all disabled prisoners, and to ensure that appropriate adjustments are made. (3.33)

Not achieved. Two members of staff were identified as having responsibility for disability

liaison but their time was not ring fenced.
We repeat the recommendation.

2.196 Disability-specific and broader diversity training should be offered to key staff in contact with prisoners. (3.34)

Not achieved. Specific training on meeting the needs of prisoners with a disability was not provided.
We repeat the recommendation.

Additional information

2.197 At the time of the inspection, there were 26 prisoners registered as having a disability. The prison identified prisoners with a disability through the health care interview on reception and by self-declaration on the prisoner passport. This information was passed to the disability liaison officer in the health and safety department, who compiled a register of prisoners with disabilities. He passed the information to the fire safety officer, who devised a personal evacuation plan for the prisoner. We were told that personal evacuation plans were not provided if prisoners declined them. During the inspection, we met an older prisoner on E wing with arthritic hips who walked with the aid of a stick and had not been registered as having a disability, despite having declared it on his prisoner passport. He was located flat but there was no personal evacuation plan in place for him. Another prisoner with cerebral palsy had had an evacuation plan when he was located on A wing, but since moving to B wing had no plan, despite his significant disability.

2.198 None of the prisoners with a disability had care plans or had been consulted about their needs.

Further recommendations

2.199 Personal evacuation plans should be in place for all prisoners with any disability which compromises their ability to respond to an emergency and these should be reassessed each time the prisoner is located to a different cell.

2.200 The register of prisoners with a disability should be reviewed to ensure its accuracy, and systems put in place to ensure that it is kept up to date.

2.201 There should be a care plan for every prisoner with a disability which is reviewed every month.

Health services

2.202 Health services should be better integrated into the management of the prison. (4.52)

Achieved. The head of health services was part of the senior management team and the health care manager attended the morning operational meeting. There were quarterly prison health care board meetings, with director level representation from Lincolnshire Community Health Services (the provider arm of the primary care trust (PCT), NHS Lincolnshire), the governing governor and the head of health services. Representatives from the health care department were included and attended a range of wider strategic prison meetings, including safer custody, security, resettlement and drug strategy. We observed positive relationships between individual health services staff and discipline staff. However, we observed significant delays for IDTS prisoners in receiving their medication, due to discipline staffing issues and

insufficient help to the nurses in getting medication administered on time; we were told that this was a regular occurrence.

Further recommendation

2.203 The prison should ensure that IDTS is appropriately staffed/supported by discipline staff to ensure that prisoners get their medication on time.

2.204 The health needs assessment should be reviewed and an action plan devised. (4.53)

Not achieved. There was no current finalised health needs assessment. We were told that a new health needs assessment had been completed in December 2009 and was currently in draft form; there was reference to this in the prison partnership board minutes.
We repeat the recommendation.

2.205 There should be a full infection control audit carried out and an action plan devised and acted upon. (4.54)

Partially achieved. There was an overarching PCT infection control policy, with specific guidance on issues such as hand washing. There was a template for wing-based audits but we did not see reports of these. There had been an external central audit in 2009 but there was no report or action plan from this. An external PCT audit was scheduled for June 2010. The treatment rooms in the dental suite had been clad with a special antimicrobial wall covering. All of the main health care treatment/clinical rooms had been refurbished and met infection control standards. Cleaning of the main health care department was done by a wing cleaner for the ground floor corridors, general communal areas and the inpatient area. All clinical rooms and offices and the upper floor were cleaned by porter/housekeepers. We did not see cleaning schedules (see also paragraph 2.7).
We repeat the recommendation.

2.206 All the current Service Level Agreements should be reviewed to ensure that prisoners receive an appropriate level of care. (4.55)

Partially achieved. Service Level Agreements for dental, podiatry, physiotherapy and genito-urinary medicine services had been reviewed in 2009. Other agreements were pending an outcome from the health needs assessment. This included optometry which had not been reviewed since 2007. There were long waiting lists for the dental and optometry services (see recommendation 2.228). The dental provider had recently withdrawn services in advance of the agreed termination date and this had further increased dental waiting times. At the time of the inspection, there was no podiatrist and services were being provided by an external podiatrist, with prisoners being escorted out for appointments.
We repeat the recommendation.

2.207 Prisoners should be given information about prison health services in a format that they are able to understand, which explains how to access the services. (4.56)

Partially achieved. Prisoners were not given any written information about health services. At the time of the inspection, a review on the information leaflet was being carried out. General health services and mental health staff each had a slot on the first day of the induction programme.
We repeat the recommendation.

2.208 Health promotion materials, including oral health promotion, should be available and health promotion activities encouraged. (4.57)

Not achieved. There was limited health promotion literature available for prisoners in the main health care department but none elsewhere; there was no literature in other languages. Oral health promotion was limited to individual dental consultations. A smoking cessation programme ran two clinics a week, with 15 prisoners a month, and there was a waiting list. There was no coordinated approach to health promotion.
We repeat the recommendation.

2.209 There should be regular, documented checks of all emergency equipment. (4.58)

Achieved. Airway bags and defibrillators were kept on A, C and E wings. B wing relied on A wing for equipment. J wing was distant from other areas and had no emergency equipment, but we were told that equipment had been ordered for this wing. Emergency medicines were kept on E wing and in the main health care department, checked by nursing staff and restocked on request by pharmacy staff. Additional equipment was kept in the main health care department, and on C and E wings. We noted daily checks documented appropriately on B, C and E wings but we did not inspect the equipment on A wing or the main health care department. Minutes of the clinical governance meetings indicated that there was a current review of the contents and siting of emergency kits.

2.210 All staff should have annual resuscitation training. (4.59)

Achieved. We were told that all nursing staff had received annual intermediate life support updates during 2009, which included practical skills training. Three of the nurses had completed advanced life support training. The band six clinical leads were responsible for managing their own staff training updates but there was no system of assurance for the head of health care. The Lincolnshire PCT policy required all staff delivering direct patient care to have annual basic life support training.

2.211 All clinical records should be kept securely in accordance with the Data Protection Act and Caldicott principles. (4.60)

Achieved. SystmOne was used, with reference to paper records confined to prisoners transferring from other prisons. All staff using SystmOne had individual password-protected access. Paper clinical records for current prisoners were stored securely in a health care room on E wing. All archived clinical records were stored securely in a locked store room in the main health care department. We were told there were plans to archive old records off site. The role of Caldicott guardian was held by the PCT governance lead.

2.212 There should be an information-sharing policy that includes obtaining written consent from prisoners to obtain and share clinical information about them. (4.61)

Not achieved. There was no general information-sharing policy and prisoners were not routinely asked to sign consent to information sharing. We saw one example of a signed compact for prisoners on the IDTS programme retained with the prescription chart.
We repeat the recommendation.

2.213 There should be triage algorithms to ensure consistency of advice and treatment. (4.62)

Not achieved. There were no triage algorithms. There were wing-based nurse triage clinics alongside medication rounds, but staffing pressures meant that prisoners had limited time in

which to see nurses. Some nurses had completed triage training.
We repeat the recommendation.

2.214 There should be a centralised system for the maintenance of lifelong condition registers. (4.63)

Not achieved. There were band six clinical leads for diabetes, asthma, coronary heart disease and blood-borne viruses. The clinical leads held separate registers but there was no centralised register enabling a systematic and structured approach to clinical management.
We repeat the recommendation.

2.215 All disease prevention programmes should be available to prisoners, in line with national and local campaigns. (4.64)

Partially achieved. Prisoners were offered screening and immunisation for hepatitis B and Chlamydia, although this was not routine. The visiting genito-urinary medicine service provided access to hepatitis A and C screening and treatment. Prisoners were not routinely offered childhood immunisations.
We repeat the recommendation.

2.216 Barrier protection should be freely available. (4.65)

Achieved. Prisoners were able to access condoms and lubricant by attending designated clinics. Prisoners were required to return all used condoms to enable resupply.

Further recommendation

2.217 Prisoners should be able to access condoms easily, without having to attend a clinic and return used items.

2.218 Prisoners should be able to see a pharmacist. (4.66)

Achieved. There were two pharmacist sessions a week to give pharmacy advice, but uptake by prisoners was low. We were told that prisoners tended to consult the nursing staff about their medication.

Further recommendation

2.219 Take-up of pharmacist consultation time should be improved.

2.220 The medicines and therapeutics committee should review and agree stock levels, and there should be an audit trail of all medications supplied, prescribed and administered. (4.67).

Partially achieved. The April 2010 committee minutes indicated that there was a 'near completed' pharmacy stock list. We were told that there were stock lists for each wing, the emergency out-of-hours cupboard and for the emergency drugs. We observed that pharmacy assistants had limited time to monitor stock, due to access to drug cupboard keys. Dual labelling was used, with one pharmacy-generated label attached to the medication pack and the second label attached to a composite stock sheet for the wing; this second label did not have the patient's name or other details on it, which made it impossible easily to audit the

stock that had been administered to individual patients. We were told that a new system was due to be trialled in June 2010.
We repeat the recommendation.

2.221 The medicines and therapeutics committee should review all health care policies and ensure that they are implemented and adhered to. (4.68)

Partially achieved. There was evidence from the April 2010 minutes that there had been some review of local standard operating procedures. There were overarching PCT policies for controlled drugs and the safe handling of medicines. There was some evidence of monitoring of adherence to policies and standard operating procedures in the minutes but we did not see records confirming this.
We repeat the recommendation.

2.222 Secondary dispensing by health services staff should cease; medication should be pre-packed and dual labelled by pharmacy staff. (4.69)

Achieved. All medication was dispensed by the provider pharmacy, either in named-patient boxes or individual blister doses, into pre-labelled Henley bags. There was no patient information in the bags. Patients given Henley bags were risk assessed for in-possession medication. All risk assessments were filed in the paper clinical records and copies held in the pharmacy. There were a few copies filed with prescription/medication administration charts. When prisoners were deemed suitable to have only certain types or quantities of medication in possession, Henley bags and/or supervised medication were used on an individual basis. Night sedation for prisoners deemed unsuitable to have it in possession was delivered in single-dose Henley bags by the nurse through the locked cell hatch to prisoners in single cells.

Further recommendations

2.223 Patient information should be included in medication bags.

2.224 In-possession risk assessments should be filed with the prescription/medication administration chart to ensure that the prescriber has up-to-date information.

2.225 Additional medication rounds should be carried out to remove the need for delivering Henley bags through cell hatches.

2.226 Prescription and administration charts should be used correctly. They must be clearly annotated by health services staff to ensure that it is possible to distinguish between witnessed administration of medication and those issued daily in-possession. (4.70)

Partially achieved. There were two separate prescription/medication administration charts for each patient, filed separately in the wing treatment rooms; one chart was only for in-possession medications and the second was only for supervised medications. Patients on the IDTS programme had a third, separate photocopied chart, with a specific chart for methadone/suboxone/buprenorphine as appropriate. Few charts contained the patient's first name, and none had photographs or diagnoses.

Further recommendation

2.227 There should be a single medication/prescription chart for each patient for both in-possession and supervised medication; where unavoidable, any additional charts should be clearly numbered and attached.

2.228 The dental contract should be revised to ensure that there are sufficient sessions to meet the demands of the population. It should be regularly reviewed by the primary care trust (PCT). (4.71)

Partially achieved. The dental contract had been reviewed and a third session commissioned since the previous inspection. There had been no formal needs assessment and there were 147 on the waiting list at the time of the inspection, with an average wait for routine treatment of three months. We were told that there was now an almost 100% attendance rate due to the new prison free-flow system.
We repeat the recommendation.

2.229 There should be out-of-hours dentistry cover. (4.72)

No longer relevant. See paragraph 2.230.

2.230 A protocol should be developed to assist the health services staff when dealing with dental emergencies in the absence of the dental team. (4.73)

Achieved. There was a protocol for dealing with routine, urgent and dental emergencies utilising the general health care services, the current dental sessions and escalating to use of the Accident and Emergency department at the nearby hospital in cases of major facial trauma and/or severe bleeding.

2.231 Health services bed spaces should not form part of the prison's certified normal accommodation, and admission should only be on the basis of clinical need. (4.74)

Not achieved. There were 11 health care beds, which were all part of the certified normal accommodation. There was an admission protocol that was poorly worded and did not restrict admission to clinical criteria. Approximately 25% of all admissions during the previous year had been for non-clinical reasons. We were told that there were plans to remove the facility for inpatients altogether.
We repeat the recommendation.

2.232 Day care services that provide constructive activity should be available to inpatients and prisoners who are less able to cope with life on the wings. (4.75)

Not achieved. There were no therapeutic activities for inpatients or vulnerable prisoners. We were told that there were plans to modify the current unused inpatient association room into a multi-purpose day service.
We repeat the recommendation.

2.233 Mental health awareness training should be provided to discipline staff, in particular those working in the health care department, the segregation unit and reception. (4.76)

Not achieved. Some segregation staff had received mental health awareness training. The new mental health service model included awareness training but had only started in April

2010 and the first priority had been to embed the clinical services.
We repeat the recommendation.

2.234 The referral criteria for the mental health in-reach team should be reviewed. (4.77)

No longer relevant. The mental health provision had changed and the new service model was integrated, with clear referral pathways and access through self-referral, and referral from other professionals and wider prison staff.

2.235 All prisoners needing assessment by specialist mental health services should be seen within seven days and transferred expeditiously. (4.78)

Partially achieved. The new mental health service model, incorporating Improving Access to Psychological Therapies (IAPT) and a Community Assertive Treatment Team (CATT), meant that all non-urgent referrals were assessed within two weeks. Newly arrived prisoners with acute needs were seen as soon as feasible, either in reception or on the induction wing, by the on-call nurse on request. Patients could be seen urgently between Monday and Saturday. Out of hours and on Sundays, there was urgent/emergency access to the local community mental health team. There had been seven transfers under the Mental Health Act in the previous year, five of which had been made following assessment in prison and two had been court-directed transfers. All of the secondary assessments had been achieved within two weeks. Six of the transfers had been achieved within two weeks and one within four weeks.

Additional information

2.236 Health services were commissioned by NHS Lincolnshire, general health care was provided by Lincolnshire Community Health Services and mental health services was provided by Lincolnshire Partnership Foundation Trust.

2.237 Health care complaints were handled as NHS complaints and responses were mainly appropriate and respectful, with some delays for those which were outside the NHS complaints target. Clinical incidents were logged in the same way as for NHS incident reporting (using IR1 and IR2 forms); there had been 94 incidents between September 2009 and May 2010. Some forms were incomplete and the IR2 form was often incomplete or inadequate

2.238 There was a reasonable range of primary care services, complemented by useful visiting specialist services, such as a genito-urinary medicine clinic, and links with local palliative care services. Reception health screens were completed by a registered nurse using a template. There was no access to SystmOne in reception and nurses recorded onto a paper template, which was then taken back to the health care department and transferred onto SystmOne, duplicating work and risking information being missed. The health care room in reception was clean and bright but had a partially glazed dividing wall, which allowed sound to be carried and compromised privacy for prisoners.

2.239 Secondary health assessments were completed the following day by a health care support worker on the induction wing (A wing). The assessments we saw were well conducted but the assessment template was brief and neither the reception screen nor the secondary assessment included clinical indicators such as blood pressure, height and weight.

2.240 Access to the GP and nurses was reasonable, although there was inequity between wings and there appeared to be no wing visits by health services staff for prisoners on J wing.

2.241 We observed satisfactory medication administration on all wings except J wing, where medicines were administered from a room shared with discipline staff. During the inspection, prescription charts had been left out unlocked in this room.

2.242 There were clinical leads for long-term conditions (see also recommendation 2.214) but no regular designated clinics owing to staffing pressures.

2.243 Pharmacy supplies were provided by the Co-operative Pharmacy. The PCT employed a full-time pharmacy technician and two full-time dispensing assistants. The pharmacy room in the health care department was too small for the number of staff and volume of equipment and supplies.

2.244 There was a range of patient group directions (PGDs), including for ibuprofen and paracetamol. Master copies of PGDs with accompanying signature lists were kept in the main health care department, with copies held in the wing treatment rooms. We saw the list of PGDs on C wing, some of which were overdue for review and contained few of the nurses' signatures. A prescribing audit had been completed recently but there had been no audit of medication administration or use of stocks.

2.245 There had been 65 admissions to inpatients in the previous year. During the inspection, there was one patient with acute mental health needs being cared for in an observation cell and on constant watch by discipline officers. The patient was visited daily by the mental health team, and the general nurses looked after his physical health needs. A forensic psychiatric assessment was carried out during the inspection to determine suitability for a secure placement.

2.246 Mental health staff were proactive in getting patients appropriately assessed under the Mental Health Act. In one case, the nurse had telephoned the medium secure unit every day to achieve appropriately timed assessment and consideration for secure placement.

2.247 Mental health staff attended reviews routinely for patients on their caseloads on open ACCT documents, and other reviews on request.

Further recommendations

2.248 Access to SystmOne should be made available in reception.

2.249 Privacy for prisoners in the health care reception room should be improved.

2.250 Reception screening and/or secondary health assessments should include basic clinical measurements equivalent to arrangements for new patients in general practice.

2.251 All prisoners should have equity of access to health services, including GP clinics and nurses, regardless of their location in the prison.

2.252 There should be a dedicated health care room for prisoners based on J wing, with access restricted to health services staff.

2.253 Regular designated clinics should be provided for prisoners with long-term conditions.

2.254 There should be an up-to date list of patient group directions, with appropriate signatures clearly visible in all areas where medication is administered.

Housekeeping points

2.255 IRI and IR2 incident reports should be completed fully.

2.256 More effective use should be made of pharmacy resources to improve prisoners' health and well-being.

Learning and skills and work activities

2.257 Allocation to activity spaces should be transparent and based on identified sentence planning needs. (5.19)

Partially achieved. The prison system for allocation to activity spaces was transparent and prisoners received written responses, including reasons for unsuccessful applications. However, the system did not deal with prisoners wanting education places and some wing staff allocated prisoners directly to wing jobs. In addition, the systems did not systematically use sentence plans to inform decisions.
We repeat the recommendation.

2.258 The various activity allocation systems should be better coordinated and streamlined to ensure efficient and effective use of resources. (5.20)

Not achieved. Insufficient action had taken place to ensure that the various allocation systems were adequately coordinated and activity places used efficiently. For example, the main prison system had 37 prisoners waiting for education places, yet education staff had short waiting lists. In addition, we were told that health care assessments sometimes arrived after prisoners had been allocated to activities; for example, a prisoner with a broken leg had been inappropriately allocated to a workshop.
We repeat the recommendation.

2.259 Young adult prisoners should be prioritised for access to education. (5.21)

Achieved. At the time of inspection, there were 42 young adult prisoners. The education department had prioritised support for young adults. In addition to the individual interview offered to all new prisoners, the careers information and advice staff identified all young adults entering the prison and ensured that they received an additional individual interview to identify their education and learning needs.

2.260 Senior managers should monitor and analyse pay levels to ensure that the application of the pay policy is fair. (5.22)

Achieved. The 2009 revised pay policy was fair, and based on prisoners' main allocated role, allowing for minority attendance at other activities, such as part-time education. Industries staff checked prisoners' varied payments against piece work outcomes. Other pay was monitored by prison senior managers. However, IDTS prisoners told us that they were often paid late and vulnerable prisoners said that they had longer working days than others because of their movement times.

Further recommendation

2.261 The number of hours worked by vulnerable prisoners should be equitable for the pay received.

Housekeeping point

2.262 Prison managers should ensure that IDTS prisoners receive their pay on time.

2.263 A post-inspection action plan should be designed and implemented with the full involvement of the quality improvement group. (5.23)

Achieved. A post-inspection action plan had been produced in response to the previous inspection to address the areas for improvement that had been identified. In June 2009, Ofsted had re-inspected the learning and skills provision and found that the prison had made significant improvements. Following this re-inspection, the prison had produced a further post-inspection action plan, which had been used effectively to monitor progress, and all actions had been completed by January 2010.

2.264 Data relating to the performance of all learning and skills activities within the prison should be collected, analysed and acted upon. (5.24)

Achieved. Comprehensive performance data had been collected in relation to learning and skills activities. These included the participation of prisoners in education and accredited training and the achievement and retention rates for courses. The data collected by the education department were robust and regularly shared with education staff. Prison managers analysed and evaluated other accredited learning and skills provision. All data were analysed and reported at the monthly learning and skills trend meeting. Data were also used effectively to inform judgements in the self-assessment report.

2.265 The quality of internal communications should be improved to ensure that teachers and instructors are fully aware of the resources available to address the individual needs of prisoners. (5.25)

Achieved. Staff information days had been provided in April and December 2009, to provide all staff working at the prison with detailed information about the range of learning and skills activities on offer to prisoners. A prospectus and booklets about each programme had been produced to provide reference information. In addition, the multi-channel prison-wide communication system was used to ensure that staff and prisoners were kept up to date about the learning and skills provision.

2.266 All prisoners entering the establishment should receive an appropriate assessment of their literacy, numeracy and language skills. (5.26)

Achieved. All prisoners entering the establishment had their literacy, numeracy and language skills assessed. Education staff visited the first night centre every day to carry out assessments, which were used to identify and discuss potential education needs with prisoners. A more detailed diagnostic assessment was undertaken for those who wanted to attend education courses, and this was used in the planning of their learning.

2.267 Effective individual learning plans should be introduced for all prisoners involved in education and skills. (5.27)

Partially achieved. All prisoners in education classes had a comprehensive individual learning plan which set out what they were aiming to achieve and what they had already achieved. These plans included a range of relevant information about their prior achievements, literacy, numeracy and language skills, ambitions and the progress they were making. A computer-

based individual learning plan had been introduced in other parts of the prison for those undertaking courses other than with the education provider. While this system had good features which included following the prisoner when he moved work area or undertook new courses, it was not used effectively. Many of the plans did not contain the prisoner's initial assessment results, inhibiting tutors' ability to plan effectively. Few of the learning plans we saw contained helpful information about the prisoner, the programme they were undertaking or the progress they were making.
We repeat the recommendation.

2.268 The access and facilities for information and communications technology training for vulnerable prisoners should be improved. (5.28)

Achieved. Vulnerable prisoners used the upper floor of the education department two days a week, with access to the same facilities and equipment used by mainstream prisoners at other times.

2.269 Adequate training facilities should be provided for training industrial cleaners. (5.29)

Partially achieved. Industrial cleaning training took place in practical situations where prison cleaners worked. This involved peer training and assessment from three appropriately qualified prisoners. New bespoke training facilities were due to be available later in 2010 as part of the prison refurbishment programme.

Further recommendation

2.270 The training environment for industrial cleaners should be improved by providing off-work-site practice areas.

2.271 The standard of teaching should be improved. (5.30)

Achieved. The quality of teaching and learning had improved significantly and was good. Staff had undertaken effective development in teaching and learning, and those in the education department were subject to robust lesson observations. There were effective processes to share good practice between all members of teaching staff.

2.272 The punctuality and attendance of prisoners should be improved and robustly managed by all staff. (5.31)

Achieved. Both punctuality and attendance at education had improved. A free-flow system of movement had been introduced and prisoners were more punctual at getting to their lessons. Recording and managing the attendance of prisoners at education classes was systematic and robust, and the attendance rate was about 88%. Detailed data were held about the number of education places available, how many prisoners were planned to attend and how many actually attended daily.

Additional information

2.273 Standards of teaching were monitored well by the education contractor, but the other training provision was not quality assured by the prison, relying on information from assessments that had been made during staff training.

2.274 There were around 60 education and 240 work places for each half-day session, equating to 50% of the population. This was not sufficient for the population, even taking into account remand prisoners and those difficult to place because of behavioural problems. Work was available in tailoring and textiles and charity workshops, as well as the laundry, prison kitchens, gardens, stores and as orderlies; 21% of the places were for wing cleaners. The workshops frequently overbooked to ensure sufficient prisoners arrived for work.

2.275 Since 2007, there had been a significant improvement in the achievement of qualifications by prisoners from across education and vocational training areas. For example, the number of laundry awards had increased from only eight in 2007/08 to 446 in 2008/09 and 664 in 2009/10 to date. In the education provision, further improvements had taken place since June 2009 to improve achievements on courses such as entry-level literacy.

2.276 The 2009 re-inspection had found that equality and diversity assessments remained unchanged, and action planning had not addressed how improvements could take place. There was insufficient funding for English for speakers of other languages (ESOL) provision for the population requiring this support.

2.277 The 2008–2011 learning and skills strategy had clear priorities, including research into the population using a range of indicators (see also paragraph 2.11). This had informed the choice of provision; for example, information about the short stays at the establishment had contributed to decisions about short-duration accredited courses. However, there was insufficient analysis of the use of places, classrooms and the new building's facilities to ensure that an appropriate number and range of courses was being offered to meet population needs.

2.278 The pay policy, which had been revised in April 2009, had the potential for confusion and disguising the insufficiency of activity places. It did not allow for the financial liability of prisoners not in activities, such as the 77 unemployed and 70 detoxifying prisoners. It also presumed that 90 prisoners were attending education, when in reality only between 32 and 54 prisoners actually did.

2.279 The leadership and management positions for both the prison and education contractor had changed since the Ofsted inspection in June 2009. There was a new education manager and temporary management cover awaiting the arrival of a new head of regimes, and covering the absence of learning and skills management staff through illness.

2.280 In the re-contracting of the Offender Learning and Skills Service (OLASS) provision in August 2009, Lincoln College had retained the education contract and gained the careers information and advice service (CIAS) contract. The library service continued to be contracted to Lincolnshire County Council.

2.281 The library provision was good. Book stock was appropriate for the size of the population and included audio books, easy readers and a variety of fiction and non-fiction titles. Book loss was effectively managed by daily visits to wings by library staff and support from the prison reception staff monitoring prisoners being released.

2.282 A range of books in foreign languages, and dictionaries in 26 languages, was stocked but prisoners in our groups seemed to be unaware of them. The library had close links with both a nearby prison with a large number of foreign national prisoners, with which it exchanged books, and also a request-a-book scheme using the Lincoln Library Service.

2.283 Access to the library was equitable; one visit a week was allowed for each wing, with unemployed prisoners visiting on weekdays and those in activities on Saturdays. There were

plans to improve access for prisoners in education classes during study times. There was less access to the library for those on the first night centre, D wing, health care centre and J wing, but all had book selections on their wings and a request system for other books.

Further recommendations

2.284 Prison-wide vocational training should have systematic observations to assure the quality and support staff development planning.

2.285 There should be an increased focus on equality and diversity throughout learning and skills, to ensure that improvements take place.

2.286 There should be a regular review of the need for English for speakers of other languages (ESOL) provision to ensure that adequate funding and support is provided.

2.287 Classroom use in education should be maximised.

2.288 The pay policy should be revised and used to inform decisions about the sufficiency of activity places to meet prisoners' needs.

Housekeeping point

2.289 The availability of dictionaries and books in foreign languages should be better promoted to prisoners, to ensure that they are aware of where to find them and how to obtain other books using the request system.

Physical education and health promotion

2.290 The showers in the gymnasium should be refurbished and made fit for purpose. (5.36)

Achieved. The showers had been refurbished. Broken tiles had been replaced and new floor mats had been installed. The showers were clean and fit for use, but with just seven showers there were too few for the number of prisoners who attended the gym.

Further recommendation

2.291 The number of showers for prisoners attending the gym should be increased.

2.292 The facilities for weights and the teaching of theory should be improved. (5.37)

Partially achieved. The weights area, although still located at one end of the sports hall, did not interfere with other activities, and was spacious and well equipped. It was screened from the sports hall with a low-level partition and netting to the full height of the hall. However, the facilities for theory teaching remained inadequate, taking place in a prefabricated building outside the sports hall.

Further recommendation

2.293 The facilities for the teaching of PE theory should be improved.

Additional information

2.294 PE provision was good. The number of accredited awards achieved in PE had significantly increased, from zero in 2007/08, to 10 in 2008/09 and 104 in 2009/10 to date.

Time out of cell

2.295 Prisoners should spend at least 10 hours out of their cell on weekdays. (5.54)

Not achieved. The prison recorded an average of 7.3 hours a day out of cell in the year to date, against a target of 6.5 hours. The experience of prisoners ranged from two hours 15 minutes for unemployed prisoners, to eight hours for some full-time employed prisoners. In our roll checks, we found 30% of prisoners locked in their cells on Wednesday afternoon and 52% on Thursday morning.
We repeat the recommendation.

2.296 The core day and criteria for association should be consistent across the prison, and any difference in approach should be justifiable and non-discriminatory. (5.55)

Achieved. The core day was consistent, with only minor variations. Prisoners on the short duration drugs programme (SDP) wing were unlocked for significantly longer than other prisoners, which was justified by the type of programme they were undertaking.

2.297 Prisoners should be issued with enough warm, waterproof clothing to go outside in all weather conditions. (5.56)

Not achieved. No weatherproof clothing was issued and exercise was cancelled during inclement weather. When exercise did not take place, prisoners were not offered association as an alternative.
We repeat the recommendation.

Further recommendation

2.298 When exercise is cancelled, prisoners should have the option of an equivalent period of association.

2.299 The published core day should be standardised as much as possible and should include all start and finish times. (5.57)

Achieved. The published core day applied to all wings, and variations in exercise times were documented. All start and finish times for each activity were shown.

Additional information

2.300 Findings from our roll checks (see recommendation 2.295) indicated that the prison's recording of time out of cell was not accurate. The amount of time unlocked for unemployed prisoners and those in part-time activities was too restricted.

2.301 Association was, in the main, reliably offered and well supervised. Interaction between staff and prisoners at these times was reasonable (see also section on staff–prisoner relationships).

Prisoners on J wing had their association curtailed too often, in order to free staff to cover other shortfalls or attend emergency escorts. On the evening visit we carried out, all J wing prisoners were locked up, as J wing staff had taken a prisoner out to hospital on an emergency, leaving no staff deployed on J wing, despite its isolated location.

2.302 Prisoners who were unemployed or in part-time activities only had association in the afternoons, which meant that they could not make evening telephone calls, restricting contact with family and friends who were not at home during the day.

2.303 The activities available during association were limited to pool, table tennis and table football. There were few tables and chairs available in association areas, which meant that prisoners did not use the board games available. No recreational education took place during association.

2.304 There were two main exercise yards and two small yards for J wing and the segregation unit, respectively. The yard used by A and B wings contained some metal benches but the other main yard used by C and E wings was bare. There was litter on both main yards.

Further recommendations

2.305 The prison should review its recording of time out of cell to provide an accurate average.

2.306 When staff shortages require prisoners on J wing to have their association curtailed, alternative provision should be made for them on other units.

2.307 All prisoners should have some evening association during the week.

2.308 Prisoners should be offered a wider range of activities during association, including recreational education, and more seating should be provided in association areas.

Housekeeping point

2.309 Exercise yards should contain adequate seating for prisoners and be kept clean.

Security and rules

2.310 All security information reports (SIRs) should be responded to in a manner that ensures that action can be taken in a timely way. (6.12)

Partially achieved. SIRs received at weekends were often not processed until Monday, unless urgent. Some suspicion drug tests were therefore carried out later than would be desirable and monitoring of suspicion testing was not sufficient to ascertain how many were carried out on time. Many target searches had not been carried out from up to three months previously owing to a shortage of staff.

Further recommendation

2.311 Suspicion drug tests and target searching should be carried out within a reasonable time.

2.312 The REO should have unrestricted access to SIRs in which a racist element is suggested. (6.13)

Achieved. The race equality officer was informed by email when an SIR had a racist element, and was able to access the SIR in full if necessary.

2.313 Security information should be recorded on the security intelligence system within 24 hours of being received. (6.14)

Partially achieved. During the week, security information was recorded within 24 hours but there were no staff available to carry out this work at weekends.

Further recommendation

2.314 Security information received at weekends should be entered on the security intelligence system within 48 hours. Urgent information should be considered by the duty manager immediately.

2.315 Sufficient staff should be trained and profiled to analyse the security data received, and the results of this should be used to establish security priorities. (6.15)

Achieved. There were sufficient staff trained and profiled to analyse security data, and detailed and well-monitored security priorities were developed and discussed at monthly security committee meetings.

2.316 Unsentenced prisoners should be held in the most convenient local prison for their domestic and legal visits. (6.16)

Partially achieved. Prisoners could apply to transfer to a prison closer to home, and efforts were made to effect the transfer, but national population pressures sometimes made this difficult. It was hard to ascertain the number of prisoners waiting for transfer but prison staff estimated that at least 35 prisoners were waiting for transfer to category C conditions.

Housekeeping point

2.317 A record should be maintained of the number of prisoners waiting for transfer to category C conditions.

2.318 Sufficient spaces should be available to move category B and C prisoners to training prisons where their sentence planning needs can be met. (6.17)

Partially achieved. While efforts were made locally to move prisoners to prisons where they could achieve their sentence planning targets, national population pressures impacted on this. There was no regional strategy to address the matter.

Further recommendation

2.319 A regional strategy should be developed and implemented to facilitate the transfer of prisoners to training prisons where their sentence planning needs can be met.

Additional information

2.320 The security department was overseen by a senior manager and managed day to day by a principal officer. The security committee met monthly and was well attended by staff from various departments. The discussions included security intelligence, closed visits, searching and drug testing information. The minutes gave a detailed account of the meeting and provided staff with information relating to security objectives and what was required of them. There had been 2,440 SIRs submitted in 2009 and 692 in 2010 to date. The main security issues were drugs, mobile telephones and bullying issues among prisoners. Relationships with other departments were reasonable and representatives from key areas attended the monthly meetings.

2.321 The physical security comprised a secure inner perimeter. Prisoner movement in this area was necessarily restricted, although managers had recently introduced some free-flow movement. Staff considered security information dating back three to six months when allocating prisoners to work or education. The police intelligence officer was involved in the work of the department and provided support to the gathering and analysis of information.

2.322 Processes relating to closed visits were over-restrictive. There were 41 prisoners subject to closed visits at the time of the inspection. Few had been placed on closed visits following illicit activity related to visits. In many cases, prisoners were placed under restrictions following a positive screening test for drugs and before the associated adjudication had been completed. Eleven visitors had been banned from visiting following incidents in the visits hall. Reviews took place monthly and prisoners were informed of the outcome of the reviews.

Further recommendation

2.323 Prisoners should only be placed on closed visits as a result of intelligence or incidents related to visits.

Discipline

2.324 During adjudications, prisoners should be provided with a pen and paper, and those found guilty given details of how to appeal. (6.34)

Partially achieved. Prisoners were not provided with a pen and paper during adjudications. Written information on how to appeal was given at the conclusion of the adjudication.

Housekeeping point

2.325 Prisoners should be provided with a pen and paper during adjudications.

2.326 A suitable waiting area should be provided for prisoners attending adjudication hearings. (6.35)

Not achieved. The waiting area had not been improved. It was a small cell containing three chairs and was dirty, hot and stuffy.
We repeat the recommendation.

2.327 Where appropriate, charges should be laid promptly to maintain the credibility of the adjudications process. (6.36)

Achieved. Charges were laid promptly where appropriate and management quality assurance checks ensured the credibility of the adjudications process.

2.328 Use of force paperwork should be comprehensively completed and properly authorised. (6.37)

Partially achieved. Use of force documentation was completed in full detail in most cases. Use of force was mainly authorised by staff who subsequently certified it (see also recommendation 2.329).

2.329 The authorising officer should not also be involved in the use of force, and all staff involved should be trained in control and restraint. (6.38)

Not achieved. In most cases, force was authorised by staff involved in the use of force. At the time of the inspection, 83% of staff had been trained in control and restraint, which was a reduction on previous months, when it had been over 90%.
We repeat the recommendation.

2.330 All planned uses of force should be video-recorded. (6.39)

Achieved. Planned uses of force were video-recorded. The quality of the recordings was poor in some instances and the prisoner was barely visible in one video that we viewed.

Further recommendation

2.331 Staff should be trained in how to use the video recorder for planned uses of force and recordings should show the prisoner clearly where possible.

2.332 Prisoners should be held in the segregation unit for the minimum practicable time before being returned to normal location or transferred to another suitable prison. When such issues are complex, the area management protocol should be quickly instigated. (6.40)

Partially achieved. Records showed that prisoners were not routinely held in the segregation unit and that most returned to normal location in the prison. A few had been transferred to other prisons where this was deemed appropriate. In two cases we saw, the establishment had sought assistance under the regional management protocol, but additional help had not been forthcoming. One of these cases had involved a segregated prisoner in a wheelchair and it looked likely that he would remain on the unit until his release date in August (which would mean a total of four months on the unit), as no alternative accommodation could be found for him.

Further recommendation

2.333 When prisoners with complex issues are held in the segregation unit, assistance should be offered from other establishments to ensure that prisoners are held in the best location possible.

Additional information

2.334 There had been 1,333 adjudications in 2009 and 783 in 2010 to date. The predominant charges were for possession of unauthorised articles, positive drug tests and disobedience.

2.335 Adjudications took place in a designated room in the segregation unit. In those we observed, prisoners were addressed respectfully and given the opportunity to state their case. They were asked if they were fit and well and this was recorded on the documentation. Access to legal advice and representation was considered and proceedings adjourned to enable this contact if required. We checked 25 adjudication records and found that charges were investigated fully and witnesses called where required. The exception was those records completed by the independent adjudicator, who recorded little information on the documentation.

2.336 There were quarterly standardisation meetings, chaired by the governor or deputy governor. Managers discussed the tariff, adjudications documentation and cases that had been quashed and mitigated, and analysed information relating to adjudications. The deputy governor carried out thorough checks of adjudication documentation and reported back any issues to this meeting. The independent adjudicator visited every three weeks to hear the more serious charges, including those resulting from positive drugs test.

2.337 Use of force was low compared with that in similar establishments, with 51 incidents between July and December 2009 and 30 in 2010 to date. However, this represented a slight increase from the previous inspection. There had been two incidents in recent months where batons had been drawn. These were well recorded and appeared appropriate in the circumstances described. There had been one use of the body belt in the previous six months but we were unable to view the documentation relating to this, as there was no copy held in the establishment. Use of force was monitored at the security committee meeting, although there was no record of video-recordings being reviewed. Individual records of use of force were reviewed by duty governors but there were concerns that these checks were not sufficient to identify where further investigation of the events might be required.

2.338 The special accommodation had been used five times in 2010 to date and the records showed that it had been used appropriately. Prisoners had been held in the accommodation for an average of one and a half hours. The short corridor leading to it was used to store furniture and other equipment.

2.339 There had been 108 prisoners resident in the segregation unit over the previous six months. The longest recorded stay during this period was 36 days, with most prisoners leaving the unit within a much shorter time. All prisoners were strip-searched on entry to the unit. At the time of the inspection, there were three prisoners on the unit, two of whom had been located there following an incident two days previously and the third had been there for two weeks. All had been appropriately authorised and knew why they were being held in the unit.

2.340 A dedicated group of staff worked on the unit, all of whom had been authorised by the governor to work there. Some had had specialist training in mental health awareness and all had been trained in adjudications, ACCT procedures and control and restraint. Staff showed a good knowledge of the prisoners in their care, although this was not often reflected in the completed documentation, which contained mainly observational comments. Reviews of segregation were timely and prisoners had access to health services staff, the chaplaincy and a governor daily.

2.341 The regime on the unit was poor and was reduced in the evenings and some weekends, when staffing was reduced to one person. Prisoners were offered the chance to have a shower on alternate days and access to activities off the unit was not permitted. In-cell electricity was available but televisions were not provided for longer-term residents.

Further recommendations

2.342 All documentation relating to the use of the body belt should be retained in the establishment.

2.343 Video recordings of planned use of force should be reviewed as part of good governance arrangements.

2.344 Management checks of use of force documentation should include an assessment of the need for further investigation of the incidents recorded.

2.345 Prisoners should only be strip-searched on entry to the segregation unit if a risk assessment indicates it to be necessary.

2.346 All staff in the segregation unit should undertake training in mental health awareness.

2.347 The regime on the segregation unit should be improved.

Housekeeping points

2.348 All records of adjudications should be completed fully and show that a thorough investigation of the charges has been carried out.

2.349 The corridor leading to the special accommodation should be cleared to enable easy access.

2.350 Staff should record interactions with prisoners in individual prisoner records.

Incentives and earned privileges

2.351 The incentives and earned privileges (IEP) scheme should be operated consistently and fairly across the prison, with any indicators of potential discrimination promptly and fully investigated. (6.48)

Partially achieved. The IEP scheme was not consistently operated, with staff still using documentation and processes from a previous policy. Management checks of review boards were carried out and indicators of discrimination could be followed up if identified.

Further recommendation

2.352 The current IEP scheme should be published to all staff and prisoners and operated consistently and fairly across the prison.

2.353 The weekly IEP review board should be formally constituted, with regular attendance or input from key departments. (6.49)

Partially achieved. The weekly IEP review boards were undertaken by individual wing

managers but not always according to the timing specified in the policy. There was regular input from required departments in most cases. Prisoners were able to attend boards or submit written representations.

Further recommendation

2.354 The weekly IEP review boards should be held in accordance with the published policy.

2.355 The IEP review process should include more consultation and involvement by prisoners. (6.50)

Achieved. The policy was under review at the time of the inspection and prisoners were being consulted as part of this review.

Additional information

2.356 The IEP scheme was used as an effective behaviour management tool. The policy detailed the usual three incentive levels of basic, standard and enhanced. There was one prisoner on the basic regime at the time of the inspection and he was being monitored according to the previous scheme (see paragraph 2.351). His record showed that staff had made efforts to encourage him to improve his behaviour and he had been set realistic and pertinent objectives. In general, prisoners could be considered for a review after receiving two behaviour warnings in two months if on standard, or one if on enhanced.

2.357 Prisoners transferring in from other establishments could retain their status from the previous prison and apply for enhanced status after being at Lincoln for 28 days. The review board documentation we examined showed that prisoners applying for enhanced status were automatically refused if they did not work.

2.358 The incentives for being on the enhanced level were sufficiently motivational. The policy allowed for prisoners to be demoted from enhanced to basic for one serious offence, although we found no evidence that this had happened.

Further recommendation

2.359 Prisoners should not be refused promotion to the enhanced regime if they are unemployed through no fault of their own.

Catering

2.360 The kitchen should be staffed with the appropriate number of industrial caterers to prepare the meals and supervise and support the prisoners who work in the kitchen. (7.10)

Achieved. Eight industrial cleaners and up to 20 prisoners were employed in the main kitchen. The kitchen had undergone a major refurbishment (excluding the flooring and walls) and the new layout provided better sight lines, improving the supervision of prisoners working there. Observation mirrors had been installed in a range of areas so that prisoners working in discrete areas such as the butcher's or baking area could be easily monitored.

2.361 All prisoners should complete the basic food hygiene certificate before preparing food in the kitchen or serving food at the hot plates. (7.11)

Achieved. All prisoners who were employed in the kitchen and serveries had either completed the basic food hygiene level two certificate or had dates identified to complete it.

2.362 The menu should provide a healthy option and the recommended portions of fruit and vegetables each day. (7.12)

Achieved. The healthy options meal choices had improved, as had the availability of fruit and vegetables. Vegetarian dishes, salads and jacket potatoes were readily available throughout the week and prisoners could have fruit and a choice of vegetables each day.

2.363 The menu should have a range of cultural meals available to reflect the diversity of the population. (7.13)

Partially achieved. There were some cultural dishes available on the menu, which attempted to reflect the diversity of the prison population. Asian, Mediterranean and some African-Caribbean meals were included, although they were relatively uninspiring. Diversity days were held, when prisoners had the opportunity to try a meal from another culture. Different religious celebrations were also catered for and the menu choices made available to all prisoners.
We repeat the recommendation.

2.364 Breakfast packs should be issued on the day they are to be consumed. (7.14)

Not achieved. Breakfast packs were issued on the evening before they were due to be consumed.
We repeat the recommendation.

2.365 Appropriate and immediate action should be taken to address prisoner concerns about food contamination, and any reported contamination of food should be investigated. (7.15)

Partially achieved. Prisoners on E wing continued to express concerns about food contamination. E wing staff selected the food trays for their prisoners first, in an attempt to eliminate any food tampering. We saw this taking place but, in our groups, E wing prisoners still maintained that their food could be identified and was contaminated. There had been one incident where E wing prisoners reported a large amount of salt being placed on one of the food trays. The investigation by catering staff had been unable to establish when (that is, before or after leaving the kitchen) the salt had been added. Catering staff took complaints seriously but there was insufficient communication directly with E wing prisoners, outside of prisoner representative meetings.

Further recommendation

2.366 Catering staff should routinely meet E wing prisoners to reassure them about food preparation standards and to discuss any concerns they have about their food.

2.367 A member of catering management should attend the prisoner representative committee each month and respond to any issues raised. (7.16)

Achieved. A member of the catering management attended the prisoner representative committee each month.

Additional information

2.368 The kitchen refurbishment had provided good storage space for food products, and halal food was stored and prepared separately. The redesign of the kitchen meant that staff and prisoners went into a changing area before entering the kitchen, thus ensuring that they were appropriately attired. There were good changing and showering facilities for prisoners working in the kitchen.

2.369 Up to a maximum of 40 prisoners could be employed in the kitchen on a rota basis; however, due to the rapid turnover of the population, a maximum of 14 prisoners worked there at any one time. Prisoners had the opportunity to undertake National Vocational Qualifications in catering at levels one and two.

2.370 Catering arrangements were reasonably good and, although prisoners in our groups were negative about the food, they were pleased with the level of access to fruit and vegetables. They selected their meals one week in advance, from a four-week menu cycle. There were approximately 70 meal choices available each week. The in-house television channel demonstrated to prisoners the food preparation process, the appearance of the completed dishes and how to make selections.

2.371 The catering department had conducted a survey in the previous year, to which there had been a response rate of just under 40%. Most respondents to the survey had been positive about the healthy options, availability of fresh fruit and vegetables, and variety of food. Religious and medical diets were catered for.

2.372 Meals were generally served at appropriate times, although evening meals were served too early, at 4.45–5.15pm, to accommodate evening association, which started at 6pm. There were no opportunities for prisoners to dine in association.

Further recommendations

2.373 Evening meals should be served after 5pm.

2.374 Prisoners should be able to dine in association.

Prison shop

2.375 Shop purchases should be distributed to prisoners as soon as possible, and no later than 24 hours after they have arrived. (7.23)

Achieved. Pre-ordered shop goods were delivered to the prison on Sunday mornings and distributed to prisoners on the same day.

2.376 Wing staff should be trained and encouraged to answer prisoners' spends account requests without reference to the main office staff. (7.24)

Achieved. Ninety-five per cent of discipline staff had been trained to use the P-NOMIS

system, and prisoners and staff we spoke to confirmed that wing staff were able to access data on prisoners' accounts in order to answer requests about accounts and orders.

Additional information

2.377 The shop was run by DHL/Booker in line with the national contract. Shop order forms were issued on Monday and collected on Wednesday morning. There had previously been an arrangement whereby orders could be faxed to the shop supplier but, under the current contract, prisoners arriving on or after a Tuesday had to wait up to 13 days before they could receive their goods from the prison shop.

2.378 New prisoners could be issued with a choice of a smoker's (£2 or £5) or non-smoker's (£2.50) pack. Prisoners could also apply for an emergency grocery pack (£5), and £5 international telephone cards were also available. The cost of all packs and telephone credits were recoverable against prisoners' private spends accounts.

2.379 There were approximately 350 items on the shop list, which included an appropriate range of cultural items, healthy options and fruit. There was access to the Argos Additions catalogue, for which there was no administration fee, and newspapers and periodicals could be ordered through the library, although only for two weeks at a time.

Further recommendation

2.380 Prisoners should be able to place a shop order on the day of arrival at the establishment.

Strategic management of resettlement

2.381 Objectives within the new resettlement strategy should be time bound to ensure delivery and allow follow-up. A review date of the strategy should be included. (8.8)

Partially achieved. The reducing reoffending strategy covered a two-year period (2010–2012) which was to be reviewed each year. The document outlined objectives under each of the pathways and those responsible for implementing them. There was no timescale allotted to each of them; they were all deemed to be ongoing pieces of work and were discussed at the monthly reducing reoffending meeting.

Housekeeping point

2.382 The objectives within the reducing reoffending strategy should be time bound to ensure delivery.

2.383 There should be a resettlement awareness session included in the prison's training days. (8.9)

Achieved. All new staff received an induction, delivered by representatives from the resettlement team, and a prison-wide resettlement awareness session had been delivered to existing staff in 2009. Wing staff we spoke to had a good knowledge of the resettlement department, its location and its function. The profile of the resettlement team had increased since the previous inspection, particularly as the team had held surgeries on the residential

wings on a rotational basis every Friday afternoon for the previous 18 months and were more visible to staff and prisoners.

2.384 A local employment needs analysis should be carried out to identify the agencies that the coordinator should be targeting. (8.10)

Partially achieved. An employer strategy had been produced and an employers' event had been held at the establishment in an attempt to attract local organisations to provide employment opportunities to prisoners. While the subsequent analysis of the event indicated that over 100 agencies had attended, few organisations had been identified as potential employment providers. Jobcentre Plus provided local market analysis information and links to employers, and staff from Nottingham Business Venture visited monthly to provide additional information and support for employment but this had yet to be linked to a local employment needs analysis and targeted employability training.
We repeat the recommendation.

2.385 Prisoners should be kept informed of work being done on their behalf between induction and the 60 day pre-release interview. (8.11)

Achieved. Resettlement staff kept extensive notes on the work that was carried out on behalf of prisoners with resettlement needs. Outcomes of referrals or correspondence were communicated to prisoners. Prisoners had the opportunity to make an application to speak to the resettlement team at any time.

2.386 Prisoner peer workers should be recruited and trained to assist in the delivery of the resettlement strategy. (8.12)

Partially achieved. One prisoner resettlement peer worker had been recruited. He had completed a range of resettlement courses at the establishment and was employed to answer prisoners' questions about the courses available and how they might be relevant to them, and promote the work of the resettlement department.

Further recommendation

2.387 More prisoner resettlement peer workers should be recruited to assist in the delivery of the reducing reoffending strategy.

2.388 After the needs analysis has been completed, the relevant interventions should be introduced into the establishment. (8.13)

Achieved. See paragraph 2.13.

Additional information

2.389 As well as a reducing reoffending strategy, there was a strategy for life-sentenced and short-term prisoners. The former outlined both Prison Service and national policy in the management of life-sentenced prisoners, and the latter outlined, under the headings of each of the seven reducing reoffending pathways, how the resettlement department would work towards reducing these prisoners' offending and support them in their return to the community.

2.390 Monthly reducing reoffending meetings were chaired by the head of offender management but attendance was sporadic, and at one meeting there had been nearly twice as many apologies as those in attendance at the meeting. While the meeting had a focus on key performance targets, there was also a useful discussion about operational and practice issues, as well as strategic planning and development. The current gaps in alcohol services, debt counselling and a cognitive behavioural programme were discussed at the meeting.

2.391 Resettlement staff formed a key part of prisoners' induction and were available subsequently to address new needs and for follow-up referrals. In our groups, prisoners demonstrated a good level of awareness of the resettlement team, with the exception of foreign national prisoners. Lincolnshire Action Trust (LAT) worked in partnership with the establishment to provide resettlement services and was involved in operational and strategic meetings. Although a range of voluntary and community sector organisations contributed to the reducing reoffending agenda, they were not part of any of the resettlement forums.

Further recommendations

2.392 Attendance at the reducing reoffending meeting should be improved and should include voluntary and community sector organisations that contribute to the resettlement of prisoners.

2.393 Work should be undertaken to improve the awareness of resettlement services among foreign national prisoners.

Offender management and planning

2.394 The prisoner resettlement passport should be a live document, which should be updated when required, and the personal officer should refer to it when setting targets for prisoners. (8.21)

Not achieved. The prisoner resettlement passport was not a live document and personal officers had little involvement in updating it. The passport document, once completed, should have been copied and placed in prisoners' wing history sheets but this was not always the case. Resettlement staff completed sections of the passport on the day after prisoners' arrival at the establishment and kept their own files on the work they were undertaking with prisoners. This made the passport document redundant, as it was not updated, reviewed or referred to by personal officers or wing staff.
We repeat the recommendation.

2.395 The backlog of assessments for all prisoners should be addressed, and a protocol introduced to ensure that offender managers complete assessments as soon as possible and submit them to the offender manager unit. Staff who carry out assessments should not be redeployed to other tasks. (8.22)

Not achieved. At the previous inspection, there had been a small backlog of OASys assessments for prisoners who were in scope of offender management. During the inspection, there were 202 in-scope prisoners, all of whom had up-to-date OASys assessments, prepared by external offender managers. The relationship between offender supervisors in the establishment and offender managers was described as positive and most attended sentence planning meetings; those from outside the Lincolnshire area contributed via video link. The management of low- and medium-risk prisoners was not as positive. There were 238 such prisoners, for whom the establishment was responsible for completing the OASys assessment;

177 were waiting for an OASys assessment or review. There were two members of staff assigned as OASys assessors, although there were more assessors across the establishment. They continued to be redeployed to other tasks and, because of this, in some months they completed no assessments. Despite discussions about the backlog in the reducing reoffending and OMU meetings, there was no strategy to deal with it, although assessors appropriately prioritised assessment for medium-risk cases. The minutes of these meetings reflected that the establishment was more concerned with the fact that OASys assessments were to form part of the service delivery indicator from 1 April 2010 than the impact on prisoners not having an assessment.
We repeat the recommendation.

2.396 Better information should be kept regarding offender assessment system (OASys) targets and followed up at the resettlement committee to establish how many have been met, and how many prisoners have been transferred to establishments offering such interventions. (8.69)

Not achieved. Information concerning prisoners' OASys targets was kept and, where appropriate, prisoners were referred to the available courses in the resettlement department. However, there was no monitoring of how many prisoners had their OASys targets met or had to be transferred to other establishments offering such interventions.
We repeat the recommendation.

2.397 A system which informs all staff of prisoners who are subject to public protection measures should be introduced. Public protection staff trained in the use of the Police National Computer should be given access to this facility. (8.23)

Partially achieved. A system for notifying staff of prisoners who were subject to public protection measures had been implemented. It identified the category under which the measures were implemented and the reason. Public protection staff trained to use the Police National Computer were still unable to access it.

Further recommendation

2.398 Public protection staff trained in the use of the Police National Computer should be given access to this facility.

2.399 The establishment should endeavour to transfer prisoners with indeterminate sentences for public protection and life-sentenced prisoners to appropriate prisons to complete their offending behaviour work. Preparations should be made for the incorporation of indeterminate sentenced prisoners (IPP) into the offender management model. (8.24)

Partially achieved. The trained lifer manager was occasionally detailed to work in the observation, classification and allocation (OCA) office and therefore had an understanding of the process and links with other establishments and the population management unit. Shortly before the inspection, 18 indeterminate-sentenced prisoners had been transferred to HMP Bure and a further six prisoners were due to be transferred there on 17 May 2010. The lifer manager told us that it was particularly difficult to transfer prisoners to category B training prisons, as the three in the region of the establishment (HMPs Rye Hill, Dovegate and Lowdham Grange) had placed a cap on the number of prisoners serving indeterminate sentences for public protection (IPP) they would take, so individual swaps had to be negotiated. IPP prisoners were managed according to the offender management model but the

new head of the OMU had insufficient awareness of the lifer manager's work. Given that the latter worked with high-risk cases, it was unclear why she was located and aligned with the resettlement team.

Further recommendation

2.400 Management of the lifer manager should come under the offender management unit and she should be co-located with that team.

2.401 A minimum of two days each year should be designated for events for IPP prisoners, to enable them to understand and engage with risk reduction and their eventual reintegration. (8.25)

Partially achieved. There had been one information-sharing event in September 2009 for all indeterminate-sentenced (including life-sentenced) prisoners. A range of departments had attended, including a representative from the parole board. Prisoner attendance had been low, with just six prisoners present, because prisoners on E wing had declined the invitation. The event had given prisoners the opportunity to discuss their concerns and provided information about their sentence, how their time in prison would be managed and the courses available to them. Feedback from those who had attended was positive. No further events had been organised.
We repeat the recommendation.

2.402 Release on temporary licence should be used whenever possible, in particular to assist the voluntary agency coordinator in securing placements with voluntary agencies. (8.26)

Not achieved. There had been no releases on temporary licence in the previous 12 months.
We repeat the recommendation.

Additional information

2.403 Responsibility for categorisation had recently been passed to the security department. Staff were often redeployed and in some weeks the department was only staffed for a day.

2.404 Records showed that recategorisation reviews were up to date. Documentation was collated and passed ad hoc to the duty governor for a final decision to be made, without a formal board being held. Prisoners recategorised to D were generally transferred within two weeks. Those waiting to go to category C establishments waited longer than this. We were unable to establish how many prisoners were waiting for onward transfer to category C conditions but this was estimated to be at least 38 prisoners. A priority list was kept of prisoners waiting to go to particular establishments, and this was consulted when transfer drafts were received. Approximately 15 prisoners a week were moved to other prisons.

2.405 Custody planning for prisoners serving less than 12 months was good. Needs identified from the prisoner passport document were developed into an action plan, which the prisoner was required to sign, and referrals were made by the resettlement department. Progress was monitored and there were sufficient courses for them to complete during their short sentence.

2.406 The OMU comprised six probation staff who were offender supervisors, two public protection officers (discipline staff) and three administrative officers. Caseloads were spread equitably but

the head of the OMU told us that the sporadic staffing of the OCA department meant that transfers were not timely (see section on security and rules). Offender supervisors attempted to see prisoners at least monthly, and some more often.

2.407 Sentence planning boards for the low- and medium-risk prisoners were managed by the resettlement department and, given the small number with up-to-date assessments, boards were not convened frequently. The OASys assessors were located in the resettlement department, which had improved communication and meant that any sentence planning targets that involved the resettlement team were communicated and implemented quickly.

2.408 There were 278 public protection cases at the time of the inspection. Public protection arrangements were reasonable and weekly interdepartmental risk management meetings were well attended, and included review of a range of intelligence and monitoring arrangements. Residential staff members' awareness of public protection issues had improved but the head of the OMU wanted to take steps to improve the quality and quantity of intelligence provided by wing staff and ensure that they understood their role in monitoring and supporting the public protection measures imposed on the prisoners in their care.

Further recommendations

2.409 Recategorisation decisions should be considered by a board, with regular attendance or input by key staff.

2.410 Staff should be provided with training to ensure that they understand their role in monitoring and supporting the public protection measures imposed on the prisoners in their care.

Resettlement pathways

2.411 The target for releasing prisoners into accommodation should be raised. (8.30)

Achieved. At the time of the previous inspection, the key performance target for releasing prisoners into settled accommodation was 66.5%. It was now 80% and the establishment was currently exceeding this target, releasing 89% of prisoners into settled accommodation over the previous year

2.412 The role of the LAT and arrangements for support and assistance should be clarified. (8.31)

Achieved. The reducing reoffending strategy outlined the primary providers of resettlement services. Communication between LAT and other departments was good, and roles and responsibilities were clearly defined. For example, accommodation was primarily sourced by LAT but the CARAT team supported them and assisted prisoners who required specialist accommodation based on their substance use, and probation staff supported prisoners in securing specialist hostel accommodation.

2.413 The work of the LAT counsellor in relation to assistance in claiming benefits should be better advertised. There should be an assessment carried out to determine whether the finance councillor is needed for more than the current time offered. (8.59)

Not achieved. Due to commissioning issues, there was no longer a LAT debt counsellor at the establishment. A budgeting course was still available (see paragraph 2.416) but it was

recognised that debt counselling was needed. At the time of the inspection, the LAT manager was attempting to develop links with organisations such as the Credit Union and Christians Against Poverty to work with prisoners and their debt concerns.

Further recommendation

2.414 A debt counsellor should be available as part of the resettlement services on offer.

2.415 Unsentenced prisoners should be offered the same service as sentenced prisoners in relation to finance issues. (8.60)

Achieved. Unsentenced prisoners had the same access as sentenced prisoners to all resettlement services, as well as a full-time accommodation officer specifically tasked with helping remand prisoners to maintain their tenancies and source accommodation.

2.416 The basic budget course should be evaluated to ensure that it is meeting the needs of prisoners in relation to finance. (8.61)

Achieved. The budgeting course had been evaluated and developed since the previous inspection. It offered advice about opening a bank account and budgeting, and explained the benefits system, how to deal with creditors and managing finances when working. The course was delivered in a group or on a one-to-one basis, based on prisoners' individual needs. Jobcentre Plus offered benefit services to those being released.

2.417 Prisoners should be assisted to open a bank account prior to discharge. (8.62)

Not achieved. There was no facility for prisoners to open a bank account.
We repeat the recommendation.

2.418 The health services team should play an active role in the resettlement process. (8.37)

Partially achieved. Health services staff did not routinely attend resettlement boards. For all prisoners due for release on home detention curfew, the health services team provided all appropriate information, subject to medical confidentiality restrictions.
We repeat the recommendation.

2.419 All prisoners should be given information and assistance to engage with health and social services on release. (8.38)

Achieved. The health care department was notified of potential releases only the day before. Prisoners under the care of the health care team usually informed them some time before they were due for release. Nursing staff ensured that appropriate take-home medication, usually for a maximum of seven days, was ordered, and if the prisoner was registered with a GP, a summary letter was faxed to the surgery. For prisoners with specific health needs and not registered with a GP, health services staff would try to identify a local practice and make a follow-up appointment with the GP or practice nurse as appropriate. Prisoners were given information about out-of-hours services where possible. Mental health patients subject to the care programme approach were linked with their local community mental health teams.

2.420 The drug strategy document should be updated. (8.49)

Achieved. The drug strategy policy had been updated in January 2010 and the document contained future objectives.

2.421 The substance misuse needs analysis should draw on information gleaned from all departments involved in offering drug treatment, including the CARAT and substance misuse teams. (8.50)

Partially achieved. A prisoner survey had been conducted in June 2009 but the response rate had been poor and 'unlikely to be truly representative of the population at HMP Lincoln'.
We repeat the recommendation.

2.422 The contingent elements of the drug strategy group should work together to ensure that effective coordination and treatment provision is available consistently. (8.51)

Achieved. The deputy governor was now the establishment drug coordinator. She chaired monthly drug strategy committee meetings, which also involved community representatives. Local management team meetings with CARAT and SDP leads and IDTS meetings took place to aid joint working.

2.423 An alcohol strategy should be developed or incorporated into the drug strategy, and should include both testing and treatment provision. (8.52)

Not achieved. The drug strategy policy fleetingly mentioned alcohol, but did not outline treatment provision or identify gaps in current services.
We repeat the recommendation.

2.424 Support following the short drug programme should be developed in conjunction with that provided by the CARAT team to ensure that learning objectives from the programme are reinforced. (8.53)

Not achieved. Due to staff shortages, the SDP had been suspended for six months but had restarted in April 2010, having merged with the SDP at HMP North Sea Camp. The programme team hoped to recruit peer mentors who would remain on J wing to help with future courses, but the high population turnover made longer-term post-programme peer support on other residential wings unrealistic.

2.425 Staff working on J wing should be offered training regarding both the actual programme and general issues of substance misuse. (8.54)

Not achieved. In the absence of a programme, training had been suspended and staff had changed.
We repeat the recommendation.

2.426 A clear distinction should be made between voluntary and compliance testing. (8.55)

Achieved. Separate compacts had been drawn up to distinguish between the two forms of testing; 127 voluntary drug testing and 53 compliance testing compacts were in operation at the time of the inspection.

2.427 The visits waiting area for vulnerable prisoners should be improved. (3.84)

Not achieved. The same waiting room was in use and had not been improved.
We repeat the recommendation.

2.428 Light refreshments and hot drinks should always be available for visitors. (3.85)

Achieved. There was a snack bar in the visits hall, operated by prison staff and prisoners. Hot and cold refreshments and drinks were available to prisoners and their visitors. In addition, there were vending machines selling a range of drinks and snacks.

2.429 An appropriate baby changing area should be available during visits. (3.86)

Not achieved. Visitors had to leave the visits hall and return to the gate if a baby required changing.
We repeat the recommendation.

2.430 The visitors' reception area should be expanded and the facilities enhanced. (3.87)

Not achieved. The visitors' reception area was the same as at the previous inspection. There was limited waiting space for visitors and no facilities for obtaining refreshments.
We repeat the recommendation.

2.431 A visitors' survey should be undertaken to inform the development of facilities. (3.88)

Achieved. A visitors' survey had been undertaken and the results published in the visits hall. Actions had been identified to address the issues raised.

2.432 The establishment should offer parenting skills courses and the opportunity for family days to appropriate prisoners on E wing. (8.65)

Achieved. Eligible prisoners who were resident on E wing were able to apply for a specific parenting skills course and family visit.

Additional information

2.433 Resettlement workers told us that many prisoners arrived at the establishment with no fixed abode. The establishment received an average of 48 prisoners each week and discharged an average of 116 each month. The database of referrals that we looked at confirmed that a large number of prisoners approached the resettlement department because they had no accommodation. The high turnover of prisoners and short time some spent at the establishment (20% of sentenced prisoners and a quarter of the unsentenced prisoners stayed for less than a month) made it difficult to secure settled accommodation for prisoners before their discharge.

2.434 Although employment, training and education (ETE) targets were regularly exceeded; for example, in April 2010, further education/training achieved 11.3% against the 5% target and employment achieved 28.3% against the 15% target, there was no coherent strategy linking what was needed in the market place with what was offered as training in the prison.

2.435 The ETE pathway staff offered a range of pre-release courses, offering around 800 places a year. The short courses, each offered monthly, ranged from one-day and two-day attendance for topics such as disclosure advice and being a good tenant, to a 10-session Work Wise

course, involving a range of useful information, including job search and interview techniques. In addition, a pre-release course was offered monthly on the resettlement (F) wing. Attendance by managers at the quality improvement group was used as a key opportunity to link the learning and skills and resettlement functions.

2.436 The CIAS involved completing the Managing Information Across Partners (MIAP) interventions with prisoners to identify support. In addition, LAT staff met prisoners individually at induction to provide focused support early in their stay at the establishment.

2.437 CARAT services were provided by a manager and five workers from Phoenix Futures, three directly employed drug workers and two officers. The team had met the target of 920 triage assessments in the previous 12 months and was actively engaging with 297 prisoners at the time of the inspection. All of the work consisted of one-to-one sessions. There were good throughcare links with the local drug intervention programme (DIP), and designated DIP link workers visited prisoners regularly. The CARAT team's remit excluded work with primary alcohol users. Alcoholics Anonymous (AA) self-help groups and AA individual support were available, but there were no alcohol awareness modules or structured interventions.

2.438 The SDP had recently restarted (see paragraph 2.424). Six groups were due to run in 2010, instead of 10, and the programme team was still not fully staffed. All prisoners undertaking the SDP were located on J wing, which offered 20 spaces.

2.439 Visits took place from Monday to Thursday between 2pm and 4pm, on Saturdays between 9.30am and 11am and 2pm and 4pm, and on Sundays between 2pm and 4pm. They could be booked through the visits booking line, and booking line staff were polite and courteous and provided detailed information to visitors about visiting arrangements. Prisoners complained to us that it had become more difficult to book visits since the implementation of P-NOMIS. Prisoners no longer sent out their own visiting orders, as these were now sent out by the visits booking clerk following applications from prisoners and after visiting orders had been written out by hand. The visits booking function was under-resourced and the opening times for the visits booking line had been reduced by an hour a day to facilitate carrying out this extra work.

2.440 Visitors we spoke to were positive about staff and their experience of visiting, despite the poor visitor facilities at the prison. There was room for 45 visits, and all prisoners had visits at the same time, with vulnerable prisoners using designated tables. Prisoners were required to wear high-visibility vests, and complained that they were not told in advance of their visits so did not have time to shower or dress smartly. The visits we observed started late, with prisoners and visitors arriving after the start of the session. Prisoners were restricted from physical contact with their visitors, including children, apart from an embrace at the beginning and end of the visits sessions. Prisoners in our groups said that they found it difficult to explain this to young children who were visiting.

2.441 The visits hall was bright and clean but noisy during visits. The furniture was unsuitable, as it should have been fixed to the floor but had remained freestanding, making it unstable at times. Prisoners complained that metal bars protruding from the furniture could be dangerous for children. Prisoner holding rooms and the closed visits booths contained graffiti, and, during the inspection, prisoners who were smoking in the larger holding room were not challenged by staff. The closed visits booths had no doors and it was particularly difficult for prisoners and visitors to hear one another in this area. Privacy was further compromised by the design of the booths, as two visits were held in one small booth. The children's play area was staffed by Play in Prison every day except Wednesday. They provided organised activities and encouraged children to take activities to the visits tables.

2.442 The security camera room was staffed by an officer support grade during all visits sessions. One camera was completely out of action and three others were not functioning properly.

2.443 Provision under the children and families pathway was well developed. A parenting course – Being Dad – took place three times a year, with 10–12 prisoners attending each course, which culminated in a family visit. Any prisoner with children under 16, including those about to become parents or who were step-parents, could apply for the courses. A second course, entitled Reading Together, which encouraged interaction between prisoners and their children through reading, ran three times a year and also finished with a family visit. There was also an 'open' family visit each year for prisoners who did not participate in the courses. Prisoners could apply for up to four further family visits once courses were complete.

2.444 A full-time children's support worker monitored contact between prisoners and their children. She met all new prisoners on induction and carried out an assessment of their needs under this pathway. She sent out packs to children to explain what happens in custody. The children's support worker also liaised with external agencies such as Sure Start to provide additional support to families. The post was funded for three years through Children in Need, with two years of funding left at the time of the inspection.

2.445 The SDP was the only accredited offending behaviour programme run at the establishment. The psychology department, which comprised a senior psychologist and two forensic psychologists, had previously delivered the A to Z motivation programme but it had been suspended until summer 2010. The senior psychologist told us that the findings of the needs analysis conducted in 2009 indicated that there was a need for a thinking skills programme (TSP). They had therefore delivered a TSP in March 2010 and it was hoped, resources permitting, that further programmes would be delivered throughout the year. One of the psychologists had designed and delivered a group specifically for sex offenders on E wing, to discuss the offending behaviour programmes on offer and prisoners' reluctance to engage with them and to dispel myths about some of the programmes, in particular the sex offender treatment programmes.

2.446 At the time of the inspection, the psychology department was working with the resettlement team to review the courses they delivered. The victim empathy group had been submitted for accreditation.

Further recommendations

2.447 An explicit local employment needs analysis should lead to targeted employability training.

2.448 The prison and the interventions and substance misuse group (now renamed the rehabilitation services group) should address the lack of services and structured interventions for primary alcohol users.

2.449 The prison should ensure that the short duration drugs programme runs effectively and assess whether reduced provision still meets the needs of the population.

2.450 The visits booking line should be adequately staffed to ensure timely booking of visits.

2.451 Prisoners should not be required to wear high-visibility vests on visits.

2.452 Prisoners should be advised in advance of when they have a visit.

2.453 Visits should start on time.

2.454 Prisoners should be allowed close physical contact with their children on visits.

2.455 The furniture in the visits room should be replaced with a more suitable alternative.

2.456 Steps should be taken to reduce the noise levels in the visits hall and closed visits booths.

2.457 The closed visits area should be improved to increase privacy.

2.458 Broken and malfunctioning security cameras should be repaired or replaced without delay.

2.459 The A to Z motivation programme should be reinstated.

2.460 Subject to the final analysis of the 2009 needs analysis, the thinking skills programme should be delivered at the establishment.

Housekeeping point

2.461 Prisoners should not be permitted to smoke in the visits holding rooms.

Good practice

2.462 *The children's liaison officer was a valuable resource for prisoners and their families.*

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.

Recommendations — To NOMS

3.1 Prisoners should arrive at the prison before 7pm. (2.16)

3.2 Under P-NOMIS, money sent in to prisoners should be made available within 48 hours. (2.45)

Recommendations — To the regional custody manager

3.3 A regional strategy should be developed and implemented to facilitate the transfer of prisoners to training prisons where their sentence planning needs can be met. (2.319)

3.4 When prisoners with complex issues are held in the segregation unit, assistance should be offered from other establishments to ensure that prisoners are held in the best location possible. (2.333)

Recommendations — To the governor

First days in custody

3.5 The reception area should be clean and welcoming and provide a spacious, properly ventilated environment which is suitable for those with disabilities and where prisoners can be held safely, provided with relevant information and interviewed in private. (2.2)

3.6 The Listeners and Insiders should introduce themselves to newly arrived prisoners and give information about the prison in a suitable venue, where prisoners can also express initial concerns and ask questions. (2.3)

3.7 Procedures should be reviewed to ensure that prisoners spend as short a time as possible in reception. (2.18)

3.8 There should be regular, formal meetings of prisoner Insiders, where they can share and develop their knowledge and practice and receive appropriate support and guidance from a nominated member of staff. (2.19)

3.9 Prisoners should be able to have a shower before being locked up on their first night. (2.20)

3.10 Prisoners should be able to make one free telephone call, in private, on reception or in the first night centre, and this opportunity should be documented. (2.21)

3.11 Wherever possible, new prisoners should remain on A wing until they have completed their induction. (2.23)

3.12 The first night centre should only be used for the purpose for which it was designed. (2.24)

3.13 Prisoners located in units other than the first night centre should receive the same essential first night procedures and a full induction. (2.25)

3.14 Insiders should see all new prisoners on arrival. (2.26)

3.15 There should be regularly updated needs assessments of all young adult prisoners. (2.30)

3.16 Cells on the first night centre should be cleaned in preparation for new arrivals. (2.36, see paragraph 2.32)

3.17 The roll boards should be maintained in an area accessible only to staff, to safeguard the identity and location of newly arrived prisoners. (2.37, see paragraph 2.34)

Residential units

3.18 All external areas should be kept clear of litter. (2.39)

3.19 Prisoners should have an opportunity to clean their cells, and the locked door policy should not hinder this. (2.40)

3.20 Cell bells should be answered within five minutes. (2.43)

3.21 All prisoner telephones should have privacy hoods. (2.48)

3.22 Prisoners should be able to use the telephones at times convenient to their families and friends. (2.51)

3.23 Cells should be checked daily for graffiti and remedial action taken where it is identified. (2.59, see paragraph 2.52)

3.24 Cells designed for one should not be shared. Where cells are shared, there should be sufficient space and furniture for two prisoners. (2.60, see paragraph 2.52)

3.25 All cell toilets should have privacy screening. (2.61, see paragraph 2.52)

3.26 All showers should have privacy screening and urinals should not be open to the wing. (2.62, see paragraph 2.54)

3.27 All prisoners on enhanced and standard levels of the incentives and earned privileges scheme should be allowed to wear their own clothes. (2.63, see paragraph 2.53)

3.28 Staffing in the mail room should be increased and predictable, to ensure that incoming and outgoing mail is dealt with within 24 hours. (2.64, see paragraph 2.56)

The vulnerable prisoners unit

3.29 Each prisoner allocated to E wing should sign up to the standard of behaviour outlined in the compact, and their compliance with this should be monitored by personal officers and reflected in their place in the incentives and earned privileges (IEP) scheme. (2.5)

3.30 Clear protocols should be drawn up to establish which prisoners should be admitted onto E wing. (2.67)

3.31 There should be regular staff on E wing. (2.68)

Staff–prisoner relationships

3.32 All supervising staff should engage with prisoners during their time out of cell. (2.73, see paragraph 2.70)

3.33 Staff should refer to prisoners using their title or by their preferred name. (2.74, see paragraph 2.71)

3.34 There should be wider consultation with prisoners than simply through peer representatives, and attendance at meetings should ensure as wide a representation as possible. (2.75, see paragraph 2.72)

Personal officers

3.35 All personal officers should introduce themselves to the prisoners for whom they are responsible and maintain weekly contact thereafter, ensuring that this is reflected in the individual's wing history sheet. (2.78)

3.36 Personal officers should be consulted and provide input on all matters relating to their prisoners. (2.80)

3.37 Management checks of the personal officer scheme should include comments on the quantity and quality of the entries made by personal officers and ensure that any improvements needed are communicated to the member of staff concerned and acted on. (2.82)

3.38 The allocation of personal officers should remain consistent on individual wings. (2.86, see paragraph 2.83)

3.39 There should be sufficient access to computers in all residential areas to allow personal officers to make relevant entries on P-NOMIS. (2.87, see paragraph 2.84)

3.40 Personal officers should be directly involved in determining the IEP status of the prisoners in their care, making a monthly assessment of whether the current level is appropriate. (2.88, see paragraph 2.85)

Self-harm and suicide

3.41 The contributions and input of the health services staff at assessment care in custody and teamwork (ACCT) reviews should be clearly recorded for the benefit of all staff. (2.98)

3.42 A member of the mental health in-reach team should attend the safer prisons committee. (2.100)

3.43 The Prisons and Probation Ombudsman action plans should be reviewed at the safer prisons meeting and incorporated into ongoing monitoring. (2.108, see paragraph 2.102)

3.44 Directly employed staff should be trained in the use of the defibrillator. (2.109, see paragraph 2.103)

3.45 Managers should make qualitative entries in ACCT documents in addition to the pre-set management check stamp. (2.110, see paragraph 2.105)

3.46 Listener suites should only be used for supporting prisoners in crisis and be maintained to provide a clean and supportive environment. (2.111, see paragraph 2.106)

3.47 All contact staff should undergo foundation and refresher ACCT training. (2.112, see paragraph 2.107)

Applications and complaints

3.48 Prisoners' applications should be subject to tracking by managers to ensure that prisoners receive a timely and adequate response to their query. (2.115)

Legal rights

3.49 There should be a full-time legal services officer, who should see all new receptions. (2.121)

3.50 Legal services should be advertised and promoted across the establishment. (2.122)

3.51 Monitoring of the legal services should take place to identify trends, workload, training needs of the legal services officer and quality of the service provided. (2.123)

3.52 There should be sufficient private interview rooms to accommodate all legal visits. (2.129, see paragraph 2.126)

Faith and religious activity

3.53 Prisoners should not have to apply to attend corporate worship. (2.130)

3.54 Multi-faith facilities should be adequate to meet the needs of those faith groups using the facilities. (2.132)

3.55 Prisoners attending corporate worship should be allowed to take exercise. (2.138, see paragraph 2.134)

3.56 Disabled access to the chapel should be provided. (2.139, see paragraph 2.134)

Substance use

3.57 The substance misuse team should be found appropriate accommodation that allows them to undertake assessments at the point of reception effectively. (2.141)

3.58 Psycho-social support should be provided to all prisoners receiving clinical support for substance misuse as part of the overall programme of provision. (2.142)

3.59 CARAT and clinical substance misuse services should be further integrated and undertake joint care plans and reviews. (2.144)

3.60 The prison, in partnership with the clinical substance misuse provider, should ensure that all patients receive regular treatment reviews. (2.146)

3.61 The establishment should ensure that suspicion testing is conducted within the required timeframe. (2.150)

3.62 Opiate dependent prisoners should have access to effective first night treatment, and substitute prescribing regimes should start without delay. (2.154, see paragraph 2.151)

3.63 The prison should ensure that prisoners undergoing severe withdrawal are managed safely. (2.155, see paragraph 2.152)

3.64 The prison should provide a supportive regime to prisoners located on the integrated drug treatment system (IDTS) unit. All discipline staff working on C-wing should receive substance misuse awareness training, and unhelpful attitudes/behaviour should be challenged. (2.156, see paragraph 2.153)

Diversity

3.65 The race equality policy should include a section on how the prison intends to engage actively with black and minority ethnic prisoners in its care, and relevant external organisations. (2.6)

3.66 The prison should develop a diversity strategy document, in consultation with prisoners, which addresses all strands of diversity. (2.158)

3.67 The diversity manager should receive formal training in his duties and his post should be ring fenced to enable him to cover his duties. (2.160)

Race equality

3.68 A deputy race equality officer (REO) should be appointed and trained. (2.162)

3.69 An intervention should be developed to address racist behaviour and bullying. (2.164)

3.70 Information circulated about prisoners presenting a risk of racially motivated behaviour should be known by wing staff and used to support effective supervision of prisoners' behaviour. (2.167)

3.71 A monthly meeting, open to all black and minority ethnic prisoners, should be held and the issues raised discussed at the Lincoln equality action team (LEAT) meeting. (2.169)

3.72 The REO should receive formal training in her duties and her post should be ring fenced to enable her to cover her duties. (2.174, see paragraph 2.171)

Foreign national prisoners

3.73 An independent immigration organisation and the UK Border Agency (UKBA) should be represented at meetings of the foreign national committee. (2.176)

3.74 A list of staff and prisoners able to speak languages other than English should be developed and kept up to date. (2.181)

3.75 Foreign national prisoner wing representatives should attend all consultation meetings, and the outcomes for foreign national prisoners should be monitored annually by prisoner consultation and surveys. (2.183)

3.76 Prisoners with close family abroad should be given a free five-minute telephone call every month, regardless of whether they receive visits, as outlined in the foreign national policy document. (2.185)

3.77 The duties of the foreign nationals coordinator should be covered by a deputy or competent staff in his absence. (2.191, see paragraph 2.187)

3.78 An independent immigration advisory service should be available for foreign national prisoners. (2.192, see paragraph 2.189)

3.79 Training in the specific needs of foreign national prisoners should be provided for all residential staff. (2.193, see paragraph 2.190)

Older prisoners and disability

3.80 A disability liaison officer should be appointed with ring-fenced time to assess and meet the needs of all prisoners with disabilities, and to ensure that appropriate adjustments are made. (2.195)

3.81 Disability-specific and broader diversity training should be offered to key staff in contact with prisoners. (2.196)

3.82 Personal evacuation plans should be in place for all prisoners with any disability which compromises their ability to respond to an emergency and these should be reassessed each time the prisoner is located to a different cell. (2.199, see paragraph 2.197)

3.83 The register of prisoners with a disability should be reviewed to ensure its accuracy, and systems put in place to ensure that it is kept up to date. (2.200, see paragraph 2.197)

3.84 There should be a care plan for every prisoner with a disability which is reviewed every month. (2.201, see paragraph 2.198)

Health services

3.85 The inpatient residential area should be refurbished or taken out of commission. Hand-washing facilities should be introduced on E and J wings. The triage room on E wing should have the carpet removed and J wing should be refurbished. (2.8)

3.86 The prison should ensure that IDTS is appropriately staffed/supported by discipline staff to ensure that prisoners get their medication on time. (2.203)

3.87 The health needs assessment should be reviewed and an action plan devised. (2.204)

3.88 There should be a full infection control audit carried out and an action plan devised and acted upon. (2.205)

3.89 All the current Service Level Agreements should be reviewed to ensure that prisoners receive an appropriate level of care. (2.206)

3.90 Prisoners should be given information about prison health services in a format that they are able to understand, which explains how to access the services. (2.207)

3.91 Health promotion materials, including oral health promotion, should be available and health promotion activities encouraged. (2.208)

3.92 There should be an information-sharing policy that includes obtaining written consent from prisoners to obtain and share clinical information about them. (2.212)

3.93 There should be triage algorithms to ensure consistency of advice and treatment. (2.213)

3.94 There should be a centralised system for the maintenance of lifelong condition registers. (2.214)

3.95 All disease prevention programmes should be available to prisoners, in line with national and local campaigns. (2.215)

3.96 Prisoners should be able to access condoms easily, without having to attend a clinic and return used items. (2.217)

3.97 Take-up of pharmacist consultation time should be improved. (2.219)

3.98 The medicines and therapeutics committee should review and agree stock levels, and there should be an audit trail of all medications supplied, prescribed and administered. (2.220)

3.99 The medicines and therapeutics committee should review all health care policies and ensure that they are implemented and adhered to. (2.221)

3.100 Patient information should be included in medication bags. (2.223)

3.101 In-possession risk assessments should be filed with the prescription/medication administration chart to ensure that the prescriber has up-to-date information. (2.224)

3.102 Additional medication rounds should be carried out to remove the need for delivering Henley bags through cell hatches. (2.225)

3.103 There should be a single medication/prescription chart for each patient for both in-possession and supervised medication; where unavoidable, any additional charts should be clearly numbered and attached. (2.227)

3.104 The dental contract should be revised to ensure that there are sufficient sessions to meet the demands of the population. It should be regularly reviewed by the primary care trust (PCT). (2.228)

3.105 Health services bed spaces should not form part of the prison's certified normal accommodation, and admission should only be on the basis of clinical need. (2.231)

3.106 Day care services that provide constructive activity should be available to inpatients and prisoners who are less able to cope with life on the wings. (2.232)

3.107 Mental health awareness training should be provided to discipline staff, in particular those working in the health care department, the segregation unit and reception. (2.233)

3.108 Access to SystmOne should be made available in reception. (2.248, see paragraph 2.238)

3.109 Privacy for prisoners in the health care reception room should be improved. (2.249, see paragraph 2.238)

3.110 Reception screening and/or secondary health assessments should include basic clinical measurements equivalent to arrangements for new patients in general practice. (2.250, see paragraph 2.239)

3.111 All prisoners should have equity of access to health services, including GP clinics and nurses, regardless of their location in the prison. (2.251, see paragraph 2.240)

3.112 There should be a dedicated health care room for prisoners based on J wing, with access restricted to health services staff. (2.252, see paragraph 2.241)

3.113 Regular designated clinics should be provided for prisoners with long-term conditions. (2.253, see paragraph 2.242)

3.114 There should be an up-to date list of patient group directions, with appropriate signatures clearly visible in all areas where medication is administered. (2.254, see paragraph 2.244)

Learning and skills and work activities

3.115 Prison managers should investigate the number and use of activity places to ensure that an appropriate range is offered to enable the population to be occupied appropriately and purposefully during the core working day. (2.10)

3.116 Allocation to activity spaces should be transparent and based on identified sentence planning needs. (2.257)

3.117 The various activity allocation systems should be better coordinated and streamlined to ensure efficient and effective use of resources. (2.258)

3.118 The number of hours worked by vulnerable prisoners should be equitable for the pay received. (2.261)

3.119 Effective individual learning plans should be introduced for all prisoners involved in education and skills. (2.267)

3.120 The training environment for industrial cleaners should be improved by providing off-work-site practice areas. (2.270)

3.121 Prison-wide vocational training should have systematic observations to assure the quality and support staff development planning. (2.284, see paragraph 2.273)

3.122 There should be an increased focus on equality and diversity throughout learning and skills, to ensure that improvements take place. (2.285, see paragraph 2.276)

3.123 There should be a regular review of the need for English for speakers of other languages (ESOL) provision to ensure that adequate funding and support is provided. (2.286, see paragraph 2.276)

3.124 Classroom use in education should be maximised. (2.287, see paragraph 2.277)

3.125 The pay policy should be revised and used to inform decisions about the sufficiency of activity places to meet prisoners' needs. (2.288, see paragraph 2.278)

Physical education and health promotion

3.126 The number of showers for prisoners attending the gym should be increased. (2.291)

3.127 The facilities for the teaching of PE theory should be improved. (2.293)

Time out of cell

3.128 Prisoners should spend at least 10 hours out of their cell on weekdays. (2.295)

3.129 Prisoners should be issued with enough warm, waterproof clothing to go outside in all weather conditions. (2.297)

3.130 When exercise is cancelled, prisoners should have the option of an equivalent period of association. (2.298)

3.131 The prison should review its recording of time out of cell to provide an accurate average. (2.305, see paragraph 2.300)

3.132 When staff shortages require prisoners on J wing to have their association curtailed, alternative provision should be made for them on other units. (2.306, see paragraph 2.301)

3.133 All prisoners should have some evening association during the week. (2.307, see paragraph 2.302)

3.134 Prisoners should be offered a wider range of activities during association, including recreational education, and more seating should be provided in association areas. (2.308, see paragraph 2.303)

Security and rules

3.135 Suspicion drug tests and target searching should be carried out within a reasonable time. (2.311)

3.136 Security information received at weekends should be entered on the security intelligence system within 48 hours. Urgent information should be considered by the duty manager immediately. (2.314)

3.137 Prisoners should only be placed on closed visits as a result of intelligence or incidents related to visits. (2.323, see paragraph 2.322)

Discipline

3.138 The segregation unit should be renovated and the facilities updated to an acceptable standard, and the special unfurnished cell completely redesigned. (2.12)

3.139 A suitable waiting area should be provided for prisoners attending adjudication hearings. (2.326)

3.140 The authorising officer should not also be involved in the use of force, and all staff involved should be trained in control and restraint. (2.329)

3.141 Staff should be trained in how to use the video recorder for planned uses of force and recordings should show the prisoner clearly where possible. (2.331)

3.142 All documentation relating to the use of the body belt should be retained in the establishment. (2.342, see paragraph 2.337)

3.143 Video recordings of planned use of force should be reviewed as part of good governance arrangements. (2.343, see paragraph 2.337)

3.144 Management checks of use of force documentation should include an assessment of the need for further investigation of the incidents recorded. (2.344, see paragraph 2.337)

3.145 Prisoners should only be strip-searched on entry to the segregation unit if a risk assessment indicates it to be necessary. (2.345, see paragraph 2.339)

3.146 All staff in the segregation unit should undertake training in mental health awareness. (2.346, see paragraph 2.340)

3.147 The regime on the segregation unit should be improved. (2.348, see paragraph 2.341)

Incentives and earned privileges

3.148 The current IEP scheme should be published to all staff and prisoners and operated consistently and fairly across the prison. (2.352)

3.149 The weekly IEP review boards should be held in accordance with the published policy. (2.354)

3.150 Prisoners should not be refused promotion to the enhanced regime if they are unemployed through no fault of their own. (2.359, see paragraph 2.357)

Catering

3.151 The menu should have a range of cultural meals available to reflect the diversity of the population. (2.363)

3.152 Breakfast packs should be issued on the day they are to be consumed. (2.364)

3.153 Catering staff should routinely meet E wing prisoners to reassure them about food preparation standards and to discuss any concerns they have about their food. (2.366)

3.154 Evening meals should be served after 5pm. (2.373, see paragraph 2.372)

3.155 Prisoners should be able to dine in association. (2.374, see paragraph 2.372)

Prison shop

3.156 Prisoners should be able to place a shop order on the day of arrival at the establishment. (2.380, see paragraph 2.377)

Strategic management of resettlement

3.157 A local employment needs analysis should be carried out to identify the agencies that the coordinator should be targeting. (2.384)

3.158 More prisoner resettlement peer workers should be recruited to assist in the delivery of the reducing reoffending strategy. (2.387)

3.159 Attendance at the reducing reoffending meeting should be improved and should include voluntary and community sector organisations that contribute to the resettlement of prisoners. (2.392, see paragraph 3.390)

3.160 Work should be undertaken to improve the awareness of resettlement services among foreign national prisoners. (2.393, see paragraph 3.391)

Offender management and planning

3.161 The prisoner resettlement passport should be a live document, which should be updated when required, and the personal officer should refer to it when setting targets for prisoners. (2.394)

3.162 The backlog of assessments for all prisoners should be addressed, and a protocol introduced to ensure that offender managers complete assessments as soon as possible and submit them to the offender manager unit. Staff who carry out assessments should not be redeployed to other tasks. (2.395)

3.163 Better information should be kept regarding offender assessment system (OASys) targets and followed up at the resettlement committee to establish how many have been met, and how many prisoners have been transferred to establishments offering such interventions. (2.396)

3.164 Public protection staff trained in the use of the Police National Computer should be given access to this facility. (2.398)

3.165 Management of the lifer manager should come under the offender management unit and she should be co-located with that team. (2.400)

3.166 A minimum of two days each year should be designated for events for IPP prisoners, to enable them to understand and engage with risk reduction and their eventual reintegration. (2.402)

3.167 Release on temporary licence should be used whenever possible, in particular to assist the voluntary agency coordinator in securing placements with voluntary agencies. (2.402)

3.168 Recategorisation decisions should be considered by a board, with regular attendance or input by key staff. (2.409, see paragraph 2.404)

3.169 Staff should be provided with training to ensure that they understand their role in monitoring and supporting the public protection measures imposed on the prisoners in their care. (2.410, see paragraph 2.408)

Resettlement pathways

3.170 A debt counsellor should be available as part of the resettlement services on offer. (2.414)

3.171 Prisoners should be assisted to open a bank account prior to discharge. (2.417)

3.172 The health services team should play an active role in the resettlement process. (2.418)

3.173 The substance misuse needs analysis should draw on information gleaned from all departments involved in offering drug treatment, including the CARAT and substance misuse teams. (2.421)

3.174 An alcohol strategy should be developed or incorporated into the drug strategy, and should include both testing and treatment provision. (2.423)

3.175 Staff working on J wing should be offered training regarding both the actual programme and general issues of substance misuse. (2.425)

3.176 The visits waiting area for vulnerable prisoners should be improved. (2.427)

3.177 An appropriate baby changing area should be available during visits. (2.429)

3.178 The visitors' reception area should be expanded and the facilities enhanced. (2.430)

3.179 An explicit local employment needs analysis should lead to targeted employability training. (2.447, see paragraph 2.434)

3.180 The prison and the interventions and substance misuse group (now renamed the rehabilitation services group) should address the lack of services and structured interventions for primary alcohol users. (2.448, see paragraph 2.437)

3.181 The prison should ensure that the short duration drugs programme runs effectively and assess whether reduced provision still meets the needs of the population. (2.449, see paragraph 2.438)

3.182 The visits booking line should be adequately staffed to ensure timely booking of visits. (2.450, see paragraph 2.439)

3.183 Prisoners should not be required to wear high-visibility vests on visits. (2.451, see paragraph 2.440)

3.184 Prisoners should be advised in advance of when they have a visit. (2.452, see paragraph 2.440)

3.185 Visits should start on time. (2.453, see paragraph 2.440)

3.186 Prisoners should be allowed close physical contact with their children on visits. (2.454, see paragraph 2.440)

3.187 The furniture in the visits room should be replaced with a more suitable alternative. (2.455, see paragraph 2.441)

3.188 Steps should be taken to reduce the noise levels in the visits hall and closed visits booths. (2.456, see paragraph 2.441)

3.189 The closed visits area should be improved to increase privacy. (2.457, see paragraph 2.441)

3.190 Broken and malfunctioning security cameras should be repaired or replaced without delay. (2.458, see paragraph 2.442)

3.191 The A to Z motivation programme should be reinstated. (2.459, see paragraph 2.445)

3.192 Subject to the final analysis of the 2009 needs analysis, the thinking skills programme should be delivered at the establishment. (2.460, see paragraph 2.445)

Housekeeping points

Courts, escorts and transfers

3.193 A record should be kept of the time of arrival of vehicles. (2.15)

First days in custody

3.194 A record should be kept of calls made on the first night centre, for managerial assurance that these are taking place. (2.22)

3.195 The schedule of actual Insider activity should be reflected in the first night policy. (2.27)

3.196 The language identification list should be widely available to Insiders and induction staff. (2.29)

3.197 There should be systems to identify new prisoners to staff on all residential units. (2.38, see paragraph 2.34)

Residential units

3.198 Prisoners should be able to access proper and sufficient cleaning materials. (2.41)

3.199 Out of order telephones should be repaired without delay. (2.49)

3.200 Out-of-order laundry facilities should be repaired without delay. (2.65, see paragraph 2.53)

3.201 Prisoners should sign for all individual monies sent into the prison. (2.66, see paragraph 2.57)

Staff–prisoner relationships

3.202 Minutes of wing representative meetings should include action points and outcomes. (2.76, see paragraph 2.72)

Personal officers

3.203 Wing file entries should refer to prisoners by their preferred name. (2.79)

3.204 Personal officers should record issues concerning the personal circumstances of the prisoners in their care and support contact with their families and friends. (2.89, see paragraph 2.83)

Bullying and violence reduction

3.205 The anti-bullying exit survey should be carried out a few weeks before discharge. (2.97, see paragraph 2.96)

Self-harm and suicide

3.206 The roles of staff attending reviews should be clearly stated. (2.99)

3.207 Staff should be reminded of the type and quality of entry required in ACCT documentation. (2.113, see paragraph 2.105)

3.208 Night-time observations should be at unpredictable intervals. (2.114, see paragraph 2.105)

Applications and complaints

3.209 A stock of the various complaint forms should be available on all residential units. (2.120, see paragraph 2.119)

Faith and religious activity

3.210 Corporate worship should be available for Mormon prisoners. (2.140, see paragraph 2.133)

Foreign national prisoners

3.211 The accuracy of translated material should be verified. (2.180)

3.212 UKBA clinics should be accurately publicised on wing notice boards. (2.194, see paragraph 2.188)

Health services

3.213 IRI and IR2 incident reports should be completed fully. (2.255, see paragraph 2.237)

3.214 More effective use should be made of pharmacy resources to improve prisoners' health and well-being. (2.256, see paragraph 2.243)

Learning and kills and work activities

3.215 Prison managers should ensure that IDTS prisoners receive their pay on time. (2.262)

3.216 The availability of dictionaries and books in foreign languages should be better promoted to prisoners, to ensure that they are aware of where to find them and how to obtain other books using the request system. (2.289, see paragraph 2.282)

Time out of cell

3.217 Exercise yards should contain adequate seating for prisoners and be kept clean. (2.309, see paragraph 2.304)

Security and rules

3.218 A record should be maintained of the number of prisoners waiting for transfer to category C conditions. (2.317)

Discipline

3.219 Prisoners should be provided with a pen and paper during adjudications. (2.325)

3.220 All records of adjudications should be completed fully and show that a thorough investigation of the charges has been carried out. (2.348, see paragraph 2.335)

3.221 The corridor leading to the special accommodation should be cleared to enable easy access. (2.349, see paragraph 2.338)

3.222 Staff should record interactions with prisoners in individual prisoner records. (2.350, see paragraph 2.340)

Strategic management of resettlement

3.223 The objectives within the reducing reoffending strategy should be time bound to ensure delivery. (2.382)

Resettlement pathways

3.224 Prisoners should not be permitted to smoke in the visits holding rooms. (2.461, see paragraph 2.441)

Good practice

Resettlement pathways

3.225 The children's liaison officer was a valuable resource for prisoners and their families. (2.462, see paragraph 2.444)

Appendix I: Inspection team

Sara Snell	Team leader
Vinnett Pearcy	Inspector
Karen Dillon	Inspector
Paul Rowlands	Inspector
Andrew Rooke	Inspector
Nicola Rabjohns	Health care inspector
Helen Carter	Health care inspector
Siggi Engelen	Substance use inspector
Julia Horsman	Ofsted inspector
Phil Romaine	Ofsted inspector

Appendix II: Prison population profile

Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

Status	18–20-year-olds	21 and over	%
Sentenced	14	385	61
Recall	3	85	14
Convicted unsentenced	15	43	9
Remand	10	80	14
Civil prisoners	0	0	
Detainees	0	14	2
Total	42	607	100

Sentence	18–20-year-olds	21 and over	%
Unsentenced	25	137	25
Less than 6 months	5	54	9
6 months to less than 12 months	3	33	5
12 months to less than 2 years	3	109	17
2 years to less than 4 years	2	132	21
4 years to less than 10 years	4	107	17
10 years and over (not life)		17	3
ISPP		11	2
Life		7	1
Total	42	607	100

Age	Number of prisoners	%
Please state minimum age	18	
Under 21 years	17	3
21 years to 29 years	283	44
30 years to 39 years	209	32
40 years to 49 years	86	13
50 years to 59 years	36	6
60 years to 69 years	15	2
70 plus years	3	
Please state maximum age	74	
Total	649	100

Nationality	18–20-year-olds	21 and over	%
British	41	526	87
Foreign nationals	1	81	13
Total	42	607	100

Security category	18–20-year-olds	21 and over	%
Uncategorised unsentenced			
Uncategorised sentenced		1	
Cat A		0	
Cat B		7	1

Cat C	1	173	27
Cat D		7	1
Other	41	419	71
Total	42	607	100

Ethnicity	18–20-year-olds	21 and over	%
White			
British	38	477	80
Irish		1	
Other white		36	6
Mixed			
White and black Caribbean		5	1
White and black African		2	
White and Asian			
Other mixed		5	1
Asian or Asian British			
Indian		5	1
Pakistani		3	
Bangladeshi		2	
Other Asian		8	1
Black or black British			
Caribbean	3	9	2
African		9	1
Other black		9	1
Chinese or other ethnic group			
Chinese	1	13	2
Other ethnic group			
Not stated		23	4
Total	42	607	100

Religion	18–20-year-olds	21 and over	%
Baptist	0	0	
Church of England	9	138	21
Roman Catholic	2	86	14
Other Christian denominations	8	89	15
Muslim	1	29	5
Sikh	0	5	1
Hindu		1	0
Buddhist		10	2
Jewish		1	0
Other			
No religion	22	248	42
Total	42	607	100

Sentenced prisoners only

Length of stay	18–20-year-olds		21 and over	
	Number	%	Number	%
Less than 1 month	12	71	96	20
1 month to 3 months	0		131	28
3 months to 6 months	5	29	126	27
6 months to 1 year	0		98	21
1 year to 2 years	0		19	4
2 years to 4 years	0		0	
4 years or more	0		0	
Total	17		470	100

Unsentenced prisoners only

Length of stay	18–20-year-olds		21 and over	
	Number	%	Number	%
Less than 1 month	12	48	35	25
1 month to 3 months	9	36	49	36
3 months to 6 months	4	16	45	33
6 months to 1 year	0		8	6
1 year to 2 years	0		0	
2 years to 4 years	0		0	
4 years or more	0		0	
Total	25		137	100

Main offence	18–20-year-olds	21 and over	%
Violence against the person	16	104	19
Sexual offences	1	64	10
Burglary	3	97	15
Robbery	1	52	8
Theft and handling	7	70	12
Fraud and forgery	0	3	0
Drugs offences	5	57	10
Other offences	9	159	26
Civil offences		1	0
Offence not recorded/holding warrant			0
Total	42	607	100