



**REPORT ON
AN UNANNOUNCED INSPECTION
OF
HMP COLDINGLEY**

19 – 21 APRIL 2004

BY

HM CHIEF INSPECTOR OF PRISONS

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INTRODUCTION

At one time, Coldingley had a flagship reputation as the Prison Service's premier 'industrial prison': a category B establishment committed to providing real work and training for its prisoners. It was then re-designated to C category status. Thirteen years on, as this inspection shows, it is well short of flagship status in the key areas of education, training and resettlement: indeed, in some of those areas it is not meeting the basic requirements of Prison Service standards. We pointed this out at our last inspection, four years ago; and it is disappointing to record that, since then, only three of our 17 recommendations for improvements to work and education had been implemented. However, it was encouraging that a new governor had already begun to put in place plans for improvement.

Coldingley was essentially a safe prison, with good staff-prisoner relationships and low levels of self-harm. With a more short-term and more challenging population, however, it will be necessary to ensure that robust procedures are in place to identify and prevent bullying and suicide.

Healthcare had improved significantly, with virtually all our recommendations achieved; and was about to move to more suitable refurbished accommodation. Race issues were beginning to be tackled, with the appointment of a full-time diversity manager; though more support was needed for the 26% of prisoners who were foreign nationals.

A major deficit was the absence of integral sanitation, and the electronic unlock system which we have criticised in all those prisons which still have this ineffective and unacceptable alternative. As elsewhere, prisoners were reduced to slopping out as a result of being unable to access toilets in reasonable time. Steps should be taken to provide either in-cell toilets or a more effective system.

But it was the absence of sufficient, and sufficiently useful, employment and training that was the most glaring gap. Eighty prisoners (over a fifth of the population) were

not in work or education during the inspection. Many opportunities to accredit vocational training and learning were being missed. Staffing shortages meant that only recreational PE could be provided. Prisoners did, however, have around 12 hours out of cell each day, even if they were unemployed; and association was predictable, if only available four nights a week.

Resettlement provision was poor. There were delays in sentence plans, and lifer work was underdeveloped. Little had been done to implement Prison Service resettlement policies, with no resettlement strategy or co-ordinated attempts to meet prisoners' needs.

It was clear that Coldingley had been drifting for some time. The new governor was clearly committed to reversing that drift and moving the prison forward: identifying resettlement as a key priority. This is a more difficult task than it was when the prison received a carefully selected intake: like all category C prisons, it now receives younger, more challenging and more short-term prisoners. However, much more can be done to provide positive opportunities and recapture some of Coldingley's past strengths. We hope that this report assists with this task and look forward to recording real progress on our next inspection.

Anne Owers

HM Chief Inspector of Prisons

June 2004

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PRE-AMBLE

The Prisons Inspectorate conducts interim inspections to visit and check establishments between full inspections. They are usually unannounced. They cannot serve the functions of a full inspection, but we believe that they are important in highlighting issues of concern, or examples of good practice in the treatment of prisoners. They are not intended to cover every aspect of the prison.

Michael Loughlin, Gabrielle Lee, Joss Crosbie, Paul Fenning, Brett Robinson, Bridget McEvelly and Neil Edwards (inspectors) carried out an unannounced short inspection of HMP Coldingley from 29 to 31 March 2004 to review progress on recommendations made after the last full inspection in 2001. The team also monitored the treatment of prisoners using the model of the healthy prison introduced in a thematic review of 1999. During their visit they met prisoners and staff and had discussions with the governor. They discussed their conclusions with the governor before they left.

FACT PAGE

Task of the establishment:

HMP Coldingley is a closed category C training prison.

Brief history:

Coldingley was opened in 1969 as a category B industrial prison, and was re-designated as a category C prison in 1991.

Area organisation:

Surrey and Sussex area.

Number held:

386.

Cost per place per annum:

£24,671.

Cost per prisoner place:

£23,648.

Certified normal accommodation:

370.

Operational capacity:

390.

Last full inspection:

12–16 June 2000.

Description of residential units:

A, B, C, D and F wings.

Each of the main wings had three landings and a ground floor with an association room, a launderette, a storeroom, showers and five PIN telephones. All cells were designed for single occupancy except on F wing. All wings contained cells accommodating two prisoners. Cells did not have integral sanitation and access to toilets at night was by an automatic unlock system.

HEALTHY PRISON SUMMARY

Introduction

HP.01 Inspection reports include a summary of an establishment's performance against the model of the healthy prison as described in the thematic review, *Suicide is Everyone's Concern*. In a short unannounced inspection such as this, an in-depth assessment cannot be made across the full range of the Inspectorate's published Expectations, which set out our criteria for assessing the treatment of and conditions for prisoners, and opportunities for checking outcomes with prisoners are limited. We examined some areas in more detail than others. Based on documentary evidence, our observations and discussions with staff, prisoners and others, the following is our assessment, based on the four tests of a healthy prison: safety, respect, purposeful activity and resettlement.

HP.02 There had been relatively few changes at Coldingley since our last inspection and progress in the implementation of some recommendations, particularly in the area of work and training, had been disappointingly slow. While the prison remained generally safe and respectful, and offered a reasonable amount of purposeful activity, little had been done in recent years to promote resettlement opportunities for prisoners. Previously, very selective criteria had been used to assess those prisoners suitable for Coldingley but this was no longer the case; the introduction of younger less compliant prisoners than in the past was bringing new challenges.

HP.03 Although Coldingley had made relatively little progress since our last inspection, at the time of this inspection a new governor had been in place for only a short period. It was evident that under his leadership Coldingley had begun to embark upon a period of substantial change and there were plans to implement a range of new systems from 1 May. The introduction of better arrangements for resettlement had been identified as a top priority.

Safety

HP.04 Coldingley was a fundamentally safe place. Reception and induction arrangements appeared satisfactory. There was little evidence that bullying was a problem and there were low levels of self-harm. F2052SH reviews were well conducted.

HP.05 Reception procedures were satisfactory. We noted that on paper there was a good induction programme for new prisoners, although during the period of this short inspection we did not have the opportunity to observe the induction programme in operation. A good range of information was displayed to help prisoners settle at Coldingley.

HP.06 There were apparently very few incidents of identified bullying; 24 had been reported in 2003 and 10 in the first four months of 2004. Incidents of bullying were investigated but the operation of the strategy needed to be more closely monitored. For example, it was not possible to establish how often the different stages of the strategy had been used. We were not able to ascertain that bullying behaviour was being challenged or what interventions were being used when bullying was identified. Most prisoners appeared to have been removed from the strategy after a short period of monitoring. There was good staff representation on the anti-bullying committee. While there appeared to have been some improvements in anti-bullying procedures since the last inspection, there had been no staff training in this area since January 2003, when nine staff had received some training.

HP.07 Levels of self-harm were low with 14 F2052SHs opened during 2003. Five had been opened in the first three months of 2004. Even though the numbers involved were low, as with bullying, benefits would be gained from improved monitoring. It was not possible to establish from the register whether F2052SH booklets were opened as a result of particular acts of self-harm or because of proactive staff care. The changing population could result in more prisoners at risk of self-harm needing to be cared for. The night sanitation arrangements made caring for prisoners in need of regular watches difficult. The care suite for Listeners was located in the observation and separation unit and, as stated in our previous report, this was not an appropriate environment within which to care for those at risk. We were told this care suite was to

be removed and that Listeners usually saw prisoners in the Listeners' cells, or if more appropriate, in the prisoner's own cell. The small sample of closed F2052SH booklets we looked at were appropriately completed and there was evidence of some good quality entries, although not all reviews involved multi-disciplinary teams.

HP.08 The prison was calm and well ordered with a relaxed atmosphere on the wings. There was a low level of use of force and punishments for disciplinary offences were measured and effective. There had been increases in positive mandatory drug testing figures over the previous year and measures were being taken to tighten security to reduce the supply routes.

Respect

HP.09 There were generally good relationships between prisoners and staff but these would be supported and enhanced by some better systems. The prison environment was good but the night sanitation arrangements were unsatisfactory. There had been significant improvements in healthcare.

HP.10 We observed reasonably good, relaxed relationships between prisoners and staff. Following a recent governor's order, staff addressed prisoners respectfully by their first name or title and surname. Prisoners told us that a minority of staff made it clear that they did so reluctantly, although most treated them well.

HP.11 Individual cells and communal areas on the wings were generally clean, but some of the association rooms were rather drab with torn and stained furniture. The grounds were attractively maintained but some parts of the external areas were littered with rubbish. There was some double occupancy of cells originally designed for one. This was unacceptable, particularly because of the poor sanitary arrangements.

HP.12 There was no integral sanitation and, once locked up in the evening, prisoners had to rely on their cells being unlocked automatically to gain access to the toilet. Prisoners told us that sometimes they had to wait for up to an hour-and-a-half and had to resort to using the pots that they had been issued with. These were sometimes

emptied through the windows. In effect, the night sanitation system resulted in some prisoners at Coldingley still having to ‘slop out’ in the mornings.

HP.13 The chaplaincy team provided good support to prisoners. There was a good balance of staff to support each of the main faiths and meet the required responsibilities. The chaplaincy had good facilities and we were encouraged by the plans to extend the outreach scheme to encompass prisoners of all and no faiths.

HP.14 Prisoners reported some inconsistencies in the application of what they were allowed on the facilities list. We accepted that the facilities list had been revised shortly before the inspection and that this dissatisfaction may have been the result of teething problems in the introduction of new arrangements. The prison’s management had recognised that the incentives and earned privileges scheme needed to be evaluated and revised. The scheme in operation offered little incentive to most prisoners and was particularly poor in offering worthwhile incentives for foreign national prisoners. Extended special visits were available for those on the enhanced level but there was a considerable waiting list.

HP.15 In an effort to tighten security measures and reduce the supply of drugs coming into the prison, new fixed furniture had been introduced in the visits room shortly before the inspection. While we understood the need to tighten security we considered that the design and arrangement of the new furniture was unsatisfactory. Groups of visitors were very close together and there was insufficient privacy. Some prisoners complained that the distance they were required to sit apart from their visitors made it difficult to hear and converse normally. The room was also used for legal visits but was unsatisfactory for this purpose. The governor believed that prisoner dissatisfaction was a natural reaction to a negative change and that this would abate over time. There was an inadequate and unsupervised play area in the visits room. Despite concerns about the physical arrangements, those visitors we spoke to during the inspection said they felt welcomed by prison staff at Coldingley.

HP.16 We examined a number of complaint forms and found that the replies to prisoners were usually respectful and timely and that apologies had been made in appropriate cases. However, there was no effective monitoring system in place to

provide useful management information, such as the type of issues being raised or whether one part of the prison or particular individuals were generating a disproportionate number of complaints.

HP.17 Managers acknowledged that food had been a major source of dissatisfaction among prisoners at Coldingley until just before the inspection. The governor considered that the general quality of the food had been acceptable but that it had been presented with little care or imagination. He had involved prisoners in a working group to seek solutions to the problem. This approach appeared to have achieved some results as prisoners told inspectors that there had been some recent improvements. The food sampled by inspectors was satisfactory and there was reasonable provision of culturally diverse food.

HP.18 Forty seven per cent of prisoners at Coldingley were black and minority ethnic. We commended the decision to appoint a full time diversity manager. The diversity manager had recently taken up post and was responsible for taking the lead on race relations issues. A racial complaints system was in place and take-up of regime and other activities was monitored by ethnic group. However, there was little evidence of any positive promotion of diversity within the establishment. Black and minority ethnic prisoners told us that while there was little direct racism, staff did not have much understanding of race and cultural diversity issues and they did not feel that concerns they raised about race issues were taken seriously. We were satisfied that the governor was aware of this difficulty and was committed to tackling it.

HP.19 One hundred and one prisoners at Coldingley, 26% of the population, were foreign nationals. A foreign nationals committee met regularly but there was a lack of clarity about its role and how it benefited prisoners. There was an appointed foreign nationals' officer but there was no formal statement outlining the responsibilities of the role and he was not a member of the diversity committee. There was a general lack of information available for prisoners in languages other than English. The Immigration Advisory Service attended the prison occasionally but more regular information and advice was needed for those foreign national prisoners who were potentially subject to deportation. There were no prisoners held at Coldingley solely on immigration warrants.

HP.20 There had been a significant improvement in the delivery of healthcare services for prisoners. Fifteen of the 17 recommendations involving healthcare in our previous report had been achieved, one partly achieved and only one not achieved. At the time of the inspection the layout and fabric of the healthcare premises were unsuitable for its purpose but relocation to good, refurbished accommodation on the ground floor of the building was imminent. The dental surgery was still unsatisfactory, but we noted that funding had been secured to relocate and install a completely new surgery in the new healthcare department. An initiative to reduce the average wait for the dentist from six weeks to three had begun. A new clinical lead nurse post was being advertised; filling this important post would help ensure that clinical governance outcomes were met and support the smooth transition of healthcare commissioning to Surrey Heath and Woking Primary Care Trust.

Purposeful activity

HP.21 There was good and predictable time out of cell. A reasonable range of activity places was available but too many prisoners were unemployed. Many opportunities to accredit work and training were being missed.

HP.22 The time out of cell for prisoners was good, at about 12 hours a day and men who were unoccupied or unemployed were unlocked on the wing. Association was planned for four nights each week, which reflected the available staff resources. While we would prefer to see evening association each day, the pattern meant that association was provided consistently and predictably rather than being subject to frequent cancellation; there had been only one cancellation of evening association for each wing in the first three months of 2004.

HP.23 Allocation to work in the prison was conducted without reference to prisoners' identified need in their sentence or life sentence plans. A check on the wings during one morning of the inspection found 49 unemployed prisoners and a further 31 men who were allocated to jobs but not required that morning for a range of reasons. This was too many for this type of establishment and interruptions to allocated work needed to be reduced. It was planned to address this problem by providing part time

education and work. A longer-term solution to provide sufficient appropriate work and training places was also being pursued.

HP.24 In the four years since the last inspection, little progress had been made on the action plan in terms of work and education. Only three out of 17 recommendations had been achieved. It was particularly disappointing to note the failure to exploit opportunities to accredit learning with nationally recognised qualifications in a wide range of work areas including the sign workshop, engineering and the laundry. Many opportunities to accredit key and basic skills in work places were also being missed. Generally, there was little achievement in education beyond level two although there were 15 prisoners participating in Open University courses. The education department needed to be more closely integrated into sentence planning and resettlement goals.

HP.25 Library opening times had been extended since the last inspection and the physical facilities had improved. A well managed basic book borrowing and reference section contained the appropriate legal and Prison Service reference material. However, we noted that our last inspection report was not in the library. There was no outreach or resettlement information, and no materials to support those with lower reading abilities or to support the courses provided in education or relevant to work skills. There was little material for prisoners with English as a second language. The little that was provided did not appear to reflect the prisoner profile; for instance there were only 11 books in Italian for two Italian prisoners.

HP.26 There were severe staffing problems in the gym as the prison had lost its physical education instructors on transfer elsewhere and was finding it difficult to recruit replacements. The gym was run by one senior officer with some sessional officer support and was mainly only able to offer recreational provision. This was unsatisfactory. There was a need to ensure that when the PE department was back to full strength it offered a range of qualifications appropriate for the future employment and resettlement needs of prisoners. In the meantime, given the staffing difficulties, it was commendable that in addition to recreational provision, daily remedial work, support to the RAPt (Rehabilitation of Addicted Prisoners Trust) programme and work with community groups was continuing.

Resettlement

HP.27 There was little to help prisoners prepare for release. Resettlement provision was very underdeveloped and little had been done to implement the Prison Service policy set out in PSO 2300. Sentence plans were delayed, the personal officer scheme was not working effectively and there was little support for lifers. However, good drug services were provided.

HP.28 When we last inspected Coldingley in 2000, sentence planning had been operating very successfully and was identified as an area of good practice. This was no longer the case and the substantial delays in the sentence planning process needed to be addressed. Linked to the deficiencies in sentence planning was an acknowledgement that the personal officer scheme was not working effectively and needed improvement. Most prisoners we spoke to knew who their personal officers were, but said they often found it difficult to see them as many were based on other wings.

HP.29 Each new lifer arriving at Coldingley was given an induction interview by the lifer team within their first weeks there. Lifers we spoke to said that their annual reviews were generally carried out on time. However, there had been some problems in the recent past in compiling dossiers for parole board reviews on time. At our last inspection we had recommended the formation of a lifer group to help support and meet some of the special needs of lifers. This had not been achieved. It was evident that there was a real need for such a group. Lifers felt unsupported and trained and authoritative staff were needed to provide good and consistent information. Lifers said they had little access to the lifer manager and probation staff and were concerned that personal officers and others, with whom they had little contact, often completed their reports. No special lifer days had been organised to provide opportunities for external people to speak to lifers or to allow them to have special days with their families.

HP.30 At the time of the inspection Coldingley was running Enhanced Thinking Skills and Think First programmes. However, the governor had taken a strategic decision to discontinue running these accredited offending behaviour programmes and

concentrate instead on developing work skills training and the RAPt programme for prisoners with drug problems. It was not clear how this decision fitted into a national or area strategy to ensure that prisoners' identified needs were met.

HP.31 There was no existing resettlement policy at Coldingley, but the deputy governor had recently been designated as head of resettlement and was tasked with developing a resettlement strategy as a priority. A resettlement committee had been meeting at regular monthly intervals under the chairmanship of the previous governor and with appropriate senior representation. However, the minutes suggested the meetings were merely an exchange of information rather than a co-ordinated approach to identifying prisoners' resettlement needs.

HP.32 It was difficult to obtain co-ordinated information about releases from Coldingley, or about the use of release on temporary licence (ROTL) and home detention curfew (HDC), although this information was available on an individual basis. There was some evidence that applications for compassionate release were being considered without the appropriate discretion, and our previous recommendation that prisoners should attend ROTL boards was rejected.

HP.33 Prisoners moved regularly from Coldingley to open conditions. During the course of our inspection we came across a small number of prisoners who had been returned to category C conditions because of a retrospective, national decision to remove long term prisoners from open conditions following a high profile failure. The lack of clarity about the status and future of these individuals was unfair to them and needed to be resolved.

HP.34 Positive random mandatory drug tests were running at approximately 15-18%. Tests indicated that cannabis was the main drug used. There were some problems with the operation of the voluntary drug testing procedures; there were no voluntary testing protocols and testing was routine rather than differentiated to meet needs. The prison was providing a reasonable standard of drug services and the CARAT team was well integrated and provided a lot of support for prisoners, including a good drop-in service. There was also a good RAPt programme, which appeared to be well

integrated into the prison. The CARAT team, RAPt workers and healthcare workers worked well together.

Main recommendations

To the Director General

HP.35 In respect of the decision to discontinue running accredited offending behaviour programmes at Coldingley, there should be clarity about national and area policy in terms of the delivery of such programmes to ensure that prisoners' identified needs are met.

HP.36 The position of prisoners moved back to category C prisons from open prisons in January 2004 because of a national decision about length of time to serve rather than individual risk assessments should be clarified.

To the Governor

HP.37 The current night sanitation arrangements were unacceptable. In-cell toilets or an alternative system should be introduced in order to ensure that prisoners have genuine 24-hour access to toilet facilities.

HP.38 All opportunities should be taken to accredit skills acquired in work, education and training.

HP.39 A resettlement policy should be agreed with the resettlement committee, operating strategically, setting targets and monitoring delivery of resettlement services on the basis of identified needs.

Chapter One

PROGRESS SINCE THE LAST REPORT

Introduction

1.01 We have used the recommendations from our inspection of 12–16 June 2000 as a framework to examine progress achieved. We have commented where we have found significant improvements, and where we believe little or no progress had been made and work remained to be done.

1.02 During this inspection, we concentrated on aspects that directly affect the treatment and conditions for prisoners and so did not examine all the recommendations from the last inspection. The paragraph reference numbers at the end of each recommendation below refer to its location in the previous inspection report.

Substance Use

1.03 *The Lifer Unit should provide clear guidance on setting substance use targets (4.17)*

Achieved. CARATS workers had been asked to make contact with treatment providers before a transfer to a different establishment for a particular programme was agreed. It was clear from speaking to many life-sentenced prisoners during the inspection, that completion of a RAPt programme continued to be set as a sentence plan target, prior to an assessment being made of their suitability for such a programme. However, all applications to RAPt were assessed prior to the offer of a place, and CARATS workers at sending establishments completed a transfer plan which summarised the prisoner's drug history, progress made and outstanding goals. The ultimate decision to accept a prisoner onto the RAPt programme lay with the programme provider.

Foreign nationals

1.04 *Parole decisions should be given on time to all prisoners, including foreign national prisoners and any subsequent deportation arrangements made to coincide with these parole dates. (4.69)*

Achieved. There were no foreign national prisoners detained solely on immigration warrants. There was efficient liaison with the Immigration Service to arrange removal or deportation when prisoners reached their release dates.

1.05 *The Prison Service should review rules pertaining to foreign nationals' access to home leave, Home Detention Curfew and category D status. In turn, provision of Town Visits and Release on Facility Licence to allow work experience should also be considered for foreign nationals on an individual basis. (4.69)*

Partly achieved. Foreign national prisoners were assessed for category D status and a national agreement was in place to involve the immigration department in the risk assessment process. A review ensuring that foreign national prisoners were not disadvantaged in relation to HDC-eligible British prisoners was also in place. The monitoring at the prison did not identify the access of foreign national prisoners to resettlement services separately from British prisoners.

Inter-prison transfers

1.06 *The efficacy of the Group 4 national escort system should be closely examined. (5.25)*

Not inspected. The director general was aware that the inter-prison transfer contract made delivering the required movements difficult. This difficulty had arisen because the demand for transfers had significantly exceeded the figure provided in the Invitation to Tender on which the contractor's bid and resource provision was based. The director general had agreed a contract amendment that he felt would provide substantial additional resources to the contract, and would ensure that all transfer requests were undertaken.

Contact with family and friends

1.07 *Rates for phone calls at Coldingley seemed excessive, and the Prison Service should renegotiate this national contract with British Telecommunications. (7.45)*

Reception

1.08 *The establishment should consider ways to expand the use of the reception orderly to help put new receptions at ease. (2.06)*

Achieved. One of the two reception orderlies was a Listener, who met new receptions, explained the arrangements for speaking to a Listener or contacting the Samaritans and helped new arrivals to settle in at Coldingley. There were also plans to develop selected prisoners as Insiders to assist in the induction process.

1.09 *The in-possession property list should be reviewed, reissued and displayed in the residential units, particularly on the induction wing. (2.09)*

Achieved. The list was displayed on unit notice boards and had been reviewed within the previous three months.

Induction

1.10 *A copy of the current in-possession property list should be attached to the prisoner compact that is issued to prisoners during their first night. (2.24)*

Not achieved. Newly arrived prisoners were not given a copy of the list of items that they were allowed to have in their possession. We were told that the list had been further revised and once printed, would be issued on induction. **We repeat the recommendation.**

Legal aid

1.11 *An assessment should be undertaken to examine the demand for legal aid services and resources put in place that meet identified need. (2.32)*

Not achieved. Although the action plan stated that a needs assessment had been undertaken, and the information was included in the induction programme, this was not the case.

1.12 *The legal aid service should not be neglected and the service provided for prisoners should be improved. (2.34)*

Not achieved. There was no easily identifiable service available from prison staff, and senior managers were unsure who managed the service.

Additional information

1.13 There was no dedicated legal service office and no information was given to prisoners during their induction period. There was no information about the availability and role of legal service officers displayed on wing notice boards. Information about the Criminal Cases Review Commission and the Prison Ombudsman was available.

1.14 Prisoners were able to obtain information and support from the Citizens Advice Bureau (CAB) in the establishment. A prisoner/advisor was able to access information held on a computer in the CAB office. The CAB had provided all of the available office equipment, and the computer contained the same information available to CABs in the community. Information was printed for prisoners when required.

1.15 The prisoner/advisor gave a presentation to new prisoners during the induction programme. He kept records of all the prisoners he saw, and produced a case sheet for each individual, a copy of which was forwarded to the CAB. Each month a short report was prepared for the senior management team, which detailed the numbers of prisoners seen, their ethnicity and types of issues dealt with.

1.16 The prisoner/advisor had dealt with 400 referrals in the 18 months that he had been providing the service. An appropriate range of legal reference books and Prison Service Orders were available within the prison library. Legal visits took place in the visits hall, but the facility offered only minimal confidentiality.

Further recommendation

1.17 An analysis of the existing legal and support services available to prisoners should be undertaken to identify and evaluate need, and target the resources necessary.

Accommodation

1.18 *Larger sinks should be provided on each wing landing for prisoners to wash and sterilise their cups and plates etc. (3.05)*

Achieved. All prisoners were able to wash plates, cups and cutlery in a sink large enough for the purpose.

1.19 *Prisoners on F wing should have single cells. (3.10)*

No longer relevant. F wing was no longer being used as a category D unit. The prisoners there were enhanced level category C prisoners. The rooms were not designed to be divided and to attempt to do so would reduce the space and amenities available to each prisoner. Prisoners on F wing had constant access to a shower, toilet and a kitchenette.

1.20 *All prisoners should be properly trained before they commence work as wing cleaners. (3.11)*

Partly achieved. While most prisoners working as wing cleaners had undertaken a five-unit training module, there was no evidence to show that all had. Some claimed that they had certificates in industrial cleaning from other prisons, but no one had verified this before allowing them to work as wing cleaners. **We repeat this recommendation.**

1.21 *Staff should ensure that cells are clean and tidy at all times. (3.14)*

Achieved. We were told that staff inspected cells for cleanliness and tidiness while carrying out accommodation and fabric checks. All the cells we inspected were clean and tidy.

1.22 *The return display figures in the internal cell door panels should be easier to read. (3.16)*

No longer relevant. All those prisoners we interviewed about this said that they had no difficulty in reading the figures.

1.23 *Each cell should have as standard issue a bucket with a lid for emergency toilet arrangements. (3.16)*

Achieved. Chamber pots were available to all prisoners who wished to have one in their cell.

Additional information

1.24 We discovered from both prisoners and senior management that on numerous occasions the unlocking system did not work well and many prisoners were forced to use their chamber pots. Although the electronic system did maintain records of waiting time and patterns of demand for the night-time sanitation system, there was no managerial oversight of this data to assess the suitability or effectiveness of the system. The night sanitation monitoring system was designed for single cell occupancy and with many holding two prisoners it was not accurately recording demand. We heard that urine and parcels of faeces were thrown from cells. We consider that the arrangements for allowing prisoners access to toilets at night were inadequate.

Further recommendation

1.25 In-cell toilets or an alternative system should urgently be introduced to provide genuine 24-hour access to toilet facilities.

1.26 *Staff should regularly patrol shower rooms when they are occupied by prisoners. (3.20)*

Achieved. The showers were patrolled and checked on a random basis when staff were seeking prisoners who had not responded to public address announcements.

1.27 *Kitchen workers should be offered the opportunity to shower after each shift. (3.21)*

Not achieved. Prisoners working in the kitchen did not have access to the shower in the kitchen or on their wing at the end of Friday and weekend afternoon shifts.

We repeat this recommendation.

1.28 *Wing launderettes should be improved. (3.22)*

Not achieved. There were no additional drying facilities in the wing laundries. We were told that the power supply was already at maximum capacity. We spoke to some of the prisoners on laundry duties and they reported few difficulties in drying clothes.

1.29 *An offensive display policy should be enforced. (3.23)*

Achieved. There was a policy in place and we found no offensive material on display.

1.30 *A smoking policy should be on display; non-smoking areas should be clearly identified and staff should enforce non-smoking regulations. (3.24)*

Achieved. The smoking policy was clearly displayed on wing and staff notice boards and we saw no one breaching the policy.

1.31 *All cell windows should have netting on the outside to prevent rubbish being thrown into the grounds and to reduce pests and vermin. (3.25)*

Partly achieved. The prison had eventually accepted this recommendation and had started to fit mesh screens on cell windows. At the time of the inspection, about 25% had been fitted, with the remainder due for completion within six months.

Hygiene, clothing and kit exchange

1.32 *Prisoners handling dirty kit should be required to wear appropriate protective clothing for sorting dirty, possibly soiled, kit. (3.26)*

Achieved. Prisoners working in the part of the laundry handling such material were issued with protective gloves and masks. Those who wished to wore overalls while others had clothing that they kept solely for use in that area of the laundry.

1.33 *Sufficient blankets should be stored and available in both clothing and kit storerooms at all times to ensure that any prisoner wanting additional blankets may be issued with them. (3.27)*

Achieved. Blankets had been replaced with duvets and all prisoners had been issued with one. There were also ample supplies of duvets in the stores.

1.34 *Mattress covers should be issued to each cell and sufficient spare mattresses and loose mattress covers should be readily available in wings. (3.28)*

Achieved. All prisoners could have a mattress cover and many had chosen to use one. There were sufficient covers in the store for all prisoners.

Time out of cell

1.35 *Staff arrangements should provide evening association every evening of each week. (3.32)*

Not achieved. However, association was planned for all prisoners for two-and-a-half hours every evening from Monday to Thursday. All prisoners were out of their cells during the core day, seven days a week. Association had been cancelled for one wing, approximately a quarter of the population, only nine times in 2003 and only five times in the first four months prior to the inspection. There was a risk that extending evening association would lead to frequent cancellation. The provision of consistent, predictable evening association was acceptable.

1.36 *Out of bounds areas should be clearly marked within the establishment and prisoners should have access to the prison grounds when they are not at work. (3.32)*

Not achieved. Prisoners were unlocked throughout the day, but were restricted to the wings if they were not working. Many unoccupied prisoners had daily access to a session in the gym during the day. Security considerations made it inappropriate to allow unoccupied prisoners to have access to all the grounds without restriction or supervision.

Anti-bullying

1.37 *The anti-bullying strategy should be widely publicised and staff training introduced alongside the introduction of the new bullying incident report forms. (4.03)*

Not achieved. The strategy was not widely publicised but Information about the anti-bullying committee was displayed on some wings. Policy statements were not displayed on all units. We were told that new display boards were being acquired to include photographs of the anti-bullying committee. There had been no anti-bullying training for staff since January 2003, when nine staff received training. **We repeat this recommendation.**

1.38 *The anti-bullying committee should be re-formed, chaired by a member of the senior management team and consist of a multi-disciplinary group of staff alongside prisoner representatives. (4.03)*

Partly achieved. We read the minutes of the six anti-bullying committee meetings held since June 2003. These had been chaired by the head of residence who was a member of the senior management team. There was good representation of uniformed staff, prison managers and prisoners. However, there needed to be more consistent attendance of staff from other disciplines such as the chaplaincy, probation and CARATs.

We repeat this recommendation.

1.39 *The review of the anti-bullying strategy should take into account prisoners' views revealed in surveys. (4.04)*

Partly achieved. The current anti-bullying strategy had been revised in June 2003. A survey of prisoners' views and experience of bullying was conducted in July 2003. There had been some delay in the completion of the survey, which was not published until April 2004. One significant finding in the survey was prisoners' reluctance to speak to members of staff about bullying incidents. Prisoners contributed to the on-going strategy through their participation in the anti-bullying committee. This had included feedback from prisoners on any experiences of bullying following their transfer to Coldingley. Prisoner representatives on the committee collated this information as part of the induction programme.

1.40 *The profile of the anti-bullying strategy and associated paperwork should be raised and developed to include the co-ordinated use of offending behaviour courses and bullying programmes carried out by education and physical education staff. Further, the establishment should implement clear procedures for dealing with bullies in-house. (4.07)*

Not achieved. More needed to be done to raise the profile of the anti-bullying strategy. There were no programmes on offer for those identified as bullies or for victims of bullying. We looked at the anti-bullying bi-monthly reports, which were completed for each anti-bullying committee meeting. These indicated that most cases of bullying were closed after a short period of monitoring. A few cases resulted in the bully being transferred. This did little to challenge problematic behaviour, which was likely to continue in the establishment to which the prisoner was sent. **We repeat this recommendation.**

Additional information

1.41 The anti-bullying co-ordinator had been on long term sick leave. His duties had been taken over temporarily by a principal officer and an assistant co-ordinator had been appointed in recent months. The strategy needed greater clarity. It included reference to four options for challenging bullies, which ranged from ‘no further action’ to ‘transferred out of the prison’. In another section called ‘anti-bullying policy’ reference was made to a three-stage strategy to challenge this behaviour. There was no reference to what stages prisoners had been placed on either in the completed investigations, the anti-bullying register or in the anti-bullying co-ordinator’s monthly reports.

Further recommendation

1.42 The operation of the anti-bullying strategy should be clarified and this should be reinforced through a programme of training for staff.

Substance use

1.43 *Drug awareness training should be actively promoted by senior management to ensure that all staff gain a basic understanding of the drug strategy and the services available within the establishment. (4.12)*

Partly achieved. Ten staff had received in-house RAPt awareness training in August 2003, and 11 had received training in the drug strategy in September 2003. In October 2003 four staff had undertaken an addictive behaviour course in the community, and three staff had received Criminal Justice Intervention Programme training. Staff were aware of the existence of CARAT services and the RAPt programme but their basic understanding of the drug strategy was unclear. **We repeat this recommendation.**

1.44 *The drug strategy should detail all initiatives taking place with protocols for working together. All documents should be dated; review dates specified and authors indicated. (4.14)*

Partly achieved. The drug strategy was under review at the time of the inspection. The existing strategy contained the required evaluation and quality assurance

procedures. However, while clear protocols existed for working together, these were not included in the strategy. **We repeat this recommendation.**

1.45 *There should be regular formal meetings of service providers to support working together and aid mutual understanding of different models, roles and tasks. (4.14)*

Achieved. There were weekly referral clinics and case management meetings attended by the drug strategy co-ordinator (DSC), CARAT workers and RAPt manager. A healthcare representative attended these meetings by invitation or on their request. All of these agencies were invited to attend the drug strategy meetings. A monthly tripartite meeting to discuss issues of mutual interest took place between the DSC, CARAT and RAPt managers.

1.46 *The number of prisoners arriving at Coldingley without having had a targeted offending behaviour intervention should be identified. (4.15)*

Not achieved. There had been no analysis of prisoners convicted of drug offences but who were not themselves drug users. Managers expected that such prisoners would be identified during reception and sentence planning procedures, but there were no formal systems in place to inform any drug strategy or resettlement targets. Drug importation courses were available at other establishments, but the need for these remained unidentified. **We repeat this recommendation.**

1.47 *The physical education department should be involved more closely in the drug strategy and its role in working with substance users clearly defined. (4.18)*

Partly achieved. The PE department offered a weekly session to prisoners involved on the RAPt programme. Their outreach work was severely reduced because of acute staffing problems. The action plan stated that the PE department was part of the drug strategy team, and that its role was defined and incorporated into the drug strategy. We saw no evidence of attendance by PE staff in the minutes of the meetings, and there was no identification of their role within the strategy. **We repeat this recommendation.**

1.48 *A local alcohol strategy should be developed, particularly given the resettlement function of the establishment (4.19)*

Not achieved. Representatives from AA (Alcoholics Anonymous), NA (Narcotics Anonymous) and CA (Cocaine Anonymous) attended the establishment weekly, but no local alcohol strategy had been developed. We were told that a national alcohol strategy was currently under consideration with the Prison Service DSU. **We repeat this recommendation.**

1.49 *An appropriate healthcare strategy, including health promotion work (essential for prisoners returning to the community) and HIV/hepatitis services within the establishment, should be developed and structures for working across departments formalised. (4.23)*

Achieved. A joint prison/PCT health improvement plan had been developed and appropriate health promotion work, including HIV/hepatitis, was in place. Specialist treatment and counselling was available to prisoners. Working protocols and integrated care pathways between healthcare and CARATs were well established and monitored regularly through joint meetings. The healthcare manager attended the drug strategy team meetings.

1.50 *The role and perception of healthcare in relation to drug users needs to be addressed. (4.24)*

Achieved. All prisoners were seen on reception by staff from the healthcare centre; any substance misuse issues and related health concerns were identified and managed jointly with the drug strategy team, and written information providing a range of healthcare options was given to prisoners. Prisoners with literacy or language problems were supported through Language Line and healthcare staff, one of whom spoke fluent Spanish.

1.51 *Category D prisoners should be able to attend self-support groups and other services in the community to build links for their release. (4.29)*

No longer relevant. Category D prisoners did not remain at the establishment.

1.52 *All sessional workers should be appropriately qualified (arts therapists must be state registered). (4.31)*

Achieved. The yoga teacher, who visited the establishment weekly, was a qualified teacher registered with The Phoenix Prisons Trust.

1.53 *A regular review of the lay-down process should take place to ensure transparency is maintained. While on lay-down prisoners should have access to purposeful activity in order to maintain active participation in the prison regime. (4.34)*

Partly achieved. Prisoners were no longer locked in their cells during their period of lay-down, but did not have access to education or PE during this time. The action plan stated that prisoners were allocated a work place although this was not the case. **We repeat this recommendation.**

1.54 *An urgent review of how voluntary testing, mandatory testing and the incentives and earned privileges scheme relate to one another within Coldingley is needed. (4.42)*

Partly achieved. Prisoners no longer felt that they were being targeted for VDT. We were told that recent changes had been made in how the IEP scheme could respond to a positive VDT. However, there was no detail included in either the drug strategy or the IEP policy document.

Further recommendation

1.55 Responses to substance use, in relation to the IEP scheme, should be included in the drug strategy, and IEP documents.

1.56 *The voluntary testing and mandatory testing procedures should be clearly separated. (4.42)*

Achieved. The two procedures had been separated. The drug strategy co-ordinator (DSC) gave verbal and written information to prisoners about VDT and MDT during the induction programme. Clear written information was available in the separate

testing areas, and throughout the establishment. Prisoners were clear about testing procedures.

1.57 *The use of the active and passive drug dogs should be improved. (4.49)*

Achieved. One dog handler managed both the active and passive dogs, and his work detail ensured that he was available to cover most visit sessions. Drug dogs searched all parcels received into the establishment, and the handler undertook target searching of visitors, vehicles and areas using intelligence information. Protocols were available that specified the areas to be searched, the frequency of searching, and search records were maintained. A protocol existed with the local area Search Team which enabled more dogs to be used if necessary and also involved the dog handler in assisting in searches at other establishments in the area.

Additional information

1.58 The drug strategy co-ordinator was knowledgeable and enthusiastic about his work. He was soon to take up another post and a new DSC was to take up the post in the near future.

1.59 The drug strategy team met bi-monthly, and was chaired by the head of resettlement. We saw minutes of three meetings that showed that the meetings had been poorly attended, apart from regular attendance by the head of resettlement, the DSC and representatives from CARATs and RAPt.

1.60 ACORN community drug and alcohol team (Surrey, Hampshire and Borders NHS Trust) provided CARAT services. The team consisted of a manager, one full time worker, one part time worker and an administrator. A CJIP (Criminal Justice Intervention Programme) worker had recently taken up post. The CARAT manager also co-ordinated services at HMP Highdown.

1.61 The team was well integrated into the prison, and undertook one-to-one work and groupwork. Groupwork was delivered in two modules. Module 1 delivered drug awareness and motivation information in 12 two-hour sessions over six weeks.

Module 2 delivered change and relapse prevention information in 10 two-hour sessions over five weeks. A one-day crack awareness course was also available.

1.62 At the time of the inspection there were approximately 30 prisoners waiting for initial assessments, the longest wait was approximately one month.

1.63 Both the CARAT and RAPt managers attended the anti-bullying and suicide and self-harm meetings. At the time of the inspection 44 prisoners were involved in the three stages of the RAPt programme. Prisoners involved with both the CARAT team and in the RAPt programme spoke highly of both services.

1.64 Separate staff in dedicated areas carried out MDT and VDT procedures. Information about both procedures was given to prisoners upon arrival and was readily available around the establishment. The percentage of positive MDTs was set at 10%, and statistics from October 2003 –March 2004 showed ‘actual to date’ positive tests of approximately 18-19%. The DSC estimated that 78% of positive tests indicated cannabis.

1.65 The establishment had a temporary non-compliance notice in regard to the operation of VDTs. All prisoners were expected to sign a voluntary testing compact, in effect a compliance testing compact, which stated that all prisoners would be tested 1.5 times per month or on a risk assessment basis if necessary. In reality, all prisoners were tested once per month, irrespective of any identified need, and there was no current matrix of risk assessment or variety in the frequency of testing. The establishment was aware of the situation, and hoped to introduce appropriate VDT in the near future.

Further recommendations

1.66 The waiting list for initial CARAT assessments should be reduced.

1.67 Revised arrangements for VDT should be introduced.

Equal opportunities

1.68 *The equal opportunities officer should be given adequate facility time to complete the task. (4.51)*

Achieved. A full time equal opportunities officer had been in post for three months prior to the inspection.

1.69 *Staff should be enabled to carry out part-time work at the establishment. (4.55)*

Achieved. Three uniformed members of staff and two administrative staff were employed on a part time basis and applications were considered positively in the light of operational requirements.

1.70 *An equal opportunities committee should be re-launched to push forward equal opportunities issues. (4.56)*

Partly achieved. A diversity committee had been launched a month before the inspection. The committee incorporated race relations, disability, and foreign national and faith issues. The governor chaired the meeting, which included prisoner representatives. The structures and staff needed to improve equal opportunities appeared to be in place although it was too soon to assess the impact of the initiative.

Race relations

1.71 *The implementation of the new racial incident procedures should be accompanied by training for staff and clear information to prisoners. (4.59)*

Achieved. Correct Prison Service complaints forms were available and were used consistently for the three months prior to the inspection. The forms were available on all wings. A notice to staff issued two months before the inspection re-iterated the definition of a racial incident and the incident report process. This information was displayed on notice boards for prisoners.

1.72 *The number of prisoners accessing areas such as the gym, the library and the chapel should be monitored by ethnic group to ensure that no ethnic groups are being disadvantaged in any of these areas. (4.63)*

Partly achieved. Prisoners using the gym were subject to ethnic monitoring, although attendance at the chapel and library was still omitted from the monitoring system.

We repeat this recommendation.

1.73 *Prisoners' attendance at work should be monitored by ethnic group and labour location. Monitoring of ROTL and re-categorisation decisions should also take place. (4.64)*

Partly achieved. Prisoners' labour was included in the monitoring system and all areas had submitted returns for the month before the inspection. The system had been amended to allow ROTL to be monitored, and the resettlement department had made returns for resettlement and compassionate licences.

Additional information

1.74 Feedback from a group of black and minority ethnic prisoners included some concerns about the awareness of some staff to racial and cultural diversity issues. Prisoners had experienced unsympathetic or negative responses to requests that they felt were legitimate and important. Forty seven per cent of the prisoners were black or minority ethnic, compared to 3.3% of the staff. The prison target, which was set with reference to the local population, was 2.8%.

Further recommendations

1.75 Training, beyond the half-day on generic diversity issues, should be provided to staff to help them develop their knowledge and understanding of racial and cultural diversity.

1.76 Ethnic monitoring returns should be provided as required by all departments.

Foreign nationals

1.77 *Foreign nationals should be allowed to save up visiting orders and combine them to allow longer telephone calls. (4.69)*

Achieved. Foreign national prisoners were entitled to exchange one visiting order for a free five-minute telephone call or two for a ten-minute call each month. These telephone calls were booked with wing officers at the weekend. Most foreign national prisoners were aware of this system.

1.78 *If telephones were installed on each landing, foreign nationals could use the night sanitation periods to phone home. This should be considered. (4.69)*

Not achieved. Access to telephones at night had been considered but not provided because of the impact that this would have on night sanitation arrangements. Additional telephones had been provided and there were no complaints from prisoners about access to telephones.

1.79 *Cheaper telephone calls should be arranged for all prisoners and particularly for foreign nationals. (4.69)*

Partly achieved. The telephone provision had been converted to a national personal identification number (PIN) system; tariffs for the calls were not displayed. A national project was reviewing the possibility of providing foreign national prisoners with access to special low rate international telephone calls.

Additional information

1.80 There were 101 foreign national prisoners at Coldingley. The foreign national liaison officer was not aware of how to access Language Line and did not have a job description. There was a foreign national prisoners' committee, although this committee did not have a clear role or terms of reference. There was an absence of written information about the support structures for foreign national prisoners and their families or about preparation for release. Although there had been occasional visits from the Immigration Advisory Service and the immigration service, this had not happened in the previous few months and prisoners were anxious about not having information about complex matters of deportation and removal. This was the key issue of concern to the foreign national prisoners group.

Further recommendations

1.81 Telephone tariffs should be displayed for prisoners' information.

1.82 There should be a job description for the foreign national liaison officer, who should be a member of, and supported in attending, the diversity team meetings.

1.83 There should be a prisoners' information leaflet to explain the support structures available to foreign national prisoners, and these prisoners should have access to the national prisoners' information booklets in a language of their choice.

Suicide awareness

1.84 *The Listeners suite should be relocated. (4.74)*

Not achieved. The Listener suite was still located in the segregation unit, which was now known as the observation and support unit. This was not a suitable environment to care for vulnerable prisoners. There were no records kept of how often the suite was used. The governor had plans to relocate it. A Listener on each wing occupied a double cell and this could provide an alternative location for their work. **We repeat this recommendation.**

Additional information

1.85 Suicide prevention team meetings were held quarterly and chaired by the deputy governor. There were frequent apologies for absence from a range of staff. The local policy had been reviewed in January 2004. There had been no self-inflicted deaths at the prison since our last inspection and there were low levels of self-harm. Fourteen F2052SH (at risk forms) were opened throughout 2003. Most were opened for only a short time. Prisoners who were assessed at high risk of self-harm were considered for transfer to Highdown prison. F2052SH forms were appropriately completed and there was evidence that staff cared for prisoners at risk. There were some good quality entries although not all reviews were multi-disciplinary. Monitoring of the reasons for opening these forms could be improved. For example, it

was not possible from the register to establish whether F2052SH booklets were opened as a result of actual self-harm or following proactive staff care for prisoners.

1.86 There was a very active Listeners' scheme supported by an enthusiastic liaison officer. Listeners contributed to the induction programme and one was based in reception, although he was not always notified when new prisoners arrived. Prisoners had access to the Samaritans at night by requesting the use of an adapted mobile phone. This presented difficulties in preserving confidentiality when in a shared cell. There had been a dedicated phone line to the Samaritans in the chapel area but this was no longer available. This meant that there was no free and confidential telephone access during the day. Free and confidential access to the Samaritans can be provided through the PIN phone system.

1.87 There had been no suicide awareness training. Two members of staff were soon to complete training that would enable them to deliver suicide prevention training.

Further recommendations

1.88 Monitoring of the F2052SH process should be improved.

1.89 Nominated members of the suicide prevention team or a substitute should attend the suicide prevention meeting regularly.

1.90 F2052SH case reviews should be multi-disciplinary.

1.91 Prisoners should have free and confidential telephone access to the Samaritans during the day in addition to the use of a mobile phone at night.

1.92 All staff in contact with prisoners should receive suicide prevention training.

Complaints procedures

1.93 *Staff should be properly trained to deal with prisoners' grievance procedures. (4.80)*

Achieved. Some training had taken place. There was evidence from wing application books that prisoners had good access to application forms, which were carefully logged.

1.94 *Targets for request and complaint forms should be strictly adhered to, delays investigated and interim replies issued as necessary. (4.81)*

Partly achieved. Since the last inspection a new complaints system had been introduced nationally. The target of answering complaints within the stipulated time-scale was being achieved. Complaints were recorded manually in a register and then distributed to relevant managers for a response. The clerk was not always notified of the progress made in responding to complaints. The register showed no evidence that interim replies were routinely being issued when managers were unable to answer the complaint within the required time limits. **We repeat this recommendation.**

1.95 *Prisoners should sign and date the originally issued request and complaint form to withdraw them. (4.86)*

Not achieved. The register recorded only one instance in recent months of a prisoner withdrawing his complaint. We found the original complaint. There was no evidence to indicate that the prisoner had confirmed by signature his decision to withdraw it. **We repeat this recommendation.**

1.96 *Management should nominate someone to investigate why forms are withdrawn or not proceeded with to ensure that no pressure has been applied to prevent prisoners from seeking resolutions to their problems. (4.86)*

Not achieved. We repeat this recommendation.

1.97 *Board of Visitors confidential application boxes should be available to prisoners throughout the establishment. (4.87)*

Achieved. These were in place on each wing. A member of the IMB (Independent Monitoring Board, formerly the Board of Visitors) held the keys for the boxes and

emptied them during their rota visits. We were told there were 60-80 applications submitted annually.

1.98 *Prisoners' grievance procedures should be open and transparent. Prisoners should feel safe from recrimination in making applications and request and complaints. Prisoners should receive prompt, courteous and fair responses from staff. (4.91)*

Achieved. The new complaints procedure gave prisoners good access to complaints forms, which were displayed next to the complaints boxes. These were collected by the orderly officer and logged by the requests and complaints clerk. We heard no complaints from prisoners that they feared recrimination when submitting complaints. We looked at a sample of completed complaints forms and responses from staff were clear and respectful. There was, however, no routine check of the quality of replies by a senior manager.

Additional information

1.99 Records of complaints were held electronically, which could enable the production of management information to monitor trends in complaints. The only available management information was in respect of key performance targets on the promptness of replies. This should be developed to include other aspects of prisoners' complaints.

Further recommendations

1.100 A senior manager should be responsible for conducting a regular quality check of the replies to prisoners' complaints.

1.101 Improved management information about complaints should be generated and scrutinised by the senior management team.

Security

1.102 *Managers should continue to monitor the requirement to 'squat' including the basis for suspicion of concealment. (5.05)*

Partly achieved. Staff were instructed to obtain permission when they had suspicions that they thought should require prisoners to squat. Managers believed that requests to squat were recorded in individual search records, but were not able to demonstrate that all instances were recorded or that permission had been granted on all occasions. However, some prisoners reported that certain staff made this request more frequently than others. There was no monitoring in place to ensure that circumstances and outcomes were always recorded to allow a proper level of management oversight.

Further recommendation

1.103 There should be a system in place for managers to monitor the requirement for prisoners to squat during strip searches and the results of these searches. Staff and prisoners should be informed of the correct authorisation procedures.

1.104 *Contingency plans should be tested as soon as possible. (5.06)*

Achieved. The prison was required to test 12 plans each year. They had achieved this target in the previous year and were up to date for the current year. Tests were recorded.

1.105 *Relevant sections of the plans should be distributed to respective parts of the prison, for example, to the gate, so that staff can familiarise themselves with their duties during emergencies. (5.06)*

Achieved. Plans were disseminated in a controlled and auditable system in accordance with national instructions.

Incentives and earned privileges

1. 106 *All double jeopardy should be removed in the revised system. (5.07)*

Achieved. Coldingley's local scheme for incentives and earned privileges had changed since the last inspection and was set out in a document dated September 2003. There were plans to review the current scheme but there was no evidence of double jeopardy in the system. It was made clear that reviews triggered by two findings of guilt at adjudications in a three-month period would not lead automatically lead to a change in status.

1.107 *Prisoners who retain enhanced status on transfer should receive the full benefits of this level of regime. (5.08)*

Achieved. The IEP document indicated that prisoners transferred into the establishment whose records indicated they had enhanced status would continue on that level at Coldingley. Prisoners we spoke to confirmed that this was the case.

1.108 *The decision to withdraw community visits should be reviewed. (5.10)*

Achieved. Community visits had been suspended temporarily at the time of the last inspection but later reinstated.

The segregation unit

1.109 *Windows in the segregation unit should be replaced with anti-ligature windows. (5.15)*

Not achieved. Plans were in place to replace the windows in the observation and supervision unit. The new windows had been built but installation was expected to take some time because of the technical difficulty of replacing the windows.

We repeat this recommendation.

Healthcare

1.110 *A sound assessment of the healthcare needs of the prisoners in Coldingley is essential if the service is to make significant progress from its current seriously inadequate base. There should be immediate discussions with the health authority to see if the needs assessment can be expedited. (6.09)*

Achieved. A health improvement and modernisation plan had been completed by Woking Area Primary Care Trust (PCT) in August 2002 and was last reviewed in July 2003. Continuing collaboration between HMP Coldingley and the PCT was progressing well and moving forward in anticipation of the transferring of commissioning responsibility to the PCT in April 2005.

1.111 *The management of healthcare during the necessary transition to a better service will require the healthcare manager to have significant experience in the management and development of a health service.*

Achieved. The current healthcare manager had been in post for three years and had an extensive background in healthcare management within the Prison Service. A new H

grade lead clinical nurse lead post was being advertised locally through the PCT to provide a Level 1 Registered Nurse (RN) (general) with responsibility for clinical activity within HMP Coldingley. The current healthcare manager was not part of the senior management team (SMT) and was directly responsible to the deputy governor.

Further recommendation

1.112 The healthcare manager should sit on the SMT in order to brief the governor and the SMT on all matters affecting the delivery of healthcare at HMP Coldingley.

1.113 *The location and functioning of the healthcare centre should be reviewed and facilities improved to meet the needs of patients and to meet current NHS standards.*

Achieved. The healthcare department was to move in its entirety to a new location on the ground floor between A and D wings. Funding had been secured to effect this relocation, which was programmed to start within the next month.

1.114 *The safety of working practices should be reviewed and injuries regularly audited. (6.15)*

Not achieved. While copies of F213s were kept on file in the health care centre no clinical audit was being maintained. **We repeat this recommendation.**

Additional information

1.115 The healthcare centre was managed by a senior healthcare officer with a background as a paramedic. He had established sound working relationships with the Surrey Heath and Woking Primary Care Trust (PCT) and met them regularly through various meetings. The part time RN was also a practice nurse in a local health centre and provided a chronic disease management service for prisoners with asthma, diabetes and chronic heart disease (CHD).

1.116 A registered GP, with his own local practice, held a clinic every morning Monday to Friday; the same GP provided an on-call service. The GP had been attending the prison for some years.

Pharmacy

1.117 *There should be at least two staff on duty at all times to ensure adequate provision of healthcare and security. (6.17)*

Achieved. Staffing levels had been increased and there were four staff providing three WTE cover. With the appointment of the clinical nurse lead there should be two healthcare staff on duty to cover treatment times. Agency staff provided additional cover as required.

1.118 *All keys to the treatment room/pharmacy should be accounted for and a controlled procedure should be adopted should the keys need to be drawn out of hours. In particular, a numbered sealed key pouch should be used to record and restrict the access of non-healthcare staff to areas other than the emergency drug trolley. (6.19)*

Achieved. No one other than HCC staff was able to access the HCC out of hours. There was a clear written policy, covering the removal of the box holding HCC keys. This outlined the action to be taken in the event of access to the HCC being required.

1.119 *A review of the contents of the resuscitation drug kit should be undertaken by the medical officer, date-expired stock replaced and the contents reviewed periodically. (6.22)*

Achieved. An emergency bag containing oxygen and appropriate medicines and equipment was in place. This was checked weekly by HCC staff and signed off as such.

1.120 *Stock should be rotated properly and date-checked regularly to remove date-expired stock. (6.23)*

Achieved. There was no out of date stock held in the HCC. HCC staff undertook regular checks of pharmacy stock.

1.121 *A written in-possession policy should be drawn up. (6.26)*

Achieved. Copies of the in-possession medication policy, dated January 2004, were displayed in the HCC and all residential wings.

Dental care

1.122 *The question of NRPB certification and display of the local rules should be investigated to confirm compliance with current regulations. (6.34)*

Achieved. The HCC manager had undergone NRPB (National Radiological Protection Board) training in March 2002, which was valid for 3–5 years. A copy of the local rules, dated January 2004, was displayed in the dental surgery.

1.123 *The surgery door should only be left unlocked whenever a clinic is being held and lockable cabinets should be provided for instrument storage. (6.36)*

Achieved. The door was locked and the key was held in the HCC suite. The room was only accessed by the dentist and HCC staff.

1.124 *The purchase of a new 3-in-1-syringe tip capable of taking disposable tips is necessary. (6.37)*

Achieved. The 3-in-1-syringe tip was in place in the surgery.

1.125 *The prison should purchase emergency drugs to the British Dental Association guidelines and arrange for them to be readily accessible, together with oxygen, to the practitioner during clinical sessions. (6.39)*

Achieved. Specialist dental requirements were held in the HCC emergency bag.

Additional information

1.126 There were some issues with regard to the dental waiting list, which was up to six weeks long. This was being addressed by extra sessions, including one in the inspection week, in which 45 patients were to receive treatment. Funding for a new dental suite had been secured and was to be set up as soon as the HCC relocated to its new premises.

Education

1.127 *The prison, the contractor and the department need to develop further the strategic and operational planning processes for education. (7.03)*

Partly achieved. The newly appointed head of learning and skills was in the initial stages of producing a three-year strategic plan. Immediately prior to the inspection, the prison had produced its annual self-assessment report and development plan. These were clearly written and had accurately identified the key issues that needed to be addressed. Progress to provide a clear strategic direction for education and vocational training at HMP Coldingley had been slow.

1.128 *The prison needs a forum where a collaborative strategy can be agreed with all contributors to regime activities to maximise the opportunities for accredited training for the full range of prisoner jobs, as well as a process for providing staff with assessor training. (7.04)*

Partly achieved. The quality improvement group had met four times since its inception last year. Although the head of learning and skills recognised the importance of this group informing the required improvements, no meetings had taken place since October 2003. A training needs analysis had identified staff who would be suitable for assessor training, although most staff in key areas such as the laundry, engineering workshop and signs workshop had not yet been trained. The opportunities for accrediting learning in these areas were not being maximised. **We repeat this recommendation.**

1.129 *The contractor and the department should consider the implementation of best practice concerning matching the learning needs of individuals from the further education sector's Inclusive Learning Quality Initiative. (7.05)*

Not achieved. The newly appointed head of learning and skills had plans to introduce individual learning plans (ILPs) across the prison. Although these were being used in the education department at the time of inspection, there was no uniform approach. The plans merely recorded a learner's progress and did not give a clear indication of long or short-term targets. No use was made of the initial assessment results to inform individual learning needs.

1.130 Further recommendation

The learning needs of prisoners should be clearly identified and individual learning plans (ILPs) should be introduced across all areas of education and training.

1.131 *Regime management and the department need to identify how evidence for key/basic skills can be generated naturally from practical, creative and work-based areas throughout the establishment. (7.06)*

Not achieved. Little action had been taken to address this issue although key skills were clearly assessed and integrated into the accredited engineering training programme. There were large numbers of prisoners working in the laundry, engineering workshop and signs workshop who were not being accredited with key skills and not being taught basic skills as part of their work programme.

We repeat this recommendation.

1.132 *The department needs to consider how to build in as much reinforcement of the learning as possible, and provide more permanent evidence of the steps achieved en route to qualification, through the documentation used with and by the learners. (7.08)*

Not achieved. Insufficient action had been taken to address this issue. Although tutors in education and vocational training areas recorded the progress of learners this was not clearly reinforced with all learners. The engineering tutor had successfully implemented a tracking board where learners' progress was clearly displayed.

We repeat this recommendation.

1.133 *Full use of classes should be maintained. (7.10)*

Partly achieved. Class efficiency was clearly recorded and retention and achievements were regularly discussed at staff meetings. There had been improvements to attendance across most areas although some classes were still poorly attended. If classes were cancelled through illness or holidays, learners were given the opportunity to attend other classes or complete individual assignments.

1.134 *The department needs to monitor that there is equitable access to drop-in provision. (7.11)*

Achieved. The woodwork shop had been closed since the last inspection to make room for a larger library facility. The drop-in provision for information and computer technology had been improved with approximately double the number of spaces now available.

Library

1.135 *The prison and the library contractor should continue to pursue means of making library routines more efficient. (7.12)*

Partly achieved. The prison had recently purchased a computerised library management information system although this was yet to be fully operational. The librarian had been trained to use this system only two weeks prior to the inspection. Action had been taken to extend the library opening hours and an additional library orderly had been appointed. Prisoners did not have access to computers in the library, which disadvantaged those who could not use the drop-in facility. Some laptops had recently been purchased and there were plans to use these with prisoners on the wings.

1.136 *The prison and the library contractor should review the possibilities for offering accreditation for library orderlies towards the Information and Library Service NVQs. (7.15)*

Not achieved. There were plans to increase the librarian's hours to 20 hours per week so that accreditation could be offered to the library orderlies. These issues had been discussed on several occasions at library contract meetings since April 2002 but no action had been taken. **We repeat this recommendation.**

1.137 *The library contractor should review the options for providing a more active and formal means of support for staff and the dissemination of good practice in prison libraries. (7.16)*

Not achieved. The library contractor had been asked to address this issue but no action had been taken. The service level agreement had been revised since the last inspection, although this issue was not included. **We repeat this recommendation.**

Vocational training provision

1.138 *Staff should have the opportunities to work together and should give consideration to the establishment of micro-businesses managed by prisoners; training of prisoners as NVQ assessors; training of production staff as NVQ internal verifiers and development of a comprehensive learning strategy. (7.18)*

Partly achieved. The newly appointed head of learning and skills was in the very early stages of developing a learning strategy to cover all areas of the provision. There were still large areas of the prison in which vocational training and learning was being undertaken by prisoners and not being accredited. These included the laundry, engineering workshop, signs workshop, gardens and painting and decorating. However, there was good use made of a prisoner to teach and assess on the industrial cleaning course and prisoners had been recently recruited to start a teaching course to prepare them as classroom assistants.

1.139 *The head of regimes, staff in the production areas and from the education department should visit good work-based learning provision in industry. (7.19)*

Not achieved. No staff had visited work-based learning providers, apart from the engineering tutor who had visited a local college to review the level 2 welding course.

1.140 *The delivery of the NVQ level 2 welding course, its length and its match with production needs, should be reviewed. (7.20)*

Achieved. The length of the level 2 welding course had been increased from 12 to an average of 20 weeks for most learners. Production tasks had also been introduced to enhance the programme.

1.141 *A full internal verification strategy should be prepared without delay, centralised storage of external verifier reports be provided, and formal action plans should be drawn up in response to external verifiers' reports. (7.21)*

Partly achieved. External verification documents were held centrally and clear plans were produced to action any recommendations made. The newly appointed head of learning and skills was responsible for this area and had yet to produce a verification strategy for the prison. **We repeat this recommendation.**

1.142 *The sign shop should be more closely integrated with the engineering workshop and, in particular, be utilised for on-the-job welding training. (7.22)*

No longer relevant. The sign workshop had been restructured and more emphasis was now placed on graphic design. A graphic design course had been written and was planned to start next month.

1.143 *Prisoners should be placed on Foundation and Advanced Modern Apprenticeships, which would give them structured programmes, designed to meet current industrial needs, including the development of key skills at a range of appropriate levels. (7.23)*

No longer relevant. Prisoners at HMP Coldingley would not benefit from being placed on a Foundation or Advanced Modern Apprenticeship programme.

1.144 *Internet access under suitable control is recommended as a necessity. (7.24)*

Not achieved. No internet access had been introduced for educational or vocational training purposes.

Physical education

1.145 *The physical education department should be better valued and resourced. (7.25)*

Partly achieved. Staff and prisoners valued the physical education department but its services had been seriously reduced by the loss of both officer grades four months before the inspection. The senior officer manager worked with some limited sessional support to provide recreational gym sessions for as many prisoners as possible. Given the severe staffing problems the department was achieving a very good level of access to prisoners: 3,391 hours in January 2004 and 3,592 hours in March 2004. The department also maintained its commitment to daily remedial sessions, a weekly session for the RAPt group and a weekly session with an external disabled community group.

Further recommendation

1.146 The physical education department should provide courses relevant to the future employment needs of prisoners when additional qualified staff are available.

Employment

1.147 *Prisoners should not be financially disadvantaged for being required to take a random drug test or miss work for any other reason outside their control.*

(7.30)

Partly achieved. Notices to staff had been issued listing the three circumstances in which prisoners' pay could be stopped, however, there were examples of instructors still continuing to stop pay for other reasons. The instruction included the stoppage of pay for attending an adjudication at which a prisoner was found guilty.

Further recommendation

1.148 Pay should not be stopped for prisoners attending an adjudication, and prisoners must be paid in accordance with instructions.

1.149 *Additional work places should be provided. (7.31)*

Not achieved. The prison roll was 387 at the beginning of the inspection; the labour clerk was aware of 44 unemployed prisoners. On one morning of the inspection there were 49 unemployed prisoners and 39 additional prisoners allocated to placements for which they were not required. There were plans to address the unemployment problem by immediately introducing part time work and education while a long term review of employment and training was planned to provide full time purposeful work.

Further recommendation

1.150 The cancellation of courses, workshop places and education should be monitored to minimise the instances in which prisoners who were allocated work were then 'not required'.

Contact with family and friends

1.151 *The F wing phone should be hooded to provide privacy. (7.39)*

Achieved.

1.152 *The establishment should consider providing phones in the workshops and allowing prisoners to use them during working hours with the proviso that this does not reduce their productivity. (7.40)*

Not achieved. However, we were satisfied that prisoners had appropriate access to telephones.

1.153 *A needs analysis should be undertaken so that the number of telephones can be reassessed in the light of the extra numbers and the demand made on them by the current population. (7.42)*

Achieved. Two additional telephones had been provided on each wing since our last inspection. A recent decision had been made to allow prisoners who were unallocated to work to use telephones during the day. This eased the demand during the evenings. We heard no complaints from prisoners about access to telephones.

1.154 *Foreign nationals should be allowed to combine unused visiting orders so that they can have longer phone calls. (7.43)* **Achieved. (See paragraph 1.77)**

1.155 *A standard leaflet should be sent out with all initial visiting orders giving information in writing about how to get to the establishment, its visiting hours and procedures. (7.47)*

Partly achieved. Information was sent out with each visiting order, which outlined procedures and visiting hours but did not include directions to the prison. **We repeat this recommendation.**

1.156 *A visitors centre should be opened and staffed for each visits period. (7.48)*

Not achieved. There was a visitors centre but at the time of this inspection it was not staffed. Toilet facilities were provided. In the week preceding our inspection we were told that volunteers from the 'Friends of Coldingley' were to staff the centre and provide refreshments and facilities for visitors. We were aware of the plans for the official launch of this new service and felt confident it would materialise.

1.157 *The provision for official visitors should be improved. (7.56)*

Not achieved. Over the previous five months there had been on average 28 official visitors per month. The arrangements for their visits had not changed. We met three representatives from solicitors firms whose visits were taking place in the main visits hall. They were allocated tables that were some distance apart and this provided some degree of confidentiality. One complained about the unsuitability of the low tables when taking notes. There was still only one small visits room available which provided greater confidentiality. **We repeat this recommendation.**

1.158 *Crèche facilities should be provided during every visits session and should be supervised by a crèche worker. (7.57)*

Not achieved. The inconsistent arrangements for the supervision of the crèche area were as we had previously found. Staff we spoke to were unsure what days the voluntary service was available to provide this service to prisoners' families. We were told this was officially Thursday and Saturday afternoons. The lack of crèche facility meant that prisoners and their adult visitors were unable to take full advantage of their time together without the immediate presence of children. This is important time that can assist in supporting or salvaging often fractured relationships and crèche facilities provide an important support to sustaining family life for prisoners. We would question the over-reliance on voluntary bodies to provide these services. **We repeat this recommendation.**

1.159 *Proper changing facilities, including changing mats, should be provided in both the men and women's toilet areas. (7.59)*

Not achieved. The toilet facilities for male visitors had been converted into a unisex disabled facility, but without any changing facilities. **We repeat this recommendation.**

1.160 *The use of town/community visits needs to be expanded to all suitable prisoners. (7.62)*

Achieved. When we last inspected, town visits were restricted to the 12 prisoners located on F wing. We felt this discriminated against category D prisoners who were located on other wings. At the time of this inspection there were 15 prisoners who had

been re-categorised as suitable for open conditions (category D). We were told that most were moved to a category D establishment within a short time of being re-categorised. Of these 15 prisoners, four had a definite date to move within the following three weeks. This meant that some prisoners would have been relocated before any application for town visits could be processed. There were 38 life - sentenced prisoners. Of these, 23 were eligible for town visits. Sixteen had had a town visit, five were eligible but had not had them and two had not applied.

Additional information

1.161 In the week prior to this inspection new furniture had been installed in the visits hall. Many prisoners complained to inspectors about this. One of the main reasons for the installation of new fixed chairs and low tables was to improve the detection of drugs passed between visitors and prisoners. The new arrangements provided insufficient privacy, and some prisoners complained that it was difficult to hear and converse normally with their visitors. Efforts were being made to acquire smaller tables to create greater space between groups of visitors. We considered the arrangements were unsatisfactory.

1.162 We looked at the written comments made by visitors. Comments had been made about the courtesy and friendliness of visits staff and this was further supported by those visitors with whom we spoke.

1.163 Enhanced visits took place each Wednesday for 16 prisoners. They commenced at 10.00am and lasted for up to six hours. Enhanced prisoners were entitled to one of these visits each month but there was insufficient space to accommodate the demand. They were booked up for the following two months. There was no system to ensure these visits were allocated equitably.

Further recommendations

1.164 Prisoners who have been re-categorised to category D awaiting transfer to another prison should be encouraged to apply for town visits.

1.165 The new arrangements in the visits hall should reviewed to ensure that visiting groups had sufficient privacy and that appropriate arrangements are in place for those with hearing difficulties.

1.166 Methods to improve access to enhanced visits should be explored to ensure the prison can provide these in accordance with its IEP policy.

Religious activities

1.167 *The new chaplaincy manager should be the best person for the job regardless of denomination. (7.65)*

No longer relevant. The chaplaincy had a new full time Church of England chaplain with appropriate range of part time and sessional ministers of other denominations.

1.168 *Chaplains should be given a full induction programme and be properly equipped to work in prison establishments promptly after recruitment. (7.66)*

Partly achieved. The chaplaincy provided an induction programme supported by their own team, but there was no generic prison induction to integrate chaplains into the wider aspects of prison routines or procedures. The newly appointed Muslim minister reported that he was supported by his team but, like the new chaplain, had no expectation of an integrated prison induction. **We repeat the recommendation.**

1.169 *The chaplaincy team should issue a leaflet about chaplaincy activities to each new reception during induction. (7.68)*

Achieved. A brief induction leaflet was issued to all prisoners on induction; this was subject to review to increase the multi-faith emphasis. Chaplains also met all prisoners within two days of their arrival.

1.170 *In some cases, there should be provision of prison officer cover when prisoners from the segregation unit attend chaplaincy services. (7.71)*

Achieved. The chaplain reported that prisoners in the observation and support unit were usually provided with relevant services within the unit, and that in some cases security arrangements would preclude the attendance of a prisoner at the chapel. However, if it was appropriate and a risk assessment had been completed, he believed that a prisoner would be allowed to attend the chapel.

Catering

1.171 *A healthy option should be provided at each mealtime and clearly indicated to prisoners. Vegan meals should also be clearly indicated. (8.02)*

Achieved. The daily menu choice indicated healthy options and those suitable for vegetarians and vegans.

1.172 *Serveries should be staffed by trained prisoners serving appropriately sized meals. (8.04)*

Achieved. All prisoners serving food had received basic food handling and hygiene training and were working towards a certificate under the supervision of properly qualified staff. Satisfactory portion control was in place.

Prison shop

1.173 *Minutes should be taken at canteen meetings and displayed on unit notice boards. (8.10)*

Not achieved. There were no canteen meetings held. The wing consultative meetings had taken over this remit, but although minutes were taken, none were displayed on notice boards. **We repeat this recommendation.**

Maintenance of the establishment

1.174 *The main feeder cables should be replaced in the near future. (8.15)*

Not inspected.

1.175 *New windows to match those fitted in the wing extensions should be made on site and the old windows replaced. (8.16)*

Not inspected.

1.176 *Lightning protection should be brought up to current standards. (8.18)*

Not inspected.

1.177 *The prison should identify the work required to meet the needs of the disabled as required now by legislation and again as required after 2004. (8.19)*

Not inspected.

Fire precautions

1.178 *The fire officer should be supported by trained assistants and adequate time allowed for his/her duties. (8.25)*

Not achieved. The designated fire officer had left in October 2003 and had not been replaced. There was no designated fire officer for the prison, but a manager grade post had been advertised. **We repeat this recommendation.**

1.179 *Staff training should be brought up to date to meet legal requirements. (8.26)*

Not achieved. Less than 25% of staff had received fire training since August 2002. **We repeat this recommendation.**

1.180 *The SDBA equipment should be brought into use. (8.27)*

Not achieved. There were insufficient staff trained to use the short duration breathing apparatus. The governor had accepted that SDBA should be available and had identified training as a priority. **We repeat this recommendation.**

1.181 *Where hose reels are inoperative, extinguishers should be provided in the same location. (8.28)*

Achieved. The hose reels were secure and regularly inspected. There were also fire extinguishers present at hose points.

1.182 *The prison should carry out evacuation drills and keep records as required by law. (8.29)*

Achieved. Drills were carried out and good records kept.

1.183 *Combined exercises with the Fire Brigade should be held and records kept. (8.30)*

Not achieved. There was no record of a combined drill for 2003. **We repeat this recommendation.**

1.184 *The shortcomings found by the Home Office Fire Inspectorate should be rectified as a matter of urgency. (8.31)*

Achieved. Fire fighting equipment was well maintained by the works department under the planned maintenance arrangements.

Health and safety

1.185 *Safety audits should be carried out as required by legislation. (8.34)*

Not inspected.

1.186 *Wing cleaners should be trained and records kept. (8.38)*

Not inspected.

1.187 *Oil should be kept in an oil store and gas cylinders should be stored according to regulations. (8.39)*

Not inspected.

1.188 *The prison should check to ensure that all clinical waste is identified and correctly disposed of. (8.40)*

Achieved. A policy, dated January 2004, clearly stated the procedure to be followed in relation to clinical waste.

1.189 *The prison should comply with radiation protection legislation and records should be available.*

Achieved. (6.34) **(See paragraph 1.122)**

1.190 *Management of health and safety on the shop floor should be improved considerably. (8.42)*

Not inspected.

Provisions for life and long sentenced prisoners

1.191 *Senior management should take steps to develop better liaison with the lifer management unit. (9.03)*

Achieved. Coldingley was regularly represented at category C meetings organised by the Lifer Review and Recall Section.

1.192 *The development of a lifer group would be an effective way in which to start addressing some of the concerns raised by prisoners. (9.06)*

Not achieved. Lifer groups were not held and it was clear from the lifers we spoke to that they felt unsupported and needed to be provided with good and consistent information by trained lifer staff. **We repeat this recommendation.**

Release on temporary licence (ROTL)

1.193 *Where possible prisoners should be invited to attend ROTL boards. (9.07)*

Not achieved. The prison had rejected this recommendation. Prisoner attendance at ROTL boards would help develop prisoners' individual responsibility, improve risk assessments by the board by enabling direct questioning of intentions and allow the board to reinforce messages about the purpose of ROTL. **We repeat this recommendation.**

1.194 *Records should be kept of all prisoners applying for ROTL, and these figures should be routinely monitored. (9.08)*

Not achieved. Only individual records of ROTL applications were kept. There was no evidence of systematic compilation of the figures by numbers eligible, type of application or regular monitoring. **We repeat this recommendation.**

Home detention curfew (HDC)

1.195 *Records should be kept of all HDC applications. (9.09)*

Partly achieved. As with ROTL, records were kept on an individual basis and there was some evidence that figures were provided to the resettlement committee. However, the prison was unable to readily provide us with the total number of prisoners applying for HDC and the numbers granted.

Further recommendation

1.196 A system should be put in place to monitor HDC applications monthly in order to provide cumulative figures.

Sentence planning

1.197 *A member of staff of at least governor 5 grade should chair sentence planning boards. (9.11)*

Not achieved. The prison did not accept this recommendation, as it would impact too heavily on management time. At the time of the inspection a number of sentence planning boards were overdue and we accepted that, in a relatively small establishment such as Coldingley, it was difficult to provide senior managers to chair such boards. How sentence planning boards would be managed in the future would need to be included in the prison's overall review of its resettlement policy.

Prisoner programmes

1.198 *Prisoners undertaking the offending behaviour course should not be transferred until they have completed the course. (9.16)*

Achieved. Prisoners undertaking offending behaviour courses were not normally transferred, unless for urgent disciplinary reasons. A decision had been made to discontinue the course so this was no longer relevant.

1.199 *The establishment should consider whether the high-risk programme continues to be a useful or efficient use of resources. (9.17)*

Achieved. A review was undertaken and it was decided to discontinue running the high-risk programme.

1.200 *Proper provision should be made for the development of a pre-release course. (9.20)*

Not achieved. No formal pre-release course was being run. Again this was an issue which would need to be considered in the context of the review of resettlement provision at Coldingley.

Parole

1.201 *Records should be kept of all applications and outcomes for parole. (9.22)*

Achieved. Records of parole were kept.

Chapter Two

SUMMARY OF RECOMMENDATIONS

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

Main recommendations

To the Director General

2.02 **In respect of the decision to discontinue running accredited offending behaviour programmes at Coldingley, there should be clarity about national and area policy in terms of the delivery of such programmes to ensure that prisoners' identified needs are met. (HP.35)**

2.03 **The position of prisoners moved back to category C prisons from open prisons in January 2004 because of a national decision about length of time to serve rather than individual risk assessments should be clarified. (HP.36)**

To the Governor

2.04 **The current night sanitation arrangements were unacceptable. In-cell toilets or an alternative system should be introduced in order to ensure that prisoners have genuine 24-hour access to toilet facilities. (HP.37)**

2.05 **All opportunities should be taken to accredit skills acquired in work, education and training. (HP.38)**

2.06 **A resettlement policy should be agreed with the resettlement committee, operating strategically, setting targets and monitoring delivery of resettlement services on the basis of identified needs. (HP.39)**

Induction

2.07 A copy of the current in-possession property list should be attached to the prisoner compact that is issued to prisoners during their first night. (1.10)

Legal

2.08 An analysis of the existing legal and support services available to prisoners should be undertaken to identify and evaluate need, and target the resources necessary. (1.17)

Accommodation

2.09 All prisoners should be properly trained before they commence work as wing cleaners. (1.20)

2.10 In-cell toilets or an alternative system should urgently be introduced to provide genuine 24-hour access to toilet facilities. (1.25)

2.11 Kitchen workers should be offered the opportunity to shower after each shift. (1.27)

Anti bullying

2.12 The anti-bullying strategy should be widely publicised and staff training introduced alongside the introduction of the new bullying incident report forms. (1.37)

2.13 The anti-bullying committee should be re-formed, chaired by a member of the senior management team and consist of a multi-disciplinary group of staff alongside prisoner representatives. (1.38)

2.14 The profile of the anti-bullying strategy and associated paperwork should be raised and developed to include the co-ordinated use of offending behaviour courses and bullying programmes carried out by education and physical education staff. Further, the establishment should implement clear procedures for dealing with bullies in-house. (1.40)

2.15 The operation of the anti-bullying strategy should be clarified and this should be reinforced through a programme of training for staff. (1.42)

Substance use

2.16 Drug awareness training should be actively promoted by senior management to ensure that all staff gain a basic understanding of the drug strategy and the services available within the establishment. (1.43)

2.17 The drug strategy should detail all initiatives taking place with protocols for working together. All documents should be dated; review dates specified and authors indicated. (1.44)

2.18 The number of prisoners arriving at Coldingley without having had a targeted offending behaviour interventions should be identified. (1.46)

2.19 The physical education department should be involved more closely in the drug strategy and its role in working with substance users clearly defined. (1.47)

2.20 A local alcohol strategy should be developed, particularly given the resettlement function of the establishment. (1.48)

2.21 A regular review of the lay-down process should take place to ensure transparency is maintained. While on lay-down prisoners should have access to

purposeful activity in order to maintain active participation in the prison regime.
(1.53)

2.22 Responses to substance use, in relation to the IEP scheme, should be included in the drug strategy, and IEP documents. (1.55)

2.23 The waiting list for initial CARAT assessments should be reduced. (1.66)

2.24 Revised arrangements for VDT should be introduced. (1.67)

Race relations

2.25 The number of prisoners accessing areas such as the gym, the library and the chapel should be monitored by ethnic groups to ensure that no ethnic groups are being disadvantaged in any of these areas. (1.72)

2.26 Training, beyond the half-day on generic diversity issues, should be provided to staff to help them develop their knowledge and understanding of racial and cultural diversity. (1.75)

2.27 Ethnic monitoring returns should be provided as required by all departments.(1.76)

Foreign nationals

2.28 Telephone tariffs should be displayed for prisoners' information. (1.81)

2.29 There should be a job description for the foreign national liaison officer, who should be a member of, and supported in attending, the diversity team meetings.
(1.82)

2.30 There should be a prisoners' information leaflet to explain the support structures available to foreign national prisoners, and these prisoners should have access to the national prisoners' information booklets in a language of their choice. (1.83)

Suicide awareness

2.31 The Listeners suite should be relocated. (1.84)

2.32 Monitoring of the F2052SH process should be improved. (1.88)

2.33 Nominated members of the suicide prevention team or a substitute should attend the suicide prevention meeting regularly. (1.89)

2.34 F2052SH case reviews should be multi-disciplinary. (1.90)

2.35 Prisoners should have free and confidential telephone access to the Samaritans during the day in addition to the use of a mobile phone at night. (1.91)

2.36 All staff in contact with prisoners should receive suicide prevention training. (1.92)

2.37 Targets for request and complaint forms should be strictly adhered to, delays investigated and interim replies issued as necessary. (1.94)

2.38 Prisoners should sign and date the originally issued request and complaint form to withdraw them. (1.95)

2.39 Management should nominate someone to investigate why forms are withdrawn or not proceeded with to ensure that no pressure has been applied to prevent prisoners from seeking resolutions to their problems. (1.96)

2.40 A senior manager should be responsible for conducting a regular quality check of the replies to prisoners' complaints. (1.100)

2.41 Improved management information about complaints should be generated and scrutinised by the senior management team. (1.101)

2.42 There should be a system in place for managers to monitor the requirement for prisoners to squat during strip searches and the results of these searches. Staff and prisoners should be informed of the correct authorisation procedures. (1.103)

The segregation unit

2.43 Windows in the segregation unit should be replaced with anti-ligature windows. (1.109)

Healthcare

2.44 The healthcare manager should sit on the SMT in order to brief the governor and the SMT on all matters affecting the delivery of healthcare at HMP Coldingley. (1.112)

2.45 The safety of working practices should be reviewed and injuries regularly audited. (1.114)

Education

2.46 The prison needs a forum where a collaborative strategy can be agreed with all contributors to regime activities to maximise the opportunities for accredited training

for the full range of prisoner jobs, as well as a process for providing staff with assessor training. (1.128)

2.47 The learning needs of prisoners should be clearly identified and individual learning plans (ILPs) should be introduced across all areas of education and training. (1.130)

2.48 Regime management and the department need to identify how evidence for key/basic skills can be generated naturally from practical, creative and work-based areas throughout the establishment. (1.131)

2.49 The department needs to consider how to build in as much reinforcement of the learning as possible, and provide more permanent evidence of the steps achieved en route to qualification, through the documentation used with and by the learners. (1.132)

Library

2.50 The prison and the library contractor should review the possibilities for offering accreditation for library orderlies towards the Information and Library Service NVQs. (1.136)

2.51 The library contractor should review the options for providing a more active and formal means of support for staff and the dissemination of good practice in prison libraries. (1.137)

2.52 A full internal verification strategy should be prepared without delay, centralised storage of external verifier reports be provided, and formal action plans should be drawn up in response to external verifiers' reports. (1.141)

Physical education

2.53 The physical education department should provide courses relevant to the future employment needs of prisoners when additional qualified staff are available. (1.146)

Employment

2.54 Pay should not be stopped for prisoners attending an adjudication, and prisoners must be paid in accordance with instructions. (1.148)

2.55 The cancellation of courses, workshop places and education should be monitored to minimise the instances in which prisoners who were allocated work were then 'not required'.(1.150)

Contact with family and friends

2.56 A standard leaflet should be sent out with all initial visiting orders giving information in writing about how to get to the establishment, its visiting hours and procedures. (1.155)

2.57 The provision for official visitors should be improved. (1.157)

2.58 Creche facilities should be provided during every visits session and should be supervised by a creche worker. (1.158)

2.59 Proper changing facilities, including changing mats, should be provided in both the men and women's toilet areas. (1.159)

2.60 Prisoners who have been re-categorised to category D awaiting transfer to another prison should be encouraged to apply for town visits. (1.164)

2.61 The new arrangements in the visits hall should reviewed to ensure that visiting groups had sufficient privacy and that appropriate arrangements are in place for those with hearing difficulties. (1.165)

2.62 Methods to improve access to enhanced visits should be explored to ensure the prison can provide these in accordance with its IEP policy. (1.166)

Religious activities

2.63 Chaplains should be given a full induction programme and be properly equipped to work in prison establishments promptly after recruitment. (1.168)

Prison shop

2.64 Minutes should be taken at canteen meetings and displayed on unit notice boards. (1.173)

Fire precautions

2.65 The fire officer should be supported by trained assistants and adequate time allowed for his/her duties. (1.178)

2.66 Staff training should be brought up to date to meet legal requirements. (1.179)

2.67 The SDBA equipment should be brought into use. (1.180)

2.68 Combined exercises with the Fire Brigade should be held and records kept. (1.181)

2.69 Combined exercises with the Fire Brigade should be held and records kept. (1.183)

Provisions for life long sentenced prisoners

2.70 The development of a lifer group would be an effective way in which to start addressing some of the concerns raised by prisoners. (1.192)

Release on temporary licence (ROTL)

2.71 Where possible prisoners should be invited to attend ROTL boards. (1.193)

2.72 Records should be kept of all prisoners applying for ROTL, and these figures should be routinely monitored. (1.194)

Home detention curfew (HDC)

2.73 A system should be put in place to monitor HDC applications monthly in order to provide cumulative figures. (1.196)

INSPECTION TEAM

Michael Loughlin	Team leader
Joss Crosbie	Inspector
Paul Fenning	Inspector
Brett Robinson	Inspector
Gabrielle Lee	Inspector

Specialist inspectors

Bridget McEvelly	Healthcare
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Education and work skills

Neil Edwards	Adult Learning Inspectorate
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APPENDIX II

POPULATION PROFILE AT 20/04/04 - HMP Coldingley

Population breakdown by:

(i) Status	Number of prisoners	%
Sentenced	386	
Civil prisoners	-	
Detainees (single power status)	-	
Detainees (dual power status)	-	
Total	386	100

(ii) Sentence	Number of prisoners	%
Less than 6 months	-	
6 months-less than 12 months	-	
12 months-less than 2 years	-	
2 years-less than 4 years	53	13.8
4 years-less than 10 years	295	76.4
10 years and over (not life)	-	
Life	38	9.8
Total	386	100

(iii) Length of stay	Number of prisoners	%
Less than 1 month	-	
1 month to 3 months	-	
3 months to 6 months	35	9
6 months to 1 year	54	14
1 year to 2 years	111	28.8
2 years to 4 years	146	37.8
4 years or more	40	10.4
Total	386	100

(iv) Main Offence	Number of prisoners	%
<i>Please see attachment for definitions of offence categories</i>		
Violence against the person	84	21.8
Sexual offences	-	
Burglary	47	12.2
Robbery	55	14.2
Theft & handling	10	2.6
Fraud and forgery	-	
Drugs offences	147	38
Other offences	37	9.6
Civil offences	-	
Offence not recorded/ Holding warrant	6	1.6
Total	386	

(v) Age	Number of prisoners	%
21 years to 29 years	141	36.5
30 years to 39 years	129	33.4
40 years to 49 years	87	22.6
50 years to 59 years	25	6.5
60 years to 69 years	4	1
70 plus years	-	
Please state maximum age		
Total	386	100

APPENDIX II

(vi) Home Address	Number of prisoners	%
Within 50 miles of the prison	240	62.2
Between 50 and 100 miles of the prison	38	9.9
Over 100 miles from the prison	30	7.8
Overseas	42	10.8
NFA	36	9.3
Total	386	100

(vii) Nationality	Number of prisoners	%
British	285	73.8
Foreign Nationals	101	26.2
Total	386	100

(viii) Ethnicity	Number of prisoners	%
<i>White</i>		
British	164	42.5
Irish	3	0.8
Other White	40	10.4
<i>Mixed</i>		
White and Black Caribbean	9	2.3
White and Black African		
White and Asian		
Other Mixed	3	0.8
<i>Asian or Asian British:</i>		
Indian	3	0.8
Pakistani	8	2.1
Bangladeshi	4	1.0
Other Asian	4	1.0
<i>Black or Black British</i>		
Caribbean	96	24.8
African	24	6.2
Other Black	13	3.4
<i>Chinese or other ethnic group</i>		
Chinese	1	0.3
Other ethnic group	14	3.6
Total	386	100

(ix) Religion	Number of prisoners	%
Baptist	2	0.6
Church of England	115	29.7
Roman Catholic	72	18
Other Christian denominations	23	6.0
Muslim	45	11.7
Sikh	2	0.6
Hindu	2	0.6
Buddhist	9	2.3
Jewish	2	0.6
Other	21	5.4
No religion	93	24
Total	386	100

DEFINITIONS OF OFFENCE CATEGORIES

Violence against the person

Murder
Other homicide and attempted homicide
Wounding
Assaults
Cruelty to children
Other offences of violence against the person

Sexual offences

Buggery and indecency between males
Rape
Gross indecency with children
Other sexual offences

Burglary

Robbery

Theft and handling

Taking and driving away
Other thefts
Handling stolen goods

Fraud and forgery

Frauds
Forgery

Drugs offences

Other offences

Arson
Criminal damage
In charge of driving under the influence of drink or drugs
Other motoring offences
Drunkenness
Blackmail
Kidnapping
Affray
Violent disorder
Perjury/libel/pervert the course of justice
Threatening/disorderly behaviour
Breach of court order
Other

Civil offences

Non-payment of fines
Other civil offences

Offence not recorded/ Holding warrant