



**REPORT ON
AN UNANNOUNCED FOLLOW-UP
INSPECTION**

OF

HM PRISON SHEPTON MALLET

18-19 NOVEMBER 2003

BY

HM CHIEF INSPECTOR OF PRISONS

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INTRODUCTION

Shepton Mallet claims to be England's oldest prison; as well as one of the smallest. It is now also the only category C prison entirely dedicated to holding life sentenced prisoners at the second stage of sentence.

This was a development that aimed to build on Shepton Mallet's strengths – as a small, cohesive environment that could build a niche role for itself, even though it lacked the space and facilities of larger or more modern prisons. However, as this report shows, the change was not well managed. Life sentence prisoners require specific structures and interventions to assist their progression and resettlement at this stage of sentence. These were not in place: far from creating a niche, the prison and its staff had been floundering and the needs of lifers had not been met.

It is to the credit of staff in the prison that they had, nevertheless, retained good and respectful relationships with prisoners. And they were responding well to the arrival of a temporary Governor who was working to build the foundations for good, focused work with lifers.

The recommendations in this report will contribute to this process. There is no reason why the original vision cannot be implemented, so that Shepton Mallet can provide a much-needed specialised resource within the prison system.

Anne Owers

HM Chief Inspector of Prisons

January 2004

PREAMBLE

The Prisons Inspectorate conducts short inspections to visit and check establishments between full inspections. They are carried out by a small team, last two or three days, and 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.

Gary Deighton, Janine Harrison, Gail Hunt and Pat Mosley carried out an unannounced short inspection of HMP Shepton Mallet from 18-19 November 2003 to review progress on recommendations made after the last full inspection in 2000. This report records our findings and describes the extent to which our recommendations had been implemented, as well as recognising changes that had taken place since the last inspection. The report also takes into account what we were told by prisoners, staff and managers.

The team also monitored the treatment of prisoners using the model of the healthy prison described in the *Expectations* document contained in Annexe 7 to the 1999-2000 Annual Report of HM Chief Inspector of Prisons. Inspectors discussed their conclusions with the governor at the end of the inspection.

CONTENTS

	Paragraph	Page
INTRODUCTION		3
PREAMBLE		5
FACT PAGE		9
HEALTHY PRISON SUMMARY	HP.01-HP.34	11
1 PROGRESS SINCE THE LAST REPORT	1.01-1.156	19
2 SUMMARY OF RECOMMENDATIONS	2.01-2.37	45
APPENDIX		
I Inspection team		i

FACT PAGE

Role of the establishment

Category C centre for life sentence prisoners.

Area organisation

South West.

Number held

November 2003: 186.

Certified normal accommodation

189.

Operational capacity

163.

Last inspection

Full announced inspection: January 2000.

Brief history

Located in the centre of Shepton Mallet, Somerset, there was a prison on this site from 1610 to 1930. The establishment operated as a US military prison from 1939 to 1966, when it was taken over by the prison department. At the time of the last inspection, in 2000, the prison had been operating as a category C training prison containing a vulnerable prisoner unit.

HEALTHY PRISON SUMMARY

Introduction

HP.01 The concept of the healthy prison was introduced in our thematic review, *Suicide Is Everyone's Concern*, 1999. The four criteria for a healthy prison are:

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

HP.02 Shepton Mallet had been a category C training prison at the time of our last inspection. It had since become a second stage prison for life sentence prisoners; all 186 prisoners at the time of this inspection were serving life sentences. The change of role had begun in August 2001, although it was not until March 2003 that all determinate sentence prisoners had been transferred elsewhere.

HP.03 The management of this transition had been poor, with insufficient planning for the change of role and inadequate execution of those plans. An example of this was the lack of staff training in the management of life sentenced prisoners. A new, temporary governor was in the process of implementing recovery plans across a range of areas at the time of this inspection.

HP.04 Shepton Mallet had also been identified for involvement in the performance improvement programme. The area manager's operational assessment, and the audit which took place at the same time as this inspection, focused on the major deficiencies that existed in the prison. At the time of this inspection, the approach of managers was more dynamic than previously. All the staff we met were willing, and determined, to work with the new governor to achieve improvements at the prison.

Safety

Shepton Mallet was a safe prison, but this was not underpinned by effective systems in all areas.

HP.05 Prisoners were well received into the prison, and reception staff gave them a good deal of written information, which they could keep. A prisoner mentor saw all newly received prisoners in the reception building, and gave them an overview of the regime at the prison and indicated what they could expect. All the recommendations from the previous inspection in this area had been accepted and implemented.

HP.06 There was a good induction programme, along with an excellent induction booklet providing prisoners with the information they needed about the prison. Prisoners were also given responsibility to attend various sessions on the induction programme, and had to complete a checklist in the induction booklet of attendance at these. All the recommendations on the induction programme from the previous inspection had been implemented.

HP.07 Anti-bullying measures at Shepton Mallet were not effective. At the time of this inspection, no prisoner was subject to anti-bullying procedures, and the policy was not being used. There was some evidence of self-policing by prisoners, which added to the relaxed and comfortable environment, but, in effect, there were no formal systems to manage bullying behaviour or to support victims of bullying.

HP.08 A comprehensive and detailed suicide and self-harm policy had been reviewed in October 2003. Most of the recommendations from the previous inspection had been addressed. The suicide and self-harm prevention committee was in place, but it was not driving practice in the establishment. Development work in this area had effectively stagnated – for example, the same items were discussed each month with no action taken.

HP.09 There was no meaningful incentives and earned privileges system at Shepton Mallet. In effect, the system had collapsed and was not in use on any wing. This system needed to be reviewed and re-launched.

HP.10 The segregation unit was small, clean and little used. Control and restraint techniques were also rarely used – they had been used only once in 2003 to the date of our inspection. The documentation relating to the use of force was, however, in the same poor state as at the previous inspection.

Respect

Despite the changes that had taken place at Shepton Mallet, and the poor way in which many of these had been managed, respectful relationships between staff and prisoners had been maintained.

HP.11 Residential areas and cells were clean. Most prisoners occupied single cells, although there were 27 double cells in the prison, which were extremely unpopular. Some of the toilet screening was poor, with prisoners using sheets or blankets to supplement the screens provided. There was little natural light in cells, but cell doors were open for most of the day.

HP.12 Relationships between staff and prisoners were respectful, friendly and polite. It was clear that staff knew their prisoners and engaged with them on a regular basis. Staff regularly recorded information about prisoners on wing files, which were open for prisoners to view.

HP.13 Shower areas were clean and well decorated, and most prisoners had access to them during the day. However, this access was limited for some workers when evening association was cancelled. There was general access to telephones during all periods when prisoners were unlocked, and all telephones had privacy hoods.

HP.14 Approximately 14% of prisoners at Shepton Mallet were from minority ethnic groups, although when we talked to staff their perception was that this figure was around only 5%. Four foreign national prisoners were held at the prison. There was an established race relations committee, including a prisoner sub-committee, but attendance at meetings was frequently poor. There were significant fluctuations in the facility time given to the race relations liaison officer (for example, 16 hours were

allocated in April 2003, but only one hour in August). There was a range of monitoring systems, and there was little evidence that cultural diversity was promoted.

HP.15 The chaplaincy was better integrated into the work of the prison than at the previous inspection, with improved relationships between chaplains and other staff. Prisoners had no difficulties in attending services, and a new, temporary chaplain was keen to expand the range of spiritual activities available to them.

HP.16 There had been significant improvements in the management of healthcare and the quality of primary care being delivered since the last inspection. There were continuing problems with the premises and facilities available, but these were due to be addressed by the relocation of the healthcare suite in December 2003. Dentistry and pharmacy services had been reviewed, and the quality of these services had improved. There was an up-to-date health needs assessment. Overall, responsive services had been developed to meet the needs of the current population (particularly older prisoners and those with chronic diseases).

Activity

Despite improvements since the last inspection, activity places overall were still not being maximised, and there were too few relevant vocational and academic qualifications available for the current population.

HP.17 Time out of cell was generally good, with prisoners unlocked on wings even if they were not engaged in structured activity. There was a free flow system for prisoners to move to activities. There were problems with association, which was cancelled too frequently, often unpredictably, and frequently at short notice, causing some frustration among prisoners.

HP.18 Work and education spaces were not filled to capacity. This, coupled with the long-term closures of some workshops as a result of staff sickness or annual leave, meant that too many prisoners were spending too long on the wings with too few opportunities for constructive activity. Opportunities for prisoners to gain qualifications were very limited, with only 15 registered for qualifications at the time of this inspection.

HP.19 A needs analysis in education had been conducted in autumn 2003, and this showed that 72% of prisoners had literacy or numeracy qualifications at level 2 or above. However, the range of qualifications and courses available did not reflect the relatively high ability of those held at the prison. Our previous recommendation that evening and weekend classes should be available had not been implemented.

HP.20 Although the physical education programme had been adapted slightly to cater for the new life sentenced prisoner population, there had not been a detailed needs analysis for the population, and it was not clear that the programme reflected what was required. The PE department experienced difficulties in covering the programme, particularly at weekends and evenings, largely because of the small number in the team. Sports and games staff had been trained, but were rarely used.

Resettlement

Some initiatives were being undertaken in this area, but the resettlement agenda had still not been fully grasped. The overall resettlement needs of the life sentence population held at Shepton Mallet still needed to be understood and met.

HP.21 There was now a resettlement policy committee, but this was not working to clear terms of reference, and no resettlement strategy had been devised. Staff did not yet seem aware of the diverse resettlement needs of the life sentenced prisoners for whom they were responsible. There was evidence of some innovative plans, but these still needed to be developed to provide a co-ordinated and comprehensive approach to resettlement.

HP.22 The preparation of annual reviews had been very poorly managed. At the time of this inspection annual reviews had not been completed for 140 out of the 186 life sentence prisoners, although a recovery programme was in place. Samples of the most recent reviews indicated that there were no written contributions from probation staff or personal officers. However, reviews were often insightful and took account of risk reduction while setting appropriate targets for prisoners. The prison was up-to-date in completion of parole reports. Escorted absences and lifer days for prisoners also took place.

HP.23 The enhanced thinking skills course was no longer offered at Shepton Mallet, but core and extended sex offender treatment programmes were delivered and these had recently achieved a 100% implementation quality rating (IQR). However, the establishment needed to consider carefully the suitability of these courses, and whether the population would benefit more from booster and relapse prevention programmes.

HP.24 The drug strategy had been significantly revised since the last inspection. The CARAT (counselling, assessment, referral, advice and throughcare) service was generally good, but only one person was providing it and no cover was available in his absence. Individual support was offered to prisoners who required it, but there were also more structured programmes for those moving on to open conditions and those returning from open conditions to closed conditions at Shepton Mallet. Voluntary drug testing had been suspended because of health and safety concerns about the area where this took place; there were, however, plans to relocate the testing suite.

HP.25 There had been little progress in the visits environment since the previous inspection. This area was very dated, functional and unwelcoming. There was a poor play area for children, and the seating arrangements had not been improved. A portakabin inside the prison wall served as a waiting room for visitors; this was an improvement since the last inspection, but still did not provide a particularly welcoming environment for visitors. Overall, relationships between staff and visitors were high quality, being relaxed, friendly and respectful.

Conclusion

HP.26 A new, temporary governor had recently been appointed to Shepton Mallet. She was in the process of implementing a rapid recovery plan to improve conditions at the prison. Her approach, and the changes she was making, had the support of all staff.

HP.27 The relatively new systems that had been established needed to become firmly embedded in the life of the prison, and to become well integrated with each other. All staff also needed to understand the particular challenges of working with life sentence prisoners. Such developments should make it possible for Shepton Mallet to realise its full potential as a second stage, life sentence, category C establishment.

Main recommendations

HP.28 The revised anti-bullying policy should be relaunched to ensure that all staff are aware of the need to use it.

HP.29 The incentives and earned privileges scheme should be reviewed and brought up-to-date.

HP.30 The suicide and self-harm prevention committee should drive developments in this area of work throughout the prison.

HP.31 Cultural and ethnic diversity should be actively promoted.

HP.32 There should be a regime review to make appropriate work and qualifications available to prisoners, and to maximise activity spaces.

HP.33 There should be an assessment of the resettlement needs of the prisoner population, and services to meet those identified needs should be delivered throughout the prison.

HP.34 The environment in the visits room should be improved.

CHAPTER ONE

PROGRESS SINCE THE LAST REPORT

Introduction

1.01 We have used the recommendations from our inspection of 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 refers to its location in the previous inspection report.*

Reception

1.03 *Reading material, a radio or a television should be provided to occupy prisoners in reception. (6.07)*

Achieved. There were magazines in the holding cells for prisoners, and a wind-up radio was also available for prisoners' use.

1.04 *Information about the listeners, Samaritans and the anti-bullying strategy should be displayed on the notice boards. (6.08)*

Achieved. All the notice boards were neat and had up-to-date notices about the prison's various policies and how to access them. These notices included information on the listeners, Samaritans and anti-bullying. There were also leaflets and other good written information for prisoners, which they could keep.

1.05 *A telephone should be installed in reception for prisoners to use while they are waiting to be processed. (6.09)*

Not achieved. The prison rejected this recommendation because prisoners were offered a telephone call once they were located on to a wing.

1.06 *Procedures to explore prisoners' immediate needs in reception should be improved. (6.10)*

Achieved. Prisoner mentors met and greeted new arrivals. The mentor met all new receptions and told them about life in Shepton Mallet. He also gave information on the listeners' scheme, and checked informally that the prisoner was content to be at Shepton Mallet.

1.07 *A system to ensure vital information is passed from reception to the wings should be put in place. (6.11)*

Achieved. Reception officers interviewed all new prisoners, and the prison service cell sharing risk assessment form was completed.

Further comments

1.08 As at the last inspection, all areas of reception were very clean. The staff were friendly and helpful when dealing with prisoners.

Induction

1.09 *First night arrangements should be improved. (6.12)*

Achieved. All new prisoners were interviewed by a wing senior officer and offered a telephone call.

1.10 *A proper, structured induction programme should be devised and implemented. (6.13)*

Achieved. All new prisoners were given an induction booklet on arrival in reception, which contained the induction programme. The prisoner had the responsibility to complete each module, which was signed off by the relevant member of staff. This was facilitated by allocating time slots to the prisoner via the computerised prisoner activity management system (PAMS). The induction programme was comprehensive and ran over two weeks. The education department ran a separate induction programme in parallel with the main programme (see paragraph 2.92).

1.11 *The time spent by prisoners locked in their cells while waiting for or participating in the induction programme should be kept to a minimum. (6.14)*

Achieved. Prisoners were not locked up while waiting to participate in the induction programme.

1.12 *Access to the induction programme should be improved. (6.15)*

Achieved. See paragraph 2.10.

1.13 *The initial assessment and induction record should be expanded and further developed. (6.16)*

Achieved. See paragraph 2.10.

1.14 *An induction booklet should be devised and introduced. (6.17)*

Achieved. See paragraph 2.10.

Self-harm

1.15 *Residential staff should attend meetings of the suicide awareness committee. (6.18)*

Not achieved. Minutes of past meetings showed that residential staff did not attend routinely. **We repeat the recommendation.**

1.16 *The Samaritans should be informed about all suicide and self-harm incidents. (6.19)*

Achieved. The secretary to the committee was responsible for this.

1.17 *Arrangements should be put in place to notify relatives in the event of a death or serious injury in custody. (6.20)*

Achieved. The prison had published a detailed local instruction on the arrangements for dealing with a prisoner death in custody or a serious injury.

1.18 *Staff training should be expedited. (6.21)*

Partially achieved. Suicide awareness training was ongoing; at the time of the inspection about one-third of staff who had prisoner contact had been trained. **We repeat the recommendation.**

1.19 *Liaison officers should be appointed on all residential units. (6.22)*

Achieved. All wings had designated liaison officers.

Anti-bullying

1.20 *Staff awareness training should be started. (6.23)*

Not achieved. No training had taken place over the past two years. **We repeat the recommendation.**

Further comments

1.21 The anti-bullying policy was not being used. No prisoners were subject to anti-bullying measures – on many wings this had been the case for the past two years. Staff were confident that the prison did not have a bullying problem; given the sophisticated nature of the population this was a naïve assertion. The lack of obvious instances of bullying suggested that the prisoners were policing themselves. Senior managers were aware of the need to deal quickly with what was an unacceptable position.

Further recommendations

1.22 **Staff training should take account of the change in prisoner population and, in particular, the sophisticated approaches that life sentence prisoners may have.**

Incentives and earned privileges scheme

1.23 *The compact should be reviewed. (6.24)*

Achieved. The compact had been reviewed and was again under review in light of the changed population of the prison.

1.24 *The rules for early consideration for enhanced status should be explained to all prisoners arriving at Shepton Mallet. (6.25)*

Achieved. Prisoners could move quickly from standard to enhanced status.

1.25 *The visits entitlement for prisoners on basic should not be restricted to the legal minimum. (6.26)*

Not achieved. The prison rejected this recommendation on the basis that the reduction in status was a reasonable response, and sufficient incentive to a prisoner to change his behaviour.

1.26 *The criteria for granting the privilege of a television should be reviewed. (6.27)*
Achieved. All prisoners on standard and enhanced status had a television.

1.27 *Entries in prisoners' wing records should be improved. (6.28)*

Not achieved. There were few entries in wing files in relation to the incentives and earned privileges scheme. Those we saw were not particularly helpful either to the prisoner in assessing his performance or to a member of staff seeking to find out about a prisoner's general behaviour. **We repeat the recommendation.**

Further comments

1.28 The incentives and earned privileges scheme was not used properly, and had effectively collapsed. No prisoners were on the basic regime, and it was difficult for staff to recall when anyone had been placed on basic. The scheme had few incentives for prisoners to reach enhanced status, and they were content to remain on standard. Staff did not see the scheme as a tool to modify, change or challenge behaviour.

Further recommendation

1.29 **The IEP scheme should provide real incentives for prisoners to progress, and should challenge poor behaviour.**

Good order

1.30 *The monitoring of control and restraint techniques should be improved. (6.29)*

Not achieved. The prison rejected this recommendation because there were few instances of use of force and, when force was used, the forms were properly completed and filed. There was little use of force – only once to date in 2003. In this case, the relevant form was not completed properly, and no form 213 (record of injury to prisoner) was attached; the file containing the forms did not match the logbook. The files were untidy and not in order, and it was difficult to match forms to the log. **We repeat the recommendation.**

Security

1.31 *Administrative support should be provided for the security department. (6.30)*

Achieved. A civilian clerk was employed in the security department.

1.32 *The siting and number of security gates should be reduced. (6.31)*

Achieved. The prison operated a free flow system throughout the day, allowing prisoner to move easily about the prison.

Segregation unit

1.33 *Access to daylight and fresh air should be improved. (6.34)*

Not achieved. While the prison had accepted the recommendation, the situation remained the same as at the last inspection. **We repeat the recommendation.**

B wing

1.34 *The screening arrangements [for in-cell toilets] should be improved. (6.35)*

Not achieved. In-cell toilets in both single and double cells still had only small wooden screens that provided inadequate privacy. Many prisoners used sheets or blankets for additional screening. **We repeat the recommendation.**

1.35 *The policy on the display of offensive material should be enforced. (6.36)*

Achieved. We saw no offensive displays in the cells we visited. Staff were alert to the appropriateness of sexually explicit or other potentially offensive material, and actively monitored this as part of the general management of prisoners and their individual risk factors.

1.36 *All prisoners should be supplied with enough clothing to allow a daily change of underwear. (6.37)*

Achieved. The clothing shortages reported at our last inspection no longer existed, and, although many prisoners wore their own clothing, those who wished to wear prison issue clothing had adequate supplies.

1.37 *The arrangements for the collection of prisoners' clothing on B wing should be reviewed. (6.38)*

Achieved. Dirty clothing was no longer thrown into the well at the bottom of the staircase.

1.38 *The showers on B wing should be refurbished. (6.39)*

Achieved. The showers were brightly decorated and well maintained.

1.39 *Access to the telephones on B wing should be improved. (6.40)*

Achieved. All telephones were switched on during periods of unlock, allowing prisoners ready access throughout the day. We received no comments from prisoners about access to, or use of, the telephones.

1.40 *The personal officer scheme should be reviewed. (6.41)*

Achieved. All prisoners had a nominated personal officer. Staff told us that no additional time had been allocated to enable them to read prisoners' case files or to complete reports – both time-consuming activities in relation to life sentence prisoners. Wherever possible, the personal officer supervised the prisoner during escorted absences; two prisoners told us they had valued this experience.

1.41 *The supervision of the cleaning party should be improved. (6.42)*

Achieved. Standards of cleanliness were high, and many wing cleaners were involved in other activities, such as education, making good use of their time.

C wing

1.42 Recommendations 6.43-6.46 and 6.48 were no longer relevant due to the change in prisoner population

1.43 *Privacy hoods should be fitted to the telephones. (6.47)*

Achieved. All telephones had privacy hoods. (See also paragraph 2.40.)

1.44 *A policy of integration should be considered. (6.49)*

Achieved. With the change of roll, the prison had introduced an integrated regime; initial complaints and difficulties among prisoners had been dealt with openly. Staff and prisoners to whom we spoke estimated that more than half of the prisoners at

Shepton Mallet had offence histories or personal characteristics that might have led them to be treated as ‘vulnerable prisoners’ in other prisons.

Faith and religious activities

1.45 *Staff on the wing should ensure that prisoners know the times of services and facilitate their access. (6.50)*

Achieved. We spoke to prisoners of different faiths who confirmed that services were well publicised, and that staff enabled prisoners to attend worship. The chaplain was satisfied that all prisoners who wanted to could attend religious services.

1.46 *Prisoners should arrive at the services on time. (6.51)*

Achieved. Prisoners were not delayed in getting to services.

1.47 *A closer working relationship should be developed between staff and the chaplaincy team. (6.52)*

Achieved. The temporary, full-time chaplain was a member of the senior management team. He reported good informal networks between staff of all disciplines in the prison, particularly when information needed to be shared to help or support a prisoner. There was potential for closer liaison between members of the chaplaincy and personal officers.

Race relations

Current situation

1.48 Fourteen per cent of prisoners at Shepton Mallet were from ethnic minority groups. While the necessary systems to manage race relations, and particularly to address discrimination, were in place, these were not always fully effective. The prison’s race relations policy had been updated in October 2003 and the race relations management team (RRMT) met regularly. Chaired by the governor, the RRMT included a prisoner sub-committee, and representation from the Somerset Race Equality Council. However, overall attendance at meetings was low. The prison’s operational assessment in May 2003 had identified problems with the delivery of diversity training, although by September 2003 most civilian staff had attended the training course.

1.49 The facility time given to the nominated race relations liaison officer to complete his duties fluctuated significantly – he had been allocated 16 hours a week for this in April 2003, four hours in June, and only one hour in August. Ethnic monitoring covered a range of areas, including work, accommodation, incentives and earned privileges, and escorted absences: this monitoring had not indicated any areas of concern. Racial complaint forms were available on residential wings, and prisoners told us that they knew how to make a racial complaint. We saw no examples in the prison of promotion of diversity.

1.50 The prison held four foreign national prisoners, each of a different nationality; no policy or strategy had yet been developed in respect of such prisoners.

Further recommendation

1.51 A policy for meeting the specific needs of foreign nationals should be developed and implemented.

Prison shop

1.52 *Systems should be put in place to cater for new receptions so that they do not have to wait an excessively long time to purchase goods from the canteen. (6.53)*

Achieved. As most prisoners now arrived at Shepton Mallet as part of a planned move, few required immediate access to the shop. However, there were arrangements to provide canteen items to new arrivals who had the money available to spend.

1.53 *The decision to restrict the amount of orange juice sold should be reviewed. (6.54)*

Achieved. This recommendation arose out of a particular situation at the time of the last inspection; it was no longer relevant and no such restrictions were in place.

Catering

1.54 *Plans to introduce certificated training in the kitchen should be pursued. (6.55)*

Not achieved. There were no internal verification systems, and there was no apparent commitment to providing national vocational qualification opportunities.

1.55 *The damaged floor should be repaired. (6.56)*

Partially achieved. The floor had been renewed since our last visit in 2000; although it was in generally good order, some areas still suffered from peeling paint.

1.56 *All staff should be trained in health and hygiene issues. (6.57)*

Achieved. This now formed part of the regular staff training programme.

1.57 *The supervision of the hotplates should be improved. (6.58)*

Partially achieved. Both catering staff and senior managers visited the serveries regularly to observe the serving of meals. However, catering staff acknowledged that there was some sloppy practice, such as failure by some orderlies to wash their hands thoroughly or to wear clean 'whites'.

Healthcare

Current situation

1.58 Shepton Mallet had established good links and effective working relationships with the local primary care trust, resulting in better management arrangements and improved quality of care to prisoners. There were also good working relationships with healthcare staff within the Dorset and Somerset prison cluster. A health needs analysis had been completed in November 2002, and a mental health needs analysis in March 2003.

1.59 Systems for identifying and monitoring healthcare needs were working well, and healthcare had been one of the few departments to respond promptly to the change in prisoner population by reviewing and making appropriate adjustments to its services. These changes included: the introduction of well man clinics for all prisoners aged over 45; the setting up of chronic disease registers; and a variety of health promotion activities.

1.60 Part-time administrative support had been allocated to the department only recently, and nursing staff continued to complete many administrative tasks, particularly as none of the systems were computerised. The physical environment was cramped and inadequate, but a purpose-designed healthcare centre was due to open in December 2003.

Progress on previous recommendations

1.61 *The governor should enter early discussions with the chief executive of the local health authority with a view to developing an improved system for contracting and monitoring healthcare services. (6.59)*

Achieved. See paragraph 2.58.

1.62 *Lockable cupboards should be installed for the storage of medicines. (6.60)*

Achieved. Lockable cupboards had been installed, and we saw them in use during the inspection.

1.63 *A maximum/minimum thermometer should be obtained and a daily written record maintained of the refrigerator temperatures. (6.61)*

Achieved. The thermometer was in place, and a log kept of the daily temperature readings.

1.64 *The arrangements for safeguarding prescribed medicines should be improved. (6.62)*

Achieved. The area pharmacist based at HMP Bristol had investigated the procedures for safeguarding prescribed medicines, and concluded that the existing arrangements met the required standard.

1.65 *All prescriptions should be dated by the doctor. (6.63)*

Achieved. All prescriptions were dated.

1.66 *The use of Henley bags should be phased out in favour of conventional containers or Venalink. (6.64)*

Not achieved. The use of Henley bags was strongly favoured by the area pharmacist, and they continued to be used as appropriate.

1.67 *A logbook should be maintained and signed by all authorised persons requesting use of the pharmacy key out of hours. (6.65)*

Achieved. The pharmacy key was held in a lockable box in healthcare, the key to which was in a sealed packet held at the main gate, along with the logbook.

1.68 *A written procedure with regard to out of hours provision should be drawn up. (6.66)*

Achieved. The procedure had been issued as an operational instruction.

1.69 *An emergency supply cabinet should be provided. (6.67)*

Not achieved. The area pharmacist had decided that, due to the low level of usage, an emergency cabinet was not required.

1.70 *Stock for use in the cabinet should be selected by consultation with the pharmacist at HMP Bristol. (6.68)*

Not achieved. See paragraph 2.69.

1.71 *A written procedure should be drawn up for use of the emergency cabinet. (6.69)*

Not achieved. See paragraph 2.69.

1.72 *There should be written evidence available for checks of the resuscitation kit. (6.70)*

Achieved. A log was held in the healthcare centre and contained regular entries.

1.73 *The pharmacist from HMP Bristol should try to visit the prison at monthly intervals, to advise and generally oversee the provision of the pharmacy service. (6.71)*

Not achieved. Although the pharmacist did visit, this was less often than once a month.

Dental services

1.74 *The provision of seamless, vinyl flooring would meet current standards and a regime of thorough, regular, cleaning should be agreed and monitored. (6.72)*

Partially achieved. As the dental surgery was to be relocated to the new healthcare centre, funding had not been approved for new flooring. The surgery was cleaned routinely.

1.75 *A waiting room during dental sessions or seating in the corridor should be provided. (6.73)*

Achieved. The dental surgery occupied a room in the offending behaviour unit: although this was an unsuitable location, it did provide good waiting facilities.

1.76 *An emergency drug kit together with suitable airways should be provided.* (6.74)

Achieved. An emergency drug kit was available.

1.77 *A telephone and a more appropriately placed emergency call button should be provided.* (6.75)

Partially achieved. See paragraph 1.74.

1.78 *Medical histories should be recorded and updated on dental record cards.* (6.76)

Achieved. Although the dentist was not available during our inspection, healthcare staff told us that the recording of medical histories did take place.

1.79 *Suitable procedures should be drawn up for the provision of 'out of hours' emergency dental treatment.* (6.77)

Not achieved. The prison had rejected this recommendation. As HMP Bristol provided the dental services, the provision of out of hours treatment was seen to be an issue for that establishment.

1.80 *A suitable storage container for endodontic instruments together with a mercury spillage kit should be provided.* (6.78)

Achieved. This equipment had been provided.

Activities

Current situation

1.81 Employment opportunities at Shepton Mallet consisted of: education; a tailoring shop; an assembly workshop; a craft work party; a home maintenance party; and a variety of orderly and domestic employment. Access to vocational and educational qualifications was limited and, during our inspection, work party spaces were not filled to capacity – resulting in far too many prisoners residing on the wings with no purposeful activity to occupy them. Shepton Mallet had offered little variation in its

regime and activities since changing its role to a life sentence prisoner centre: those changes that had occurred had not been driven by any systematic needs analysis of the current population.

Progress on previous recommendations

Employment

1.82 *The arrangements for moving prisoners to work and activities should be reviewed. (6.79)*

Achieved. A system of free flow movement had been introduced since the last full inspection, and access to activity areas was subsequently much improved. However, there were anomalies – a few gates were still locked for no apparent reason, most notably that leading to the library.

1.83 *Full use should be made of the employment activities offered. (6.80)*

Not achieved. There was a complex and confusing system of work allocation, and the local inmate database system (LIDS), prisoner activity management system (PAMS) and the manual allocation tracking (T-card) system did not always offer the same information. While work parties were allocated to capacity, the full numbers rarely attended. **We repeat the recommendation.**

1.84 *Parties should be filled to their maximum capacity thus limiting the number of prisoners locked in their cells during the day. (6.81)*

Partially achieved. Prisoners not in activities were no longer locked in their cells during the day. However, during the inspection work parties were not filled to their maximum capacity, and many prisoners were left on the wings during the core day. **We repeat the recommendation.**

1.85 *Work opportunities should be expanded. (6.82)*

Partially achieved. In-cell work for those prisoners who were physically unable to be otherwise employed was offered as part of one of the existing contracts, but this work was limited and prisoners complained that it was sporadic. The number of domestic cleaners on each wing was far higher than necessary.

1.86 *Efforts to expand existing contracts should be encouraged. (6.83)*

Achieved. Four contracts were currently managed, providing work in the manufacturing and tailoring workshops. A further two contracts were being explored.

1.87 *A more realistic working environment should be created in the workshops. (6.84)*

Achieved. During the inspection, the tailoring shop was closed due to annual leave of the instructor, and the craft shop was also closed due to long-term sick leave. Prisoners were working well in the remaining activity places. The introduction of piecework in the manufacturing and tailoring workshops had led to an industrious attitude, with prisoners acknowledging that the harder they worked, the more money they could earn.

1.88 *The operations of the DIY party should be based on skills acquired through formalised training. (6.85)*

Achieved. All prisoners working in the now renamed home maintenance workshop were registered on a City and Guilds multi-skills course.

1.89 *The provision of certificated training should be expanded. (6.86)*

Partially achieved. The provision of certificated training had expanded slightly since the last inspection. However, too few prisoners could access these courses and, at the time of our inspection, only 15 were registered on any course offered outside of induction. **We repeat the recommendation.**

Further recommendation

1.90 **The gate leading to the library should be locked-back to increase access to the facility.**

Education

1.91 *The induction process on C wing should be improved. (6.87)*

Achieved. An integrated regime was in operation, and prisoners on C wing underwent the same induction process as in the rest of the prison.

1.92 *The induction process should be reviewed. (6.88)*

Achieved. A comprehensive and thorough induction course was offered, with the opportunity for prisoners to achieve Open College Network level 2 Welfare to Work as part of the process.

1.93 *The provision of accredited training should be expanded and supported by appropriate key skills training. (6.89)*

Achieved. A range of accredited training courses in information technology was offered, providing opportunities for employment-relevant qualifications. Skills acquired were also applied practically, with prisoners creating web pages with prison-specific information for use in the library.

1.94 *The introduction of evening and weekend classes should be considered. (6.90)*

Not achieved. No evening or weekend classes were offered. **We repeat the recommendation.**

1.95 *The imbalance in the provision of education between the different wings should be addressed. (6.91)*

Achieved. With the integrated regime, all wings now had the same access to education.

1.96 *More provision should be made to allow inmates to progress to higher levels of achievement. (6.92)*

Partially achieved. A needs analysis by the education department in autumn 2003 highlighted that 72% of the population were on education level 2 and above. A few courses were offered to levels 3 and 4 in the education department alone. **We repeat the recommendation.**

1.97 *The contractor and the prison education department should work together to minimise any sense of isolation felt by staff and provide them with broader and extended professional training opportunities. (6.93)*

Achieved. Strode College, the education provider, had expanded into several more prisons since the last full inspection. Seconded staff working in Shepton Mallet were now invited to staff development days and training courses.

1.98 *Careers advice and literature should be improved. (6.94)*

Partially achieved. A limited number of reference books were available to prisoners who were considering their future career. Funding had recently been secured for the development of a careers information and guidance centre based in the library.

1.99 *The provision of pre-release courses, job clubs and other vocational guidance should be introduced. (6.95)*

Not achieved. No job club or pre-release courses were offered through the education department at Shepton Mallet, but the introduction of the careers information and guidance centre would provide advice on vocational training.

1.100 *The display of prisoners' work should be improved. (6.96)*

Achieved. As no recreational education was offered at Shepton Mallet, the work available for display was limited. However, work from the desktop publishing and web page design course were displayed within the department.

1.101 *Part-time administrative support should be provided to cover absences. (6.97)*

Achieved. Students undertaking the business administration course in the education department assisted the education administrator on a daily basis. In her absence, the students undertook a limited version of her role to assist the education department.

Further recommendations

1.102 There should be a review of the number of courses offered above level 2 to ensure that the qualifications available in the establishment are not set too low.

1.103 The development of the careers information and guidance centre should be carried through speedily.

Library

1.104 *The library should be open more frequently, and access should be equally good for inmates on all wings. (6.98)*

Achieved. Following its relocation in November 2001, the library was now housed in the education department. This move, and the introduction of free flow prisoner

movement, had increased prisoner access to the library during its opening hours. The librarian's hours had also increased from five to 14 hours per week during 2002-03.

1.105 *The library should be expanded and developed. (6.99)*

Partially achieved. The relocation had enabled an increase in library stock and facilities. An electronic booking out system had been introduced, and books could be ordered from elsewhere in the county. The plans to develop a careers information and guidance centre would enable the library to become a resource centre to support learning.

Physical education

1.106 *The exercise yard should be resurfaced. (6.100)*

Not achieved. Minor capital bids had been submitted annually by the works department, but no funding had been received to date. The exercise yard was still used for team sports throughout the year. **We repeat the recommendation.**

1.107 *Ventilation to the ground floor exercise areas should be improved. (6.101)*

Achieved. The ventilation system installed in May 2001 had greatly improved the conditions in the ground floor weights and multi-gym area. A storeroom had been converted into a small running room since the last inspection. This room had no ventilation, and both staff and prisoners complained that it got extremely hot and stuffy.

1.108 *Plans to repair and improve the roof should be expedited. (6.102)*

Achieved. The gymnasium roof had been completely replaced.

1.109 *Funding should be provided for an extra physical education instructor (PEI). (6.103)*

Not achieved. The staffing level in the gymnasium was still one senior officer physical education instructor and two PEIs. This resulted in staffing difficulties if any member of the team was absent for any reason, particularly during weekends and evenings. **We repeat the recommendation.**

1.110 *Sports and games staff should be deployed to ensure the full PE programme is provided for prisoners. (6.104)*

Not achieved. Staff reported that sports and games staff were trained but rarely, if ever, used to assist the PEIs in delivering a full PE programme to prisoners. **We repeat the recommendation.**

1.111 *The number of prisoners receiving accredited training should be increased. (6.105)*

Achieved. New accredited courses had been introduced since the last inspection. Records indicated that a number of prisoners had achieved qualifications in the gymnasium during the previous 12 months.

1.112 *First aid refresher training for the PEIs should be carried out. (6.106)*

Partially achieved. This recommendation was ongoing because of turnover of staff in the department. Currently, one of the PEIs was on a waiting list to attend the next suitable first aid refresher training course.

1.113 *PE staff should be encouraged to take an active part in the anti-bullying strategy. (6.107)*

Partially achieved. A PEI was on the core membership of the anti-bullying strategy committee and attended the meetings regularly. However, the role was not an active one and it required clarification.

Further recommendations

1.114 **Ventilation should be installed in the new running room.**

1.115 **The PE department should be fully integrated into the establishment's anti-bullying policy; the role of the PE representative on the anti-bullying committee should be clarified.**

Time out of cell

Current situation

1.116 Prisoners at Shepton Mallet were unlocked throughout the core day, even if they were not engaged in any form of activity. Evening association was often cancelled due to staff shortages. Prisoners complained that these cancellations were unpredictable and

they were often given little notice. There was a roster, for staff use, to ensure that lock downs were rotated between each of the wings. However, prisoners were not given notice of when it could be their turn to lose association, resulting in a great deal of frustration when they were unable to make planned telephone calls to friends and family.

Further recommendation

1.117 There should be a system to inform prisoners of potential lock downs during evening association.

Visits

Current situation

1.118 Little progress had been made in this area since the last inspection. The visits room was uninviting, and the hard, fixed seats either side of relatively high tables were neither comfortable nor effective in exposing any smuggling of drugs. A portakabin had been placed inside the prison wall for visitors to wait in. This was warm, but sparsely furnished, and contained little information for visitors; a drinks vending machine was available. The visits environment needed a thorough review (see main recommendation 1.34). Relationships between staff and visitors were respectful, polite and relaxed.

Progress on previous recommendations

1.119 *Posters and other relevant information should be displayed on the walls of the visits room. (6.108)*

Not achieved. Information was available, but it was not always easy to read: some was in small print and away from areas where visitors sat; other information was pushed behind bars on windows in the room. **We repeat the recommendation.**

1.120 *Staff should be trained in the use of the CCTV. (6.109)*

Achieved. The staff operating the CCTV equipment at the time we inspected were competent. A major drugs find had been made in the week prior to this inspection, using the skills of the operator and co-ordination with other visits staff.

1.121 *Communications between the CCTV operator and visits staff should be improved. (6.110)*

Achieved. See paragraph 2.120.

1.122 *The seating arrangements in the visits room should be improved. (6.111)*

Not achieved. Seating arrangements were the same as during our previous inspection.

We repeat the recommendation.

1.123 *Proper access to toilet facilities within visits should be provided for visitors. (6.112)*

Achieved. A new toilet block for male and female visitors had been built.

1.124 *Management responsibility for visits should be clearly defined. (6.113)*

Partially achieved. This was now the responsibility of a designated senior officer.

However, in his absence – as at the time of this inspection – no other senior officer, other than the one nominated to work in the area on any particular day, had overall responsibility for visits arrangements.

1.125 *The visitors' waiting room should be cleaned and made more welcoming. (6.114)*

(6.114)

Achieved. The portakabin inside the prison wall, which served as a waiting room and searching area for visitors, was clean at the time we inspected.

1.126 *The facilities for prisoners' visitors should be improved. (6.115)*

Not achieved. The portakabin contained only a drinks vending machine and lockers.

1.127 *A review of the policy for pregnant staff should be undertaken. (6.116)*

Partially achieved. The policy had not been reviewed completely, but the particular incident, which gave rise to this recommendation, had been reviewed and corrective action taken.

1.128 *There should be proper facilities for strip searching prisoners which afford a reasonable level of privacy. (6.117)*

Achieved. The area was appropriate for its purpose.

1.129 *Management of the closed visits system should be improved. (6.118)*

Achieved. This system was managed satisfactorily through the security department.

1.130 *The system for identifying children potentially at risk on visits should be improved. (6.119)*

Partially achieved. The system had been improved, but the visits room still contained an untidy file with the names of prisoners – some of whom were no longer at the prison – who presented a risk to child visitors. Not all visits staff were aware of this documentation. **We repeat the recommendation.**

Probation

1.131 *The roles of probation staff should be clarified and restricted to that which requires their special expertise. (6.120)*

Achieved. The contract between the chief probation officer and the governor had been reviewed in July 2003, and this made clear the role of seconded staff.

Throughcare

Current situation

1.132 Shepton Mallet needed to do much work to build an effective and comprehensive resettlement strategy that met the needs of the life sentence prisoner population. Various initiatives were in place and new ones, involving outside agencies, were planned. However, there was little evidence that a coherent and integrated strategy was developing, and this would be unlikely until the resettlement policy committee had clear terms of reference, and there had been a needs assessment of the population.

Progress on previous recommendations

1.133 *The strategy for throughcare should be reviewed and based on a needs assessment of the population particularly those dealing with release issues. (6.121)*

Not achieved. No needs analysis had been undertaken and there was no resettlement strategy in place (see main recommendation 1.33).

Drug strategy

Current situation

1.134 There had been major changes in this area since the last inspection. As a result of a short needs assessment in May 2003, and a review of the drug strategy, services were now provided to meet the individual needs of prisoners. Ongoing support work was available for those requiring it, as well as structured programmes for those leaving the prison for open conditions, and those returning to Shepton Mallet having failed in open conditions. Although a major programme of voluntary drug testing should have been in place, this had been suspended because of staffing difficulties and the unsuitability of the environment for testing. Positive mandatory drug testing figures were low.

Progress on previous recommendations

1.135 *The role of the drug strategy forum should be reviewed. (6.122)*

Achieved. The drug strategy forum no longer existed.

1.136 *The deployment of the drug dog handler should be reviewed. (6.123)*

Achieved. A review had taken place as part of the action planning following the previous inspection.

1.137 *Written information on drugs and related issues should be made available within the drug-testing suite. (6.124)*

No longer relevant. The voluntary drug testing suite was not in operation at the time of this inspection.

1.138 *The drug strategy forum should agree which statistics are relevant to their planning and ensure that data and information are presented in a format which would allow them to respond in the most effective manner. (6.125)*

No longer relevant. There was no longer a distinct forum. The drug strategy team did, however, have adequate information at its disposal.

1.139 *The drug strategy group should confirm the required contribution and timetable from the education department to addiction rehabilitation centre (ARC) (6.126)*

No longer relevant. The addiction rehabilitation centre no longer existed, and the education department no longer offered the drugs awareness course.

1.140 *The area drug co-ordinator should review the original drug strategy. (6.127)*

Achieved. The area drug strategy co-ordinator had carried out a review and short needs analysis as part of the overall operational assessment of Shepton Mallet commissioned by the area manager in May 2003.

1.141 *The future role of the addiction rehabilitation centre should be considered. (6.128)*

Achieved. This had been reviewed and was no longer in existence.

1.142 *The drug rehabilitation programme should not commence until senior management is satisfied there are enough staff trained to provide a therapeutic intervention. (6.129)*

No longer relevant. No drug rehabilitation programme was in place.

1.143 *The drug strategy group should ensure the chosen programme meets the requirements of this type of therapeutic model. (6.130)*

No longer relevant. See paragraph 2.142.

1.144 *Steps should be taken to ensure the programme delivered meets accreditation criteria. (6.131)*

No longer relevant. See paragraph 2.142.

1.145 *Support and relapse prevention groups should be provided. (6.132)*

Not achieved. Groups were not provided; the emphasis was now on individual work with prisoners.

1.146 *The healthcare department should be supported in developing and providing a comprehensive health promotion service to drug users and in particular the delivery of an effective strategy on hepatitis C. (6.133)*

Achieved. A health promotion service was available to all prisoners, as was information on hepatitis C.

1.147 *The development of Shepton Mallet as a specialist provider of drug rehabilitation services in the area should be supported. (6.134)*

No longer relevant. As the prison was now a second stage prison for life sentence prisoners, this function would be inappropriate.

Life sentenced prisoners

1.148 The prison had recently completed its change of prisoner population to become a second stage main centre for life sentenced prisoners. The change had not been well managed or led. As a result, the unit responsible for managing prisoners' sentences and organising reviews was not resourced as it should have been, was not properly organised, and was seen by staff as separate and distanced. The acting governor had made it a priority to address these problems.

1.149 Although the life sentence plans were all held securely, not all were properly filed. About half were sorted and neatly filed, and a clerk was working steadily to complete the other half.

1.150 There was a backlog of about 140 annual reviews to be completed. The prison had devised and implemented a recovery plan to get back on track; this appeared to be working. We sampled about 10% of the annual reviews that had been completed. The review boards consisted of the lifer liaison officer, a probation officer and the prisoner. There were no written contributions from the personal officer or seconded probation officer. The boards gave good reports on the prisoner's progress, and highlighted any change in risk factors. The targets that were set were based on need, and were achievable and measurable. It was clear that the prisoner was involved in the process. The prison was up-to-date with parole reports, and had hosted about 70 oral hearings over the previous six months.

1.151 Prisoners received no specific induction into the local life sentenced prisoner system, and the generic induction did not include any information on how this system worked at Shepton Mallet. The lifer liaison officer was aware of this gap, and was due to start seeing all new life sentenced prisoners within the following month. He had devised a very good policy document setting out how Shepton Mallet would work with

life sentence prisoners. This had been issued to staff and was to be issued to prisoners on their lifer induction.

1.152 There had been six events for life sentenced prisoners so far in 2003 – each spread over three days to ensure that everyone had the opportunity to participate. Prisoners who were entitled to escorted absences had three each year. There were no life sentenced prisoner groups, although there were plans to introduce them. Staff on D wing delivered a pre-open conditions course. This gave prisoners information on licence conditions, the pre-release process, supervision, recall, hostels, and victims and risk assessments.

1.153 The prison saw staff training as a priority. At the time of the inspection, about 90% of staff who would have prisoner contact, or would have to write reports, had been trained in working with life sentence prisoners. The training was delivered by the lifer liaison officer, who took the opportunity to bring staff closer to the work being done in the lifer unit.

Further recommendations

1.154 The senior management team should receive a report on the progress on the annual review action plan, and ensure it is complied with.

1.155 The seconded probation officer and personal officer should attend annual review boards, and provide written contributions.

1.156 There should be a specific induction for prisoners on how the life sentenced prisoner system works at Shepton Mallet.

CHAPTER TWO

SUMMARY OF RECOMMENDATIONS

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

- 2.01 **The revised anti-bullying policy should be relaunched to ensure that all staff are aware of the need to use it. (HP.28)**
- 2.02 **The incentives and earned privileges scheme should be reviewed and brought up-to-date. (HP.29)**
- 2.03 **The suicide and self-harm prevention committee should drive developments in this area of work throughout the prison. (HP.30)**
- 2.04 **Cultural and ethnic diversity should be actively promoted. (HP.31)**
- 2.05 **There should be a regime review to make appropriate work and qualifications available to prisoners, and to maximise activity spaces. (HP.32)**
- 2.06 **There should be an assessment of the resettlement needs of the prisoner population, and services to meet those identified needs should be delivered throughout the prison. (HP.33)**
- 2.07 **The environment in the visits room should be improved. (HP.34)**

Duty of care

- 2.08 Residential staff should attend meetings of the suicide awareness committee. (1.15)

2.09 Staff suicide awareness training should be expedited. (1.18)

2.10 Staff awareness training should be started. (1.20)

2.11 Staff training should take account of the change in prisoner population and, in particular, the manipulative and sophisticated approaches that life sentence prisoners may have. (1.22)

Incentives and earned privileges scheme

2.12 Entries in prisoners' wing records should be improved. (1.27)

2.13 The IEP scheme should provide real incentives for prisoners to progress, and should challenge poor behaviour. (1.29)

Good order

2.14 The monitoring of control and restraint techniques should be improved. (1.31)

Segregation unit

2.15 Access to daylight and fresh air for prisoners in the segregation unit should be improved. (1.33)

Residential units

2.16 The screening arrangements for in-cell toilets should be improved. (1.34)

Race relations

2.17 A policy for meeting the specific needs of foreign nationals should be developed and implemented.

Activities

2.18 Full use should be made of the employment activities offered. (1.83)

2.19 Work parties should be filled to their maximum capacity, limiting the number of prisoners locked in their cells during the day. (1.84)

- 2.20 The provision of certificated training should be expanded. (1.89)
- 2.21 The gate leading to the library should be locked-back to increase access to the facility. (1.90)
- 2.22 The introduction of evening and weekend classes should be considered. (1.94)
- 2.23 There should be greater provision to enable prisoners to progress to higher levels of educational achievement. (1.96)
- 2.24 There should be a review of the number of courses offered above level 2 to ensure that the qualifications available in the establishment are not set too low. (1.102)
- 2.25 The development of the careers information and guidance centre should be carried through speedily. (1.103)
- 2.26 The exercise yard should be resurfaced. (1.106)
- 2.27 Funding should be provided for an extra physical education instructor (PEI). (1.109)
- 2.28 Sports and games staff should be deployed to ensure that the full PE programme is provided for prisoners. (1.110)
- 2.29 Ventilation should be installed in the new running room. (1.114)
- 2.30 The PE department should be fully integrated into the establishment's anti-bullying policy; the role of the PE representative on the anti-bullying committee should be clarified. (1.115)
- 2.31 There should be a system to inform prisoners of potential lock downs during evening association. (1.117)

Visits

2.32 Posters and other relevant information should be displayed on the walls of the visits room. (1.119)

2.33 The seating arrangements in the visits room should be improved. (1.122)

2.34 The system for identifying prisoners potentially posing a risk to child visitors should be improved. (1.130)

Life sentence prisoners

2.35 The senior management team should receive a report on the progress on the annual review action plan, and ensure it is complied with. (1.154)

2.36 The seconded probation officer and personal officer should attend annual review boards, and provide written contributions. (1.155)

2.37 There should be a specific induction for prisoners on how the life sentence prisoner system works at Shepton Mallet. (1.156)

