REPORT ON

A FULL ANNOUNCED
INSPECTION OF

HM YOUNG OFFENDER
INSTITUTION
LANCASTER FARMS
8 – 12 MAY 2000

BY

HM CHIEF INSPECTOR OF PRISONS
For some years now, HMYOI LANCASTER FARMS has been regarded as a centre of excellence within the Prison Service because of the high standards of the treatment of and conditions for young offenders that it provides under its motto ‘Prevent the Next Victim’. Recently it has been required to undergo a change in its population, following the introduction of the Youth Justice Board (YJB), which contracts custodial arrangements for those between the ages of 15 and 18 from the Prison Service. I am pleased to report that the high quality of treatment of young prisoners continues. Furthermore staff need to be encouraged to continue to aspire to the excellence for which Lancaster Farms is well known.

The YJB requires that all Prison Service establishments holding juveniles are inspected every three years and receive an educational inspection every year. I welcome this because it ensures that the treatment of and conditions for this particularly impressionable and vulnerable group of offenders are kept under constant review, enables good practice to be spread and informs those responsible for the allocation of the necessary resources of possible areas for improvement.

I mention resources at the start because it was disturbing to find that sufficient had not been provided, either in content or in time, to enable LANCASTER FARMS to cope either with the increased numbers that it is required to hold, or to prepare to provide the particular requirements of juveniles. It had been known for some time that the YJB would assume responsibility on 1 April 2000, but it was not until March 1999 that the Governor learned that he was to receive 120, including some serving long sentences under Section 53 (2) of the Children and Young Persons Act 1933, some sentenced under the new Detention and Training Orders (DTOs), some sentenced under former youth custody provisions and some on remand. These disparate groups present staff with a variety of different needs, and, in theory at least, should be kept separate from one another. Those under Section 53 (2) have been convicted of an offence punishable in the case of an adult to 14 years or more imprisonment. But, in
the case of LANCASTER FARMS, all have had to be put together in one wing, with the results that are described in detail in Chapter 10 of the report.

But whatever their age, it is important that sufficient activities are available to occupy young prisoners in a full, purposeful and active day. This means a combination of education – in its widest sense – work and physical exercise. Unfortunately LANCASTER FARMS was not resourced with any additional workshops when its population was increased, and so now lacks sufficient workplaces for the needs of its population. These should have been provided when the numbers of young offenders went up, irrespective of the needs of the additional juveniles. Additional educational resources have been made available for the juveniles, but not – proportionally – for those over the age of 18. As far as Physical Education is concerned, I have to admit that I have serious reservations about the relevance of what are described as ‘traditional’ weight training arrangements for this age group. ‘Traditional’ refers to arrangements made in adult prisons for adult prisoners. Adolescents need access to fresh air and the opportunity to exercise in it. That is not to say that some weight training may not have a part to play in aiding physical development, but it is only a part, and I believe that there should be far more emphasis on outside activities.

In order to gain an early indication of the outcomes of the change of direction in establishments holding juveniles, I decided to inspect three of the five that we are required to inspect in the year 2000/2001 early on, Brinsford, Castington and LANCASTER FARMS. In addition to commenting on issues particularly affecting the establishment being reported on, I have included a number of issues for the YJB in the preface to each, suggesting that the three reports should be read together.

There are some issues on which LANCASTER FARMS provides the best evidence. For example I am extremely concerned about the impact that late delivery of juveniles to establishments has on essential first night procedures, designed to ensure the safety of the juvenile concerned. I have long suspected that too many juveniles are spending nights in police cells because they cannot be got to suitable accommodation in YOIs in time, for a variety of reasons, including the known and reported fact that escort drivers are also being used as court officers, meaning that they cannot begin to deliver
prisoners until the court has finished sitting for the day. I believe this to be wrong, and something that needs to be examined by those responsible for drawing up, awarding and monitoring escort contracts.

But this is compounded by initial difficulties over the allocation of juveniles to establishments, for which purpose the YJB set up its own placement unit. I must ask all concerned to read paragraphs 9-11 and 19 of Chapter 10 of the report, which detail what happened to two 15-year-old boys remanded to LANCASTER FARMS. This is precisely the situation that the new arrangements were designed to prevent, which it is not doing.

The reported incident also draws attention to the large distances between establishments and courts, and what this means in terms of time. For example boys from Swansea and Aberystwyth in Wales have to travel to Ashfield near Bristol and boys from Lowestoft and Great Yarmouth to Onley near Rugby. I must recommend that a re-examination of court areas be made to ensure that establishments are not responsible for too great a geographical area.

I have mentioned the subject of documentation in the report on Brinsford, but must comment here on the YJB requirement that a case conference for every DTO should be held within five days of an order being made. The Prison Service suggested ten days, to allow the necessary assessments to be made and to give time to assemble both the Youth Offender Team (YOT) concerned and the family of the offender. In practice I believe that the Prison Service is right, as the figures prove. For example, at Hollesley Bay, where the ten-day principle was being applied, 76% of conferences were attended by the YOT concerned and 55% by a family representative. These are encouraging figures, and better than we found at LANCASTER FARMS, where there seemed to be general ignorance of the YJB stipulation.

I mention this because I am concerned at the problems YOT workers are having not only in meeting the time-scales for such conferences, but the distances they are having to travel and their constrained travel budgets, which prevent them from visiting all establishments in which their charges are held three times in a sentence. I have
argued before for the introduction of video-conferencing, so successfully piloted between courts and prisons in Bristol and Manchester. I believe that their standard installation, in custodial establishments and probation or other selected offices, would save both time and money, and enable conferencing to be more timely and more complete. I have commented in the Brinsford report on the benefits of the introduction of YOTs, and I am not recommending that all conferences should be video conducted. The value of inter-Agency personal relationships is too great for it to be put at risk. But better to conduct them by video link than on paper or on the telephone. The number of YOTs based some distance from LANCASTER FARMS emphasises the need for such consideration.

The short notice given to LANCASTER FARMS had an impact on the amount of essential training that could be given to staff, to prepare them to look after children, there being time only to complete one of the YJB modules. With only limited training time available it is essential that there should be concentration on the role and responsibilities of staff in dealing with children, and the basic understanding of their needs and characteristics. It is useful to understand the workings of the YJB, but I submit that that must come second when time is short.

LANCASTER FARMS also provided evidence of the need for particular attention to be paid to the needs of juveniles in the application of Prison Service strategies and policies which have been designed for adults. For example there is ample evidence that much juvenile crime is alcohol-abuse based, but the CARATS programme does not include alcohol. Too little attention has been paid to the needs of those serving long, determinate sentences, which may include transfer from the young offender to the adult estate. I know that this is under consideration as part of the debate about whether or not all those under the age of 18 should be regarded as young adults. But there is a paucity of offending behaviour programmes suitable for adolescents.

This may seem like a litany of negatives, which the report is not. The results of this inspection emphasise that outcomes for young prisoners at LANCASTER FARMS are well above the standard of those in many other YOIs, and that there has been consolidation of the ethos put in place by the first Governor. Successful operations
depend not on the inspiration of one individual, but on continuous good work by all concerned. This is happening at LANCASTER FARMS, which is why staff should be supported and resourced to enable them to carry out their important task. But I hope that the point will be taken that not only should lessons be learned from the early experience of the admirable YJB initiative for juveniles, but that the needs of the greater number of young prisoners over the age of 18 should not be ignored. There is a ‘them and us’ situation now, which must not only be arrested, but also eliminated.

Sir David Ramsbotham
HM Chief Inspector of Prisons

September 2000
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EXECUTIVE SUMMARY

Lancaster Farms was last inspected in 1995 when it was within its first two years of operation. It was described at the time as being "well on the way to achieving its aim to be a model establishment for adolescents". Its statement of purpose, and a very powerful one at that, was "our aim is to prevent the next victim". Strong leadership from the Governor and senior staff had given staff confidence in their ability and allowed them to develop initiatives.

This inspection revealed that Lancaster Farms remained an establishment of high quality whilst developing into a much more complex organisation.

The culture instilled in staff at the opening in 1992 had been sustained. The establishment had promoted very high standards and any reductions in these standards since 1992 had largely been brought about by cuts in resources. Outcomes for young prisoners were still well above the standard we see in most other young offender establishments. However, we were concerned to find that the Prison Service had failed to provide sufficient additional ancillary resources when it increased the units of living accommodation.

The initial drive and enterprise of the early years, whilst excellent, relied heavily on individual personalities, their enthusiasm and leadership. Understandably, an organisation cannot sustain that approach when individuals move on and frameworks, systems and formalisation of practices must be introduced. The introduction phase of this formalisation is usually not as inspiring or exciting for staff as the actual initiatives themselves, but is nonetheless necessary. This was the situation which Lancaster Farms management was working through at the time of our inspection and some staff were feeling rather dejected about it, comparing their work unfavourably....
with that which they had achieved previously. It should also be remembered that a significant number of staff had arrived since the early years and only recognised the establishment for what it was now.

This is important because much good work was being carried out as is evident from this report. Staff needed to be reminded of their efforts and achievements by clear and visible management at senior level.

A new challenge lies ahead in the juvenile work required by the Youth Justice Board and staff were keen to demonstrate their willingness to accept this new work. What must be resisted at all costs is the temptation to use the bulk of available resources to bolster the juvenile regime at the expense of the 18-21 years old population whose regime must not suffer any further.

We have based our assessments on the four tests of a healthy prison described in Chapter 7 of the Thematic Review "Suicide is Everyone's Business" published by HM Chief Inspector of Prisons in 1999.

**Test 1 – All young prisoners should be safe**

- Lancaster Farms had a very good anti-bullying programme, which was well established in the culture of staff and of the young people.

- From the results of our questionnaire to young prisoners, 78% of young adults and 80% of juveniles said that they never or rarely felt unsafe. Interestingly, the part of the establishment identified by both groups in which they felt least safe was the Gymnasium. This was almost certainly to do with the showering arrangements which need careful attention.

- Although most young people told us that they felt safe the number of fights was too high. 40% of adjudications in March 2000 were for fighting and we wondered how young people felt safe in an environment in which fighting was so prevalent.
• Applications from youngsters for protection from others were very low and we were very pleased to note that identified bullies were segregated and dealt with rather than the victims.

• Staff were concerned about recent changes in the administration of the Incentives and Earned Privileges scheme which resulted in anomalies and a reduction in the speed of dealing with good or bad behaviour. We were also concerned about apparent "unofficial" punishments being given by some staff, such as loss of association, without due process.

• Overall, the level of supervision and relationships between staff and youngsters led us to conclude that Lancaster Farms did provide a reasonably safe environment.

Test 2 - Young prisoners are treated with respect as individuals

• We noted a high degree of cleanliness and a pleasant environment free from graffiti, damage and vandalism.

• Regrettably, some cells had been doubled to increase the capacity; in these cells there was a lack of decency and respect as there was no privacy screening around the toilet and insufficient furniture for two young people.

• Food was generally of a high standard and served at appropriate times during the day. The exception to this was in reception where food was often of poor quality because it had been left too long in the hotplate.

• As in some other young offender institutions, we identified that in certain conditions access to fresh air could be very limited or even non-existent for some. Those who were unemployed and chose not to go to the Gymnasium, for example, could spend all their time indoors, which was both undesirable and unhealthy.
• Periods of association were more frequent than in some other young offender institutions but had reduced since the establishment first opened; for example, there was no longer association on weekend evenings.

• In an establishment with such a positive reputation for dealing with young people, we expected greater use of first names and more easily visible name badges for staff.

Test 3 - Young prisoners are fully and purposefully occupied and are expected to improve themselves

• Education provision and programmes presented a good picture.

• The range of employment was impressive but there were insufficient places.

• The Physical Education department offered an excellent programme in good facilities.

• Sentence planning was very good.

• Offending behaviour programmes were available and of a good standard.

• There was good integration between those staff involved in Throughcare.

• The Chaplaincy team was extremely positive both in its approach towards young prisoners and in the level of inter-denominational co-operation.

Test 4 - Young prisoners can strengthen links with their families and prepare themselves for release

• We were disappointed to find comparatively little use of resettlement licence.

• Pre-release work was being undertaken and included housing issues.
• Facilities for visitors were very good and included an impressive Visitors Centre. Less impressive were the long waiting times which had to be endured by visitors before they were able to start their visits.

• Opportunities for youngsters to maintain contact with families and friends by letter were good but access to telephones could be improved.

Conclusion
This report on Lancaster Farms is good but also identifies scope for further progress. It reflects favourably on the positive culture of staff and their “can do” attitude in carrying out their duties in caring for young people in custody.
CHAPTER ONE

INTRODUCTION

History
1.01 The Prison Service had owned three large farms on the fells just outside Lancaster for a number of years. One of them provided not only land for the new establishment but also its name. The farmland selected lies in a hollow, is somewhat marshy and not very suitable for agriculture. The development was planned, designed and completed in 1992. Later it was decided to add a fourth residential block to be built on the newly laid artificial turf sports area. This block is now the new juvenile unit which is used to house youngsters as required by the Youth Justice Board.

The Population
1.02 At the time of this full, announced inspection of HMYOI/RC Lancaster Farms, the total young prisoner population was 440. This comprised 228 sentenced young adult offenders (aged between 18 and 21 years), 114 remanded young prisoners, 60 sentenced and 38 unsentenced juveniles (aged between 15 and 17 years). According to the information provided, the greatest percentage (27%) of the convicted population had been awarded sentences of between two and four years. Of those, 86% were young adult offenders and 14% were juveniles. The greatest proportion of juveniles had sentences of less than six months whilst the greatest proportion of young offenders had sentences of between two and four years, reflecting the pattern described for the total convicted and sentenced population. Violence against the person was the most common offence for the population as a whole, followed closely by burglary. Whilst the vast majority of the population was white (91%), 5% were black and 4% were of an Asian ethnic origin.
What We Were Told

1.03 During our inspections we listen to the views of many prisoners, staff and representatives from staff associations, individually and in groups. We believe this to be important and record what was said because they reflect the feelings of people living and working in the establishment. Where appropriate, we record our own findings alongside these comments, particularly those made by prisoners. However it should not be assumed that where there are no such bracketed findings, views expressed by prisoners, staff and staff associations in the following paragraphs necessarily accord with our own judgements; these are to be found in the main body of the report.

Young Prisoners

1.04 We spoke to two groups of young prisoners who told us the following:

- staff treated them fairly in the main
- staff called them by their surnames though young prisoners would have preferred staff to use their first names
- the food was good although the portions were small. The food was better for those who got to the servery first as they had more choice. The food was very predictable from week to week. On occasion, staff would ask servery workers to put meals under the servery for them. No servery workers had received health & hygiene training whilst at Lancaster Farms
- the mailbox wasn’t emptied every day. Mail was sometimes up to seven days late arriving [this was disputed by staff]
- everyone learnt how the establishment worked from other young prisoners
- this was a safe place with a good Anti-Bullying scheme
- the Probation Department were very responsive to requests from young prisoners
- the Gym was good
- all cell windows had restrictors on them so no air could get in
- young prisoners were sometimes able to eat in association
- everything had to be ordered from the catalogue although trainers could be brought in through visits
- when postal orders were sent in, private cash was always calculated wrongly
- on the Induction unit, young prisoners were not allowed to be put in a double cell with another young prisoner [staff told us that youngsters would be doubled when necessary i.e. when thought at risk of self harm, suicide etc]
- nurses provided a poor service to young prisoners, they had a poor attitude and they didn’t seem to care
- there was not a very good service from the Dentist
- staff often forgot to enter young prisoners wages on the computer which meant they were unable to buy from the canteen
- young prisoners didn’t routinely get any time in the open air
- there were two distinct sides to each unit, the convicted side always having the better regime
- during Induction, young prisoners would receive alternate nights association which meant too much time in cell
- the Induction varied in length depending on whether there were spaces available on other units
- there were different rules on different units and all had a different regime
- it depended on whether you got on with the staff as to whether you got to go to the Gym
- cell inspections were carried out every week, toiletries were confiscated if you had more than two of each
- searching carried out in Reception involved squatting as did searching during cell searches
- the food served in Reception was the worst in the establishment and was not the same as was distributed on the other units [we found that the food was the same but had been left to dry out in the hotplate, so was of considerably poorer quality]
- young prisoners were unable to make a telephone call in Reception
- the reception packs were distributed the day after reception rather than on arrival
- blankets distributed on the units were dirty
- quilts could be purchased but had to be bought from earnings
- if a young prisoner arrived on a Thursday he had to wait two weeks before he could get any canteen
- the staff on the Induction unit were the strictest, to prepare young prisoners for the rest of the place
- there was electricity in all cells but it was only supplied to young prisoners on Gold level of the IEP scheme which meant all the others had to spend a lot of money on batteries
- this was a good jail to be in; if anyone was being bullied, staff would see it and deal with it
- the restriction of money that could be spent caused a lot of friction
- there was a Personal Officer scheme but it was not run on Coniston (Induction unit)
- there had been many young adult prisoners shipped out to make room for the juveniles
- sentence planning was infrequent and young prisoners were not encouraged to participate
- shop prices were expensive and there was little selection compared with other jails
- the Governor tested the food at the weekend but it was not the same as that served on the wings
- there were no pests in the prison
- showers were only available during association or after using the Gym, but not everyone went to the Gym every day. In addition, only one person was allowed in the wing showers at a time (it used to be five) due to fights, but it was difficult for 60 young prisoners to shower in the space of two hours
- up to 40 young prisoners had to have a shower (of 15 cubicles) in five minutes in the Gym
- the water was not always hot in the showers
- there was kit change once a week and there was a launderette on each unit
- the tracksuits given out in Reception were smelly
- lots of the clothes had rips in them
- there were no problems getting Request and Complaint forms if needed
- the hairdresser only attended every eight weeks
- Education was good, but if people wanted to just sit in their pad all day there was little encouragement for them not to do so
• the boiler suits that had to be worn during visits were dirty
• strip searches carried out after visits could be seen by other young prisoners leaving the visits area
• an application had to be made to attend the religious services, Muslim services were held on Tuesdays
• the Listener scheme was good
• racism was not a problem
• there were two telephones on the sentenced units but only one on the others and young prisoners were only allowed three minutes per call
• anyone could be sacked from their job without knowing why.

**Juveniles**

1.05 We saw a group of eight juveniles who told us the following:

• all knew the identity of their Personal Officers, they were their first point of reference, and staff were well thought of
• there was lots of ‘bang up’, it was not yet a very stimulating environment in the evenings except for Gym provision and Education one evening a week
• only ten young people were allowed access to a telephone each evening
• they felt safe, the Anti-Bullying scheme permeated everything, juveniles would have no problems speaking to the Officers first about bullying and they knew the staff would act on this
• the Anti-Bullying part of the Induction programme was the most memorable.

1.06 More comments from juveniles are given in Chapter Ten.
Staff

1.07 We saw a group of ten multi-disciplinary staff who told us the following:

- the works staff were concerned about the ongoing works review and the uncertainty surrounding their future, but they had a good works department and worked well as a team.
- administrative staff were concerned about the extra work load and resulting stress caused by staff on long term sick. There was uncertainty as to their future in relation to Quantum.
- the introduction of the juvenile unit had been rushed with few systems in place when it opened. The Prison Service had expected a lot to be done in a very short period of time.
- education successes were common in the establishment.
- the YMCA had a full-time funded worker, but the funding was due to run out in June 2000. A further funding decision would not be made until September 2000 which meant the YMCA would lose staff only to take them on again if they won the funding.
- overall, staff did not feel that the introduction of the new criteria for juveniles would detract from the provision of services to the rest of the population, although initially staff were having to devote time to implementing the new procedures for juveniles.
- there was a lack of staff in Reception early in the morning for the work required.
- there were concerns over rumours that Buttermere (the juvenile unit) would be providing association on Saturday and Sunday nights when no other units would be offering the same (this was in response to Youth Justice Board requirements). This also had implications for the availability of a response team in the event of an incident.
- assaults had increased since the juveniles had arrived on the unit.
- staff had not had sufficient training to work with juveniles; there had been only one module of the TSA training completed so far.
- magistrates who had not previously used imprisonment now appeared to be awarding Detention and Training Orders.
- the reception of two to three new juveniles a day was causing unrest on the unit
- the staff shift system, which was introduced five months before, employed too many A shifts (long shifts)
- there was concern that many parts of the establishment would start to wear out at once it now being eight years since the commissioning of the establishment, but the money allocated to cover these repairs was reducing
- some of the equipment in the Kitchen was in need of replacement
- a pre-select menu was being introduced in the juvenile unit before any of the others
- there were very few Requests and Complaints about food
- there was a high staff turnover in catering as staff were not being paid enough or they didn’t like working in a prison environment
- staff facilities were acceptable, though there were some issues over space
- there were good relationships between different disciplines
- the IEP scheme shared a clerk with the CARATS team, but the clerk had no spare time to devote to CARATS
- a smoking policy had been established, but was not policed sufficiently. Staff were therefore still smoking in the establishment which raised a particular issue for prisoners under 16 years
- there was no occupational health hour
- there was good rapport between staff and prisoners
- not all prisoners were in employment, but the majority were.

**Middle Managers**

1.08 We met a large group of middle managers who told us that:

- there was a lack of visible leadership among senior managers, particularly on the residential units
- Lancaster Farms was a good place to work but senior managers did not talk enough to middle managers. They had been consulted over profiling work but ignored. They told senior managers that the recently imposed Senior Officer shift pattern would not work but, again, felt ignored
• there was no consistency in the use of Senior Officers who could sometimes be expected to do three jobs in one day
• staff morale was low. They used to feel valued but now felt "like another number". Ground had been lost since the opening of the establishment. There was less association for young prisoners
• no extra facilities had been given to take account of increased numbers and different types of young prisoners
• the Incentives and Earned Privileges scheme had changed for the worse because it involved more paper work and resulted in rewards or punishments two weeks after the event. This was too long for young people
• staff in the Education Department felt supported by others and enjoyed good relationships with all departments
• staff in the Probation Department were impressed with the multi-disciplinary strength and commitment of staff
• discipline staff were always made available for group work to be carried out with young prisoners
• they thought that young prisoners would say that there were too many petty rules but that the environment was safe and that it was normal to approach staff if they had problems
• the Anti-Bullying Strategy and culture developed during the opening period had been maintained and was very strong. The Induction programme was used to inculcate the ethos into new receptions.
Governor

1.09 We met the Governor who told us that:

- there was now a much more coherent management team after long periods of absences and movement. The team had a good range of skills. When systems were in place and industrial relations problems resolved they could move forward.
- the establishment could not constantly be operating as if it was still a new place. It had begun to mature, developing from being a newly opened establishment to a place of permanency.
- managers had to develop systems to manage initiatives. There was a need for large organisations to establish consistency as individuals moved on. As a result there had been a difficult period of transition with much change management.
- Lancaster Farms had been described as "innovative" by several people and was still regarded very highly.
- the juvenile project had been a success but staff only saw the problems. They were always seeking further success.
- although the population had increased by over 160 in recent years there had been no additional funding until the decisions on juvenile regimes were taken last year.
- there were not enough activity places since the increase in population.
- Lancaster Farms had been built as a Category C training prison but had become a YOI. It was now a far more complex establishment taking young adult offenders, young remands, juveniles and juvenile remands.
- the population rise from 380 to 540 may have been the point at which the establishment moved from being a "village" to a "city".
- there were bids in for projects to enhance drugs work and personal development.
- the juvenile project provided aspirational goals which may be transplanted into the rest of the establishment in due course.
Board of Visitors

1.10 We met three members of the Board of Visitors who told us that:

- the Board was concerned about the implications of the juvenile population change. There had been a degree of "ad-hoccing along" as it had been difficult to de-cant from one wing to another and buildings were not ready. It had not been the best of starts. There had been slow initial progress and disappointments; for example, when a promised Gym did not materialise
- there was a vibrant eagerness amongst staff who wanted to be at Lancaster Farms. This was replicated in Buttermere (the juvenile unit)
- Buttermere unit spelt the future for the establishment
- the provision of up to 30 workplaces on the newly acquired farms would be helpful
- staffing levels were too tight for comfort and problems were caused if there was sickness or if a bed watch had to be provided. Activities were often closed when this happened
- there were not enough workplaces. The establishment had been built and resourced for 360 but the population was now nearly 500. Work was mainly course-based. A production workshop would be advantageous particularly for shorter-term offenders and those on remand
- the Library was inadequate in size. It had not been enlarged to take account of the increased population
- the Health Care staff deserved to be commended for the way they dealt with difficult young people
- Race Relations were good
- the anti-bullying ethos was still very strong
- the Visitors Centre was good and the way staff received visitors was exemplary
- Lancaster Farms was still a good place, looking after young people with humanity. The motto adopted at the outset - "Prevent the next victim" - was still the honest aim.
CHAPTER TWO

ADMISSION ARRANGEMENTS

Reception

2.01 The Reception area at Lancaster Farms was designed to allow receptions in through one way and discharges out another. However, there was no way of keeping the clean and dirty areas completely separate. The area comprised three holding rooms that were used to hold newly received young prisoners and two secure cells. There was also a counter where the details of the young prisoners were checked, a property room, and a room holding young prisoners’ kit, two larger holding rooms one on each side of the reception counter i.e. one ‘clean’ and one ‘dirty’ and a number of showers. The area also had a medical room in which a nurse saw each new reception. A staff room was just off the main Reception area. Generally, Reception was clean, except for the floors and some of the furniture, which were in need of deep cleaning. All the holding rooms were very basically furnished; the two larger ones had televisions and hard benches, but little else. **The holding rooms should be made more welcoming by introducing more comfortable furnishing, the provision of reading materials and better décor including posters etc.**

2.02 We were surprised to see two large posters of semi-clad women on display in the kit store and fully visible to all staff and young prisoners coming into Reception. **It was not appropriate to have pictures of semi clad women displayed in an area in which young prisoners are received into the establishment; they should be removed.**

2.03 Young prisoners were greeted by name in a courteous manner. However, as we observed in the whole of the establishment, young prisoners were referred to by surname only. **Young prisoners should be referred to by their full name or using the prefix mister or by the name preferred by the young prisoner involved.**
2.04 Once young prisoners were received, their details were properly checked. The young prisoners we observed arrived with adequate documentation. Those arriving with F2052SHs (the form used to identify young prisoners at risk of self harm or suicide) were quickly identified and dealt with accordingly. The young prisoner’s escort record (the PER) was checked by Reception staff. Unfortunately Schedule One offenders did not seem to be readily identified or, if identified, this information was not passed on to the wing on which the prisoner was located. (Schedule One offenders are those convicted of offences against children).

2.05 We were concerned to find that a number of juveniles (trainees) were arriving, having been sentenced to Detention Training Orders (DTO), but without the necessary Youth Justice Board booking number required in advance of any reception of a juvenile on a DTO. We were also concerned that on many occasions trainees were arriving having spent an excessive amount of time en route from the court, in which they had been sentenced, to the establishment. We have commented on this problem in previous reports. Young prisoners and juveniles were being sentenced perhaps in the morning but then were spending the whole day either in court cells, or travelling around on cellular vehicles from court to court picking up other young prisoners from other courts and for other establishments. On many occasions those youngsters who had been sentenced perhaps at 11am were not arriving at the establishment until just before 7pm. Staff explained to us how it was common for a van containing several young prisoners to arrive just before their reception cut-off time of 7pm; indeed on the night that we inspected the reception procedures, six young prisoners/trainees were received at approximately 6.40pm.

2.06 During the six months prior to the inspection there had been 34 occasions when escort contractors arrived with several youngsters after the cut-off time, the latest of these being at 7.46pm. Most of the late arrivals in the weeks just prior to the inspection were from the Merseyside area (Liverpool Crown, Magistrates and Youth Courts, Birkenhead, Runcorn, Wirral etc.). In previous months there had been a number of late arrivals from the Preston/Blackburn areas.
2.07 The knock-on effects of such late receptions were clear. Youngsters were very tired, and some as young as 15 were having their first reception into the establishment delayed by many hours. They were unable to contact their families (according to the questionnaire only 33% of juveniles and 42% of YPs were given the opportunity to make a phone call on their first day – see Appendix IV), settle down into the wing that they were to be located in, or be adequately risk assessed on their arrival. The late arrival of youngsters into the establishment must be reduced and kept to an absolute minimum. Young people were being seriously put at risk by the escort contractor’s inability to provide separate transport for young prisoners and deliver them without delay to the establishment. We urge that the CCG section of the Prison Service resolve this problem with escort contractors urgently.

2.08 During the inspection, nine new receptions arrived from Liverpool courts one evening. Four of these new receptions had received Detention and Training Orders; the escort arrived at 6.58pm. Only one of the four DTOs had been booked in through the Youth Justice Board booking agency and one of these had arrived in the establishment without any documentation whatsoever. We urge that the proper application of the Youth Justice Board DTO procedures should be adopted.

2.09 Strip searches were carried out in private behind a small, screened area. Whilst we did not observe the strip-searching in Reception, we were told that all strip searches included asking the prisoner to squat. Such a provision is possible under Prison Rules. Prisoners should not be required to squat for routine searches; only when there is reason to suspect in an individual case that contraband is being smuggled in.

2.10 Young prisoners were interviewed in front of the main reception counter, which was not a particularly private place. It was thus not conducive to allowing youngsters to easily express their concerns. Approximately 40% of the YPs and trainees felt they had immediate problems which needed dealing with on arrival (see Appendix IV). Usually, the time young prisoners spent in Reception was kept to a minimum and they were quickly located onto Coniston unit for those youngsters of 18
years and over and Buttermere wing for the younger age group. According to the questionnaire only 9% spent more than an hour in reception (see Appendix IV).

2.11 The holding cells in reception could be used for holding any young prisoner asking for protection or anyone proving to be a disciplinary problem. These cells were extremely small and contained no furniture. We did not view any new receptions asking for protection, but we were told that these cells would be provided with a chair if they were used for someone requiring protection. We were pleased to note, however, that very few youngsters needed to be placed in these cells and that staff were successful in most cases in avoiding youngsters having to be segregated for their own protection. We also did not observe any suicidal or self-harming young prisoners being received into Reception but were told that such young prisoners would be located in the hospital wing when necessary. This was clearly not the only course of action possible, however, and some of these young prisoners were risk assessed to be suitable for location on the main wings.

2.12 Little information was given to young prisoners in Reception but more information was given once they arrived on their residential unit. (This is discussed under ‘First Night’ arrangements below).

2.13 Young prisoners were allowed to take showers in Reception in some cases, but often they had to wait until being located onto their unit. Late receptions however did not have time to have showers either in Reception or on their new unit.

2.14 From our observations we concluded that young prisoners were effectively supervised during their time in Reception and the large number of holding rooms did allow for adequate separation of different types of young prisoners. There appeared to be little distinction between young prisoners arriving in the establishment for the first time and those returning in terms of the information being provided by staff. However, the process was considerably faster for the latter group. According to the questionnaire 72% were asked by staff whether it was their first time in prison (see Appendix IV)
2.15 Youngsters’ external needs, for example contact with families, dependant relatives etc. were more likely to be given proper attention once they arrived on their residential unit, and telephone calls were made to their next of kin by staff on the residential units once they had arrived there.

2.16 We were surprised to note that young prisoners were not given advances of phone cards or tobacco etc. whilst in Reception. These advances were given on the day after reception. Thus they were unable to make their own telephone calls to family etc. until at least the day after their reception. Furthermore, smokers were unable to smoke until the day after their reception unless they could borrow tobacco from another resident. Such a practice could leave young prisoners open to bullying by perhaps forcing them into debt on their first night. **Advances of phone cards and tobacco should be made available in Reception.**

2.17 Young prisoners’ property was properly recorded and held in a secure storage area. Proper access to property not held in possession was available eg we saw young prisoners being allowed to take their discharge clothing onto their residential wing, a few days before being discharged, so that they could prepare their clothing for their release or their court appearance. This was ideal as it allowed young prisoners to ensure their clothing was clean and ironed before release.

2.18 **Young prisoners were issued with a pack of toiletries with items such as toothbrush, toothpaste, deodorant, comb, razor etc. These were all pre-bagged and provided an excellent starter kit for the young people coming into Lancaster Farms.**

2.19 Two members of staff from Buttermere interviewed all juveniles being received into the establishment and then took them to the wing themselves.

2.20 Food for new receptions was delivered from the main prison Kitchen and was fine if eaten shortly after delivery. However, we saw examples of plated up food kept in the hotplate for several hours and this had the effect of drying out and considerably reducing the standard of the food given. **We recommend the establishment consider the use of the pre-packed airline meals seen in other establishment.**
Receptions. The advantage of such microwavable meals is that these can be heated up individually as receptions arrive.

2.21 Young people were given a cup of tea whilst waiting in Reception. Unfortunately this provision of a cup of tea in Reception had meant that young prisoners were not given a tea pack once they arrived on their Induction unit. If they were early enough to join in with association, they were unable to make themselves a drink before retiring to their cells. **Young prisoners should be issued with tea packs once they are received on their initial unit.**

2.22 Overall, according to the prisoner questionnaire, 35% of prisoners felt they were treated well, 52% neither well nor badly and 13% badly (see Appendix IV).

First night
2.23 New receptions were located on Coniston unit if they were 18 or over, and Buttermere unit if juveniles (15 to 18 years old).

2.24 Telephone calls were made for young prisoners to contact their next of kin once they arrived on these units. However, **new receptions should be issued with advances of phone cards and allowed to make essential contacts with family and friends before being locked up for their first night.** Staff on the wing usually dealt with enquiries from young prisoners’ families and friends.

2.25 Youngsters were given an initial leaflet entitled “Lancaster Farms What You Need To Know”. This gave basic information about the timetable of the Induction wing, visits, smoking, use of the prison shop, phone, money, applications, letters, Board of Visitors, and an initial interview form for them to complete and bring with them to their first Induction session. Also staff verbally gave information to young prisoners as they were received on the wings. 29% of the prisoners in the survey felt they were not given any information about the first night / first day in prison. 60% felt confident on their first night / first day but 40% did not (see Appendix IV).
2.26 Both Induction units had double cells, which could be used if young prisoners were risk assessed as needing this. We were satisfied that they were only used when absolutely necessary. There were young prisoner Listeners located on both sides of Coniston unit; certainly therefore young prisoners from eighteen upwards were able to be located with Listeners overnight during their first night, if necessary.

2.27 Juveniles were interviewed in Reception by Buttermere staff and taken over to the unit by the staff. New young prisoners over the age of eighteen were taken to Coniston 1 unit and were all interviewed. Staff filled out an Induction unit profile form on each and young prisoners’ next of kin were telephoned to let them know that they had arrived. These interviews were individually carried out on a one-to-one basis. All young prisoners were issued with tracksuits in order to cut down on the bullying for items of clothing. Young prisoners were asked to sign their compact. These compacts were explained to each young prisoner but they were not issued with a copy. Each new reception was issued with a letter and a pen to write it with.

2.28 Young prisoners were issued with an information leaflet but late arrivals did not have time to visit the unit Library facility. Consequently if they arrived without reading materials, they had little to occupy themselves during the first night. Reading materials and/or radios should be provided on the first night.

2.29 New receptions were not identified to night staff in a consistent manner as we found during our night visit. Night staff on both Coniston and Buttermere units, were unable to identify their new receptions. New receptions should be made known to night staff and their particular needs communicated between staff.

2.30 The one-to-one interview during reception gave individuals a chance to obtain help with any initial personal problems. Any young prisoner identified as vulnerable to bullying etc. could receive special help to cope with imprisonment at this stage. We particularly liked the arrangement by which staff from Buttermere unit interviewed juveniles in Reception and located them on the wing; this was an example of good practice.
Induction

2.31 The juvenile unit, Buttermere, had only recently been opened. (The Induction programme arrangements for this unit will be discussed in the section about juveniles). Young men over 18 were placed on Coniston 1 for an initial Induction programme and then moved onto Coniston 2 for a more in-depth series of Induction sessions.

2.32 All new receptions were assessed by a Reception board, the day after their arrival in the establishment. This board consisted of a member of the Health Care Centre, the Chaplain, an Education Department representative, Legal Aid Officer and a wing Senior Officer or Principal Officer. This session started phase one of Induction, which lasted 72 hours. Its aim was to give young prisoners the basic rules and regulations of the establishment, discuss the activities available, the Incentives and Earned Privileges Scheme, the Anti Bullying Policy, the arrangements for Home Detention Curfew, and the making of bed packs. The first day arrangements also included a trip to the Library. There was some confusion amongst staff as to whether pool radios were available in this unit. The Principal Officer actually showed us a number of pool radios that were available but not all staff knew about them.

2.33 After the first 72 hours, young prisoners were supposed to be moved onto Coniston 2 but we saw examples of youngsters being left on Coniston 1 for much longer periods before starting the next Induction programme. According to the prisoner questionnaire analysis the length of time taken before the induction course was given ranged from one day to two months. 17% had to wait more than a week (this is both YPs and trainees - see Appendix IV). This more in-depth programme consisted of two weeks of morning and afternoon sessions covering subjects such as coping with imprisonment, Anti-Bullying, basic health care, discipline and finance, education, drug awareness, and domestic training. The domestic training session included advice on personal cleanliness, the making of bed packs and fire precautions.

2.34 The discipline and finance session was confusingly named for a new reception in that it did not deal with discipline as such, but the role of the discipline office in the Management Services department; for example, the calculation of release dates. It
also covered young prisoners’ private cash accounts and the arrangements for spending their wages. Unfortunately, we were informed, that because of staff shortages in the Management Services department, admin staff were not appearing for these sessions. Prison Officers had to deliver the information within other sessions. Information about the calculation of release dates and young prisoner’s cash accounts should be explained to them in a consistent way by appropriately trained staff.

2.35 The drug awareness session was supposed to be carried out by the CARAT worker who was able to attend some sessions but not all due to other work commitments. CARAT workers should also be made available to address youngsters on Induction. Every afternoon, inductees were taken to the Gym for physical education, which was obligatory for those on the programme.

2.36 We found sanctions being applied to young prisoners who misbehaved on the Induction unit that were outside the provision of the Incentive and Earned Privileges scheme. (This issue is discussed further in the section about Incentives and Earned Privileges).

2.37 The Induction programme helped young prisoners to receive detailed information on life in custody and covered a whole number of areas, including Anti-Bullying, applications, association, bail information, the basic rules of the prison, the Board of Visitors, coping with custody, compacts, classification and allocation, drug awareness, education, grievance procedures, health care, Incentives and Earned Privileges scheme, Legal Aid, Library, Listeners, Chaplaincy, suicide awareness, visits, letters, telephones. The education session involved the description of what courses and work was available in the establishment, plus the basic skills testing required of all new receptions.

2.38 Young prisoners were not allocated Personal Officers until they were moved from the Induction wing but there was a duty Personal Officer detailed daily on the Induction wing to carry out any Personal Officer work. According to the prisoner questionnaire 9% did not think they had a personal officer whilst 11% did not know
(see Appendix IV). We found evidence of a number of young prisoners who had been kept on Coniston unit for well over the two weeks period that their induction should have taken. Staff explained that this was because it was felt that the numbers of young prisoners should be spread across the wings of the establishment; this was unacceptable. Coniston Unit should only be used for those young prisoners on the Induction programme, and they should be moved onto their permanent unit as soon as their Induction programme is complete.

2.39 Any young prisoner not able to take part in Induction on either Coniston or Buttermere units, e.g. those having to be located directly into the Care and Separation and Health Care units were visited by Induction staff so that Induction information could be passed on to them. In some cases, youngsters were brought over from the Health Care Centre daily to take part in the programme.

2.40 Young prisoners on Induction were not always offered exercise; (this issue was an establishment-wide problem that is discussed further in the section about residential units). Information about Request and Complaints, the policy statements for Race Relations and Equal Opportunities, and other useful information was displayed on notice boards around the wing.

2.41 At the end of the Induction programme, an Induction Assessment was carried out by one of the Induction Officers. This assessment was passed on to a young prisoner’s Personal Officer, once they were located on their permanent wing.

2.42 All sentenced new receptions were seen during the first few days of Induction by the OCA staff (Observation Classification and Allocation) and ICA 2s (Initial Classification and Allocation forms) completed for all youngsters. OCA visited young adult prisoners and juveniles in their cells to complete these forms and this gave them a chance to brief youngsters about where they could be transferred to and gave them an overall view of the opportunities available in other establishments.

2.43 A number of plans for the development of Induction unit provision were in their infancy. *The wing manager, a Principal Officer, had approached the Hilden*
Charitable Fund for money to provide young prisoners on Induction with talking books in their cells. This was an excellent initiative and we very much hope it is successful. She had also initiated work done by YMCA volunteers and paid workers who came into the Induction units on Monday, Wednesday and Friday mornings. This work was part funded by the prison and supported by volunteers from the St Martin’s Teacher Training College. We discussed these YMCA sessions with Induction unit young prisoners who clearly enjoyed and benefited from the work that was being done with them in these sessions.

2.44 We saw an excellent example of a locally written booklet entitled “Information for New Arrivals”. This covered all the information given on Induction in an easily digested form. Unfortunately, not all young prisoners were issued with this booklet, which was available on request only. Whilst we were very happy with the information that was already being given to all young prisoners, we urge that this information booklet be offered to all new arrivals at Lancaster Farms. We were satisfied that staff knew the usefulness of repeating Induction information both verbally and in written form so that inductees could effectively take in the information that was given to them.

Bail Information / Legal Aid

Bail Information
2.45 A Probation Service Officer who worked 50% of her time in that role provided bail information services. We were told that there were also seven bail information trained Prison Officers but that they were never detailed to undertake bail information. This appeared to be an inexplicable waste of those skills.

2.46 All new receptions were seen by the Bail Information Officer within two days of arrival at Lancaster Farms and, thereafter, could gain access to bail information services through the application procedures. The work of the Bail Information Officer was processed through the Lancaster Probation Service’s central bail referral unit. This afforded the establishment the benefits of access to a range of provisions for young prisoners in their care requiring bail services such as:
• bail hostels
• hostels for mentally disordered offenders
• diversion schemes
• bail support schemes.

2.47 We were concerned that whilst the Bail Information Officer had access to a phone/answer machine and a fax, there was not a fully functioning Bail Information suite available. **We urge that a fully functioning Bail Information suite should be made available.** Records of contacts and work undertaken we viewed were of a good standard but would be greatly improved with the provision of a computer to download and update information and should be considered in light of the above.

2.48 The establishment had been reasonably successful in helping young prisoners acquire bail but had not undertaken any monitoring of the outcomes they had achieved e.g. ethnic monitoring. It was not clear therefore whether any particular group of young prisoners were being disadvantaged by the system. **Work relating to the monitoring of outcomes for bail applications should be undertaken as it provides a useful means of evaluating the quality and attainment of provisions.**

**Legal Aid**

2.49 Prison Officers provided legal aid services. We were told that an Officer was detailed each day for Legal Aid and that it was extremely rare for this to be cancelled. Seven Officers were said to be Legal Aid trained and this ensured that there was always a qualified Officer undertaking the work. Legal Aid Officers interviewed all new receptions and thereafter could be accessed through the wing application procedures. Approximately 50 young prisoners were seen each month.

2.50 There were no relevant posters or information on view. **Posters and information pertaining to Legal Aid services should be displayed around the establishment.** Records of contacts and work undertaken, that we saw, were of a good standard and this was reflected by the enthusiasm and perceptible commitment
of the member of staff with whom we discussed this important area of the establishment’s work.
CHAPTER THREE

RESIDENTIAL UNITS

Accommodation

3.01 Young prisoners and trainees were located in one of the residential accommodation units as follows:

<table>
<thead>
<tr>
<th>Residential Unit</th>
<th>Certified Normal Accommodation</th>
<th>Operational Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coniston (Induction)</td>
<td>120</td>
<td>130</td>
</tr>
<tr>
<td>Derwent</td>
<td>120</td>
<td>130</td>
</tr>
<tr>
<td>Windermere</td>
<td>120</td>
<td>130</td>
</tr>
<tr>
<td>Buttermere (Juveniles)</td>
<td>120</td>
<td>130</td>
</tr>
<tr>
<td>Health Care Centre</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Care and Separation Unit</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>496</strong></td>
<td><strong>536</strong></td>
</tr>
</tbody>
</table>

3.02 There were two special accommodation rooms and 12 punishment and restraint rooms on the Care and Separation Unit plus another 12 spaces in the Health Care Centre, which were not included in the CNA. The four main units were divided into two with 60 single cells on each side. The total Certified Normal Accommodation (CNA) was 496 and the Operational Capacity (Op. Cap.) was 536.

3.03 We found inaccuracies in the CNA certificate. Young people and children on remand were also detained at the establishment, and this should be indicated on the certificate with the establishment being shown as a Remand Centre and a Young Offender Institution. Although doubling of cells accounted for 30 additional spaces there were potentially 48 double cells in total i.e. 20 double cells on Coniston, 15 on Derwent and 13 on Windermere yet no double cells had been identified against any wing; the authorised 30 additional spaces should be properly identified. The Care and Separation Unit was still listed as a Segregation Unit and finally, the establishment’s previous Area Manager signed the certificate and not the Director General of the
Prison Service, as should be the case. The CNA certificate should be correct at all times.

3.04 Apart from a four bedded ward in the Health Care Centre and three purpose built double cells on both sides of Buttermere unit, residential accommodation consisted of single cells except for the 48 cells that could be used as doubles as mentioned above. Those cells had been converted into double accommodation by the provision of bunk beds. We did not approve of the doubling up of the single cells on Coniston, Derwent and Windermere since no toilet privacy screens existed in any of them, while on Coniston there was only one fixed cell table and seat and one locker available for use by two people. Double cells should only be used in emergencies or for the care of suicidal young people. When required, double cells should be properly equipped for double occupancy and toilet privacy screen curtains should be fitted.

3.05 When doubled up, no formal risk assessment was carried out to determine the suitability of young people to share cells together. If complaints were made by either occupant the morning following location together, they would be separated e.g. to keep non-smokers and smokers together, drug free people together etc. Young people should not be located together unless a formal risk assessment has been carried out to decide suitability.

3.06 Some cells were hot and stuffy. Window restraint bars were in place outside to prevent windows from opening to any degree to prevent passing of property, contraband and rubbish between cells. Some rubbish was however seen in the grounds, behind the units in particular, which spoiled an otherwise very pleasant environment. Some asthmatic young people said that they felt claustrophobic when they were locked up and that they could not get enough fresh air through the small window gaps.

3.07 Positive staff / resident relationships existed (see Appendix IV, ‘How well do you get on with staff?’); good staff observation was facilitated by the open space that existed on units and the controlled unlocking arrangements. However, we received
complaints that cell searches were over zealous and each occupant was routinely expected to squat during the strip search. **Residents should not be routinely expected to squat during cell searches.**

3.08 Residential units were uniformly clean, tidy and quite well decorated. Bed packs were made daily throughout the accommodation except where continental quilts were used by Gold regime young prisoners. New razors were issued daily at unlock if required. Prison Officers used checklists to inspect cells every day; cells were then inspected at weekends by a Governor grade. We saw no sink plugs anywhere and only a small amount of graffiti most of which was on pillows or mattresses. **Sink plugs should be provided, as should loose mattress and pillow covers for each bed to enhance cell appearance and improve hygiene for the residents.** Some young prisoners said that they only saw a Governor grade when their cells were inspected at weekends; that was “the only time they got to talk to them”. We saw the inspection checklists on display in each cell and were concerned that Prison Officers had the authority to award loss of evening association for residents who achieved three poor marks in any one week. We asked why the minor reports system was not in place. We were told that local management started the process years earlier but that it was dropped soon after it started through lack of interest. **Sanctions should only be awarded following the approved system of ‘Minor Reports’.”

3.09 **Throughout the cells on each residential unit we saw numerous certificates of achievement on display e.g. British Amateur Weight Lifting Association (BAWLA) and various educational qualifications etc.** but we also saw numerous “girlie pictures”. We did not see an offensive displays policy but staff told us that if pictures of semi-naked women offended anyone they could ask the cell occupant to remove them. **An offensive displays policy document should be published, staff and residents should be informed of the policy on their induction to the establishment and the policy should be enforced. Similarly, the smoking policy should be enforced and senior management should lead by example.**

3.10 The four main residential units were very well equipped. Each had an office with large observation windows on either side with a secure link corridor between the
two. Various group and interview rooms were available. There was a clean food hot-plate area from which meals were served three times each day. Young prisoners were unlocked for meals starting with different cell numbers daily so that all had the opportunity for first choice of meals at least once throughout the week. Unfortunately, young prisoners dipped their fingers into a communal salt pot by the hotplate which was very unhygienic. **Salt should be provided in salt sellers or individual salt sachets should be issued.** Meal trays were washed and sterilised by wing cleaner orderlies before the next mealtime but were not dried properly and many were wet when used again. A Gold association room was able to be used by those on the highest level of the IEP scheme with easy chairs, a television and computer games. We saw one or two card telephones on each side of each wing in very effective, private, telephone box type kiosks. There was also a large bathroom that contained numerous showers, toilets and sinks and a large central carpeted association area with various table games, television and video and with dining tables around the edge on hard flooring, which facilitated cleanliness. Each wing had a Library and an adjacent exercise yard. During association, residents had access to showers, the television and a variety of games but cell doors were kept locked to prevent cell thefts.

3.11 We pressed a number of cell call bells throughout residential units and all were responded to promptly by wing staff. When this question was asked of the young prisoners and trainees 61% felt staff responded to a cell call bell in under three minutes (see Appendix IV). Buttermere unit had individual top-lock cell door type keys for each cell occupant but they had not been issued. That was unfortunate since there were times when staff opened cell doors at the end of a period of activity without the occupant being present and the contents inside were vulnerable to theft by other residents, since lockable lockers had not been provided in cells. **Lockable lockers should be provided to protect the possessions of individuals from theft.**

3.12 Buttermere was more difficult to control than the other units due especially to the very different types and groups of children detained there. We found no trainees sentenced to Life imprisonment but there were unconvicted young people there on remand for a few weeks, some children on a Detention and Training Order for a few
months, some young people serving several years detention as a Section 53 / 2 (CYP Act 1933) and also numerous young people serving Youth Custody sentences of various lengths. **For care and control reasons juvenile units (for under 18’s) should have no more than forty occupants in each unit.**

3.13 After 1st July 2000, children (under 18’s) sentenced to Detention and Training Orders will be located on Buttermere wing and older young offenders (18 - 21’s) will be located elsewhere. Otherwise, convicted sentenced young prisoners were generally located on one half side of each wing but no policy existed on the other half units occupied by mixed classifications, remands and convicted, to keep unconvicted and convicted people in separate accommodation. **Convicted and unconvicted young prisoners/trainees should not have to share cellular accommodation except by their express wishes.**

3.14 Some residents on Coniston had been there for several weeks after they had completed the Induction programme. Staff told us that they did not move them onto other units because it was important to keep occupation of cells evenly spread out across the residential units so as not to overburden any one area. No Personal Officer scheme existed on Coniston and Sentence Management did not “kick in” until residents were on the other units. **Residents should move off Coniston as soon as they have completed the Induction course and spaces become available on Derwent and Windermere units in order not to obstruct or disadvantage their progress through sentence and preparation for release.**

3.15 Apart from Coniston wing, cell cards included the name of Personal Officers, sometimes Miss X, Ms Y or Mr Z at other times the Officers’ surnames were logged just like that of the children and young people who were known only by their surnames or by a nickname. Many staff, especially Prison Officers, did not wear name badges or have visible their photograph identity cards; **staff identification badges should be visible at all times.**

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Hygiene, Clothing and Kit Exchange

3.16 Because children and young people sometimes arrived too late at the establishment, they were not always guaranteed a shower in Reception. However, if they wanted and were motivated to do so, they were able later to wash themselves on the wing where they had access to a sink in their cell. Clean kit was available from Reception and it was refreshing that t-shirts and sweatshirts etc. were not stamped with the establishment code across the chest. Weekly kit exchanges were arranged by Wing Cleaning Officers after that, or more frequently if accidents occurred. Every new reception should be allowed and encouraged to shower in Reception.

3.17 Replacement bedclothes and kit, including clothing and underwear, were issued by Prison Officers on units. This prevented interference by wing cleaners and helped to reduce bullying. Most residents were well attired although some of the clothing could have fitted better especially for smaller people. There were problems getting Prison Service clothes small enough for many of the residents, so small clothing had to be ordered and provided locally. The clothing supplied by Prison Service Central Stores was often not the size ordered or the size stated on the boxes. Waists and leg lengths had to be measured to check sizes upon arrival at the establishment. Small clothing should be available from Central Prison Service Stores. Clothing supplied by Branston should be the correct size as ordered and as stated on the boxes.

3.18 Wing showers were excellent consisting of a large tiled room containing five shower heads, two baths, urinals, toilets and wash basins but unfortunately, as a result of previous incidents, only one wing resident at a time was locked in there during association periods. We were told that maybe 14 residents showered each evening during association but that all residents had access to showers daily if they had gone to the Gym. We fully accept that showers are a dangerous area for bullying in young offender establishments but single occupancy of the showers was an awful waste of excellent facilities. With some minor building work or changes to staff supervision and wing routines, the use of showers could be much more effective. Wing shower arrangements should be improved and adequate staff supervision should be provided to enable more than one resident to shower or bathe at a time.
3.19 Although a little crowded at times, clothing and equipment storerooms on units were all clean and tidy. We ascertained that although colour coded cleaning equipment was used in all wing areas, not all cleaners had been properly trained and some of the cleaning equipment storerooms themselves smelled stale. **Wing cleaners and food servers should all be trained in health & safety, COSHH (Control of Substances Hazardous to Health) and hygiene procedures prior to, or upon commencement of, that employment. Achievements and qualifications should be noted on their training record cards. Cleaning equipment storerooms should be cleaned daily and well aired.**

3.20 Although new receptions and inter-unit transfers sometimes moved into cells that had not necessarily been thoroughly cleaned by the previous occupant, they were allowed unlimited access to cleaning equipment to clean the cell upon arrival on the wing. **Cells should be cleaned properly and fully equipped prior to occupation by each new cell resident.** Toothpaste (the adhesive used by previous occupants to stick up pictures, photographs etc. onto cell notice boards) stains should be washed off prior to reoccupation of any cell and an alternative adhesive for photographs and pictures should be supplied.

3.21 Two green cell blankets were issued for each bed but they were sometimes damaged and very shabby. Two sheets, a pillowcase and two towels were also issued; top bed blankets (bed rugs) were available from the Main Stores if required. **Cleaning Officers should ensure that bed rugs are available to be used.** Some young prisoners on the Gold regime level had purchased and supplied their own continental quilts. Other young prisoners complained that cells were cold during inclement weather. **Colour co-ordinated continental quilts and curtains should be issued in each cell.**

3.22 Water-soluble cases were available for soiled laundry, which in turn was placed in white laundry sacks with a red stripe down one side. This procedure should be used for soiled laundry throughout the establishment.
3.23 Green boiler suits were used on visits. We received numerous complaints that they were dirty, smelly and were often thrown onto the floor after use. **Green visits boiler suits should be laundered regularly.**

3.24 Plans to deploy staff who worked in the Main Stores along with other Operational Support Grades should be reconsidered to ensure that efficient routines and stock control are in place.

**Time Out of Cell**

3.25 The establishment timetable was generally well adhered to although we were told that too much happened at the same time on weekend mornings including church services, wing inspections and Gym activities. Staff and young people told us that they got confused over the timetabling of religious services which changed each week.

3.26 Trainees and young prisoners were unlocked on units. They then walked outside on supervised ‘free flow’ from residential areas to activity centres at scheduled times throughout the day. The safety of young people was protected through prompt, controlled unlocking. Residents only reported feeling unsafe in Gym showers where up to 40 trainees or young prisoners showered and changed clothes at the same time in the fifteen minute changeover period between the different groups using the facilities. According to the prisoner questionnaire of those who feared for their safety, for 63% the gym was the most unsafe area.

3.27 **Several fights or other assaults** had been reported and numerous **injury reports (F213s)** had been submitted in the months prior to our inspection. **They should be carefully investigated and closely monitored by management to ensure the safety of residents and staff is maintained.** Young prisoners/trainees reported that staff responded very quickly to violent incidents and stated that although bullying inevitably continued to occur, they were confident to report incidents and to seek help from Officers, other staff and members of the Board of Visitors etc.
3.28 Good notice boards throughout units gave residents information about events and routines on typed and coloured paper. Illiterate people and foreign nationals (very few) were identified on induction and were made a priority for education classes. Young residents helped to inform each other where necessary. **All notices should be dated and laminated** and needs assessments should be regularly carried out to determine whether information should be provided in foreign languages or in another format e.g. pictorial displays as in part the PE induction booklet and application forms had been produced.

3.29 Wing association facilities consisted of board games, pool, snooker, table football, table tennis, satellite television and videos. As described above there was also a Gold room on each wing where wing cleaners on the gold regime status could watch television or play computer games after they had finished their work. Gold regime residents were also entitled to in-cell televisions. In-cell electricity was available throughout the establishment but fixed plates on the terminal boxes in cells prevented access to residents other than those on the gold regime level of the Incentives and Earned Privileges Scheme (I&EPS). **In-cell electricity should be made available to all cells** to save on battery purchases.

3.30 Staff toilets were available on units; otherwise staff facilities were limited and **should be improved**. Association chairs had recently been replaced and were all in good condition. Breakfast was eaten in association and lunch was eaten in cell. On Monday to Friday evenings half the unit ate their meal in cell whilst the other half ate in association. Those young prisoners who ate their evening meal in association remained unlocked until 8pm for evening association. Most residents had alternate evening’s association and all were allowed access to hot water in order to make a hot drink for supper; new tea packs were issued each morning. There was no evening association on Saturday or Sundays. The regular redeployment of residential staff caused a lack of continuity on residential units; there was a danger that staffing arrangements in the establishment seemed to be for the benefit of staff and not for the most effective control, care and training of the young people who resided there.
3.31 We were concerned that, although attendance at off wing activities meant a walk through the establishment grounds to Education, Workshops, Chapel, Gym, Visits etc., there were no formal wing exercise periods. It might have been possible for an individual who was not employed, who did not use the Gym or go to Chapel, and who did not get visits, to remain indoors without any time outside in the fresh air for their whole period of time in custody. This was also confirmed by the prisoner questionnaire (see Appendix IV). We saw some wing exercise taking place but staff said that it was not a daily occurrence; it had been arranged at their discretion. They reported that other staff in the establishment had complained when they had arranged evening exercise previously and managers had chastised them for doing so. The wing profile did not allow for formal exercise periods and yet we saw Prison Officers carrying out other duties such as opening in-coming mail, which was work that could be carried out by administrative or Operational Support Grades. A quality period of time in the fresh air daily should be provided for all residents in exercise yards properly equipped for that purpose.
Anti Bullying

4.01 Lancaster Farms has, for some time, had a well-established reputation for its work on anti-bullying. The establishment’s motto: ‘Prevent the next victim’ was a fair indicator of the approach taken by most staff both in relation to the youngsters in their care and to the public. The establishment had not rested on its laurels; moreover it had tried to further develop work in this area. From the onset of the inspection, both staff and young prisoners told us that Lancaster Farms had a safe environment. According to the prisoner questionnaire 80% had never or rarely felt unsafe (see Appendix IV).

4.02 The Anti-Bullying strategy had been revised just before the inspection. This had led to the development of a new Bullying Incident Report form (BIR) and recognition of the need for further staff training. There had also been some acknowledgement that the system was too ‘paper-orientated’ and that this had led to staff not always completing the required paperwork.

4.03 All concerns relating to bullying and young prisoners safety were, in general, discussed at the monthly Anti-Bullying Committee meeting which the Governor 5, Head of Programmes, chaired. This was a multidisciplinary meeting attended by uniform staff from each residential unit and included the Chaplain, Education, Probation, Psychology and the PE Department. This was an example of good practice.

4.04 All young prisoners received training on anti-bullying awareness during the Induction programme. We observed the delivery of this programme and found it interesting and delivered to a high standard by the Induction Officer. The message
given was clear and unambiguous; bullying would not be tolerated. This was an example of good practice.

4.05 The procedures for dealing with identified bullies involved four stages:

- Stage 1 – warning
- Stage 2 – removal of privileges
- Stage 3 – removal of privileges / inform parents
- Stage 4 – Good Order and Discipline (GOAD)/transfer.

4.06 The Psychology Department were involved to a great extent in the anti-bullying processes and indeed had developed much of the work relating to it. We were surprised that there did not appear to be any programmes for confronting identified bullies about their bullying behaviour. However, we were told by the Psychologist working on the anti-bullying programme, that she was not convinced of the benefits of anti-bullying programmes and that often perpetrators of bullying were complex in that often they were victims of bullying themselves and that in this context programmes often did more harm than good. In place was an assessment tool used to measure the institutional behaviour of all young prisoners at Lancaster Farms (called sentence management – attainment profile). This measured a number of behaviours which included:

- Conduct with staff
- Conduct with other youngsters
- Time management
- Use of facilities and self-motivation
- Flexibility and response to change
- Self-management of work opportunities
- Cleanliness and tidiness of cell
- Night time behaviour.

4.07 It is worth noting that the minutes from the March 2000 Anti-Bullying meeting showed that there had been an increase in reported bullying incidents especially on Buttermere Unit (Juveniles) and that there was a need to develop an
'alternative method of dealing with and challenging their behaviour’. However according to the prisoner questionnaire the young prisoners reported more bullying for the most part, than did the trainees (see Appendix IV). Whilst we recognise that quality of the work undertaken to address bullying behaviour at Lancaster Farms was largely defined by the development of the ‘whole prison approach’ (both staff and young prisoners working to eradicate it), it still remained an issue, albeit a small one. It was unclear whether programmes designed to confront perpetrators about their bullying behaviour have ever been developed at Lancaster Farms. **However, in light of the increase in reported incidents, programmes should be considered as an appropriate option.**

4.08 Victims of bullying were supported through the Personal Officer scheme and encouraged to undertake a *Life Skills Course*. We did not get an opportunity to observe this course but were informed that it was not a course that was used just for the victims of bullying and therefore young prisoners who attended were not considered weak or labelled by other young prisoners. *This was an example of good practice.*

**Drugs Strategy**

4.09 One of the four main aims of the Government's drugs strategy is to help young people resist drug misuse in order to achieve their full potential in society. This may be done through a variety of means including education, prevention, treatment and relapse management work. These interventions should be identified in the Drug Strategy of an establishment and integrated into throughcare processes.

4.10 The Drug Strategy Meeting, chaired by the Head of Programmes, was held on a bi-monthly basis. A Principal Officer attended the Lancashire Drug Action Team. Lancaster Farms' Drug Strategy was developed through the area approach of the Northwest Area Drug Strategy. *We noted a strong commitment by the Drug Strategy Team to multi-disciplinary working.*

4.11 A Drug Practitioners Group Meeting was also held bimonthly. Attendance at this meeting was generally poor. *The terms of reference for this group needed to...*
be reviewed in order for it to be relevant to the needs of the establishment and those responsible for front-line service delivery

4.12 The written Drug Strategy had recently been reviewed (March 2000). Whilst it was a comprehensive document, it should detail all initiatives taking place with protocols for working together, clear performance indicators and outcome targets for individual services to both the young prisoners and juvenile populations. A Four-Tier Model of interventions for working with these groups had been identified (see

We recommend that to maximise best practice and effective interventions this and other recent guidance for working with children and young people should inform the Strategy.

4.13 As there had not been a co-ordinated population needs analysis prior to the development of the Drug Strategy or CARAT tendering process, we were unable to determine whether available resources were being deployed most effectively. There were ongoing difficulties with the collection, collation and interrogation of data both in relation to urine analysis and drug services. This data would provide essential information to inform the strategy.

4.14 Whilst we recognised that there was no national Prison Service alcohol strategy, we recommend that a local alcohol strategy to complement the Drug Strategy should be developed, particularly given the nature of the population.

4.15 We were also concerned at the lack of national guidance on tobacco smoking with 15 - 21 year olds in a custodial environment, particularly given the law relating to under 16 year olds buying tobacco. The complexities of managing nicotine withdrawals, consequent behavioural and emotional problems, bullying and bartering
for tobacco, health and ethical issues all needed to be addressed centrally rather than worked out at a local level.

4.16 All young prisoners were screened for drug use on arrival by health care staff. According to the prisoner questionnaire, 20% of the trainees and 23% of the young prisoners felt they had a drugs problem on arrival at Lancaster Farms (see Appendix IV). Detoxification could be provided where necessary. **First night arrangements for substance users should be reviewed by the Drug Strategy Team to ensure a multidisciplinary response.** This would include meeting the needs of those who do not require a medical inpatient detoxification and those for whom it is their first time in custody. It should be recognised that for substance users who are withdrawing for the first time, even mild withdrawal symptoms can be disturbing.

4.17 Health care staff had clear treatment guidelines for opiate, benzodiazepine and alcohol detoxification. For those physically dependent on opiates, a regime of dihydrocodeine and thioridazine was mainly used, although lofexidine was available. The detoxification procedures should be reviewed to include the necessary counselling/support alongside the medical prescribing. It is essential that prescribing is seen as part of a comprehensive plan of care. The young person's experience of this intervention may influence his willingness to engage with other drug services both inside and out. For this reason and as appropriately trained health care staff were not always available, formal **protocols for priority referral to CARATs should be developed.**

4.18 Consideration should be given to introducing auricular acupuncture and other complementary therapies as part of the detoxification process and to support those non-opiate users for whom they are appropriate.

4.19 Some of the health care staff were well trained in the care and management of drug users. **We would recommend ongoing training with particular attention to issues for children and young people.**
4.20 Information about HIV and Hepatitis was provided during reception and at Induction. Some health care staff were trained as counsellors. **We recommend HIV and Hepatitis services within the establishment should be reviewed and structures for working across departments formalised.** The review should include the written strategy having clear performance indicators in relation to access to pre/post test counselling, length of time waiting for testing, for results and for Hepatitis B immunization. The written information provided to both young adults and juveniles should be regularly up-dated and accessible to those with literacy problems and to speakers of other languages.

4.21 The role and perception of the Health Care Department in relation to drug users needs to be addressed. Health care staff and other staff and young prisoners, to whom we spoke, felt the department was isolated within the establishment. Health Care had played an important role in delivering drug education prior to the CARAT tendering process, having developed a three week Drug Awareness Course which was no longer being provided in light of accreditation requirements. To date there had been no evidence based courses for young people available and we were concerned that essential health promotion and harm minimisation work in a group setting was being neglected because of this.

4.22 The Counselling, Assessment, Referral, Advice and Throughcare (CARAT) Team comprised three full-time Prison Officers, a full-time drug counsellor employed by Lifeline, a part-time administrator and "sessional" input from a number of additional drug workers from Lifeline, New Start and Trafford Trust. The Team appeared well motivated and enthusiastic. They had had contact with 234 young people between January 1st and April 30th 2000. However, it was unclear whether the external agencies had provided appropriate cover for all their contracted hours and with impending staff changes we were concerned about the further disruption of services. All staff involved in direct service delivery to young prisoners had received some training in relation to working with substance users.

4.23 The Head of Programmes managed the CARAT Team. While fully committed to the Drug Strategy, workload issues meant the day-to-day management
essential to the effective implementation of the Strategy could not be provided. There was no funding available for CARAT Management hours. This shortfall was reflected in the lack of a co-ordinated approach across the establishment and need for collation and analysis of data to inform the best use of available resources both inside and on release. We were concerned about the evaluation of services and quality assurance, as there was no clinical supervision available for the CARAT Officers and no coherent line management function within the establishment for the CARAT Team as a whole. It was also unclear whom the administrator was working to and whether those hours were being used to best effect.

4.24 The written Drug Strategy recognised the needs of dependent drug users within the population. We were told that the drug counsellors' main caseloads were injecting opiate users and the need for appropriate support for this group was borne out in conversations with young prisoners. It was essential to balance the necessary education, prevention and harm minimisation services to the majority with the needs of this group whose substance use was at a later stage. A two day Drug Awareness Course and a relapse prevention group were planned to be run by the CARAT Team. An Alcohol Course was also being considered by Health Care.

4.25 The Physical Education Department recognised the need to offer education in relation to steroid use but did not have sufficient staff at the time to do so. The Young Men's Christian Association in conjunction with Probation facilitated the delivery of the Peer Led Addiction Group, a self-help support group for substance users. This course was very well received by participants.

4.26 The YMCA/Probation partnership had also delivered two Peer Leader Training Courses to 20 young prisoners since January 2000. We recommend that the group work programme should be as a response to the population needs analysis; targeted effectively within a continuum of interventions and taking into account the particular needs and learning styles of young people. There was a need for co-operation across disciplines to ensure a more holistic and integrated approach to substance users needs.
4.27 Referral and access to CARATs needed to be refined in order to ensure the earliest possible assessment and prioritising of need. The drug workers were establishing community links with services in the home areas of most young prisoners to support post-release work.

4.28 The establishment operated a voluntary testing programme run by the CARAT Officers. All people seen by the CARAT staff were signed up to it as well as those on Windermere unit (60). 150 young prisoners (no juveniles) were currently involved and since 21st January 2000, 371 tests had been carried out, including weekend and evening testing. There were 23 (6%) positive results (19 for cannabis). The Voluntary Testing Programme was linked to the Incentive and Earned Privileges Scheme.

4.29 No significant substance problems were reported, with the Mandatory Drug Testing (MDT) results being cited as evidence. MDT returns from April 1999 to April 2000 were 571 (93.5% of the required 10% of the population) with 18 (3%) positive results. Targeted testing on suspicion (243) produced 32 (13%) positives and those for risk assessment (60) produced 2 (3.3%) positives. The majority was for cannabis. There were some difficulties with the MDT process as there was no holding room available although a suitable adjacent room had been used for storage for the past three years. Nor was there Officer cover over the lunch period for those waiting to provide a sample. These young prisoners had to be returned to their Units without being tested, undermining the credibility of the system.

4.30 It is important to note that while the urinanalysis was indicative of the young peoples' current drug use, it may have given a false impression of substance use requirements within the establishment. For example resources are needed to tackle substance related offending, including offences committed by non-drug users under the Misuse of Drugs Act. Referral to CARATs, as the current practice, was not appropriate for this group.

4.31 We noted that the establishment's new Searching Strategy (March 2000) included guidance on the searching of juveniles and those who may have religious or
cultural concerns. However, we were concerned that no national guidelines had been provided in relation to juveniles and urine testing. 65-70% of Security Information Reports were drug related and searching had produced a number of finds of paraphernalia. During the past year, one visitor had been caught bringing drugs in. The establishment had no drug dogs of its own but borrowed one from HMP Preston. A proposal had been put in for a passive dog. **New monitors for the cameras in the Visits area and staff to survey them had also been requested.** The security procedures were not functioning effectively with current resources.

4.32 The Visitors Centre and Visits area had a good balance of information for visitors in relation to security issues and regarding external agencies offering support for family, carers and friends of substance users. It is also essential to consider ways of more formally involving families and carers in the work with young prisoners if solutions to their substance use are to be more than temporary.

4.33 We are concerned that the current national Drug Strategy Model has been developed for the adult prison estate rather than with the specific characteristics and needs of young people in mind. Staff and young people, with whom we spoke, felt constrained at having to work within this framework. **It is essential that national guidance is given on how CARAT services fit with the work of Youth Offending Teams and Personal Officer casework.**

4.34 Whilst we recognise the importance of an area approach to the Drug Strategy, we recommend consideration is given to the particular needs of the population at Lancaster Farms and a strategy is developed that takes those into account. The Area Drug Strategy Co-ordinator should be consulted in order to establish formal links with HMP Hindley and HMYOI Thorn Cross along with other Young Offender Institutions and Juvenile Units in order to develop best practice, support staff and improve transfer arrangements.

**Race Relations**

4.35 Race Relations at Lancaster Farms, we were informed by young prisoners, were good. It appeared that there were more problems between youngsters from
different areas of the country e.g. Manchester and Liverpool, than there were between the races. Indeed according to answers given in the prisoner questionnaire 11% had been victimised because of the area of the country they were from, whilst 3% were victimised because of their race or ethnic background (see Appendix IV). Staff demonstrated respect for young prisoners, other staff and visitors from ethnic minorities, as did most of the young prisoners. The identities of the establishment’s Race Relations Liaison Officer and other members of the Race Relations Management Team were well known. Members of the Race Relations Management Team had their pictures displayed in the Education Department and in the Gate Lodge.

4.36 Unfortunately the Race Relations Management Team had not completed the full team training provided by the Prison Service and the Race Relations Liaison Officer had also not been formally trained. **The Race Relations Management Team and the Race Relations Liaison Officer should undergo the formal Prison Service training for these roles.**

4.37 The Race Relations Management Team consisted of representatives from the wings, the Senior Probation Officer, a health care staff member, the Chaplain, a member of the Board of Visitors, the chair of the local branch of the Prison Officers Association (POA), the Secretary of the Whitley Committee, the Race Relations Liaison Officer and his deputy, a member of the Training department staff, the Head of Activities and a Senior Psychologist; it was chaired by the Deputy Governor.

4.38 The Race Relations Management Team met quarterly and although it included staff representatives from each unit, it did not include young prisoner representatives. **The establishment should consider the inclusion of young prisoner representatives in the Race Relations Management Team.**

4.39 Young prisoners were soon to be trained in race relations as part of an Induction session, called generic work skills; this we were told was due to start just after our inspection. There were also plans to put a race relations session into the Welfare to Work programme offered under the Government’s New Deal scheme. Training for staff was delivered on a three-year cycle.
4.40 We found some example of “positive action” e.g. the staging of a cultural activities week that had taken place in early 1998. The Deputy Governor explained their plans for a similar cultural activities week to take place during 2000. We fully endorse the use of such events to promote the understanding and celebration of ethnic diversity.

4.41 The Race Relations Liaison Officer received eight hours per week facility time and he was able to use this time flexibly. He provided a summary of the monitoring that he carried out of the ethnic make up of young prisoners’ attendance at workshops, education, work parties, adjudication, their place in the Incentive and Earned Privileges scheme, activities such as Gym, positive urine tests for drugs, and their location in the prison. It would be appropriate for these figures to be shared with the Race Relations Management Team.

4.42 We were pleased to note that the minutes of the Race Relations Management Team meetings indicated a number of cases in which discrepancies in the figures had been looked at closely. For example, the number of urine tests carried out on suspicion for young prisoners from ethnic minorities was at one point disproportional, or so it appeared to us. This issue was discussed in the RRMT and two members of the team were tasked with looking at the figures in more detail. Once this was done, they were able to satisfy themselves that there was no underlying discrimination against young prisoners from ethnic minorities taking place. The issue was thus dealt with properly.

4.43 The Race Relations Liaison Officer also completed the quarterly race relations return sent to the Area Office. Statistical information was taken from the Local Inmate Database System (LIDS) and a monthly management information booklet was produced by the Psychology Department that included the ethnic make up of each wing.

4.44 We were pleased to find that a survey of young prisoners had taken place in February 1999. 200 forms had been issued and there had been 125 returns. 16% of
those returns reported some racially unfair treatment at the establishment. When we looked at these figures in more detail the individual numbers were very small; so for example one person had felt discriminated against because he was from Liverpool, one from Afghanistan, and two because they were Irish travellers. It also appeared, from the responses, that the examples of discrimination were unrepresentative.

4.45 Questionnaires had also been sent out to all Muslim young prisoners. The Race Relations Liaison Officer had then met with them all. They raised the following issues: the insensitive searching of religious artefacts, not being woken up for Ramadan, and inappropriate icons in the room used for Muslim prayers i.e. posters of different religions. The latter problem had been partially resolved by giving the Muslim group a set of covers to hide the posters. We had concerns about the location of this meeting room, which was just outside the main Chapel and just off the main thoroughfare into the Education department. There was an excellent group room upstairs from the Chapel, which also had the advantage of a shower. We recommend that this room be used for Muslim prayers.

4.46 These surveys served to show us that the establishment was actively on the look out for signs of racial discrimination and was acting decisively to deal with any such signs. A recent complaint that had been made was the quality of food for Muslim young prisoners and a meeting was being set up between catering staff and the Muslim young prisoners in order to improve what was being offered. It had been suggested by the Deputy Governor that the Kitchen should employ young prisoners to advise the catering staff how to provide more suitable food for ethnic minority young prisoners. This was an excellent idea.

4.47 The establishment was a member of the Preston and Lancashire Race Equality Committee and the Lancashire Multi-Agency Panel. Both the Race Relations Liaison Officer and the Deputy Governor had attended these meetings.

4.48 Racial Incident forms and the new definition of a racial incident were available in every residential unit. The Race Relations Liaison Officer had received approximately eight Racial Incident forms in the year preceding our inspection.
These incidents had been properly investigated and the Race Relations Liaison Officer appeared to receive effective support from the chair of the Race Relations Management Team in carrying out these investigations and resolving them.

4.49 There were very few staff from ethnic minorities at Lancaster Farms with only two Officers and a PO PEI within the Officer grades. There was one other member of staff from the ethnic minorities who worked in the Administration department. The part of Lancashire, within which Lancaster Farms was situated, had only a small proportion of people from the ethnic minorities. In order to meet the requirements of RESPOND, the Prison Service initiative to increase the numbers of staff from ethnic minorities in the Prison Service, the Prison Service Area within which Lancaster Farms was placed, had initiated an Area-wide strategy. The Governor of Lancaster Castle prison chaired the Area committee, which was organising a programme of outreach work in order to proactively recruit staff from the ethnic minorities into the prisons in the Area. Lancaster Farms had not yet carried out any specific recruitment work, but was keen to provide staff for attendance at job fairs and job centres etc.

Equal Opportunities

4.50 The establishment had an Equal Opportunities Officer (EOO) who had completed the two-week Equal Opportunities training course run by the Prison Service. It also had an Equal Opportunities Committee that met quarterly and was chaired by the Governor Four, Head of Residence who was also the Equal Opportunities Officer. A multi-disciplinary staff team, including representatives from the Prison Officers Association and departments across the establishment, also attended it. All members of the Committee had been trained. The meeting was timed to occur just after an Area Equal Opportunities Team meeting which also took place quarterly and was also chaired by Lancaster Farm’s EOO.

4.51 We were pleased to discover that a good proportion of Prison Officers were female including one Senior Officer and three Principal Officers. There were only two female staff in the Senior Management Team, the Head of Residence and the Head of the Psychology Department.
4.52 There was good access to the establishment and there were two disabled parking spaces in the staff car park; these were located near the Gate. The Equal Opportunities Officer had devised an excellent temporary disabled parking permit for staff who had sustained injuries which would get better or who were at the end of a pregnancy, so that they could use these spaces. Within the establishment there was good access for staff with mobility problems as there were ground floor offices, lifts to the area above the Gate, to Visits and in the Hospital, and wheelchair ramps in the grounds. Access was also good for disabled young prisoners, juveniles and trainees.

4.53 The establishment had an appropriate Equal Opportunities Policy Statement and good written procedures which were widely displayed. The identity of the EOO was well known.

4.54 There were between six to ten formal complaints per year. These included complaints about bullying and victimisation, complaints about corrupt Masonic influences and a small number of sexual harassment cases. The complaints were appropriately investigated by the EOO but there were long delays in senior management responding to the investigation reports. One complaint made in June 1999 and another in December 1999 had not been responded to at the time of the inspection. This served to further exacerbate the alleged victims’ grievances. Any complaints made by staff should be investigated quickly and properly and the complainant should receive a speedy response. The Prison Service should consider a time-bounded, auditable complaints system for staff similar to the Request and Complaints System for young prisoners.

4.55 Local training in Equal Opportunities was taking place for staff on an ongoing basis.

4.56 We were surprised to see many nude photographs of women being displayed in young prisoners’ cells. In some cells we saw whole walls covered with nude pictures including outside walls, which also had security implications. Nude photographs were inappropriate and should be removed. In other units, however,
we saw no posters of nude women displayed and there was a clear policy on the display of offensive materials.

**Foreign Nationals**

4.57 There were a small number of Foreign Nationals at Lancaster Farms at the time of the inspection. Despite their small numbers, we were satisfied that they had good access to legal advice and the establishment had contacts with the Refugee Council which provided legal contacts for Foreign Nationals located there. There was no system for phone calls in lieu of visits. We were assured that Foreign Nationals were allowed phone calls home and the establishment facilitated this but there should be a system of phone calls in lieu of visits implemented.

4.58 Because of the small numbers of young prisoners involved, the establishment felt able to provide individual care for each one. When translators were needed they were usually obtained through the Library. *The establishment had even used the local radio station to ask for books and other reading materials for non-English speaking young prisoners.* The prisoner information pack was available in 30 different languages and on audio tapes as well as in written form. The Custody Office in the Administration Department had good contacts with the Immigration Service and with Customs.

**Suicide Awareness**

4.59 The expectation of staff at Lancaster Farms was that suicide awareness was “everybody’s business” and attempted suicide was not considered attention-seeking behaviour. However this was sometimes difficult with young prisoners who did not understand their mortality. Prison staff were trained in how to identify the indicators of this type of behaviour and received regular updating. At the time of our visit, 71 members of staff had been trained as part of a cycle of monthly mandatory training sessions.

4.60 *We were particularly pleased to hear that one of the nurses had produced a ‘coping with custody’ course; this was good practice and should be developed for longer term young prisoners.*
Management of Suicide Risk

4.61 To manage suicide awareness, Lancaster Farms had set up a Suicide Awareness Team (SAT), chaired by a Governor and had representatives from the Board of Visitors Chaplaincy, Nursing, Senior Medical Officer, Prison Officers and Security staff, Listeners’ Key Officers, Group 4 and the Lancaster Samaritans. The meetings were held monthly and had wide ranging terms of reference.

4.62 A Key Officer had been identified on each wing and all young prisoners were screened and assessed for risk of self-harm or suicide immediately on their arrival at the establishment by one of the qualified nurses. Any young prisoner who was identified as being at ‘risk’ had a Self Harm At Risk Form F2052SH opened. This procedure addressed their psychiatric and psychological needs and associated health care, security observation, counselling, conditions of watch, visiting arrangements and housing.

4.63 Records showed that approximately six F2052H were opened each month. The quality of the content of the F2052SHs varied with some not having been updated for some six hours during the period of our inspection. The Suicide Awareness Team should carry out random audits on F2052SHs to monitor the quality and frequency of entries made.

Listeners Scheme

4.64 The Listeners Scheme at Lancaster farm was called “Talking Point.” At the time of the inspection, there were eight young men on the scheme. The Listeners had produced their own literature that unfortunately we were not able to examine during the inspection. Listeners were selected by the Chaplain and one of the senior nurses and training was provided by the Samaritans. Ideally the staff said they would like to see an increase to 12. The Listeners were given extra tobacco, which may be appreciated by some but raised other implications not least for their health. Staff should consider other reward systems that do not impinge on the health of young men.
4.65 The role of the Samaritans Volunteers should be evaluated and a protocol on disclosure of information agreed by the Suicide Awareness Team and the Samaritans.

4.66 The Listeners attended a support group meeting each Monday. They received individual counselling and were encouraged to talk about their experiences. An external counsellor facilitated the meetings. This was an example of good practice.

Lancaster Samaritans

4.67 We were told that one evening per week two female Samaritans attend the establishment and were given the names of young men who had open F2052Hs for interview. However, they could not feed back any of their observations or concerns because of the confidentiality requirement.

Applications

4.68 Young prisoners were told about unit applications during their Induction programme. We tested residents’ understanding of procedures and confirmed that they understood how to apply for various entitlements, how to contact off unit departments including members of the Board Of Visitors\(^1\) (BOV), the Prisons Ombudsman and how to pursue grievances e.g. complaints against staff. Young prisoners invariably did not make complaints\(^2\) but we saw records that indicated that the application system was used quite readily. Some residents said they would not be inclined to make a complaint against a member of staff to another member of staff but we saw that complaints against staff had indeed been made and had been investigated, including one allegation of racism. There was no evidence that young prisoners’ pursuit of grievances had been obstructed in any way.

4.69 Applications were made differently on each of the four main residential units. Coniston, the Induction unit, Windermere and Buttermere had the same system. After being unlocked for breakfast, residents queued behind each other at a pool table where

\(^1\) 48% of the respondents from the questionnaire knew how to get access to the BOV, 25% did not know who they were (see Appendix IV)
a Senior Officer took applications. On Derwent, where residents praised unit staff the most, applications were taken at unlock by an Officer at each cell door. Derwent staff argued that their system was the most effective since, as they were not in a queue, residents had privacy whilst making applications. Also, the Senior Officer was free to supervise activities whilst residents queued for breakfast. Applications made were also processed more quickly to other departments e.g. property applications for Reception. We liked the approach of Derwent staff and felt that the applications system should be consistent across the wings.

4.70 Applications were not routinely taken at weekends except for emergencies e.g. urgent unplanned requests to visit sick or dying relatives etc. and attendance at PE, Gym and Church services. Two Roman Catholic and Anglican church services took place on Saturdays and Sundays; which unit attended and at what times each weekend varied according to a planned and published rota but those variations confused some staff and residents. Church service times should be better published in advance on each unit each weekend to ensure that they are known by all and that no one missed the opportunity to attend.

4.71 Some wings used application forms that had pictorial displays on them e.g. for employment, Health Care applications etc. This was an example of good practice, which should be used for all applications, where appropriate. Some wings noted applications on sheets printed off the Local Youngster Database System (LIDS) that morning e.g. for am, pm or evening PE sessions, and some issued application forms as requested directly to individual residents e.g. for Health Care, Probation etc. Other applications, usually the more serious ones, were transferred into Governor’s Application books and then copied onto the History sheet booklet of the individual residents concerned. Some staff complained that the Duty Governor did not visit their unit daily. Governor’s applications were often done over the telephone and for those applications done on the unit, the Governor grade did not always see the resident concerned. Governor grades should always see the residents who have applied to see them. No audit trails were maintained for the applications referred off wings to

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2 In the questionnaire only 9% of the respondents had made a complaint. 10% said they did not know how to (see Appendix IV)
other departments and residents sometimes had to ask for an application form e.g. to Probation, on a number of occasions without receiving any replies. **Young prisoners should receive prompt replies to all applications made, audit trails of applications referred off wings to other departments should be maintained, and unit staff should actively pursue outstanding replies.**

**Request and Complaints**

4.72 Staff tried to deal with young prisoners’ problems but did not obstruct their access to Request and Complaint (R&C) forms. 34% of the respondents felt that it was easy to get a R&C form, 10% felt that it was difficult (see Appendix IV). R&C forms were issued promptly, usually on the day of request. The R&C log in the Custody Office was well maintained and readily available to us, as were copies of R&C forms completed earlier. 68 R&C forms had been issued in the year to date. 86% of these had been responded to within the seven-day time limit for responses and 100% of forms received from other establishments were replied to on time. As ever, some delays occurred with R&C forms referred to Prison Service Headquarters. **Replies on R&C forms should not read like a statement to the Governor but should be a communication to the resident concerned. In every case, staff handwriting on the reply section of R&C forms should be legible and staff should print their name after their signature so that the author of the reply can be easily identified in case a resident has to appeal against a reply received.**

4.73 We noted a couple of issues relating to Request and Complaints that particularly concerned us. Firstly, one R&C referred to a query about double jeopardy. The resident had been adjudicated on for a misdemeanour and had also been reduced one level on the Incentives and Earned Privileges Scheme (IEP). Young prisoners should only drop a level on the IEP after a pattern of poor behaviour and not after one incident.

4.74 Secondly, numerous R&C forms had been issued that had later been withdrawn and not proceeded with. Young prisoners signed withdrawal forms which was good practice but one R&C form referred to an assault by staff in which the young prisoner signed his withdrawal slip stating that it had all been a joke. **In the**
case of serious complaints, management, or perhaps a member of the Board of Visitors, should investigate all withdrawn Request and Complaint forms to satisfy themselves that no pressure has been put on the resident to withdraw the form.

4.75 Grievance procedures should be transparent and this generally was the case at Lancaster Farms. Young prisoners were thus encouraged to go through proper channels during the rest of their period in custody.

Board of Visitors Applications
4.76 Applications taken on wings at unlock in the morning to see a member of the BOV were noted in books retained on residential wings. A member of staff also telephoned the BOV clerk in the Custody Office and he noted when applications had been made. Members of the BOV attended almost daily. They heard applications on their rounds as well as seeing those residents recorded in unit BOV application books. Residential units did not have confidential BOV application boxes, which meant that residents had to approach staff to contact the BOV. We applaud the BOV for their regular attendance but we were concerned that a number of young prisoners were locked in cells throughout the day and might miss the opportunity to speak to a BOV member. Private and secured Board of Visitor application boxes should be available in discrete but accessible places throughout the establishment so that residents can write to members of the Board without the knowledge of staff, if they wish.

Prisons Ombudsman Applications
4.77 We contacted the Prisons Ombudsman’s Office before we inspected Lancaster Farms and were told that no grievances had been received from that establishment. Young prisoners were told about the Ombudsman during Induction and we saw posters about the services of the Prison Ombudsman on notice boards throughout the establishment. Young prisoners confirmed that they would use that facility if they needed to.
CHAPTER FIVE

GOOD ORDER AND DISCIPLINE

5.01 We do not carry out a security audit or anything approaching one. Indeed the establishment was still reeling from a recent audit by the Prison Service Standards Audit team when it had received a "deficient" rating. Unfortunately, this had followed previous audits on a downward pattern from "superior" to "good" and the most recent "deficient". There seemed little doubt that some of the deficiencies were as a result of inadequate systems which the Governor also saw as a problem in other areas of the establishment.

5.02 We did not seek to revisit ground so recently covered by the Prison Service itself, but nonetheless noted several features which gave us cause for concern.

5.03 In terms of safety, our questionnaire revealed that 78% of young prisoners and 80% of juveniles felt safe which indicated that good order and discipline was of a significantly high level. Less conclusive was the high level of adjudications involving fights between the young prisoners. The establishment should undertake some research to determine whether good supervision results in more adjudications or whether other factors are present.

5.04 Adjudications themselves were carried out in the Separation and Care Unit, a name deliberately chosen to avoid the traditional term of "Segregation Unit". During those adjudications we observed, the adjudicator did not ask young prisoners if they needed assistance in the hearing as required by the procedure. It is particularly important for young people to have every opportunity to fully understand what is happening to them and short cuts for administrative convenience should not be taken. Young prisoners should always be asked if they need help during adjudications.
5.05 On inspecting records of previous hearings, we found that young prisoners were not always being seen by the Medical Officer prior to adjudications. Some of these cases had resulted in awards of cellular confinement being made by the adjudicator. **Cellular confinement should not be awarded at adjudications unless the young prisoner has been medically fitted by the Medical Officer.**

5.06 Young prisoners held in the Separation and Care Unit were not allowed to smoke but we saw Officers who were unlocking cells whilst smoking. As well as being against the establishments no smoking policy, it must have been very provocative for young prisoners deprived of tobacco.

5.07 We were informed by young prisoners that they were required to "squat" as a matter of course during strip searches. Although we did not witness any strip searches we were told by staff that this, indeed, was the case. This was degrading and unnecessary and should stop. **Young prisoners should not be required to squat during strip searches unless there is good reason to suspect that something may be concealed.**

5.08 There were elements of physical security that implied a degree of complacency amongst staff. For example, class two locks were frequently left unlocked, thus compromising the security and safety of young prisoners and staff.

5.09 The Separation and Care Unit consisted of 12 normal cells, three unfurnished rooms and two special cells although the latter were very rarely used. On average the population was four or five although staff told us that numbers were increasing with the rising numbers of juveniles. On the day of inspection there were four residents including three juveniles serving punishment following adjudications.

5.10 The regime for residents was reasonable with in cell education for suitable young prisoners, ready access to Chapel services and weekend Physical Education. Exercise took place "weather permitting" and a card phone was available. We could not however understand why showers were only available at weekends. **Young prisoners in the Separation and Care Unit should have daily access to showers.**
5.11 Record keeping in the Separation and Care Unit was generally good although we noted that the Medical Officer did not always sign to confirm his visits. We suggested that the daily occurrence book should indicate which residents had showers, exercise and telephone calls on a daily basis.

5.12 The Incentives and Earned Privileges scheme had recently changed so that assessments of individual young prisoners were made on a fortnightly basis by staff. The system was not popular with staff who saw it as being over complicated, involving onerous administration and resulting in delayed rewards or punishments for young prisoners.

5.13 We were sympathetic to the notion that, for young people in particular, rewards and punishments needed to be more immediate to be effective. Management were aware of these feelings and were considering how the scheme could be improved. Possibly as a method of introducing immediacy into their control over their charges, we noticed what we considered to be "unofficial" punishments such as loss of association by wing staff. Management should review wing procedures to ensure that "unofficial" punishments are not taking place.
CHAPTER SIX

HEALTH CARE

Background

6.01 Health Care at Lancaster Farms was provided by directly employed nursing staff and medical services were provided through a contract with a local General Practice of four doctors, through a contract with the local NHS Trust and an individual medical contract for the reception of new young prisoners. At the time of our visit, there were 15 beds in the Health Care Unit of which there was 50% occupancy.

Standards used in assessing the health care service

6.02 During our inspections of health care in prisons we make assessments of the scope and quality of the care provided against the standards set by the Prison Service in Prison Rules, Standing Order 13 and the nine health care standards (HCS). The HCS’s stated objective is ‘To give young prisoners access to the same quality and range of health care services as the general public receives from the National Health Service’ and they are ‘first and foremost addressed to governing Governors, who have overall responsibility for the delivery of health care services to young prisoners and for the implementation of the Standards’. The HCSs were agreed by the Prisons’ Board in 1994 and should have been implemented in all prisons by mid-1997. For areas not covered by the HCSs we make assessments against the standards that obtain in the NHS.

Staffing

Medical

6.03 Doctors from a local NHS practice gave the great majority of primary care attending each weekday morning. Out of hours cover was from the local NHS emergency rota. All these doctors were certificated in primary care. Medical care of
in-patients was the responsibility of a doctor with some psychiatric training and considerable experience who was employed as a clinical assistant in the local NHS mental health trust. He also covered receptions and primary care on Saturdays.

**Nursing**

6.04 The clinical manager was an ‘I’ grade registered general and mental health nurse. The manager was also responsible for the management of health care at HMP Lancaster. Three ‘F’ grade nurses deputised for the manager each having responsibility for different areas - outpatients, in-patients and community work. In addition, there were 13 ‘E’ grade staff (one worked permanently at HMP Garth) and four ‘D’ grade staff all of whom worked part time. Nurses were working a 13-week shift pattern with only the ‘E’ grade nurses working internal rotation. The shifts were 7:30 am -1 pm, 8 am-5:30 pm and 12:30 pm -9:00 pm. The night shift was 8:30 pm - 8:00 am. At the weekend there was an ‘F’ grade nurse on duty from 8:00 am - 8:30 pm.

6.05 At night there was only one nurse on duty who was responsible for the whole prison. This left any in-patient on the Health Care Centre very vulnerable if the nurse was called away to an emergency on one of the wings. In the event of the nurse being called away a Prison Officer who had no health care training was sent to the Health Care Centre from the Separation and Care Unit. **Night nursing cover should be reviewed to ensure that the needs of youngsters both in the Health Care Centre and in the residential units can always be met.**

**Discipline staff**

6.06 There were no Health Care Officers or other Prison Officers employed in the Health Care Centre.

**Clerical and secretarial**

6.07 There was a full time secretary who had been on long term sick at the time of our visit. During this absence, secretarial support was only provided on a part time basis in the mornings. Because of this, nurses still spent a large proportion of their time making and checking appointments. **The provision of clerical staff should be**
sufficient to ensure that scarce and expensive health professional time is not wasted in inappropriate work.

Cleaners
6.08 Contract cleaners cleaned all the offices and treatment rooms. There were no young prisoner cleaners used in the outpatient area. *The use of contract cleaners in sensitive clinical areas saved scarce and expensive health professional time in supervising young prisoner cleaners and was good practice. However the service provided by contract cleaners required monitoring and a programme to do so should be implemented.*

Continuing professional development
6.09 All registered health care professionals have an obligation to maintain their skills up to date through continuing professional development.

Medical staff
6.10 *The doctor employed by the local NHS Trust had one session a week in his contract for personal training. This was good practice.* We were unclear as to the supervision available for this doctor from his employing Trust. *Supervision arrangements for the doctor should be explicit and should involve the supervisor regularly attending the prison.* As NHS GPs, both doctors were taking part in the NHS PGEA scheme. However, the GPs found it difficult to obtain funding from the establishment to attend training sessions specific to prison health care that would not feature in the PGEA scheme. *Funding to allow prison health care specific training must be made available.*

Nursing staff
6.11 All nurses had their education and training needs assessed as part of their ongoing appraisal system and had access to a range of training activities including updates on primary care issues and pre and post HIV test counselling. They also had the opportunity to attend conferences and complete courses related to their work and needs. All staff were encouraged to keep professional portfolios. The only State
Enrolled Nurse employed in the Health Care Centre was in the process of completing the conversion course to RGN.

6.12 It has been recommended for some time by the Chief Nurse that all nurses and their professional leaders should introduce a system of clinical supervision which allows the individual nurse become a more reflective practitioner. Apart from being good practice it is required by HCSs 2.d and 4.d but clinical supervision was not taking place at Lancaster Farms. **Clinical supervision of nurses should be introduced.**

**Quality improvement**

6.13 There was no formal quality improvement programme and no agreed programme of audit. Both should be in place. We noted that in the current year 50% of reported injuries (F213) were recorded as due to fights. At another YOI inspected the comparable figure was 25%. Audit raises questions that require answers and allows for both local improvements in service and also for the compilation of comparative data.

**Management of health care**

6.14 The service manager was a registered general and mental health nurse who had been employed since the opening of Lancaster Farms in 1992. He attended Operational meetings every day and had a good professional working relationship with the Governor. The Health Care Manager did not hold the staffing budget. There were concerns that this might make it difficult to ensure that the skill and grade mix of the nursing staff met the needs of patients should the nature of the prison change. **The Prison Service’s Directorate of Health Care should consider devolving responsibility for the budget for nursing staff to the Health Care Manager in establishments where the manager has the necessary experience and training.**

**Needs assessment and the commissioning of health care**

6.15 Health Care Standards 2,3,4 & 8 all require establishments to have undertaken an assessment of the need for health care in the establishment to provide a sound basis for setting a budget for health care and commissioning services. **Health Authorities**
HA) and Governors are now required to work together to conduct a needs assessment and to include the establishment in the HA’s health improvement programme. HAs can help to ensure that the needs of young prisoners are met most cost-effectively. Effective partnership with the local Health Authority had been slow to get off the ground and at the time of our visit there had been no needs assessment. The timetable set by Department of Health and the Prison Service requires that by the end of April 2000 a joint team of senior staff from the Health Authority, from NHS providers and from the establishment should have been established. The Health Authority had identified a specialist registrar in public health medicine to work with the establishment on application of the toolkit for health care needs produced by the University of Birmingham but a full joint team had not been established and consideration of the requirement to ‘make provision from 2000/2001 for joint work to improve the health and health care of young prisoners’. Since agreed, costed and timetabled prison health plans are required by March 2001, this work should be proceeding urgently; it did not appear to be. In the past, the Prison Service has been content to ignore its own deadlines aimed at improving health care for young prisoners. Neither the Prison Service nor the NHS must allow such attitudes to continue.

6.16 As part of the needs assessment the impact on the health of young people of the apparent high rates of prescribing of benzodiazepines, particularly in the Barrow and Carlisle areas should be considered.

Services for patients
6.17 20% of the respondents who filled in the questionnaire felt that the quality of the health care they experienced at Lancaster Farms was good. However, 18% felt that it was bad (see Appendix IV).

The Health Care Centre
6.18 In general, the primary care and outpatient area was suitable for its purpose and was clean and well equipped. The in-patient area was very much less satisfactory and had not originally been built for health care. The day area was inadequate with no room that could accommodate all patients. Consequently, the main corridor was used
for dining out and for association. The numerous tables and chairs in this corridor would prevent rapid evacuation in case of fire. Doors to patients’ rooms were too narrow to admit a stretcher or a wheelchair. Windows in some patients’ rooms had been adapted to reduce the risk of suicide attempts but the consequence of this was that the rooms were very dark and had no ventilation. They were unsuitable for occupation and this should have been apparent to Governors during their visits to the Health Care Centre. We were very troubled to hear that replacement windows had been available in the Works Department since June 1999 but the only promise for installation had been ‘some time this year.’ This seemed to us to show scant regard for the needs of sick young people. Unsurprisingly, since it had not been designed for health care, the in-patient area was seriously inadequate. The original in-patient area (now offices) would have been much better but had been regarded as too small. However, we noted that occupancy was rarely above 50%, that a significant number of admissions were ordered by Governor grades and not because 24 hour health care was needed and that the in-patient facility was used as a refuge for those who found it difficult to manage on general location. The need for in-patient beds should form part of the needs assessment and the size and location of the in-patient area should be reviewed in light of these findings. Pending this, the rooms with poor lighting and ventilation should be taken out of commission or the windows replaced.

6.19 The area for outdoor exercise was bleak. There were no seats and nothing for patients to do but walk about. The area was clearly not conducive to young people wanting to go out. Exercise areas should provide for occupation and relaxation.

Primary care

6.20 Patients reported sick to their wing staff who then informed the health care service. Many young people did not like the triage by nurses which was in operation in the mornings. Triage ensures optimal use of doctors and nurses’ time and skills. Much recent research shows that patients often prefer to see a nurse and the fact that triage was unpopular did not mean that the service was inappropriate or uncaring. It may mean that the nursing staff had insufficient time to explain to patients why they proposed a particular course of treatment particularly if what the staff consider
appropriate was different from that which the patient requests. Research shows that one reason patients value being seen by nurses is that their interviews are often longer than those with doctors. Some young prisoners did not think that the nurses who held a mental health qualification were able to deal with their physical needs. **The time available for nurse triage should be reviewed.**

6.21 A counselling service was provided in the afternoons that appeared to be well used. *One of the ‘F’ grade nurses provided a ‘Coping with Custody’ training programme for trainees. This was good practice and will need to be increased when the full complement of juveniles is present in the prison.*

**In-patient care**

6.22 We have commented above on the poor conditions in the in-patient unit. The daily life of in-patients was very restricted. Education or the Gymnasium was available for an hour most weekday mornings from 9-10 am and there was association in the evening from 6-8 pm. Outdoor exercise was only available if a majority of patients wanted this and those not wanting exercise had to be locked in. Much of the remaining time patients would be unlocked in ones or twos for showering and cleaning or to attend the daily ward round. Patients were locked in from 8 pm to 8 am. This regime failed to meet the requirements of the Health Care Standards and was far from providing the ten hours unlock required for juveniles. The manager told us that he had not been asked whether he would need additional staff to meet this new requirement but had been given one additional nurse to cover juvenile receptions. **The in-patients’ day should be reviewed and current standards met.**

**Visiting specialists and secondary care**

6.23 There was an adequate range of visiting specialists and referral to the NHS in general worked well though transfers of mentally ill patients was often slow. A genito-urinary consultant had visited the prison but demand had been low and, after some training this work was no done by the doctor from the local trust. **We repeat our recommendation above about the need for more formal supervision arrangements.**
Pharmacy

6.24 There was no pharmacist employed at Lancaster Farms, and the pharmaceutical service was provided from HMP Garth. The Head of Health Care was an I Grade nurse. In addition there were three F Grades, twelve E Grades and four part-time D Grade nurses.

6.25 The whole Health Care Centre was open on a 24-hour basis, but the actual Treatment Room was open from 8 am to 4.30 pm each day. Medicines were distributed between 11.30 and 11.45 am directly to the young prisoners’ cells. When necessary a further distribution took place at 8 pm. This was a good procedure, which should cut down the possibility of exchange etc of medicines between young prisoners.

Treatment Room (outpatients)

6.26 The Treatment Room, in which the medicines were stored, was large, clean and tidy. The British National Formulary was present as a reference book. The refrigerator was clean and tidy, but did not contain a maximum/minimum thermometer. The refrigerator should have a maximum/minimum thermometer, and daily records should be kept of the temperature of the refrigerator.

6.27 A resuscitation kit was present and was marked with an expiry date of 7/2000. We were told that the contents of the kit were regularly checked. Medicines were stored in locked cabinets. All the nursing staff held the keys to the cabinets. The treatment room was locked at 4.30pm. The keys were then placed in a locked box, to which all nursing staff had access if necessary.

6.28 There was a capacity for 15 in-patients on the first floor. Again medicines were stored in a clean and tidy room with good facilities. A refrigerator was present which carried an external temperature display with maximum/minimum capability, although no monitoring of the temperature appeared to be taking place. We recommend that a daily record of the maximum and minimum temperatures of the refrigerator should be maintained.
A resuscitation kit was present and was clearly marked with an expiry date of 7/2000. We were told the contents of the kit were regularly checked.

**Storage**

Internal and external preparations were stored separately. All patient specific medicines appeared to be correctly and clearly labelled. A large proportion of the young prisoners appeared to receive their medication In-Possession, either on a daily or weekly basis. For each patient receiving medication daily, there was a labelled tray carrying the individual’s name and number. In the tray there were pre-packs, properly labelled, holding that young prisoner’s daily medication. This was conducted directly to the respective cell. Young prisoners who were allowed weekly in-possession medication usually received their medication in the Venalink monitored dosage system.

A number of correctly labelled pre-packs were present. We were told that these were for the use of the doctor, if there was not time for the item to be obtained from HMP Garth. If the doctor used one of the pre-packs, he filled in the young prisoner’s name and number on the label himself.

There appeared to be only a few stock items present, and we were told that they would be used on the doctor’s authority only, or as appropriate for special sick. Stock items were segregated from patient specific items. We saw no date expired stock, and were told that stock checks were undertaken weekly.

Unused or returned medicines, together with date expired stock, was segregated then returned to HMP Garth. In the event of a drug recall, the information was received directly from Medicines Control Agency.

**Supply of Medicines**

Medicines were supplied on the authority of a doctor’s prescription. The prescription and administration chart being used was one raised locally, but closely resembled the standard (HR013 5/96) form, except that the form used was based on 14 days supply rather than 28. Forms that we saw appeared to be correctly and fully
annotated. Prescriptions were faxed through to HMP Garth by about 10.30 am each day and the dispensed items received back at HMYOI Lancaster Farms the same afternoon. If a prescription was needed at the weekend, and the item was not present, either a local community pharmacy or Lancaster Royal Infirmary was used.

6.35 There was a written policy with regard to in-possession medication, but it did not appear to have been reviewed for some time. The in-possession policy should be reviewed on a regular basis. A policy for supplies to be made to youngsters going special sick was present, together with a list of medicines that nurses could supply. It consisted of various homely remedies. The policy had not been reviewed for some time. The policy for supplies for special sick should be regularly reviewed. We were told that only occasionally were medicines supplied to those going special sick, and the administration chart for the prisoner was annotated accordingly. We did not see any such annotations on the forms, but that could be due to the scarcity of such supplies.

6.36 There was no prescribing formulary. A prescribing formulary should be formulated. It should be drawn up by consultation between the pharmacist at HMP Garth and the doctors at Lancaster Farms.

6.37 There appeared to be no dispensing of items by the nursing staff. All supplies were by way of dispensed medicines from HMP Garth or by the doctor using pre-packs or sometimes from the limited stock items.

Out of Hours Procedures

6.38 The Health Care Centre opened on a 24-hour basis, and consequently there was no out-of-hours procedure, or emergency cupboard. However, resuscitation kits were present both in outpatients and in-patients.

Controlled Drugs

6.39 There was a controlled drugs cabinet. The only item in the cabinet at the time of our visit was an open foil pack of Ritalin Tablets. It was labelled (HMP Garth) as a stock item and not patient specific. The only way in which the Ritalin Tablets should
have been present would have been as the result of a prescription written in the approved manner forwarded to HMP Garth, and dispensed for a named patient. A controlled drugs register was present, which had the facility to record running totals. The total entered for Ritalin in the book and the number of Ritalin tablets in the cabinet balanced. **Supplies of controlled drugs must be on the authority of a properly written prescription. The label must always carry the name of the patient, dose, and date of dispensing.**

**Development of Pharmacy Services**

6.40 The pharmaceutical service was provided from HMP Garth. *The pharmacist visited Lancaster Farms once a month.* A Drugs and Therapeutics Committee had only recently been set up, and met on a quarterly basis. It appeared that the usefulness of the last two meetings had been reduced due to the absence of key personnel at both. **A higher priority should be given to the Drugs and Therapeutics Committee, which would be an ideal forum to discuss the setting up of Prescribing Formulary, and review the in-possession and special sick policies.**

6.41 No log of interventions or errors was kept. We were told it was not deemed necessary because there had not been any required interventions. **We recommend that a log should be kept of interventions or errors.**

**Dental**

6.42 The dental services were provided under the General Dental Services (NHS contract). It was understood that the Dentist had been abroad for a considerable period of time and was likely to be away for further time. Other members of his practices had covered the dental sessions in his absence; the dentist who was working on the day of the inspection was a locum dentist who was an assistant. **It was not considered good practice that the contract holder was not available for such a long period of time.**

6.43 The surgery was of good size and the equipment was modern, with the following additions it would be considered satisfactory.

- **A mercury spillage tray and kit should be provided.**
• Emergency drugs to be in the surgery when sessions are taking place.
• It was noted that the patient, dental nurse and practitioner did not have eye protection during the provision of treatment – **eye protection needs to be provided**.
• A protective bib for the patient should also be provided and used during treatment.

6.44 *There was self referral for the patients and there was no/minimum waiting lists – this was considered good practice - also good practice was that on the reverse of the referral forms various types of health advice was given, one of these gave advice on dental care.*

6.45 The range of treatments available was acceptable, with different ranges depending on the status of the young prisoner – either sentenced or on remand.

6.46 **It is suggested,** especially in view of the ages of the young prisoners/trainees, both **that oral hygiene and dietary advice is given** to them. This could be provided by dental health educators or a dental hygienist. It would not be necessary for a dental practitioner to carry out these duties.

6.47 **It would be prudent to make checks on claims for treatments provided, as a number of the recipients for treatment are exempt from patient’s charges due to their age.**

6.48 The medical histories of the patients undergoing treatment were accessible to the practitioner, and relevant medical histories applicable to dentistry should be entered on the treatment card.

6.49 It was understood that, on occasion, difficulties were experienced in collecting and delivering patients from their unit/place of work. It might be helpful if a dedicated Prison Officer could be available when the Dentist is working.
CHAPTER SEVEN

ACTIVITIES

Education

Management

7.01  The education contractor had taken positive action to deal with the requirement to provide separate educational provision for juveniles. For example, an Education Co-ordinator for juveniles had recently been appointed along with a team of qualified and experienced teachers who had experience of working in secondary and special schools with 15-17 year olds.

Induction

7.02  The Education Department had established an impressive and comprehensive set of procedures relating to Induction. For example, new arrivals were made aware of the education and training opportunities on offer through the provision of up-to-date information, the opportunity of one-to-one guidance interviews and the provision of taster courses. Most students completed a Basic Skills Agency test during the Induction programme which was effective in identifying those students who had difficulty in reading and writing but it did not provide sufficient information regarding the nature of specific individual needs. 34% of the respondents in the prisoner questionnaire felt that they had educational needs and wants (see Appendix IV).

Curriculum

7.03  Students were offered a good range of subjects by the Education Department. In addition to classes in basic, key and life skills, students were offered sessions in arts and crafts, woodwork, childcare and cookery. However, there was no provision for drama and very limited provision of information technology (IT) sessions. The ability to offer IT classes was severely restricted by the lack of up-to-date equipment
and resources. Provision for students in the Health Care Centre and the Care and Separation Unit was unsatisfactory and should be improved.

7.04 Teaching sessions were generally well attended. Most students arrived for classes on time. Evening classes were offered on one evening each week. There was no weekend provision.

7.05 The Education Department had recently established a separate section to deal specifically with the needs and requirements of juveniles. 25 per cent of the education budget had been allocated to support this initiative along with an additional sum of £90,000. As a consequence, the Education Department was developing two programmes, one for juveniles and one for young prisoners, both concentrating on the essential requirement to cover basic and key skills. A consequence of this development was that the Education Department was struggling to maintain its commitment to providing a broad range of provision for all students.

Teaching

7.06 The quality of teaching ranged from satisfactory to good. Relationships between teachers and students were excellent. Teachers offered constant reassurance and support. Teaching sessions were well planned. Course documentation, including schemes of work, was thorough.

7.07 The Education Department was attractive and maintained in good order. Teaching rooms were also attractive, clean and conducive to learning. There were many examples of student work on display.

7.08 Most students behaved well and made good progress. Record keeping was generally up-to-date and attempted to record the progress and achievements of short stay students as well as those serving longer sentences.

7.09 Students made good progress in Art and Cookery. The Links Programme enabled new arrivals to gain first hand experience of the range of options on offer. The Video Debate group responded well to the topic under review.
Literacy

7.10 The Basic Skills Agency screening test provided a useful initial view of students’ attainment in literacy. However, test results were not always available when students joined classes and it was difficult therefore for teachers to match work to the student. Diagnostic testing that could help in devising individual work to address students’ particular weaknesses did not follow screening.

7.11 In each classroom there were students at different levels. The majority were working at an appropriate level but students with lower skills in reading and writing were not consistently making satisfactory progress. They were often asked to attempt the same work as others and found it too difficult.

7.12 Most students had sufficient skills in reading and writing to cope with the demands placed on them in their learning. This was a significant achievement given that many had attended school irregularly and had no qualifications in English. 75%, according to the prisoner questionnaire had been excluded from school and 84% used to truant (see Appendix IV). A few students had significant difficulties with reading straightforward texts but most could read with sufficient competence and write sufficiently accurately to communicate information and understanding. When given the opportunity, many students were also capable of writing at length but they were often asked to write briefly. Students needed more opportunities to write persuasively as well as to convey information to ensure they were challenged and developed their writing. Most students listened attentively and the majority were confident in speaking, answering questions clearly and occasionally raising points during discussion.

7.13 Teachers planned effectively and took care to discuss students’ progress with them and ensured they were involved in identifying areas for improvement. There was, however, scope to improve learning by also planning work for individuals and more precise assessment of individual progress in reading and writing. Marking was not always precise in identifying specific aspects for improvement. Teachers
managed classroom behaviour well. On occasion the range of learning activities within a session was not sufficiently varied to consistently challenge students.

7.14 Teaching sessions were too long. The limited range of books available in classrooms did not help teachers to encourage students to develop their reference skills or to read independently. In addition, the lack of information technology restricted learning because there were no regular opportunities to draft writing or to use technology to help students spell or learn to read at their own pace. The information technology restriction in helping students to spell or learn to should be addressed.

**Numeracy**

7.15 Initial screening for numeracy was carried out in a very thorough way, but the results did not always reach tutors before students joined their classes. The Education Department had a very comprehensive system of differentiated learning materials, allowing individual students to work at appropriate levels; this was supplemented by good key skills assignments, which were designed to relate directly to students’ vocational or other interests.

7.16 The numerical capability of students was generally satisfactory and sometimes good, particularly in view of the limited prior educational experience of many of them. Mental arithmetic was often quite strong. Most young men were building up suitable files of work, providing evidence of progress in their studies. However, the rate of progress was sometimes reduced by the time spent on repetition of exercises in which they were already competent. Levels of motivation were relatively high in most numeracy lessons. The positive features of students' achievement and response owed much to the hard work put in by tutors, the good relationships they built up with the students, and their constant encouragement.

7.17 More precise assessment and diagnosis of specific difficulties in numerical understanding would allow materials and teaching to be better targeted. Other areas for development include the introduction of greater variety into styles of teaching and learning, and the use of information technology to help aid numerical understanding.
Teaching sessions were too long for anyone to sustain attention on numerical work; shorter teaching sessions would enable available time to be used more effectively.

**Resettlement**

7.18 _Insufficient attention was being given to the resettlement of juveniles and young prisoners in preparation for release._ Links with employers, and external groups in ‘home’ areas were underdeveloped. The quality of information on site relating to possible opportunities in employment, training and further education was poor. The ‘welfare to work’ programme, targeted at young people over the age of 18 years, was only providing for a small percentage of the total population.

7.19 A local careers company had recently agreed to provide a full-time careers adviser to work specifically with juveniles. This post should provide much needed individual guidance relating to possible opportunities in employment, training and further education. Further work was necessary to determine where the careers adviser would be located and whether the careers adviser had a role in providing courses and classes in the teaching programme offered to juveniles. The post will also provide a mechanism for developing stronger links between Lancaster Farms and key personnel in ‘home’ areas.

7.20 Case conferences, recently established for juveniles, involving representatives from Youth Offending Teams, Education and Prison Officers were very effective in agreeing and planning individual programmes and in setting special goals and targets.

**Library**

7.21 The Library was centrally located on the ground floor of the Education Department but it was too small to meet the demands of a growing prison population. For example, the lack of space in the Library made it impossible for students to conduct individual research, browse or even sit down. A visit to the Library was nothing more than an opportunity to return or exchange books.

7.22 The Library, although well managed, was poorly equipped. For example, there were no computer or CD-ROM facilities. Overall stock levels were satisfactory
but there was a shortage of easy readers for those with reading difficulties and audiotapes were only available on request. There was very little up-to-date information relating to employment, training and further education opportunities.

**Employment**

7.23 The most significant feature of work and training for young prisoners at Lancaster Farms was that there was not enough of it. 26% of those who completed the survey were employed in the prison. No additional workshop places had been provided since additional accommodation had been built and little account had been taken of the needs of this changing population.

7.24 The facilities were very good with a wide range of courses available including catering, industrial cleaning, painting and decorating and plastering. Each workshop closed for half a day each week so that the young people could attend key skills sessions in the Education Department. The Instructors we met were enthusiastic and clearly provided well-organised work in a safe environment. There was also a multi-skills workshop specifically for eight juveniles at a time, which provided short-term courses suitable for the length of sentences being served.

7.25 The gardens, which were in excellent order, provided employment for more young people and the manager proudly showed us a young man who was cutting grass with a power mower for the first time after instruction. The young man also looked very pleased with his new-found skills and the trust placed in him. Further work places were about to be created as the establishment took over the management of three farms previously run by HMP Kirkham. It was envisaged that 16 additional work places would be provided although there was an acknowledgement that it might be difficult to find suitable youngsters who could be temporarily released. Coincidentally two young prisoners ran away from one of the farms on the first day of our inspection.

7.26 Even if 16 suitable youngsters could be found, local management thought that the pool of suitability would then be empty and reduce the chances of any other work
requiring temporary release. Virtually no community work was being undertaken at the time of this inspection.

7.27 We frequently found young prisoners who were locked up on the wings because there was insufficient work. Some of these were on remand and therefore work was voluntary but, in any event, the type of workshops already described did not lend themselves to a remand population. Another workshop, possibly a production shop, suitable for remands or short term sentenced young prisoners should be provided.

7.28 We noticed during our inspection of the workshops that most were under utilised. Instructors told us that youngsters had been required elsewhere for courses or interviews. Best use of limited resources was not being made. We have already mentioned that numerous youngsters remained locked up for most of the day and yet at the same time we found that others were required to be in two centres of activity at the same time. We recommend that there should be improved procedures for allocating young prisoners to work to make more efficient use of activity places.

7.29 The Instructor for the catering course was on leave for three weeks and consequently the pupils on the course had been redeployed to other jobs. We were told that one young prisoner would be discharged before completing the course as a result of missing three weeks work. We accept, of course, that staff must have leave but it was a waste of time and effort and frustrating for such a situation to arise. The establishment’s staff in post figure should include sufficient Instructors to cover absences of staff.

NVQ (Catering)

7.30 Lancaster Farms offered national vocational qualifications (NVQs) at level 1 in catering and hospitality. Programmes lasted between three and six months and all trainees undertook some training in basic cookery before embarking on the NVQ programme. Trainees did not have access, at any level, to the establishment’s main Kitchen and were not involved in preparation of meals for young prisoners. All training took place in a separate catering workshop. The workshop was well equipped
and suited to the development of domestic cookery skills at a basic level. The catering workshop, however, did not provide a realistic working environment, although records indicated that it had been approved as such by the awarding body. Establishment Instructors were fully aware of the severe limitations of the workshops for the effective delivery of NVQ training and the difficulties encountered in giving trainees opportunities to acquire a full range of job skills. Instructors planned to develop schemes that would enable trainees to be utilised within the main food production areas of the establishment and thereby give trainees’ wider experience and greater opportunity to achieve occupational competence. **Trainees should be integrated into a realistic, or a real, working environment immediately.**

7.31 The catering training programme had a capacity for a maximum of ten trainees at any one time. At the time of inspection, there were eight trainees who usually attended training sessions and, of those, three were working towards NVQs at level 1. No training in catering was taking place during the inspector’s visit, however, owing to the absence of the catering NVQ trainer on a three-week annual leave. Catering trainees were either locked in their cells during times scheduled for training, or they were completing other jobs not associated with catering. One trainee, due for release within a week following the inspection, had only a few assessments to complete in order to gain his full NVQ. The temporary absence of any Instructors able to assess trainees’ competencies for NVQ catering, coupled with the failure to integrate training into catering activities in the main food production areas and provide assessment opportunities, was likely to result in the trainee leaving establishment without a full qualification. **Consideration should be given to provide a consistent assessment service, particularly during planned holiday periods for Instructors.**

7.32 Trainees’ files were neat and tidy and contained adequate information to support trainees’ learning for the NVQ and different aspects of cookery. Before commencement of NVQ training, each trainee attended a series of sessions on basic health and safety and basic food hygiene. **Trainees’ knowledge and understanding of topics covered was systematically tested at the end of these short courses, and their achievement acknowledged through the award of nationally recognised certificates.**
This was good practice. It acted to motivate trainees and encouraged them to achieve.

7.33 Trainees had access to a good range of interesting learning resources, including a small number of videos and CD ROMs. The catering NVQ Instructor had prepared workbooks and information packs to support the different units of the NVQ. Trainees commented that this information was given to them immediately following theory training sessions. Trainees found these theory sessions interesting and informative.

7.34 Records indicated that in the 12 months between March 1999 and March 2000, 14 trainees left the catering and hospitality NVQ programmes. Of those leavers, three achieved a full NVQ. Remaining trainees achieved an average of six units. These were poor results.

Physical Education

7.35 The PE Department was very busy indeed and since procedures to keep juveniles separate from other young prisoners had just been introduced prior to our inspection, attendance at PE activities had lately been quite delicately balanced.

7.36 The latest PE programme was comprehensive but it was only two weeks old; it still needed refinement as revised procedures with those children sentenced to Detention and Training Orders settled down.

7.37 Staff worked hard to meet the needs of individuals in each wing; applications for PE sessions (am, pm and evening on weekdays, am and pm on weekends) were taken on all wings except Buttermere. PE staff collected juveniles themselves from Buttermere for each session, which caused delays in unlocking them. It was necessary to decide whether juveniles should go to PE activities already changed, whether they should have separate changing facilities at the garden shed area and, in fact, whether completely separate facilities should be provided for juveniles.
7.38 According to the prisoner questionnaire, 48% of trainees and 61% of the YPs went to the gym over three times per week. However, numerous hours were lost in PE since each session only lasted approximately 45 minutes to account for the 15 minutes changing and changeover times between each group that attended the facilities. Where both groups were scheduled to attend, young prisoners came in, got changed and went out, then juveniles came in, got changed and went out. After approximately 45 minutes of activity, young prisoners came in to shower, got dressed and came out, then juveniles came in to shower, got dressed and came out. **We recommend that separate PE facilities be provided to meet the needs of juveniles so that existing facilities can be made available for young prisoners and neither group is disadvantaged. A swimming pool should be provided in the activities centre courtyard area.**

7.39 The department was well staffed and kitted out with modern equipment. There was a grassed rugby pitch, an Astroturf football pitch, a multi purpose hall, a traditional weights room, a large changing and showers room and a cardio-vascular exercise studio off the VTC workshop yard. There was a classroom upstairs where course study and paperwork was completed and where staff did Control and Restraint training.

7.40 Relationships between young prisoners/trainees and PE staff were very positive, even though PE staff had the authority to exclude them temporarily from PE activities for serious misdemeanours. From enquiries made, and after viewing Request and Complaints completed relating to PE activities, we concluded that no one was unfairly excluded from PE activities.

7.41 Young prisoners/trainees claimed that the showers room in the Gymnasium was the most unsafe area in the establishment. At least 40 trainees or young prisoners got changed and showered in the same area at the same time despite there being only 13 showerheads along one wall and in one corner. Many youngsters felt vulnerable even though PE staff were in attendance throughout and there was a curved mirror in one corner to aid supervision. Some bullying was still reported e.g. name calling and towel flicking. The showers were examined and we found some issued kit left
behind, paint coming off the ceiling and plastic sachets on the floor where youngsters had brought their own soap solution to the Gym. Soap solution was provided in the showers to stop individual youngsters bringing their own toiletries to help prevent theft and bullying.

7.42 Every juvenile and young prisoner attended PE induction, which included kinetic lifting techniques and basic British Amateur Weight Lifting Association (BAWLA) certification. Kinetic lifting was also available for staff. Numerous BAWLA certificates were seen on display in cells throughout the establishment. Achievements, including Gym induction and Basic BAWLA, were noted on individual training record cards. A comprehensive PE leaflet, which included pictorial displays of clocks to indicate timings, and the different PE activities available at those times, was issued to everyone during Induction.

7.43 Remedial PE was provided for youngsters who needed it and a physiotherapist also visited them one day each week. One-to-one PE sessions, recreational therapy sessions for beginners, were arranged to help none-copers enter into mainstream PE and then to cope with other mainstream establishment activities.

7.44 PE staff were allocated to the different wings. Although they said they did not have sufficient time to seek out individuals who did not use PE facilities regularly to enquire why and encourage them to go to the Gym, we saw minutes of meetings between PE staff and wing representatives. PE staff also attended establishment wider ranging committee meetings e.g. Anti-Bullying, Anger Management and Drugs Strategy etc. when they were available and assisted Education staff with healthier lifestyle classes covering diet, exercise, effective use of recreation time etc.

7.45 We particularly liked the complaints / suggestions box that was available to youngsters who used the Gym. However it should be relocated lower down the wall so that shorter people could reach it. We were pleased to see questionnaires had been used to get feedback from residents about PE and available facilities.
7.46 PE staff were all male but some trained female Sports and Games staff from Buttermere also worked in the Gym at times.

7.47 We saw copies of youngsters’ injury reports and were pleased to see that Health & Safety “Accident or Near Miss” forms were also completed where appropriate.

7.48 No work was taking place with visiting special needs groups at the time of our inspection but staff planned to introduce courses for the Duke of Edinburgh Awards Scheme soon. Some discharged youngsters had since written into the establishment for references so that they could get jobs in the leisure industry and we saw a letter from a local rugby club who had recruited a youngster who had “found rugby” whilst in custody at Lancaster farms.

**Contact with Family and Friends**

7.49 We were pleased to find that youngsters were informed of their entitlement to letters, telephone calls and visits within 24 hours of admission to the establishment. The importance of youngsters maintaining contact with family and friends was recognised by staff at all levels and we saw evidence of staff encouraging young prisoners to do so throughout the course of the inspection.

**Mail**

7.50 Young prisoners did not receive stationery and telephone cards in Reception but were given a reception letter and pen on admission to the induction wing for young prisoners and to Buttermere for juveniles. More stationery and telephone cards could be purchased the following day when inductees were taken to the prison shop. These items could then be purchased weekly thereafter. Young prisoners could write as many letters as they could afford and receive as many letters as they wished.

7.51 Young prisoners outgoing mail was posted within 24 hours (48 hours when posted on Saturday) as the wing letterboxes were emptied twice on a weekday and once on Saturday. Incoming mail was received by young prisoners within 24 hours of receipt by the establishment and this included registered and recorded mail. Very few
of the respondents to the prisoner questionnaire felt that there were problems with sending letters (10%) or receiving letters (15%) (see Appendix IV). There was an efficient messenger system facilitating these collections and deliveries of mail. The messenger was responsible for collating and sorting all the mail both external and internal. This system had the added advantage of enabling all parts of the establishment to receive internal documents quickly and it also served to cut down on the Prison Officer time often used for such activities. We were therefore surprised to see that young prisoners’ mail was opened after it had arrived on the wing and they also carried out “on suspicion” censoring whilst checking all mail for enclosures. Whilst the process we observed was both quick and efficient, we felt that this was a waste of valuable Prison Officer time.

7.52 The messenger also looked after the delivery of special items such as postal orders, cash disbursement forms, clothing applications etc. We were concerned to note that postal orders were left unattended in a pigeonhole in the Post Room. Though these periods were short, this did leave these valuable items insecure. Any valuable items such as postal orders should not be left unattended in the Post Room and should be kept securely.

7.53 The Post Room was both cramped and badly organised. It was clear that it needed new pigeonhole arrangements. Also located in the post room were two photocopiers, which were very large, one colour and one black and white. If more than about three or four people were in the room at once it became excessively cramped. The Post Room needs reorganising.

Telephones
7.54 As mentioned above, youngsters were not issued with phone cards on their arrival in the establishment and had to wait until the following day when they could visit the prison shop to buy them. Staff made phone calls on behalf of new receptions to their next of kin to let them know of their arrival at the establishment. Youngsters were not usually allowed to speak to their families themselves on their first night at the establishment. Young prisoners should be allowed to speak to their families or close friends on their first night in the establishment.
7.55 Young prisoners were given an advance of a phone card or cigarettes on the day after their reception. This meant that smokers had to choose between one and the other. **An advance of both a phone card and/or cigarettes should be issued to young prisoners on reception.** We were told that a selection of phone cards was available on wings for smokers in this situation but a more liberal use of advances would formalise this situation.

7.56 Young prisoners had use of at least one telephone in a wing holding up to 60 young prisoners. Youngsters had to put an application in to use the phone during evening association. Young prisoners could also use the phone on the weekends. Each phone was located in a telephone box, which gave excellent privacy. Youngsters were allotted approximately ten minutes for their calls. We estimated that youngsters would probably only have access to the phone once every six days at the most. Considering the importance that the establishment evidently did give to contact with families and friends, **we felt that youngsters should have at least daily access to telephones.** We noticed that Windermere Unit had two boxed phones on the sentenced side, only one on the remand side, whilst Coniston and Derwent and Buttermere wings had one phone on each side of the unit. It may be that **standardising the units by putting two boxed phones on each side of the wing would facilitate daily access** and allow some young prisoners to maintain shorter but more regular contact with their families. **This should be considered.**

7.57 Foreign nationals were not given phone calls in lieu of visits but we were told that the establishment did facilitate their calls abroad. **We recommend the establishment implements a phone calls in lieu of visits system for foreign nationals.**

7.58 The messenger also delivered free wing newspapers to each unit, four being issued for each side of the wing. He also delivered the newspapers that young prisoners had ordered. Newspapers were usually received when youngsters arrived back from their morning’s labour period.
The establishment's switchboard was efficiently staffed by an ex-BT engineer. The operator dealt with initial enquiries but would also put enquiries through to the units to be dealt with by staff who knew the youngsters involved. He had created and was constantly updating the staff telephone list. He dealt with queries efficiently and politely. The switchboard itself was located in a very small oppressive room with no windows.

Visits
7.60 Young prisoners were informed of their entitlement to visits and the arrangements associated with visits during the first 24 hours following reception. Youngsters were given a Reception Visiting Order and this gave details of the visiting times, the arrangements for bringing in property and details as to how to get further information. It also informed visitors of the identification they would have to bring to be allowed access to the establishment.

7.61 Young prisoners received their statutory entitlement to visits and the overall number of visits allowed for each was linked to the Incentive and Earned Privileges scheme. No young prisoners were deprived of their statutory entitlement to visits as a punishment. Young prisoners’ access to the visits was not inhibited by competing regime activities. Young prisoners who required extra visits for compassionate reasons for instance bereavement and other domestic difficulties were allowed extra visits to assist them. The major problem with visits was that they regularly started late and the visit times were cut daily. This is discussed in more detail below.

7.62 Opposite the establishment was a purpose built Visitors’ Centre, which was well equipped, though a little small for the number of visitors it now was dealing with. It had been built when the Operational Capacity of the establishment had been much lower and thus designed to deal with fewer visitors.

7.63 The centre was ably run by a Probation Service Officer with cover from a casual Probation Service Officer at the weekends. A WRVS volunteer staffed the tea bar. This provided cheap drinks and snacks. The centre had a sufficient number of comfortable chairs for visitors, and an excellent display of leaflets available dealing
with such subjects as stress, drugs, sexual health and included a visitors’ information booklet which expanded on the information given in the visiting order and included excellent directions to the establishment. **This information booklet should be sent out with all Reception Visiting Orders as it provides valuable advice for new visitors.** Also of note was another locally produced booklet for children visiting the establishment. This explained in easy language what Lancaster Farm was, what a prison is, what a Prison Officer looks like and included jokes and puzzles for children to complete while waiting for their visit. **This booklet was an example of good practice and the use of such information aimed at young prisoners’ children should be encouraged across the Prison Estate.**

7.64 There was also a small, children’s play area, which though well equipped, was inadequate for the number of children it was obviously catering for. **More children’s play area space is required.** This might be achieved by providing an outdoor play area such as the one we saw recently at Downview Prison. The establishment was fortunate in having excellent car parking facilities and in fact space could be reclaimed for an outside play area leaving sufficient car spaces available.

7.65 Visitors who were not travelling by car could catch a bus service operating every half-hour from the Lancaster bus station. Information was available about the Assisted Prisons Visits Scheme. This information was referred to in the visitors’ information booklet. The Probation Service Officer also provided assistance to visitors, explaining the visits procedures if necessary and generally trying to put visitors at ease. She felt well supported by the establishment and reported good relationships with Visits staff. The Visitors’ Centre was equipped with an alarm bell system but we were informed that this had only been used twice in the history of the Centre and that the response from the establishment had been very quick and efficient.

7.66 The atmosphere in the Visitors’ Centre was excellent. The Probation Service Officer and the WRVS were creating a pleasant, welcoming environment for visitors to wait in. We asked visitors for their comments during the inspection and were consistently told that they were very happy with the facilities and the way they were
treated by all staff. Their major complaint was that visits sessions always started late (see Appendix IV).

7.67 We watched the procedure for channelling visitors from the Visitors’ Centre up to the Visits Room and many of the reasons that the sessions were always late became apparent. The Probation Service Officer in the Visitors’ Centre sent visitors over to the establishment in batches. Visiting Orders were taken by Gate staff. Visitors who had come over from the Visitors’ Centre were then asked to wait again in the Outer Gate waiting room. This was an extremely claustrophobic room in which visitors were having to stay for up to ten to 15 minutes after having waited for at least half an hour in the Visitors’ Centre.

7.68 Visitors then went through sliding doors into a long, thin corridor at the start of which were 72 lockers for securing visitors’ property. This number was adequate for the number of visitors. Some visitors were then taken to a small room just off this corridor where their photographs were taken with a digital camera. Photographs were taken of all male visitors under the age of 25 and all female visitors under the age of 18 (the under 18s were photographed for child protection reasons and the older males for security reasons). Photographs were taken by an Operational Support Grade.

7.69 Visitors then proceeded down the corridor and showed their ID to a Prison Officer. If visitors came with insufficient ID on their first visit they were usually allowed in anyway but given advice as to what to bring in the future. We were concerned that if ID was insufficient and staff wanted to turn away a visitor for any reason that this was not an environment where this could safely be done. Any altercation would be difficult to manage in such a small area and visitors were already within the secure confines of the establishment by this point. Identification should be checked at the Gate before visitors are allowed into the secure confines of the establishment.

7.70 Once identification had been checked, visitors went through an X-ray machine. Two Officers carried out pat down searches of all visitors. Both staff were female which meant that there were women searching male visitors. It would be wise
to reconsider the use of female Officers to pat down male visitors. We were impressed by the courtesy all staff showed towards visitors whilst carrying out the above tasks. The process however was very long winded and conducted in an unsuitable environment. This whole area should be reorganised. We were surprised also to see Prison Officers carrying out these tasks when these jobs are more commonly carried out by Operational Support Grades in other establishments.

7.71 Those photographed were given sticky badges with their photographs on them to wear in the Visits Room providing staff with an easy way of checking their identity.

7.72 Visitors were then taken upstairs to another waiting room. The stairs were tidy but were in need of deep cleaning. There was good camera cover to this area. The waiting room was clean and there were a good range of posters displayed about, for example, the Anti-Bullying policy, World Aids Day, and acceptable forms of identification for visits. There was a small property room off this waiting room where visitors could hand property in for young prisoners. Youngsters had to make an application for anything they wanted handing in except for socks and boxer shorts. A Reception Officer attended the property room to endorse property cards and bag up property taken in from visitors.

7.73 Visitors were then finally allowed into the Visits Room. The process we saw was, as described above, extremely lengthy. Visitors who had arrived at approximately one o'clock for a 1:30 pm visit did not in fact get into the Visits Room until 2:30 pm. Visit sessions should start on time. The delays being regularly experienced by visitors were simply unacceptable.

7.74 The Visits Room was large and bright with a high ceiling. It was equipped with 39 tables and had camera cover from four domed cameras. The monitoring of these cameras was carried out by Communications staff. It was felt that this was inadequate and an area next to the Visits Room was being refurbished and this included a new camera observation point to be staffed by Operational Support Grades. This new area was also to include a renovated prisoner searching area and separate
holding rooms for young prisoners and juveniles in order to comply with the Youth Justice Board requirement for the separation of juveniles from other young prisoners. These rooms were to be installed with a cell call system. As mentioned before there was also camera cover over the stairwell going up to the visits room, in the waiting room outside the visits room and near the WRVS tea bar. The new system was planned to be up and running by the end of June 2000.

7.75 Off the main Visits Room were seven closed visits boxes. Staff reported that these boxes were very rarely used and that there were approximately 20 young prisoners subject to closed visits at the time of the inspection. We received no complaints from visitors or young prisoners about the closed visits arrangements. Also just off the Visits Room were two Official Visits Rooms. Official visitors could also use the whole of the Visits Room during the morning sessions. The separate Visits Rooms for official visitors were useful even in this period for particularly sensitive interviews, for example with police.

7.76 The WRVS provided the tea bar mentioned above for both the official visit sessions in the morning and the social visit sessions in the afternoon. Two volunteers staffed the tea bar at all times. They provided a good range of drinks and snacks and appeared to have good working relationships with staff and visitors.

7.77 The Visits Room was decorated with pictures of for example Winnie the Pooh, and the atmosphere in the area was relaxed and welcoming and not oppressively restrictive. It was however well supervised by staff.

7.78 All young prisoners wore green overalls for visits in order to make it harder for them to smuggle illicit items into the prison internally. We received complaints from young prisoners that these overalls were not regularly laundered and they would have to wear sometimes badly fitting and unclean overalls for their visits. The establishment should make sure that there are a good selection of green visits overalls in a range of sizes and that these are regularly laundered so that young prisoners do not have to put on dirty overalls for visits.
7.79 There were a number of visitors’ toilets available just off the waiting room, including those for disabled visitors. It would be difficult for a visitor to visit the toilet during a visit. **This provision should be reconsidered.**

7.80 We were particularly concerned to note that there was no children’s play area in the main Visits Room. We observed large numbers of children visiting and the lack of play facilities meant that children were often getting bored with sitting at a table which was causing disruption for the visit and to other visitors. **We urge that the Visits Room be provided with a children’s play area with volunteer supervisors.**

7.81 All male visitors under the age of 25 had their hands marked with an UV stamp on entering the Visits Room. Bearing in mind the elaborate photographing of these same visitors that had happened earlier and their adornment with copies of these photographs, we felt that this extra security measure was a little superfluous. **The use of UV stamps should be reconsidered when looking at the whole of the visits arrangements.**

7.82 There was evidence that Personal Officers did have contact with families and worked with young prisoners to improve contact between youngsters and their families where appropriate. We saw that some of this contact did take place during social visits. We were also heartened to note that the juvenile DTO casework conferences already organised had been attended in 60% of cases by parents.

7.83 After visits, visitors and youngsters were speedily processed and this did minimise the delays in departure.

7.84 Overall, when asked how they felt they were treated by visits staff, 37% of the respondents felt it was well, 38% okay and only 4% badly (see Appendix IV).

**Religious Activities**

7.85 It was a pleasure to meet an enthusiastic and dynamic chaplaincy team who clearly played such a significant part in the care of the Young prisoners at Lancaster
Farms. We were able to meet the full-time Church of England and Roman Catholic chaplains and the visiting Imam, all of who were very committed to their work and who also spoke highly of the relationships between each other. Other denominations were supported by Jehovah's Witnesses, Quakers, Sikhs and Buddhists as and when required.

7.86 The programme for young prisoners was comprehensive with weekend and midweek activities providing for their spiritual needs. Approximately 80 attended the several Church of England and Roman Catholic services on weekends whilst about 12 attended the Imam’s meetings on Tuesday afternoons. Whilst the facilities for Christian services were very good a local limit of 60 per service had been set for security reasons. Facilities for Muslims were less good with no dedicated room available. We recommend that a multi-faith room or separate accommodation for Muslim services should be provided.

7.87 All Chaplains said that the young prisoners were extremely well behaved during services and, in their experience, far better than some congregations in the wider community. Access to the services was readily available even for those in the Health Care Centre or Care and Separation Unit. Although separation of juveniles from young adults had taken place in most parts of the establishment, this was not yet the case at religious activities. Chaplains told us that a rethink of the whole programme would be necessary if separation had to be introduced.

7.88 As it was, the Church of England and Roman Catholic teams were trying to create a family atmosphere by drawing together the work of the week into church services. Saturday and Sunday activities also included ecumenical groups of ten or so young prisoners in the Chapel during the afternoons.

7.89 Midweek activities consisted of a Listener support group on Monday evenings, a Church of England group on Wednesday evenings and Roman Catholic group on Thursday evenings. The Muslim service was held on Tuesdays due to the commitments of the Imam, who incidentally, also administered to adult prisoners at nearby Lancaster Castle prison.
7.90 The Chaplaincy played a major part in the wider regime of the establishment and chaplains were particularly well received in all parts. Unusually the Church of England Chaplain was a member the Senior Management Team and there was also representation on most committees with priority given to Anti-Bullying and Suicide Awareness. Contributions to sentence plans were made whenever it was thought useful or when youngsters requested it.

7.91 A member of the Chaplaincy team, who formed part of a formal reception board, saw all new receptions. 80% of those who responded to the questionnaire had seen a member of the Chaplaincy team within the first week. However, 11% had not seen him or her (see Appendix IV). This duty was increasing, as there were frequently 12 or more to see each morning. There used to be a session for the Chaplaincy team in the Induction programme but this had ceased. There was a feeling amongst the team that although there were two full-time posts, the workload which had increased in recent years and this meant that they were having difficulty in carrying out all their work. We recommend that there should be a review of the staffing levels in the Chaplaincy Department.
CHAPTER EIGHT

RESETTLEMENT

Provision for Life and Long Sentenced Young Prisoners

8.01 When we inspected Lancaster Farms, there were several juveniles and young prisoners sentenced to long periods in custody but no one sentenced to detention for Her Majesty’s Pleasure (juveniles) or to Life imprisonment (young prisoners). Details of those young people on remand who had allegedly committed very serious offences which, if found guilty might attract a Life sentence, had on security grounds been referred to Headquarters to be considered for potential Category A status. Otherwise they were not treated any differently than any other young person on remand, since staff operated on the principle of “innocent until proven guilty”.

8.02 We were told how juveniles sentenced to Her Majesty’s Pleasure (HMP) and young prisoners sentenced to Life imprisonment would be received, risk assessed for suicidal tendencies on reception and risk assessed again after 72 hours in the Health Care Centre. They would be located in the Health Care Centre if necessary, have individual support and care plans designed to meet their individual needs and then Personal Officers took the lead on the young persons progress helping to arrange attendance at education, work, on training courses etc. These procedures appeared to be sound. Young prisoners sentenced to HMP or Life imprisonment were then swiftly allocated and transferred within a couple of days of sentence to a Young Offender Institution that had appropriate facilities for them; usually to Castington in Northumberland for those with general needs and to Swinfen Hall in the Midlands for sex offenders. We were concerned that family ties would be adversely affected for youngsters transferred to Castington and Swinfen Hall; we were told that some juveniles and young prisoners had been transferred to Feltham Young Offender Institution in Middlesex to help maintain ease of visits etc.
8.03 Probation Officers carried out their statutory duties with regard to Schedule One young prisoners (those guilty of violent or sexual offences against young people under 18 years of age) otherwise Schedule Ones were not identified to staff on wings or in visits etc. **Local Schedule One procedures should be reconsidered.** Child Protection Procedures, Prison Service Order (PSO) 440, were in place but not for violent incidents within the establishment. **Child protection procedures involving the local Area Child Protection Committee should be introduced without delay.**

8.04 Juveniles sentenced to HMP and young prisoners sentenced to Life imprisonment were not detained at Lancaster Farms because the establishment did not have the facilities to meet their needs. It seemed inconsistent therefore that young people with long determinate sentences could be detained in Lancaster Farms. **The establishment should be objectively assessed to determine whether adequate facilities, education, work, other purposeful activities, offending behaviour programmes and release preparation work are in place to meet the needs of all the population detained there.**

**Probation**

8.05 The Probation Team comprised a Senior Probation Officer; four Probation Officers including one who worked exclusively with the juvenile unit and one (0.75) who worked on Home Detention Curfews (HDC); a Probation Service Officer who split her time between Bail Information and the Visitors’ Centre and a part time (0.5) Probation Service Officer who covered her in this latter task. The work of the Seconded Probation Team was defined within the terms of the Throughcare Business Plan between the Governor and the Chief Probation Officer for the Lancaster Probation Service, although this did not take account of an additional Probation Officer who had been recruited to work within the Juvenile Unit. Given that the Probation Service has no statutory responsibility for this age group, it was unclear why a Probation Officer and not a Social Worker had been employed to undertake this task.

8.06 The Probation Team were wing based which afforded them a good level of integration with their uniformed colleagues. Prison Officers spoke highly of
individual Probation Officers and the team in general. Young prisoners said that they had good access to Probation staff through the application procedures. Unfortunately, the Senior Probation Officer informed us that he was currently re-thinking the location of the Probation Team and was currently considering making all Probation staff centrally based on one unit. **We believe that this would lead to the isolation of Probation staff and lead to a breakdown in the good relations that have been developed between uniformed and non-uniformed staff. It should be avoided.**

8.07 The work of the Probation Team was integrated as a whole into the business of the establishment. The team were involved in statutory reporting relating to:

- General Throughcare issues/committee.
- PSI 54/94 Schedule One offenders
- CYPA Section 53/2
- Sentence Planning/Boards
- ROTL
- HDC
- Bail Information

8.08 Whilst there was a good and effective Personal Officer Scheme in place, the team also undertook work on units through the application procedures and generally made themselves available as a unit resource.

**Prisoner Programmes**

8.09 The team also worked with uniform staff and the Psychology Team facilitating the offending behaviour courses available in the establishment:

- Alcohol Awareness
- Anger Management
- Crime and Consequences
- Peer Led Alcohol Support Group
- Peer Led Drug Support Group
- Enhanced Thinking Skills (ETS)
8.10 The ETS course was the only accredited programme offered and we were told that the Anger Management course had been validated using the ‘what works’ principles. At the time of the inspection, the other courses were not being run and consequently the quality of those courses remained unclear. It would be prudent to evaluate the quality of all courses offered so that their worthiness and purposefulness for addressing offending behaviour can be assessed.

8.11 Good use was made of the sentence planning process for identifying offending behaviour needs and linking these to the programmes offered (see Sentence Planning section below for details).

8.12 The Probation team also had a quality input into the Induction programme (see Induction). This was an example of good practice.

Observation, Classification, Allocation (OCA) and Progressive Transfers

OCA
8.13 The OCA Department was located on Coniston unit where new young prisoners were inducted. OCA staff carried out one-to-one interviews with all new receptions including those on the juvenile wing in the first few days after their arrival. Staff went to youngsters’ cells to carry out these interviews and complete the initial classification and allocation forms (ICA 2s). The categorisation allocation decisions made were clear, objective and coherent and took into account information from wing staff and other sources such as the Health Care Department, Psychology Department etc. Young prisoners carrying out offending behaviour work etc. with Psychologists were, at times, held back from transfer so that this work could be properly completed. The handbook describing all young offender institutions and prisons was given to youngsters so that they could make informed choice about where they wished to be transferred.

8.14 OCA staff said that they often had to make initial allocations and categorisation of young prisoners without having their previous convictions. We have seen the piloting of some prisons’ access to the Police National Computer working
extremely well and we urge that Lancaster Farms be given such access so that previous convictions can be easily obtained and used by OCA staff.

8.15 Recategorisation boards took place as and when required. Young prisoners could apply for recategorisation but boards usually seemed to take place when the establishment became short of space. The recategorisation form that was used included a section for the Personal Officer’s recommendations and OCA staff were clearly consulting Personal Officers before recategorisation decisions were made. Once a board had taken place and a decision was made by the Governor Grade chairing the board, a tear off slip giving the decision was handed to a youngster’s Personal Officer. This information was passed on either verbally or by giving the young prisoner the slip. There was no formal procedure to provide youngsters with an explanation of their categorisation and allocation in writing or to identify the staff that had made the decisions. The reason given for not allowing recategorisation was usually written, as either “OCA staff don’t agree due to the length of sentence” or as “Governor’s decision”. The latter reason was inadequate so often led to requests to see the Governor involved for a fuller explanation. The establishment should consider allowing youngsters to attend their recategorisation boards so that decisions can be explained there and then, and young prisoners can give their own representations to the board.

8.16 There did not appear to be any systematic progression of those young prisoners who had successfully completed periods of temporary release to consideration for recategorisation to open conditions. The establishment should consider any young prisoner who has successfully completed a period of release on temporary licence for transfer to open conditions.

8.17 Young prisoners were sometimes transferred to complete offending behaviour courses, such as the Sex Offender Treatment Programme, and OCA staff received referrals from Psychologists or Personal Officers when such work was required.

8.18 Young prisoners remanded in custody at Lancaster Farms were not generally moved whilst awaiting trial, conviction and sentence. Once sentenced, one of the
criteria used by OCA staff was closeness to home. However, because of the limited number of young offender institutions and secure juvenile accommodation units within England and Wales, young prisoners were often located long distances from their homes. There were few choices for those young prisoners who had been given long sentences and youngsters were generally allocated to either HMYOI Castington in the Northeast or HMYOI Swinfen Hall in the Midlands. Overcrowding drafts had taken place in the year preceding the inspection and usually consisted of the movement of young prisoners to Lancaster Farms from Hindley. Staff described the disruption this had caused to those young prisoners’ lives and how there had been some disturbances on board the vehicles used to transport these overcrowding drafts because youngsters were very unhappy to move.

Progressive Transfers

8.19 There was evidence that young prisoners were moved as part of their sentence plan, for example, to complete the Sex Offender Treatment Programme (as above). Young prisoners were not moved, in the main, whilst completing courses and whilst undergoing ongoing offending behaviour work etc with Psychologists. Young prisoners were informed if they were going to be moved and allowed calls to contact their families in advance. Unfortunately, because the inter prison transfers run by Group 4 did not always occur as planned (OCA staff estimated that cancellations took place at least every six weeks), families had in some cases been told of moves which were then cancelled. Some had even set off to visit the young person in the wrong establishment. The regular cancellation of inter prison transfers organised by Group 4 should cease.

8.20 Transfers sometimes took place for disciplinary reasons. Usually these transfers were to Hindley and occasionally to HMP & YOI Altcourse. These young prisoners would not always be informed in advance of their removal from the establishment for understandable reasons.

8.21 Lifer Management Unit in Prison Service Headquarters allocated lifers and it usually took between three and four months for a newly sentenced young prisoner to be allocated to a lifer main centre. Another centrally organised set of transfers was
that of the reallocation of young prisoners to adult establishments once they had reached 22 years of age. OCA staff described this as taking many months and the process was only speeded up if a deal could be made Governor to Governor. The transfer of young prisoners changing to adult status should be expedited.

8.22 The OCA department was given information about available spaces in other establishments by the Population Management Unit in Prison Service Headquarters and Group 4 gave them information on Fridays about the moves to take place the following week. The department had clearly experienced some problems in getting this information as it only had an outgoing fax and incoming decisions were going to the fax machine in the Governor’s Secretary’s office. The OCA department should be provided with a fax machine that takes incoming as well as outgoing communications.

Release on Temporary Licence (ROTL)

8.23 Much work was needed to develop the use of ROTL. At the time of the inspection, only four young prisoners (who worked on the farm) were being released on Facility Licences each week. We were told that there were a few young prisoners that had been released on Compassionate Licences, although the actual figures were not available at the time of the inspection.

8.24 The use of Resettlement Licence was non existent. This was unacceptable; young prisoners should be encouraged to work towards Resettlement Licence as a part of their sentence plan (if appropriate) and the establishment should take steps to ensure that this option is made available to them.

Home Detention Curfew (HDC)

8.25 All young prisoners who were eligible for HDC were informed within one week of their reception at Lancaster farms. Having completed the relevant form for their application, young prisoners had no further input into the process. Young prisoners, with whom we spoke, said that they had no idea of what the process involved.
8.26 A Governor and a Probation Officer, having examined the available risk assessments, made all the decisions as to who would be afforded HDC although the Deputy Governor had to sign these off. We were told that there were not the resources to board every applicant for HDC; so none were seen. Answers were given verbally and those that were refused, were able to appeal to the Governor in the first instance and then through the Request and Complaint procedures to the Area Manager.

8.27 It occurred to us that a young prisoner could apply for HDC and be refused having not had any involvement in the process. Whilst we acknowledge that it may be difficult to allow HDC applicants to be boarded, **the benefits and demonstration of respect to young prisoners, in giving feedback on decisions made verbally should not be ignored.**

8.28 Out of 628 applications for HDC only 156 had been approved; this was a disappointingly low proportion. Predictably the establishment had a good record of success. **No ethnic monitoring of outcomes for HDC had been undertaken. This should be addressed.**

**Sentence Planning**
8.29 Excellent systems were in place at Lancaster Farms to manage the Sentence Planning processes. The Sentence Planning clerk opened files for all young prisoners on their reception to the establishment. However, only 48% of those sentenced felt that they had a sentence plan, 32% felt that they did not and 20% did not know (see Appendix IV). Files were then sent to units for completion of reports, by Personal Officers, at the appropriate time. The Sentence Planning clerk chased up all late reports and scheduled Sentence Planning boards. We found the Sentence Planning clerk refreshingly knowledgeable and enthusiastic about her work and clearly playing a key role in the success of the process as a whole. **We examined a number of Sentence Plans that had been written on residential units. These were mostly of a very high standard and staff should be commended for the quality of their work.**
8.30 We were told that all young prisoners, whether subject to Automatic Conditional Release (ACR) for young prisoners serving up to four years or Discretionary Conditional Release (DCR) for young prisoners serving four years or more, attended Sentence Planning boards; this was an example of good practice.

8.31 We observed two Sentence Planning boards. These were both chaired by an acting Governor and attended by staff from a variety of disciplines including e.g. Probation, Education, Psychology and residential units. Written contributions were received from other groups who did not have representatives attending such as the PE Department. The boards were conducted in a semi-formal manner and young prisoners were given the opportunity to express their own views on what had been said of them.

8.32 The boards we observed gave the young prisoners the opportunity to play a key role in their own development and more crucially a real sense of autonomy. They were friendly, open, but focused. We were impressed with what we saw; this was an example of good practice.

8.33 Excellent use was made of sentence planning targets for linking young prisoners to offending behaviour courses, although it was unclear whether targets were based on ‘real needs’ or the availability of courses at the establishment.
Catering

9.01 The catering service at Lancaster Farms was contracted out to Sutcliffe Catering which had worked in the establishment since it opened some seven years ago. 24 staff were employed including the Catering Manager and his deputy. Staff worked a two-shift system, which meant that half of them were at work at any one time. We were told that there had not been a high turnover of staff, which had provided continuity of service to the establishment.

9.02 We were surprised to find that there were no young prisoners working in the Kitchen. The Catering Manager was unclear as to why this circumstance had been maintained. We were told that they were keen to start an NVQ Catering course and that both the Catering Manager and his deputy were NVQ trained assessors. It was noted that there was already a NVQ Catering course being run in the establishment by the Vocational Training Catering Department. However, if there is the demand there seems little reason why one should preclude the other. The establishment should consider the merits of young prisoners undertaking NVQs in Catering that involves them working in a real Kitchen.

9.03 The Kitchen was large and suitably equipped for its purpose. It was clean and in good repair. We were told that some additional equipment was needed and that the Head of Management Services was currently considering this.

9.04 Two food surveys were undertaken each year to develop menus and the quality of food that was prepared was said to be good by the majority of young prisoners with whom we spoke. However, several said that the portions were often too small and sometimes cold and that staff sometimes consumed their food. The consuming of food by staff should be stopped. According to the prisoner
questionnaire 24% felt the food to be good whilst 29% felt it to be bad (see Appendix IV).

9.05 We observed several mealtimes and were pleased to find that a member of the Catering Team attended mealtimes on all units. This was an example of good practice. Food temperatures were taken from the hotplate prior to meals being served and records show that these were generally well above required temperatures. The young prisoners who served the meals were suitably attired but most had not undertaken any training. Those who said they had undertaken training at previous establishments said that staff were unaware of their qualifications. This was unacceptable; all young prisoners working in serveries should undertake training in basic food handling and/or health and hygiene.

9.06 The hotplates were poorly designed with no sneeze screen or lamps to keep food warm throughout serving. This was particularly unpleasant as many young prisoners opted to smell the food before making their choice, placing their noses just inches above the food. We tested the temperature of the food when the last young prisoner had been served and found that it was well below the required temperature. This supported some observations that had been made to us by young prisoners who had told us that their food was sometimes cold. This must be addressed and all hotplates should be fitted with sneeze screens.

9.07 We sampled the food, which was mostly well prepared. The portion sizes also gave no cause for concern. On the contrary we were concerned with the amount of food that was wasted at the end of mealtimes. We were told that this was because a pre-select menu was not offered and that additional meals were prepared in an attempt to allow young prisoners, not at the front of the queue, the opportunity to have their first choice. In fairness to unit staff they had introduced a rota system so that the same young prisoners did not get served first all the time, but inevitably somebody would be left with choices they did not want.

9.08 As a result of the waste of food we were told that the catering service rarely kept within its seemingly small budget of £1.40 per young prisoner, per day. We
were told that plans were at an advanced stage for the introduction of a pre-select menu and that indeed it had already been introduced on Buttermere Unit (Juveniles). The implementation of a pre-select menu should be considered as a matter of urgency.

9.09 Whilst staff told us that food comments books existed we were unable to find one on any of the residential units we visited. Young prisoners with whom we spoke also told us that they had never seen them and were mostly unaware of their purpose. Food comments book should be made readily available on all residential units

**Prison Shop (Canteen)**

9.10 Young prisoners were given access to the Prison Shop (Canteen) once a week. The arrangements for receiving their orders were excellent. *Canteen staff delivered their goods in sealed bags to their cell doors, staff then opened the cell doors and remained with the young prisoners until they had checked all the items in their bag. This was an example of good practice.* Young prisoners should be given receipts for the goods that they had purchased.

9.11 We were told that although Canteen staff did not attend unit meetings they received feedback on requested goods to be put on canteen lists. However, some of the young prisoners with whom we spoke, said that they were not happy with the range of goods that were sold and felt that the prices were unduly high. Indeed, according to the prisoner questionnaire, 50% of respondents were not happy with the canteen. We examined the canteen list and whilst we felt that more goods should be offered, the prices charged were in line with retail recommended prices (RRP). We were concerned at the lack of products for ethnic minority young prisoners. We were told that if there were a request for a product they would endeavour to get it for the individual. *We believe that ethnic minority young prisoners should not have to make special requests for products and recommend that an appropriate range of goods be offered as a matter of course.* We were also concerned about the unavailability of fresh fruit. *Fresh fruit should be made available.*
The procedures for canteening had some flaws that should be remedied. Young prisoners arriving in the establishment on the same day that youngsters in their residential unit received canteen would not be eligible to purchase from the Prison Shop for at least seven days. Whilst all new receptions were offered a choice of a phone card, tobacco or a writers pack, it was deemed unduly punitive that those who had the means were unable to have access to the Canteen. **The procedures should be reviewed to allow young prisoners the opportunity to purchase goods on their arrival to the establishment.**

**Maintenance of the Establishment**

Lancaster Farms had been well designed, well laid out on the site and well constructed to good modern standards. Maintenance of the estate had clearly been to a very competent standard and economically carried out. Since completion, the only change had been the addition of a new residential unit to the same design as those already existing on the site. At the time of the inspection, the former internal Works base was being changed to a new Reception for juveniles.

The adjacent farms were in the process of being handed over to the establishment. All required a considerable amount of work, mostly routine maintenance.

**Library**

We saw that the Library was housed in a room which was too small for the number of people using it. Bids had been made to improve matters but so far had not succeeded. **A larger Library should be provided.**

**Workshops**

There was clearly insufficient workshop space for the number of youngsters at the prison. There was plenty of space to increase shop floor area adjacent to the existing workshop, without disrupting the site planning. **More workshop accommodation should be provided adjacent to the existing workshop area.**
Heat gain

9.17 We saw that the ambient temperature in the workshops reached an uncomfortable level and were told that this was the case for much of the year. Paint had been purchased, but not applied, for the glazing strip along the length of the roof. Whilst this would reduce solar gain it would also reduce daylight and in any case is only a cheap, short term palliative. Although more expensive a brie soleil is the correct solution.

9.18 The workshops were seen to be subject to heat gains other than through the glazing, which could have a much greater impact on the ambient temperature. All heat gains should be checked and reduced. If it is found necessary to reduce solar gain through the glazing a purpose designed brie soleil should be used.

The farms handover

9.19 The considerable farms adjacent were being transferred to Lancaster Farms’ responsibility from a nearby prison. The transfer itself appeared to be protracted and inconclusive; we could find no funds earmarked for either running costs or maintaining this considerable addition to the real estate. Funds should be identified and allocated so that the farm estate can be operated economically and to allow maintenance arrears to be carried out.

Farm emergency lighting

9.20 All the farms were outside Lancaster with little or no stray illumination from adjacent sources. None had automatic standby generators; one had a generator which required the connection of a tractor power take-off. Movement on all the farms must be hazardous when the power supply fails. Battery maintained lighting should be provided at all the farms to ensure safe movement in the event of a power supply failure.

Derelict portacabin accommodation

9.21 We have commented adversely in previous reports on the derelict state of the portacabin used as messing and changing accommodation at one of the farms. It had become progressively more derelict as the years passed. We noted on this inspection
that decay had reached the point where the wind was blowing away complete panels. It had become a hazard to life and limb to youngsters and staff outside as well as inside. **The portacabin should be urgently demolished before it is the cause of an accident.**

9.22 We saw that at one of the farms a slated barn roof had lifted for part of its length along the eaves. There was a real danger that a strong wind would lift a considerable area of the roof. In the same building, a large door had remained unpainted for so long that the wooden cladding had both lifted and rotted to the point that a new door was needed. **The barn roof and door should be repaired.**

**Cell certification**

9.23 We looked at the cell certificates for the establishment and found that they were both inaccurate and unsigned. Some cells in the Health Care Unit had been altered so as to deprive them of ventilation. It is arguable that these cells should have been noted on the cell certificates as “not fit for use”. **Cell certificates should be kept up to date.** (See also Chapter Three).

9.24 The room used in the Education Department for Living Skills suffered from heat gains, which gave rise to uncomfortable conditions. A run of extract ventilation trunking had been fixed above the row of cookers but was moving only a very small amount of air which was insufficient to have any effect. A larger extract volume would make conditions in the room more acceptable. **The extract air volume should be increased.**

**Health and Safety**

9.25 Health and Safety matters in the prison were generally in good order with only a limited number of minor items seen to be needing attention at the workplace. There was a good, effective management structure in existence but application in the workplace was not as good as it could be.
Cleaning standards
9.26 We found cleaning standards to be good throughout except in the Reception where the corridor floor needed attention and the holding cells needed brushing out.

9.27 The VTC Cleaners Course provided training for Cleaning Officers in the wings, who were responsible for training youngster wing cleaners. This arrangement resulted in commendably clean wings but we found that the F2055C training records were not used. **Cleaning in Reception should be improved. F2055C training records should be used throughout.**

Waste disposal
9.28 The use of yellow bags for clinical waste and soluble bags for foul and infected laundry was known to management but not to staff in the Care and Separation Unit. **All staff should know the system for the disposal of clinical waste and dealing with foul and infected laundry.**

Emergency stop buttons
9.29 There were a number of perfectly adequate lightweight power operated woodwork tools in the DIY shop but they did not have emergency stop buttons, merely stop switches. **Emergency stop buttons should be fitted to all machinery.**

Portable Appliance Testing
9.30 No portable appliances had been tested in April and the programme for this statutory testing was not being met. **All appliances should be tested at the intervals required by legislation.**

Education Woodwork Shop
9.31 There was a very old blacksmith’s leg vice in use in the Education Woodwork Shop. This type of vice is specifically designed for blacksmith’s work, is hazardous in unskilled hands and has no place in the woodwork shop. It had all the appearance of being a piece of private, rather than prison, property. **The vice should be removed.**
Fire
9.32 The whole subject area of Fire precautions was in great disarray. It was
difficult to discover who was in fact the Fire Officer. We could not find any of the
records required by Statute, nor could we ascertain if the prescribed work had been
carried out. Enquiries and observation indicated that the Fire Officer’s duties were
totally neglected, and consequently the establishment was not meeting any of its legal
obligations in this respect.

9.33 We were told that there had not been any Fire Surveys carried out by the
Home Office, but it was believed that one was planned. As a matter of urgency the
establishment should identify its responsibilities and ensure that they are met at
the earliest possible date. A Home Office Fire Survey should be carried out in
the very near future.
CHAPTER TEN

JUVENILES

Introduction

10.01 This chapter draws together and elaborates upon inspectors’ conclusions about the treatment of juveniles at Lancaster Farms.

Background

Buttermere 1 and 2

10.02 These two units were the most recent of the Lancaster Farms complex. They were selected to provide the 130 places for children under 18 for which the Youth Justice Board (YJB) contracted the establishment because they lay outside the original perimeter and could thus operate with some independence from the rest of the establishment. The accommodation was of a high quality, well maintained and clean, located on two levels, surrounding three of the four sides of a large well-lit and carpeted activity area. There were some smaller group rooms which doubled as classrooms; one acted as a small Library, the stock of which was shortly to be upgraded.

10.03 This inspection took place barely five weeks after the most radical reform of the youth justice system for over ninety years had taken place on 1 April 2000 and many teething problems were to be expected. We were told that Lancaster Farms had only been designated as a unit to be contracted to the YJB in October 1999, which had meant that it had not received quite the same level of resources for new staff or additional buildings as other similar establishments. The short lead time had also allowed little time for planning or staff training. After a very brief partial closure following the cessation of its previous functions, the Buttermere units had re-opened with their new youth justice designation less than three weeks before the start of the inspection. Some appointed staff had not yet taken up their post, and those who had
were concerned that they had so far only completed one of the three two-day YJB training courses and wondered whether they would ever be released to complete these. Pressures on staff were added to by the fact that two of the six senior officer posts were effectively unfilled, that key administrative support was not yet available and that the units had virtually been filled to capacity from day one with a very heterogeneous group of young people.

10.04 This population comprised 36 serving long sentences under Section 53(2) of the Children and Young Persons Act 1933 and 75% of these were aged 17 and over; 30 sentenced under the new Detention and Training Order, mainly to a four-month term (which means two months in custody) and 60% of these were aged 16 and under; 40 sentenced under the former youth custody provisions and 11 remands.

10.05 Buttermere had a very enthusiastic staff group, 38 officers and six senior officers at full complement and all volunteers or new appointments specifically selected for this work. They were very well led by a Governor Grade and a Principal Officer both working in a ‘hands on’ fashion. It was a tribute to them all that Buttermere had risen to the challenge of this very difficult and demanding group of young people. We were impressed by the ‘can do’ attitude of staff, but had to agree with them that the lack of opportunity for preparation, the absence of a number of important procedures that needed to be in place, meant that they were having to work out the plot as they went. It was regrettable that staff had had little opportunity of visiting establishments such as HMYOI Huntercombe, HMYOI Hollesley Bay and HMYOI Werrington, which have had a longer experience of providing constructive and purposive regimes for children.

What the young people said

10.06 At the start of the inspection, we met with a group of juveniles who were well representative of all but the old youth custody element of the population. There were four long term Section 53s, two four month DTOs and two remands, both under 17 and in custody for the first time. They told us the following information
they were well treated by the Officers; they felt they were easy to approach and there was a good response when they put in applications or requests
those who had been there for a period of time knew who their Personal Officers were; however those on remand did not and those on the DTO found it hard to distinguish between their Casework Officer and their Personal Officer
those remanded complained vociferously of the escort arrangements for transportation to Lancaster Farms and how they had spent up to eight hours in vans or sitting in a series of court or police cells
they found the Induction course useful and remembered in particular the anti bullying components
however, notwithstanding this, bullying was endemic, it particularly being directed at new arrivals, younger boys, those in custody for the first time and those who came from rural areas or provincial towns. Their comments were that ‘you had to look after yourself’ and ‘your fists were your best friend’
there was a dearth of evening activities; all the unit either had to be having indoor association or be on the games field. The alternative was remaining in your cell.
the children on remand or on DTOs said that some of the long term Section 53 young people dominated or hassled them
most liked the education or vocational training opportunities but said that they were not geared to the needs of the longer-term sentence.

10.07 Following this meeting, we examined in detail aspects of the regime that particularly affected the different elements of the population.

Reception and First Night
10.08 At the time of our visit, children were being processed in the main Reception area of the establishment, in which little could be done to separate them from the over 18 admissions. A specialist reception facility was scheduled to open in July for Buttermere, where we hoped that the emphasis would be much less on processing and much more on establishing the foundation of a continuing relationship between the children and the staff who will be caring for them whilst in custody. The existing
reception arrangements, although staffed by humane and well-intentioned officers, did not do this.

10.09 This was illustrated when we observed the reception of two bewildered 15 year olds, one in custody for the first time, who after a weekend in police cells, had appeared in St Helens Youth Court that morning and been remanded at 1130hrs. From there they had been taken to Liverpool Crown Court where they had been held in a cell (with a 21 year old adult) for two hours, been given a sandwich, then transferred to Liverpool Bridewell. There they were held for a further hour before leaving again in an escort van that arrived at Lancaster Farms at 1845hrs. Staff told us that this was an early arrival for this particular court run. Their reception process was further delayed because their places had not been booked and registered by the court or the YOT team through the YJB placement service in the way that is now required. This was something that was happening more often than not, Reception staff told us. The meal these children were offered in reception consisted of chips and ham that had been held in a hot plate so long as to be seemingly inedible.

10.10 After this, they were taken onto Buttermere unit to arrive at 1945hrs where Casework Officers had to undertake the vulnerability assessment prescribed by the YJB in an inevitably hasty manner before lock up. Remands were a new experience for Buttermere staff, confronted as they were by the diverse demands of their population, and on this particular evening, they were understandably preoccupied having broken up yet another quite violent fight. The two 15 year olds involved were locked in cells by 2015hrs. As yet, first night procedures did not appear to have been developed for example staff made a phone call to family and carers instead of allowing the child to speak directly as advised in PSO 4950 and there were no systems in evidence for briefing night staff on the oversight and care of new arrivals unless documentation denoting a risk of self harm (F2052 SH) was formally drawn up.

10.11 The way in which we observed two frightened and traumatised 15 year olds to be treated by the court and their escort and admission arrangements as a whole confirmed what the young people had told us when we had met with them. Staff also told us that there were examples of extended delays in arrival, sometimes much worse
than we had observed, several times a week. On one occasion the previous week, a 16
year old had completed his court appearance at 6.30 pm and had not arrived at
Lancaster Farms until 7 pm the following day. Radical changes were therefore
required in the escort and reception arrangements operating for juveniles/trainees.

10.12 **We recommend that:**

- **Children should be taken direct to their custodial establishment immediately
  after their appearance in court.**

- **The reception process should be closely integrated with the roles of Casework
  and Personal Officers.**

- **There should be an expectation that children arrive on their living unit by 5
  pm at the latest so that vulnerability assessment and first night arrangements
  can be properly undertaken.**

- **All children should be allowed to make a telephone call to parents or carers
  themselves.**

- **Night staff should be fully briefed on children in custody for the first night
  and should maintain such contact with them as their needs require.**

**Induction and Bail Support/Remand Review**

10.13 Although we did not directly observe the Induction process, we saw evidence
that the five-day Buttermere programme was operating effectively. In the case of
those sentenced to the DTO, it was closely integrated with preparations for the initial
training plan conference which Buttermere staff commendably convened within five
days of the child’s arrival, assisting in the initial assessment by both teaching staff and
Casework Officers

10.14 In the case of children remanded, interviews with the remand review workers
of the Children’s Society were closely integrated with the Induction process and
normally took place within 48 hours of arrival. As in other establishments where the Children’s Society scheme operates, we were very impressed by the skill and determination of these staff who had clearly succeeded in their first few weeks at Buttermere in finding alternatives to custody for something in the order of 30% of the children remanded. They in turn spoke very highly of the collaboration they received from Buttermere Officers. We followed through the cases of the two children that we had observed on their first night. As a result of one of these interviews the worker’s objective became to achieve a transfer to a secure unit. The child tearfully told of feeling overpowered by both the size of the unit and the bigger boys and this raised issues as to why the YJB placement staff and YOT worker had not organised such a placement in the first place.

10.15 Although a few children remanded were being visited by their YOT workers within five days of their original remand, as required by YJB standards, this was clearly the exception, nor were the YOT workers engaging with the establishment to discuss the programme to be offered to the child whilst in custody.

10.16 Recommendations

- The Youth Justice Board and YOT teams should carefully assess the capacity of immature and/or vulnerable children to cope with a prison environment and only make such a placement if it is quite clear that there is no alternative.

- The YJB should remind YOT teams of the requirement to visit a young person within five working days of a remand to a secure facility and to discuss with that establishment the programme to be offered.

Sentence, Training and Review Plans

10.17 Staff at Buttermere had taken the training plan arrangements prescribed by the YJB for those sentenced to the Detention and Training Order very seriously and were to be much commended for this. 12 Officers, a third of the unit’s staff, were designated as Casework Officers and each spent an average of two days a week on this activity. They convened the initial training plan conferences with YOT staff and almost without fail these were taking place within five working days of the child’s
arrival i.e. they were meeting the more severe YJB target rather than simply conforming to the ten day requirement of the Prison Service Order. However of the 33 juvenile respondents who had been sentenced, only 16 had a sentence plan and of these only one had had a meeting which took place within the first week of arrival (see Appendix IV). NB – these 33 may not all have been sentenced to the DTO. Casework Officers then convened the subsequent review meetings on their due dates. Much of their time was spent chasing up YOT teams for reports and other documentation that should have arrived with the child. This may have been attributable to teething problems and the unfamiliarity of YOT workers with the new arrangements; however it was a situation that clearly required close monitoring. We examined the records of all 41 children sentenced to the DTO or remanded and found that 27, or 66%, were missing important information or documents that should have been provided by the YOTs.

10.18 We sat in a total of seven of these initial review meetings, each chaired by the units’ Governor Grade or the Principal Officers and held in a comfortable meeting room on the upper floor of one of the units. The supervising YOT workers, the unit’s education co-ordinator and the nominated Casework Officer attended together, of course, with the child himself. In four of the seven meetings, at least one parent was present, and in those where this was not the case, there was considerable discussion as to why they had not felt able to attend. In three of the meetings, the local Careers Officers accompanied the YOT worker. We were told that the attendance that we had observed was representative of the experience so far. We were very heartened by the welcome that was given to both parents and community based workers, with an offer of a tour of the unit (including the child’s room.)

10.19 All these conferences related to DTOs of four months, apart from one of eight months. With just two months in custody, it was important that the tight time targets were met. Each meeting lasted an average of one hour and a quarter; they were challenging to both child and parent, often with matters being talked about which had lain undiscussed for years. We were impressed at the depth to which they went and how well structured they were, focussing on the background to the offences, the targets to be achieved both during the custodial and community elements of the
sentence. However a number of common issues arose which may prove to be a general feature of those sentenced to short DTOs:

• the age of most children being discussed was 15, or just 16
• none had attended school since the age of 13; all had very significant education deficits
• all but one had been taking drugs indiscriminately together with large quantities of alcohol
• five out of seven were not living at home at the time of the offence, and appropriate accommodation was a significant issue in their resettlement
• all had had past contact with social services; some were still officially in care, although had lost touch and re-establishing an active social service engagement had to be a key part of any resettlement plan
• for almost all of them, the only real hope they saw of breaking from their offending behaviour was the prospect of a paid job, which offered them money legitimately. The presence of the Careers Officers in such situations was therefore vital.

10.20 The impact of custody, for the first time in most cases, had been considerable, but clearly diminished as they got used to it. We were very concerned about the obvious impact that the high proportion of older more sophisticated offenders, in particular those sentenced under Section 53(2) were having on these significantly younger and less mature children sentenced to the DTO. There was clearly both contamination and harassment. In spite of the best efforts of staff to prevent it, we were told they were exposed to initiation rites, including water being poured through cell windows.

10.21 Buttermere staff, with the full engagement of the Education Department were doing their very best to devise and deliver individual programmes for juveniles related to identified targets and needs but:

• as yet there were effectively no offending behaviour programmes available for this age group, although there were plans for enhanced thinking skills, crime and consequences and alcohol programmes to start later in the year. We felt that the
dearth of these resources was something that Buttermere shared with most of the rest of the under 18 estate

- most of the young people we saw were only likely to re-engage in education if it was made available in a practical context and the ten places available in the multi-skills workshop were quite insufficient to meet the needs for vocational training that were being identified
- there were no classes or other constructive activities in the evenings or at weekends which would offer more targets for young people to meet – and assist them in meeting them.

10.22 Fundamentally, the needs of the young people were both long standing and long-term; what could be done in custody was a palliative and staff rightly saw the only prospects of realistically preventing re-offending was tackling the accommodation, employment and relationship difficulties of the young people. In this last area, they were in danger of getting out of their depth and we concluded that additional social work support to Casework staff and Personal Officers was an urgent requirement.

10.23 Impressive though it was, we felt that the emphasis being put on planning for the 30 sentenced to the DTO was perhaps at the expense of the majority who were not. We felt that this could have been adding to the problems of managing the very heterogeneous population. In particular:

- conferences and reviews were as yet not taking place on those remanded, thus not assuring that they enjoyed a regime equivalent to the DTO
- those serving the DYOI continued to be planned for and reviewed under the much more basic procedures associated with that order. In as much as this was a population that would rapidly diminish over coming months, this was probably understandable
- more seriously, the high Sec 53 (2) population had all been sentenced prior to April 2000 and were thus not subject to the new training plan procedures. As most of these young people had long sentences to serve, it is very important that
planning arrangements for them be harmonised with those for those on serving the DTO as soon as possible.

10.24 **Recommendations**

- Arrangements for training plans equivalent to those required by the DTO be introduced for those remanded, particular if is clear that they are to remain in custody after the first weeks initial remand period.

- The Prison Service should advise on arrangements for planning for those detained under Section 53 (2) prior to 1 April 2000 and that these be brought into line with those sentenced after that date.

**Purposeful regime**

10.25 Buttermere had moved further than many other Prison Service establishments to meet the requirements of PSO 4950, viz.:

- Ten hours out of cell, as stipulated by PSO 4950 was being broadly achieved on weekdays (but not at weekends, when there was no evening association).
- Six hours of purposeful activity per day was broadly available on weekdays (but not at weekends).

10.26 However, as in other Prison Service establishments, achieving these targets created another set of issues:

- Was the purposeful activity on offer relevant to the assessed needs and identified targets of individual children?
- Were the opportunities presented to children in such a form that they could be motivated to make use of them? It was one thing to have facilities notionally on offer, it was another to link them with individually planned training programmes and to motivate the child to engage with them?

10.27 Buttermere illustrated well both the dilemmas for the Prison Service and the challenge that it faces in meeting the YJB specifications. Children in custodial care
are well experienced in opting out of virtuous activity and those who think that just because they are in custody they can be dragooned into it should pause to reflect.

10.28 Overall we were satisfied that during the day time, there were sufficient places in the Gym, in Education, in the anticipated offending behaviour courses, on Induction and on the very recently established industrial cleaning courses, which undertook unit cleaning, for nobody to be needlessly locked up during the day time.

10.29 That is however a different matter than concluding that what was on offer was relevant to the identified needs and that it was available when required, particularly for those on short sentences. The regime at Buttermere was suffering from the short time that senior staff had had to plan it, the lack of opportunity of learning from the experience of other establishments and the incompatible demands of the diverse population that had so rapidly filled almost all the available accommodation. The lack of adequate training plan processes, and vocational training facilities for those sentenced to long terms under Section 53(2) meant, that apart from basic education, there was little on offer and that this was a very frustrated group of young people.

10.30 The consequence of all this was that we found a group of able and committed staff who were consumed with crisis management for much of the day, and invariably every evening. They simply had not the time, the training nor the experience to develop the quality of experience they wished to offer and we considered that they would benefit greatly from outside support and advice in developing the regime, particularly in building up a range of outside community activities in which children could take part at an appropriate point in their sentence.

10.31 The high level of violence that they faced during association periods understandably preoccupied staff at all levels. We developed respect and admiration for the good humour and patience with which they responded and contained the fights that took place, usually around the pool tables. The reasons for this violence were complex, but seemed to include:

- difference in ages, and in particular the difference in status, between those on section 53(2) and on the DTO
• the absence of programme for long-term sentences
• different geographical loyalties. Children from rural or provincial towns told us they felt intimidated by older boys from large cities
• the overall size of the group. Staff and children alike told us that sixty adolescents milling around a few pool tables in the same enclosed area was just too many
• the absence, as of yet, of any smaller group activity, such as YMCA activity, Chaplaincy group or evening classes.

10.32 This raises a number of issues upon which we recommend serious reflection.

• Living units of 60 adolescents, irrespective of their make up were too large; a maximum should be 40 and these should be sub-divided into smaller groups of 10.

• The possibilities of safely and constructively accommodating remanded adolescents, and those serving both long and short sentences in one confined space should be urgently reviewed.

• The introduction of a modular programme, should be considered such as operates at HMYOI Huntercombe. This is built of six week terms with a break or taster week in between and has proved to be a useful framework for providing purposeful activity for those sentenced to both longer and shorter terms.

• External support and advice should be provided to Buttermere in developing the range and quality of its regime, particularly at weekends and in evenings. Outside community contacts are particularly required, both to assist in activities on the units and to provide constructive opportunities for children outside.

The Maintenance of Good Order
10.33 Staff were understandably perplexed as to how to manage the behaviour problems that confronted them. They particularly felt that they had, since April 2000,
lost their two major sanctions i.e. the loss of remission and removal to the Care and Separation Unit (although at the time of our inspection this facility was largely occupied by those removed from Buttermere). Staff told us that it was here that their lack of training and preparation was showing itself. We agreed with them and felt that they should have more support in developing alternative approaches built around closer and more dynamic relationships between staff and children. Central to these would be the creation of smaller groups, each associated with an identified group of Personal Officers who would work as a team. We were concerned that the creation of a specialist team of caseworkers might unintentionally have created an ambiguity as to the role of Personal Officers which was confusing to both children and staff alike. Certainly, few children to whom we spoke knew the names of either their Casework Officers or their Personal Officers and none could distinguish the roles; this may obviously have been attributable to the system being so new. However our concerns were reinforced when several Officers who had not been selected as Casework Officers told us of their regret at losing that element of their Personal Officer role. The casework element seems to us to be central to the work of the Personal Officer and it is important that every unit Officer acts as Personal Officer.

We would suggest that Buttermere explores the arrangements at HMYOI Hollesley Bay, and that more recently established at HMYOI Castington, where all unit Officers carry casework responsibilities for an average of three children each.

10.34 Recommendations

- Buttermere staff are given training and support in alternative approaches to maintaining good order.

- Way are explored of integrating the roles and work of Casework and Personal Officers.

Management of Vulnerability

Anti-Bullying Strategies

10.35 At the time of our inspection, Buttermere unit had not been yet able to develop an Anti-Bullying strategy appropriate to its age group, although we were told that this
was an urgent objective. Staff were very conscious of the need to watch for bullying, and were obviously doing so. However, they also felt often impotent in confronting it. The children, from what they themselves told us, were equally aware of the priority that staff attached to preventing bullying but at the same time children told us that it was widespread. The problems of the size of the unit, the age range and mix of the population that we have described earlier all aggravated the situation. A more settled group of children and a more securely based Personal Officer system would certainly ease some of the pressures. There was however an urgent need to develop specific programmes to confront the bullies and support victims. See Appendix IV for a breakdown of the percentage of bullying going on amongst juveniles.

Child Protection

10.36 There were as yet no local procedures in place as required by Annex B to PSO 4950 which had been issued shortly before our inspection. Senior staff assured us that it was proposed shortly to convene the first meeting of the mandatory Child Protection Committee and that informal preparatory discussions had already taken place with the Lancashire Area Child Protection Committee (ACPC). The experience of the Buttermere units was demonstrating just how urgent this was. It was important that the Lancaster Farms local procedures should elaborate upon Annex B, ensuring that it made clear when action should be taken, and by whom, in cases of:

- disclosure of abuse allegedly perpetrated on a child prior to his arrival at the establishment
- allegations against staff within the establishment
- abuse, or risk of it, of one child by another.

10.37 The last category presents particular problems for the Prison Service generally as it is cleanly impracticable for every fight or incident of bullying to be made the subject of a formal conference convened under the auspices of the ACPC. However, there will quite often be situations where this necessary, for example, as a result of the incident which occurred during our inspection when a 15 year old had his jaw broken after an assault by a 17 year old.
10.38 Further guidance on what should trigger ACPC intervention will probably be required from the Prison Service once the initial experience of the arrangements set out in Annex B have been evaluated. In the meantime, there should be a keen awareness that the level of violence of the abuse is just one consideration; equally important is the perceived vulnerability of the child. For this reason, it is very important that the Child Protection Committee should be closely connected to the establishment’s self-harm and anti-bullying arrangements.
CHAPTER ELEVEN

RECOMMENDATIONS AND EXAMPLES OF GOOD PRACTICE

Recommendations

To the Director General

Accommodation

11.01 The CNA certificate should be correct at all times. (3.03)

Employment

11.02 Another workshop, possibly a production shop, suitable for remands or short term sentenced young prisoners should be provided. (7.27)

11.03 The Prison Service should consider system of relief instructors to cover absences of staff. (7.29)

Maintenance of the Establishment

11.04 A larger Library should be provided. (9.15)

11.05 More workshop accommodation should be provided adjacent to the existing workshop area. (9.16)

11.06 Funds should be identified and allocated so that the farm estate can be operated economically and allowed maintenance arrears to be carried out. (9.19)
Management of health care

11.07 The prison health policy unit should consider devolving responsibility for the budget for nursing staff to the health care manager in Prison Service establishments where the manager has the necessary experience and training. (6.14)

Needs assessment and the commissioning of health care

11.08 In the past the Prison Service has been content to ignore its own deadlines aimed at improving health care for young prisoners; neither the Prison Service nor the NHS must allow such attitudes to continue. (6.15)

Observation, Classification, Allocation (OCA) and Progressive Transfers

11.09 The regular cancellation of inter prison transfers organised by Group 4 should cease. (8.19)

Physical Education

11.10 Separate PE facilities should be provided to meet the needs of juveniles so that existing facilities were available for young prisoners and neither group would be disadvantaged. (7.38)

Reception

11.11 The late arrival of juveniles into the establishment must be minimised and the CCG section of Prison Service headquarters should resolve the problem with escort contractors immediately. (2.07)

11.12 The proper application of the Youth Justice Board DTO procedures should be adopted. (2.08)

Time Out of Cell

11.13 In-cell electricity should be made available to all cells. (3.29)
To the Governor

Accommodation
11.14 Double cells should only be used in emergencies or for the care of suicidal people. (3.04)

11.15 Young people should not be located together unless a formal risk assessment had been carried out to decide suitability of personality etc. (3.05)

11.16 An offensive displays policy document should be published, staff and residents should be informed of the policy on their induction to the establishment and the policy should be enforced. (3.09)

11.17 The smoking policy should be enforced and senior management should lead by example. (3.09)

Anti Bullying
11.18 Anti bullying programmes should be considered as an appropriate option. (4.07)

Applications
11.19 Applications should be made in a consistent fashion across the wings. (4.69)

11.20 Church service times should be better published in advance on each unit each weekend. (4.70)

11.21 Young prisoners should receive prompt replies to all applications made, audit trails of applications referred off wings to other departments should be maintained, and unit staff should actively pursue outstanding replies. (4.71)

Bail Information / Legal Aid
11.22 A fully functional Bail Information suite should be made available. (2.47)
11.23 Work relating to the monitoring of outcomes for bail applications should be undertaken. (2.48)

11.24 There should be posters and information pertaining to Legal Aid service displayed around the establishment. (2.50)

**Board of Visitors**

11.25 Private and secured Board of Visitor application boxes should be available in discrete but accessible places throughout the establishment so that residents may write to members of the Board without the knowledge of staff if they wished. (4.76)

**Catering**

11.26 The establishment should consider the merits of young prisoners undertaking NVQ’s in Catering that involves them working in a real kitchen. (9.02)

11.27 All young prisoners working in serveries should undertake training in basic food handling and/or health and hygiene. (9.05)

11.28 A pre-select menu should be considered as a matter of urgency. (9.08)

11.29 Food comments book should be made readily available on all residential units. (9.09)

11.30 Young prisoners should not be required to squat for routine searches. (2.09)

11.31 Advances of phone cards and tobacco should be made available in Reception. (2.16)

11.32 The establishment should consider the use of the pre packed airline meals seen in other establishment Receptions. (2.20)
11.33 Young prisoners should be issued with tea packs once they are received on their Induction unit. (2.21)

Contact with Family and Friends

11.34 Any valuable items such as postal orders should not be left unattended in the Post Room and should be kept securely. (7.52)

11.35 Young prisoners should be allowed to speak to their families or close friends on their first night in the establishment. (7.54)

11.36 Youngsters should have at least daily access to telephones. (7.56)

11.37 The establishment should implement a phone call in lieu of visits system for foreign nationals. (7.57)

11.38 The information booklet should be sent out with all Reception Visiting Orders as it provides valuable advice for new visitors. (7.63)

11.39 Identification should be checked at the Gate before visitors are allowed into the secure confines of the establishment. (7.69)

11.40 Visit sessions should start on time. (7.73)

11.41 The visits room should be provided with a children’s play area with volunteer supervisors. (7.80)

11.42 UV stamps should be reconsidered when looking at visits arrangements. (7.81)

Continuing professional development.

11.43 Supervision arrangements for the doctor should be explicit and should involve the supervisor regularly attending the prison. (6.10)
11.44 Funding to allow prison health care specific training must be made available. (6.10)

**Dental**
11.45 It was not considered good practice that the contract holder was not available for such a period of time. (6.42)

11.46 Checks should be made on claims for treatments provided, as a number of the recipients for treatment are exempt from patient’s charges due to their age. (6.47)

**Drugs Strategy**
11.47 The terms of reference of the Drug Strategy Team should be reviewed. (4.11)

11.48 A local strategy to complement the Drug Strategy should be developed, particularly given the nature of the populations. (4.14)

11.49 First night arrangements for substance users should be reviewed by the Drug Strategy Team to ensure a multidisciplinary response. (4.16)

11.50 HIV and Hepatitis services within the establishment should be reviewed and structures for working across departments formalised. (4.20)

11.51 The group work programme should be as a response to the population needs analysis; targeted effectively within a continuum of interventions and taking into account the particular needs and learning styles of young people. (4.26)

11.52 New monitors for the cameras in the Visits area and staff to survey them should be provided.

11.53 It is essential that national guidance is given on how CARAT services fit with the work of Youth Offending Teams and Personal Officer casework. (4.33)
Education
11.54 Provision for students in the Health Care Centre and the Care and Separation Unit was unsatisfactory and should be improved. (7.03)

11.55 The lack of information technology, which restricted learning, should be addressed. (7.14)

11.56 Insufficient attention was being given to the resettlement of juveniles and young prisoners in preparation for release. (7.18)

Employment
11.57 There should be improved procedures for allocating young prisoners to work to make more efficient use of activity places. (7.28)

Fire
11.58 As a matter of urgency the establishment should identify its responsibilities for fire prevention and ensure that they are met at the earliest possible date. (9.33)

11.59 A Home Office Fire Survey should be carried out in the very near future. (9.33)

First night
11.60 New receptions should be issued with advances of phone cards and allowed to make essential contacts with family and friends before being locked up for their first night. (2.24)

11.61 New receptions should be made known to night staff and their particular needs communicated between staff. (2.29)
Good Order and Discipline

11.62 The establishment should undertake research to determine whether good supervision is the reason for an increase in adjudications or whether other factors are present. (5.03)

11.63 Cellular confinement should not be awarded at adjudications unless the young prisoner has been medically fitted by the medical officer. (5.05)

11.64 Young prisoners in the Care and Separation Unit should have daily access to showers. (5.10)

11.65 Management should review Wing procedures to ensure that "unofficial" punishments are not taking place. (5.13)

Home Detention Curfew (HDC)

11.66 The benefits and demonstration of respect, to young prisoners, in giving feedback on HDC decisions made verbally should not be ignored. (8.27)

11.67 No ethnic monitoring of outcomes for HDC had been undertaken. This should be addressed. (8.28)

Hygiene, Clothing and Kit Exchange.

11.68 Every young prisoner/juvenile received should be allowed a shower in Reception. (3.16)

11.69 Small clothing should be available from central stores at Branston; clothing supplied from Branston should be the correct size as ordered and as stated on the boxes. (3.17)

11.70 Wing shower arrangements should be improved, adequate staffing supervision should be provided to enable more than one resident to shower or bathe at a time. (3.18)
11.71 Cleaning equipment storerooms should be cleaned daily and well aired. (3.19)

11.72 Cells should be cleaned properly and fully equipped prior to occupation by each new cell resident. (3.20)

11.73 Colour co-ordinated continental quilts and curtains should be issued in each cell. (3.21)

11.74 Green visits boiler suits should be laundered regularly. (3.23)

**Induction**

11.75 Information about the calculation of release dates and young prisoners’ cash accounts should be explained to them in a consistent way by appropriately trained staff. (2.34)

11.76 CARAT workers should also be made available to address youngsters on Induction. (2.35)

11.77 Young prisoners should be moved onto their permanent unit as soon as their Induction programme is complete. (2.38)

11.78 An information booklet should be offered to all new arrivals at Lancaster Farms. (2.44)

**Maintenance of the Establishment**

11.79 All staff should know the system for the disposal of clinical waste and dealing with foul and infected laundry. (9.28)

11.80 Emergency stop buttons should be fitted to all machinery. (9.29)

11.81 All appliances should be tested at the intervals required by legislation. (9.30)
NVQ (Catering)
11.82 Trainees should be integrated into a realistic, or a real, working environment immediately. (7.30)

11.83 Consideration should be given to provide a consistent assessment service, particularly during planned holiday periods for instructors. (7.31)

Observation, Classification, Allocation (OCA) and Progressive Transfers
11.84 The establishment should consider allowing youngsters to attend their Recategorisation boards. (8.15)

11.85 Any young prisoner who has successfully completed a period of release on temporary licence should be considered for open conditions. (8.16)

11.86 The OCA department should be provided with a fax machine that takes incoming as well as outgoing communications. (8.22)

Pharmacy
11.87 In-Possession medication policy should be reviewed on a regular basis. (6.35)

11.88 Supplies of controlled drugs must be on the authority of a properly written prescription. (6.39)

11.89 Labels must always carry the name of the patient, dose, and date of dispensing. (6.39)

11.90 A higher priority should be given to the Drugs and Therapeutics Committee. (6.40)

11.91 A log should be kept of interventions or errors. (6.41)
Prison Shop (Canteen)
11.92 Young prisoners should be given receipts for the goods that they have purchased. (9.10)

11.93 Ethnic minority young prisoners should not have to make special requests for ethnic minority products. (9.11)

11.94 Fresh fruit should be made available. (9.11)

11.95 Procedures should be reviewed to allow young prisoners the opportunity to purchase canteen on their arrival to the establishment. (9.12)

Probation
11.96 The Probation team should avoid becoming centrally based. (8.06)

11.97 The quality of all offending behaviour courses offered should be evaluated. (8.10)

Provisions for Life and Long Sentenced Young
11.98 Local Schedule One procedures should be reconsidered. (8.03)

11.99 Child protection procedures involving the local Area Child Protection Committee should be introduced. (8.03)

Race Relations
11.100 The Race Relations Management Team and the Race Relations Liaison Officer should undergo the formal Prison Service training for these roles. (4.36)

11.101 The establishment should consider the inclusion of young prisoner representatives in the Race Relations Management Team. (4.38)
11.102 The group room upstairs from the Chapel, which also had the advantage of a shower should be used for Muslim prayers. (4.45)

Reception
11.103 The holding rooms should be made more welcoming by the use of more comfortable furnishing, the provision or reading materials and better décor including posters etc. (2.01)

11.104 Young prisoners should be referred to by their full name or using the prefix mister or by the name preferred by the young prisoner involved. (2.03)

Release on Temporary Licence (ROTL)
11.105 The establishment should take steps to ensure that the option of Resettlement Licence is made available to suitable young prisoners. (8.24)

Religious activities
11.106 There should be a review of the staffing levels in the chaplaincy department. (7.91)

Request & Complaints
11.107 Management, or a member of the Board of Visitors should investigate all withdrawn Request Complaint forms. (4.74)

11.108 Sanctions should only be awarded following the approved system of ‘Minor Reports’. (3.08)

Health Care

Services for patients
11.109 The need for in-patient beds should form part of the needs assessment and the size and location of the in-patient area should be reviewed in light of these findings. (6.18)
11.110 Exercise areas should provide for occupation and relaxation. (6.19)

11.111 The time available for nurse triage should be reviewed. (6.20)

11.112 The in-patients’ day should be reviewed and current standards met. (6.22)

**Staffing**

11.113 Night nursing cover should be reviewed to ensure that the needs of patients both in the Health Care Centre and in the residential units can always be met. (6.05)

11.114 The provision of clerical staff should be sufficient to ensure that scarce and expensive health professional time was not wasted in inappropriate work. (6.07)

11.115 The service provided by contract cleaners required monitoring and a programme to do should be implemented. (6.08)

**Suicide Awareness**

11.116 The Suicide Awareness Team should carry out random audits on F2052SH to monitor the quality and frequency of entries made in F2052SH’s. (4.63)

11.117 The staff should consider other reward systems that do not impinge on the health of young men. (4.64)

11.118 The role of the Samaritan Volunteers should be evaluated and a protocol on disclosure of information agreed by the Suicide Awareness Team and the Samaritans. (4.65)

**Time Out of Cell**

11.119 A quality period of time in the fresh air daily should be provided for all residents in exercise yards that are properly equipped for that purpose. (3.31)
EXAMPLES OF GOOD PRACTICE

National

Contact with family and friends
11.120 This booklet gave good information aimed at younger prisoners’ children and should be encouraged across the Prison Estate. (7.63)

Continuing professional development
11.121 The doctor employed by the local NHS Trust had one session a week in his contract for personal training. (6.10)

Dental
11.122 There was self referral for the patients and there was no minimum waiting list. Also on the reverse of the referral forms various types of health advice was given, one gave advice on dental care. (6.44)

First Night
11.123 We particularly liked the arrangement by which staff from Buttermere unit interviewed juveniles in Reception and located them on the wing. (2.30)

Sentence Planning
11.124 We were told that all young prisoners, whether subject to Automatic Conditional Release (ACR) for young prisoners serving up to four years or Discretionary Conditional Release (DCR) for young prisoners serving four years or more, attended Sentence Planning boards. (8.30)

Suicide Awareness
11.125 Some wings used application forms that had pictorial displays on them for employment, Health Care applications etc. (4.71)
Local

Anti Bullying
11.126 All young prisoners received training on anti-bullying awareness during the Induction programme. We observed the delivery of this programme and found it interesting and delivered to a high standard by the Induction Officer. The message given was clear and unambiguous; bullying would not be tolerated. (4.04)

Catering
11.127 We observed several mealtimes and were pleased to find that a member of the Catering Team attended mealtimes on all units. (9.05)

Drug Strategy
11.128 We noted a strong commitment by the Drug Strategy Team to multi-disciplinary working. (4.10)

NVQ Catering
11.129 Trainees' knowledge and understanding of topics covered was systematically tested at the end of these short courses, and their achievement acknowledged through the award of nationally recognised certificates. (7.32)

Probation
11.130 The Probation team also had a quality input into the Induction programme. (8.12)

Sentence planning
11.131 The young prisoners who attended the boards were friendly, open but focused. We were impressed with what we saw. (8.32)
Services for patients

11.132 One of the ‘F’ grade nurses provided a ‘Coping with Custody’ training programme for trainees. (4.60)

Staffing

11.133 The use of contract cleaners in sensitive clinical areas saved scarce and expensive health professional time in supervising young prisoner cleaners. (6.08)

Suicide Awareness

11.134 The Listeners attended a support group meeting each Monday. They received individual counselling and were encouraged to talk about their experiences. An external counsellor facilitated the meetings. (4.66)