Thematic report by HM Inspectorate of Prisons

Report of a review of the implementation of the Zahid Mubarek Inquiry recommendations

June 2014

Report of a review of the implementation of the Zahid Mubarek Inquiry recommendations

A thematic review

by HM Inspectorate of Prisons

June 2014

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the Glossary of terms on our website at:
http://www.justice.gov.uk/downloads/about/hmipris/Glossary-for-web-rps_.pdf

Crown copyright 2014

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit http://www.nationalarchives.gov.uk/doc/open-government-licence/ or email: psi@nationalarchives.gsi.gov.uk

Where we have identified any third party copyright material you will need to obtain permission from the copyright holders concerned.

Any enquiries regarding this publication should be sent to us at the address below or:
hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justice.gov.uk/about/hmi-prisons

Printed and published by:
Her Majesty's Inspectorate of Prisons
Victory House
6th floor
30–34 Kingsway
London
WC2B 6EX
England

Contents

Glossary 4

Introduction 6

Section 1. Background 8

Section 2. Methodology 10

Section 3. Scope 12

Section 4. Findings 13

Section 5. HMYOI Feltham – recent inspection findings 34

Section 6. Appendices 36

- Appendix I: Recommendations made at the Mubarek Inquiry 36
- Appendix II: Methodology 43

Glossary

This glossary explains some of the commonly used terms in this report.

Assessment, care in custody and teamwork (ACCT)
Assessment, care in custody and teamwork is the documentation and procedure used to monitor and support those at risk of suicide or self-harm.

Asset
Standard assessment tool used by youth offending teams to collate information on a young person who has come into contact with the criminal justice system. It is intended to identify a range of factors that may have contributed to the offending behaviour of the young person.

Cell-sharing risk assessment (CSRA)
Cell-sharing risk assessment tool

National Offender Management Service (NOMS)
NOMS is responsible for commissioning and delivering adult offender management services, in custody and in the community, in England and Wales.

OASys (offender assessment system)
The nationally designed and prescribed framework for probation and prisons to assess offenders, implemented in stages from April 2003. It makes use of static and dynamic factors.

Offender management unit (OMU)
Staff in this unit are responsible for assessing and managing the risk of prisoners who fall within scope for offender management, in collaboration with offender managers in the community.

Person escort record (PER)
The PER is used to pass on information about the risks posed by prisoners on external movement from prisons or transfer within the criminal justice system.

Personal officer
An officer allocated to each prisoner who is located on their residential unit and offers assistance with day-to-day problems or concerns

P-Nomis
Prison national offender management information system, the Prison Service IT system holding personal details of all prisoners

Prisons and Probation Ombudsman (PPO)
The Prisons and Probation Ombudsman investigates complaints from prisoners and investigates all deaths of prisoners.

Prison rules
Secondary legislation that provides national rules for the management of prisoners

Prison Service Instructions (PSIs)
A range of national policies developed by the Prison Service, which provide mandatory instructions and guidance to establishments on how to manage their prison population

Remand prisoner
Includes unconvicted and convicted unsentenced prisoners

SystmOne
Electronic clinical information system

Unconvicted prisoner
A prisoner awaiting trial

YOI
Young offender institution

Introduction

The racist murder of Zahid Mubarek by Robert Stewart in HMYOI Feltham in March 2000 has been described as the Prison Service's Stephen Lawrence moment.

Shortly after his attack on Zahid, the police discovered that Stewart had strong racist views. They also learned that he had had a violent past while previously in custody, and that his mental health had been questioned. Some months before the attack he had bragged about committing the first murder of the millennium. As much of this was known by some of the prison officers at Feltham, there were obvious questions to be asked about how he and Zahid – someone from an ethnic minority – had been placed in the same cell. Had any assessment been made of the risk Stewart presented to anyone who was required to share a cell with him? Had what was known about him been circulated to all who needed to know, including responsible managers? In convicting Stewart of murder, the jury rejected the suggestion that he should be convicted of manslaughter, on the grounds of diminished responsibility.

For four years after his murder, successive Home and Justice Secretaries refused the call by Zahid Mubarek's family and others for an Inquiry into his murder, on the grounds that Prison Service internal inquiries had been sufficient to identify any weaknesses in the system. Eventually the House of Lords ruled that, in order to comply with its obligations under the European Convention on Human Rights, the United Kingdom was required to conduct a Public Inquiry. The subsequent Inquiry by Mr Justice Keith, published in 2006, laid bare a series of institutional failings and made far-reaching recommendations for change. Ministers and the National Offender Management Service have since stated that almost all the recommendations have been accepted and most fully implemented.

The Zahid Mubarek Trust was established by members of Zahid's family who were determined to ensure that positive words about change and implementation were translated into action. Frustrated by a lack of communication from the National Offender Management Service and concerned that implementation of the recommendations was no longer a priority, the Trust encouraged us to use our inspection evidence to assess what progress had been made and sustained. We shared many of their concerns and were pleased to do so.

The Zahid Mubarek Inquiry found over 186 failings across the prison system, and made 88 recommendations designed to 'reduce the risk of something like this ever happening again'[1]. This short report does not attempt to assess how far each of the individual Inquiry recommendations has been implemented. Too much has changed with regard to the prison population itself, procedures and policies to make that a meaningful exercise. Rather we looked at the broad themes that the Inquiry addressed and examined what evidence there was of positive change.

There has been positive change. New systems and processes have been put in place and there is no doubt that electronic case records have made sharing and using information easier. However, the implementation of these new processes has been inconsistent and there is a real danger that, with the passage of time, the drive that led to their introduction has been weakened or forgotten and the issues with which the Inquiry was concerned have not been given enough priority when considering how to use the Prison Service's now diminished resources.

Following Zahid Mubarek's death, Martin Narey, the Director General of the Prison Service at the time, told his family: 'You had a right to expect us to look after Zahid safely and we have failed. I am very, very sorry'. Zahid's death was preventable and there is no doubt that action has been taken by the Prison Service in response. There are now better systems in place to make it less likely that a

---

[1] Home Office (2006) *Report of the Zahid Mubarek Inquiry;* London, The Stationery Office, Volume 1, pg xviii

violent racist could be placed in a cell with a vulnerable prisoner, to ensure that a prisoner has someone they can turn to for help and support, and to identify and tackle unequal or discriminatory treatment.

However, it could happen again. Risk assessment processes that might identify a prisoner who posed a risk to others are too often delayed or poorly completed and information sharing is still a considerable weakness across the prison estate. Too many prisoners still share cells designed for one and inspections have found this occurring regardless of sentence status (remanded with convicted prisoners), age or other issues of compatibility. Prisoners from black and minority ethnic groups consistently report a worse experience than white prisoners.

We hope this report will be timely. As it was being completed, the government announced an independent inquiry into the deaths of young adults in custody. The results of the inquiry will influence a review of the young adult estate which provides an opportunity to consider again the unresolved issue posed in recommendation 17 of the Keith report: 'The Prison Service should review whether the advantages of holding young offenders on the same wing as adult offenders outweigh the disadvantages and whether the practice should be extended to other prisons.'

There was a real danger that the Keith Inquiry into Zahid Mubarek's murder had become filed under 'completed business'. This report shows that there is no room for such complacency and we hope this review will provide those responsible for the current inquiry with a clear and helpful reminder of why the lessons from the Keith Inquiry are still relevant today and why work is still urgently required to ensure those lessons continue to be understood, accepted and acted on.

Nick Hardwick June 2014
HM Chief Inspector of Prisons

Section 1. Background

1.1 The report of the Inquiry into the racist murder at HMYOI Feltham of Zahid Mubarek in March 2000 was published in April 2006[2]. Zahid Mubarek, who was serving a short sentence, was murdered on the morning of his release by Robert Stewart, with whom he had shared a cell for six weeks. It took a four year campaign by the family and a judgement by the House of Lords, to secure the Inquiry. The following account of Zahid Mubarek is taken from the Public Inquiry report:

1.2 'Zahid was born in 1980. He came from a large and close-knit family who lived in Walthamstow in East London. He was educated at local schools, where he showed a particular talent for art and enjoyed playing sport. But he was thought not to be making the most of his skills, and there was a problem with his attendance at school. No member of the family, save for a remote cousin, had ever been in trouble with the police before things began to go wrong for Zahid. His brushes with the law occurred to fund a growing dependence on drugs. Over a period of less than 10 months, he committed 11 offences, mostly for breaking into cars and stealing from them. He was given a number of opportunities to co-operate in the search for a suitable community sentence, but he failed to keep many appointments which had been made for him to meet members of the community drugs team and other agencies, and on two occasions he did not turn up at court. Eventually, on 17 January 2000, he was sentenced to 90 days' detention in a young offender institution for a total of five offences, and a few weeks later he received a similar term to be served concurrently for four further offences. He served the whole of his sentence at Feltham.[3]

1.3 'While there, he wrote movingly to his parents, admitting his shortcomings and expressing a determination not to let them down again. He was due to be released on 21 March.

1.4 'But he was never to get the chance to prove that he had put his past behind him. In the early hours of that morning, he was brutally attacked by another young prisoner, Robert Stewart, with whom he had been sharing a cell for the previous six weeks. According to Stewart, Zahid had been asleep at the time, though some prisoners claimed to have heard screams. What is not in doubt is that Stewart clubbed him several times about the head with a wooden table leg. When help came, Zahid was barely conscious. Such was the ferocity of the attack that his father told the Inquiry that when he saw Zahid in hospital: 'his head looked like a huge balloon. He was almost unrecognisable. His face was full of blood with bruising all over it.' He died from his injuries a week later. He had been in a coma and never regained consciousness.'[4]

1.5 Robert Stewart had bragged about his plans to commit murder. He had convictions for violence and mental health problems, and was known to have expressed racist views. The Inquiry found 186 failings by the Prison Service and made 88 recommendations (see Appendix I for a list) designed to 'reduce the risk of something like this ever happening again'[5]. In particular it identified some 'key stages when, had appropriate action been taken, the tragedy which befell Zahid could have been prevented'[6].

1.6 In 2011, Ministers stated that the National Offender Management Service (NOMS) had fully implemented 71 of the recommendations. NOMS reported that 15 had been partially

---

[2] Home Office (2006) *Report of the Zahid Mubarek Inquiry;* London, The Stationery Office
[3] Ibid, Volume II, pg 620
[4] Ibid, Volume I, pg xvii
[5] Ibid, Volume I, pg xviii
[6] Ibid, Volume I, pg xviii

implemented or had become obsolete[7] and two had been rejected at the time the report was published. Recommendation 7 that a remand prisoner should only share a cell with a sentenced prisoner when they had consented to share with a particular prisoner was rejected on the grounds that prison rules would not allow it to be implemented (see 4.47 to 4.50 for more detail). Recommendation 88 that each prison should be required to publish a race equality scheme was rejected as prisons were considered to be covered by the Home Office[8] race equality scheme.

1.7 Despite the significance and the wide scope of the Zahid Mubarek Inquiry findings and recommendations, until now there has not been an independent review of the extent to which the Inquiry's recommendations have made a difference to the way black and minority ethnic prisoners are treated and all prisoners protected from racist violence. A one-day conference took place in June 2011, organised by the Centre for Public Law, to attempt to assess the impact of the Inquiry[9]. The conference heard from members of Zahid Mubarek's family, prison and NOMS staff, Independent Monitoring Board members, leading academics involved in research on race and criminal justice, and the former HM Chief Inspector of Prisons. While positive changes were acknowledged, a number of challenging questions were raised about the extent to which the recommendations of the Inquiry had been fully implemented. These included the significance of prisoners' continued perceptions of racism, poor promotion or explanation of policy changes, and the need for improved mental health and cultural awareness in prisons.

1.8 During 2012, the Zahid Mubarek Trust discussed with HM Inspectorate of Prisons (HMIP) the possibility of carrying out an independent thematic review of the extent to which the Zahid Mubarek Inquiry recommendations had been implemented and embedded in NOMS practice. The Justice Select Committee then wrote to HM Chief Inspector asking for his views on the progress the Prison Service had made in implementing the Inquiry recommendations. HMIP offered to review existing Inspectorate evidence to assess, where possible, the progress that had been made in implementing the Inquiry's recommendations.

1.9 A number of relevant changes in policy and practice have occurred since the Zahid Mubarek Inquiry report was published. Many of the systems and processes that were in place in 2000 and on which the Inquiry commented had changed significantly by 2013. For example, a new person escort record form (PER) was devised and introduced in 2009 to try to improve the quality of information about risk that accompanies detainees; revised guidance on its completion was also issued. The focus of this review therefore is not to examine how specific procedures have been amended to minimise the opportunities for a racist prisoner to kill his cell mate. The purpose is to explore the extent to which the changes that the Inquiry called for have become embedded in culture and practice, and whether prisons and young offender institutions have become safer as a result of the initiatives and the work the Prison Service has undertaken since the Inquiry reported.

---

[7] Hansard, 29 June 2011: http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/110629-0001.htm#11062963000004

[8] The Home Office was responsible for NOMS at this time. Responsibility transferred to the Ministry of Justice when it was created in 2007.

[9] Centre for Public Law (2011) Assessing the Impact: the Zahid Mubarek Inquiry – Five Years On. See http://www.cpi.law.cam.ac/ZM%20conferenceAug29_docx(1).pdf. (Retrieved 23.7.2013)

Section 2. Methodology

2.1 HM Inspectorate of Prisons publishes its 'Expectations' [10] for prisons, children and young people's establishments and other detention facilities. Expectations set out the detailed criteria which are used to inspect and appraise prisons and young offender institutions, covering every aspect of the treatment of prisoners and young people and the conditions in which they are held, from reception to resettlement. All Inspectorate of Prisons inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

2.2 This paper presents the findings from a desktop review of our inspection reports and the prisoner/children and young people surveys which form part of every inspection (see Appendix II for more detail on the survey methodology). All 55 reports of inspections of adult prisons and children and young people establishments published between 4 April 2012 and 27 March 2013 were analysed, together with responses from 48 surveys carried out during the period[11] (see appendix II for a full list).

2.3 Inspection reports were analysed by identifying findings relating to the recommendations made by the Mubarek Inquiry. Each report was read and findings within the remit of the Inquiry recommendations were collated in a database for analysis. We identified the position at the establishment at the time of inspection, the nature of the concern or positive practice that inspectors had found and we then determined the extent to which the report showed that there had been any improvement or deterioration in the areas of concern raised by the Inquiry.

2.4 Relevant findings from HMIP thematic reports, third joint Prison Offender Management Inspection (POMI) report[12] and HMIP responses to consultations have also been included.

2.5 Some of the events and failings described in the Inquiry report were specific to HMYOI Feltham. The findings from the most recent 2013 inspection report of HMYOI Feltham[13] are therefore summarised in Section 5.

---

[10] Inspectorate of Prisons (2012) *Expectations: Criteria for assessing the treatment of prisoners and the conditions in prisons (Version 4).*
HM Inspectorate of Prisons (2012) *Expectations: Criteria for assessing the treatment of children and young people and conditions in prisons (Version 3).*
HM Inspectorate of Prisons (2012) *Expectations: Criteria for assessing the conditions for and treatment of Immigration detainees (Version 3).*
[11] Surveys were conducted for full inspections only. For children and young people establishments any surveys conducted during this period were analysed, including those conducted on behalf of the Youth Justice Board.
[12] HM Inspectorate of Probation and HM Inspectorate of Prisons (2013) Third aggregate report on Offender Management in Prisons
[13] HM Inspectorate of Prisons (2013) Report on an unannounced full follow-up inspection of HMP/YOI Feltham (Feltham B – young adults).

2.6 We have referred to significant reports produced by other organisations where these address issues raised by the Inquiry.

2.7 Our findings are set out in Section 4 and follow a prisoner's journey from reception through to release. They are reported under the subheadings used in the Inquiry report, with the italic text summarising the Inquiry's concerns. The actual recommendations made by the Inquiry are listed in Appendix I.

Section 3. Scope

3.1 HM Inspectorate of Prisons does not collect data on every aspect of NOMS policy and practice covered by the Inquiry recommendations and some recommendations made by the Inquiry fall outside the remit of the Inspectorate. For example, information is not collected on changes in legislation, staff training, selection of cell furniture and handling of information about previous convictions at court. Some of the Inquiry's recommendations were very prescriptive, for example the processes by which prisoners may ask to share a cell. It has therefore not been possible to comment on every recommendation that was made by the Mubarek Inquiry. Instead, rather than addressing how procedures are managed, this review focuses on the extent to which the broader changes in outcomes for prisoners that the Inquiry's recommendations were intended to accomplish have been achieved.

Section 4. Findings

Person escort record

4.1 ***Concern:*** *The Inquiry found that systems for passing information about the risks prisoners posed from a sending to a receiving establishment were inadequate. The person escort record (PER) form was regarded as of little value as it consisted of a series of tick boxes which failed to detail why certain risk factors were highlighted. The Inquiry urged that the form should be revised to help escort staff and receiving establishments to manage risk.*

4.2 The PER form is used to pass on information about the risks posed by prisoners on external movement from prisons or transfer within the criminal justice system. This aims to ensure that any potential risk that a prisoner poses to themselves or others is appropriately shared so that it can be managed accordingly. A new PER form was introduced in 2009, with guidance on how to complete it. Despite this, our 2012 PER thematic review[14], which focused on the use of the PER as a means of imparting information about risk of self-harm, found that concerns remained about the quality of information contained in PERs and how they were used. Implementation was variable, with patchy quality assurance and even, in some areas, police and escort staff taking it upon themselves to use an old, outdated version of the document because they believed it to be easier to use. There remained a lack of understanding by police and escort service personnel of what information they should provide in the PER, partly because they did not know how the information would be used at the receiving establishment. That raised questions about the effectiveness of staff training and suggested that the PER form might not always effectively 'inform the prisoner's management in the receiving establishment' as the Inquiry had recommended.

4.3 The thematic indicated that, in the area of self-harm at least, there were concerns about how PER forms were completed, with scant or illegible detail in many. It was common for PERs to contain vague statements such as 'may try to kill himself in custody' and 'O/D (overdosed) the other night', with little information about context or what may have triggered self-harm. It was often left to chance whether information in the PER about self-harm would be seen by prison staff completing ACCT (assessment, care in custody and teamwork - case management for prisoners at risk of suicide or self-harm) assessments. At one establishment, there was no systematic procedure for picking up information about risk of self-harm and instead it depended on reception nurses 'rifling through' as many PERs as they could to extract information about risk of self-harm. Inspectors judged that only 24% of the PERs they read had information that would be helpful to the receiving establishment in determining the level of self-harm risk and drawing up a care plan.

4.4 Many inspections have found that night staff do not always know who the new arrivals to the prison are and prisoner surveys often indicate that about a fifth of prisoners say they did not feel safe on their first night. At Northumberland (2012), first night officers completed all the necessary forms about newly arrived prisoners, but night staff did not know who they were. At Liverpool (2012) we found a case of a prisoner who had arrived with a suicide risk warning but this was not indicated in his P-NOMIS electronic case notes on his arrival or during his first night interviews: staff did not learn this information until the following morning. At the time of the Liverpool inspection, the Prisons and Probation Ombudsman

---

[14] HM Inspectorate of Prisons (2012) The use of the person escort record with detainees at risk of self-harm: A thematic review.

(PPO) was investigating a death at the prison that appeared to have occurred under similar circumstances.

4.5 The PER thematic found that some officers undertaking ACCT assessments struggled to obtain information about previous self-harm. It was usually kept in the prisoner's core file, which they rarely had time to read before undertaking assessments and reviews.

Conclusion

4.6 As recommended by the Inquiry, the PER form had been revised. However, our PER thematic review found that there was often still not enough detail recorded to support receiving establishments in their risk assessments and this linked to the need for adequate training with relevant staff across the criminal justice system. Although the thematic focused on information relating to self-harm, there is no reason why these findings would not also apply to information on risk to others. There were still examples where not all relevant information was easily available to the appropriate prison staff. Since the publication of the PER thematic report, NOMS has produced and begun to deliver a plan to implement its recommendations. At the time this report was produced, it was too early to assess whether the NOMS plan has resulted in the required improvement.

Data migration – transfers between establishments

4.7 ***Concern:*** *The Inquiry highlighted the importance of a receiving establishment being aware of the reason for any transfer and if the prisoner was particularly problematic. In addition to ensuring that all the correct files followed a prisoner to their new establishment, the Inquiry felt that directly informing an establishment of the reason for the transfer would reduce the possibility of important information being missed.*

4.8 Since the Inquiry report was published, NOMS has rolled out P-NOMIS across the prison system. This is a computerised case record system to which all relevant prison and YOI staff have access and which has, to a large extent, replaced the old system of paper-based wing or residential unit files. The transfer of information between establishments has been simplified, but still depends on the quality and timeliness of the data entered, which are not always consistent.

4.9 Inspections found that there were still many cases of prisoners arriving at an establishment without an up-to-date OASys assessment[15], or with no assessment at all. This was supported by our joint POMI report[16] which also found that many prisoners were transferred from local prisons without an up-to-date OASys assessment. Many assessments failed to address the risks that prisoners posed to other prisoners and staff. Some inspection reports note that some prisoners arrive without a complete printout of their criminal record. This, as the 2013 inspection report of Winchester notes, prevents the completion of accurate cell-sharing risk assessments (CSRAs) and impedes meaningful public protection work.

[15] All prisoners serving 12 months or more should have an OASys assessment completed.

[16] Criminal Justice Joint Inspection (2013) *Third Aggregate Report on Offender Management in Prisons: Findings From a Series of Joint Inspections by HM Inspectorate of Probation and HM Inspectorate of Prisons*

4.10 An HMIP thematic review of resettlement provision for children and young people[17] found that in most cases relevant information arrived with the young person. However, there were occasions when it did not. Missing information sometimes included Asset, the standard assessment tool that draws together information about a young person, including the factors that may have contributed to the young person's offending behaviour. In these cases, staff would chase up the missing information.

Conclusion

4.11 P-NOMIS has simplified and improved the transfer of information between establishments. However, this is dependent on the quality of information recorded. Backlogs in OASys assessments meant that prisoners were not always transferred with an up-to-date assessment, including their risk to others. In children's and young people's establishments it was rare for young people to arrive with missing information, although there were still examples of this.

Information flow - documents on the wing

4.12 ***Concern****: The Inquiry highlighted the importance of the wing file containing up-to-date information about the behaviour of a prisoner and arriving on the wing at the same time as the prisoner so that any known risks can be managed by staff. The Inquiry was informed that all establishments would have access to P-NOMIS by 2007, replacing the old paper-based wing files.*

4.13 P-NOMIS was fully implemented in all prisons in 2011, later than planned. This system is undoubtedly an improvement on the previous wing files and has improved the ability to identify and share concerns, including the use of alerts to flag key issues and potential risks. However, as mentioned previously (see 4.4, 4.8, and 4.11), it is not always being used to its full potential because prison staff and those working with prisoners do not consistently record all relevant information on individual prisoners on P-NOMIS. For example, offender management staff are concerned with sentence planning, sentence management and assessment of risk. However, the 2013 third aggregate POMI report found that 'virtually no offender management units used P-NOMIS and some set up their own case recording system that no-one else could see. This undermined the centrality of the offender management unit and was a serious waste of public resources given the large scale investment in P-NOMIS.' [18] In consequence, wing staff might know very little of what to expect from prisoners and what aspects of their behaviour might give cause for concern. Some offender management staff refused to enter information about prisoners on P-NOMIS on the grounds that wing or residential unit staff might disclose it to prisoners inappropriately. The report concluded that 'changes have failed to address the culture of poor communication or mistrust between prison departments that undermines the potential of offender management. Successful offender management requires good communication and co-operation and a holistic approach to work with prisoners. The inability of custodial establishments to adopt this approach is nowhere more apparent than in their failure to use the electronic case record P-NOMIS'. [19]

---

[17] HM Inspectorate of Prisons (2011) Resettlement provision for children and young people: Accommodation and education, training and employment.

[18] Criminal Justice Joint Inspection (2013) *Third Aggregate Report on Offender Management in Prisons: Findings From a Series of Joint Inspections by HM Inspectorate of Probation and HM Inspectorate of Prisons*

[19] Criminal Justice Joint Inspection (2013) *Third Aggregate Report on Offender Management in Prisons: Findings From a Series of Joint Inspections by HM Inspectorate of Probation and HM Inspectorate of Prisons*

4.14 PSI 14/2012[20] requires that all offenders should be subject to a needs assessment as identified in Output 15 of PSI 14/2012. For prisoners sentenced to more than 12 months and young adults with more than four weeks left to serve, OASys should be used and contain information about prisoners' previous convictions and the nature and extent of risks that they pose. In many establishments, inspectors found a backlog of uncompleted OASys assessments or a significant number of prisoners whose assessment was more than a year out of date.

Conclusion

4.15 P-NOMIS is an improvement on the old paper based wing files and enables better information sharing within and between establishments, including the use of alerts to flag potential risks. However, it is not currently being used to its full potential by all staff working with a prisoner. Backlogs in OASys assessments mean that a prisoner's risk assessment is not always up to date.

Information flow – documents held elsewhere in the establishment and monitoring information flow

4.16 **Concerns:** *The Inquiry had concerns about the information held elsewhere in the establishment which may affect the management of prisoners, for example in security files. The Inquiry noted the importance of this information being available across the prison estate and of security departments obtaining the security file of prisoners who had already served a sentence and therefore highlighted the need for a national database for security information to ensure this. They also highlighted the need for wing staff to be informed of security information relevant to managing a prisoner.*

4.17 *The Inquiry was also concerned at the lack of some officers' awareness and understanding of prison service orders and, sometimes, their scant knowledge of recommendations for improvement that had been made by external organisations such as the PPO or HMIP. The Inquiry recommended that the extent to which all relevant information was disseminated in the establishment should be monitored.*

4.18 A new networked, intelligence management system, Mercury, is being introduced across all establishments to record security information. Sharing of security information relies on individual security managers, and our inspections have found that these arrangements are generally reasonable.

4.19 In most establishments we generally find reasonable knowledge among relevant staff of our expectations and previous inspection reports and recommendations. HMIP routinely follows up the recommendations made to an establishment. In 2012 to 2013, 67% of recommendations made to prisons and YOIs had been achieved or partially achieved[21].

4.20 The PPO investigates all deaths of prisoners and makes recommendations so that lessons may be learned and preventable deaths avoided. The PPO annual report[22] refers to their completed investigation of three homicides and states 'our investigations into these cases suggest that there remain lessons to be learned, not least in respect of sharing information effectively and ensuring that this is appropriately used to inform risk assessments and management'.

[20] NOMS (2012) *PSI 14/2012 Implementation of the Service Specification for 'Manage the Sentence: Pre and Post Release from Custody' (transitional version).*
[21] HM Chief Inspector of Prisons for England and Wales (2013) Annual Report 2012-13.
[22] Prisons and Probation Ombudsman (2013) Annual Report 2012-13.

4.21 HMIP routinely follows up recommendations made by the PPO during inspections. At Stoke Heath (2012), there had tragically been two self-inflicted deaths since the previous inspection. Both cases had been fully considered by the governor with the safer community committee and an action plan had been implemented following investigations by the PPO. We saw that this plan had been used to inform permanent changes to the prison's response to prisoners in crisis. However, this is not what we normally find. The usual prison forum for discussing deaths in custody is the safer custody committee but we often find no, or inconsistent, discussion at these meetings. Completion of actions too often relies on a notice or instruction to staff with no means of ensuring that all staff read it or understand their role in the implementation of recommendations. We are not always confident that recommendations are consistently reinforced where necessary.

Conclusion

4.22 Sharing of security information was generally reasonable and a national security database is being introduced as recommended by the Inquiry. Lessons from deaths in custody had not always been effectively acted on or recommendations implemented. The PPO's annual report highlighted continuing issues with information sharing to inform risk assessment and management.

Violence reduction

4.23 ***Concern****: The Inquiry identified the importance of the introduction of violence reduction strategies, which at the time of the report were in their infancy, to coordinate and drive work to reduce violence in prisons. The Inquiry felt that the best way to reduce the scale of prison violence was to encourage prisoners to have a role in making the prison a safer place and they suggested that one way to do that was through prisoner forums.*

4.24 Prisoner surveys, and the prisoner groups that are held during inspections, ask prisoners detailed questions about the extent to which they feel safe, whether bullying takes place, and if staff take effective action to stop violence and intimidation (survey findings are detailed in 4.65; and 4.71 to 4.79). Inspections found that most establishments had a violence reduction strategy, although the extent of meaningful consultation with prisoners in drawing up the strategy varied. At some prisons we found prisoner surveys being carried out but it was not always clear to what extent the data obtained shaped the violence reduction strategy. Some inspection reports identify prisoner council meetings which discussed violence reduction: attendance at some councils was poor, with, in some cases, obscure links between their work and the production of the violence reduction strategy.

4.25 Inspectors have noted that at some establishments there is little connection between equality and diversity work, including the investigation of discrimination incident report forms (DIRFs), and violence reduction. Violence reduction work should include work to address and reduce discriminatory behaviour.

Conclusion

4.26 Most establishments had a violence reduction strategy but consultation with prisoners was inconsistent and did not always feed in to the violence reduction strategy. Work to address and reduce discriminatory behaviour needed to be included in violence reduction work.

Prisoners at risk of self-harm

4.27 ***Concern****: The Inquiry recommended that enforced cell sharing should be eliminated, but noted that it may sometimes be desirable, for example, for a prisoner who was at risk of self-harm. In this case, cell sharing could potentially provide them with someone they could talk to and a source of support.*

4.28 All inspections address the systems in place for caring for prisoners who are vulnerable to self-harm. There is no reason why a prisoner who is vulnerable to self-harm would not share a cell provided the CSRA indicated that it would not incur any significant risk to either prisoner. Peer support schemes such as Listeners (prisoners trained by The Samaritans to provide confidential emotional support to fellow prisoners) are also available across prisons, offering a highly valued service to prisoners at risk. In most prisons, access to peer supporters was good, even at night. However, access for young adults and young people was often poorer than for adults. At Stoke Heath (2012) we noted a good Listener scheme on the adult side but not on the young adult side and we recommended that young adults should be recruited as Listeners. In inspection survey analysis conducted to support our 2013 response to the government's consultation on the future of young adult YOIs[23], only 46% of young adult men told us that, if they wanted to, they were able to speak to a Listener at any time, compared with 61% of adult men. From our 2012-2013 'Children and Young People in Custody[24]' survey report, 39% of young men and 50% of young women said they could speak to a peer mentor.

4.29 Inspections have also found that in some establishments, such as Norwich 2012, Listeners did not feel valued or supported by all staff. At two prisons where there had recently been self-inflicted deaths, Lincoln (2012)[25] and Gloucester (2012), inspectors found there were no peer supporters in reception.

4.30 Inspections have found mental health in-reach teams providing good support at some establishments. At some, a range of initiatives have been put in place to support prisoners at risk of suicide or self-harm, including counselling, weekly support meetings for vulnerable prisoners, and fast-tracking of counselling referrals for prisoners subject to ACCTs. Unfortunately, inspectors have also found establishments where many prisoners on ACCTs were locked in their cells for long periods with nothing to keep them constructively occupied.

4.31 The preservation of life should be the main imperative for staff responding to emergencies: all should be aware of how to implement emergency procedures including carrying out a dynamic risk assessment to ascertain whether it is safe to go into a cell, using the sealed cell key to enter the cell, carrying an anti-ligature knife, and giving first aid. Despite this, some inspection reports describe staff being reluctant to enter cells on their own even when they believed a prisoner's life was at risk. At Elmley (2012) we found staff on duty at night who lacked the confidence to respond to emergency situations, would not enter a cell on their own under any circumstances and were not carrying anti-ligature knives. At Gloucester (2012), Wakefield (2012), Glen Parva (2013) and Lewes (2013), staff were reluctant to enter cells even if they thought a prisoner's life was at risk. This was of particular concern because there had been self-inflicted deaths at some of these establishments.

---

[23] HM Chief Inspector of Prisons (2013) Response to the Ministry of Justice consultation: Transforming Management of Young Adults in Custody

[24] HMIP and YJB (2013) Children and young people in custody 2012-13: An analysis of 15-18-year olds' perceptions of their experiences in young offender institutions

[25] At the 2013 inspection this had changed and there was good use of peer supporters in reception.

4.32 The number of self-harm incidents has fallen in women's prisons from 11,516 in 2010 to 2011 to 6,317 in 2012 to 2013[26]. This is an impressive reduction. In contrast, the number of self-harm incidents has risen for men in custody from 14,769 in 2010 to 2011 to 16,370 in 2012 to 2013[27]. At the time this report was being finalised in early 2014, the number of self-inflicted deaths in male prisons was higher than it had been for a number of years. While there has undoubtedly been progress in improving the management of prisoners vulnerable to self-harm since the Inspectorate published '*Suicide is everyone's concern'*[28] in 1999, many of the findings remain relevant today. These include poor communications about prisoners who are suicidal, not ensuring proper care, inadequate staff training, lack of awareness of sources of support for prisoners, inadequate support plans, inconsistent case conferences and delays in responding to cell call bells.

Conclusion

4.33 Unless the CSRA indicates a risk, a prisoner at risk of self-harm would be able to share a cell. Other peer support services are available in prisons, although young adults and children reported poorer access to these. At some prisons night staff were reluctant to enter cells even if they thought a prisoner's life was at risk. Although there had been a welcome reduction in self-harm figures for women in prison, there had been an increase for men. Despite improvements in how self-harm is managed in prison, many of the issues identified in our 1999 thematic review remain relevant today.

Cell-sharing risk assessments

4.34 ***Concern****: The cell-sharing risk assessment (CSRA) was introduced by the Prison Service in 2002 in response to the murder of Zahid Mubarek to assess the risk a prisoner poses to another prisoner in a locked cell. The Inquiry found that, in the absence of any training in completing the form, the completion and use of the form varied across the prison estate. This problem continued throughout the prisoner's time in custody, with reviews not taking place on time or following other significant events such as a further conviction or adjudication for a violent, racist or homophobic offence.*

4.35 The consistent completion of CSRAs became subject to national policy under PSI 32/2005 which required establishments to appoint a manager to oversee the risk assessment process as part of the violence reduction strategy and to improve the consistency and quality of risk assessment and risk management in relation to cell sharing. It clarified the role of risk assessment in identifying racist, homophobic and violent prisoners and it required establishments to ensure that previous convictions and existing risk assessments were seen by staff completing CSRAs.[29] The CSRA process was further revised, with a new risk assessment introduced in 2011 when PSI 09/2011 was published. A training package was launched nationally and new audit baselines were created. The CSRA is a paper document and, when it is completed, the result is logged on P-NOMIS.

4.36 In the 12 months to end of June 2013 there were two homicides in prison[30]. There has been a reduction in homicides in prison since 2000 which is viewed as coinciding with the introduction of the CSRA. From 2000 to June 2013 there have been 18 homicides compared to 26 between 1990 and 1999[31].

---

[26] HM Chief Inspector of Prisons for England and Wales (2013) Annual Report 2012-13.
[27] Ibid
[28] HMIP (1999) *Suicide is Everyone's Concern*
[29] HM Prison Service (2005) PSO 32/2005: Cell Sharing Risk Assessment.
[30] Ministry of Justice (2013) Safety in Custody Statistics England and Wales. Update to June 2013.
[31] Ibid

4.37 Inspection reports comment on the extent to which CSRAs are properly completed during prisoners' early days in custody. At Dartmoor (2012) there was evidence that some risk assessments had not been countersigned by the night patrol on the vulnerable prisoner first night landing. Inspectors were also not certain that first night patrols focused on the risks for newly arrived vulnerable prisoners. At some establishments, CSRAs were not always conducted in private, which might deter some prisoners from disclosing important information about risk. At one establishment, inspectors found that prisoners were involved in undertaking first night interviews, a practice which ceased immediately when inspectors pointed out the risks incurred. At Garth (2012) and Wolds (2012), reports made recommendations that CSRAs should be carried out at reception, before prisoners were moved to the first night centre. Many prisons complete CSRAs in the first night centre, which the Inspectorate considers acceptable if it is done in private and before the decision is made about where the prisoner will be located. This helps establishments to achieve the expectation that prisoners stay in reception for as little time as possible. Many prisons have established first night centres since 2000 in recognition of the additional support required for those recently arrived in prison.

4.38 A recent NOMS Quick Time Learning Bulletin notes that some staff do not understand the form or use it properly, which could adversely affect the safety of prisoners[32]. It is important that CSRAs are completed by trained staff who are experienced in their use and have all the information they need. As noted earlier in this chapter there are still issues in information sharing which prevents the completion of accurate CSRAs.

4.39 At some establishments, including Werrington (2013), Buckley Hall (2012) and New Hall (2012), a process was in place to review CSRAs. The Elmley 2012 inspection report recommended that CSRAs should be reviewed whenever prisoners were first located in the same cell.

Conclusion

4.40 The CSRA was a welcome initiative and is believed to have helped reduce the number of homicides in prisons. However, the completion and review processes for this risk assessment continue to be implemented inconsistently across the prison estate. Better staff training and information sharing are necessary to ensure cell-sharing decisions are based on thorough risk assessment.

Enforced cell sharing

4.41 ***Concern****: The Inquiry felt that the most obvious way to reduce in-cell attacks was to eliminate enforced cell sharing. While it noted that this would be difficult to achieve, it recommended that eliminating enforced cell sharing should be an objective for the Prison Service.*

4.42 *The Inquiry recognised that eliminating cell sharing would be difficult to achieve and therefore indicated that if it continued, decisions should be based on a coherent process overseen by senior staff and should take into account prisoners' preferences about whom they shared with. There could, for example, be benefits in putting a prisoner who did not speak much English with someone who spoke the same language.*

---

[32] National Offender Management Service (2013) *Quick-time Learning Bulletin: Risks Associated with offence and status.*

4.43 Many prisoners are frequently required to share a cell which is not always designed for more than one person. In 2011 to 2012 the average number of prisoners 'doubling up' (two prisoners sharing a cell designed for one or three prisoners sharing a cell designed for two) was 20,157[33], a situation exacerbated by prison overcrowding. The 2013 HMIP Annual Report highlighted this issue, reporting that the prison population of England and Wales was 7.1% above its certified normal accommodation (CNA)[34]. This figure had increased to 11.9% in November 2013 which meant that prisons were holding 9,089 people above their CNA[35]. This increase has been the result of recent prison closures. While plans are in place to build a new 2,000 capacity prison in Wales and to increase the capacity of existing prisons, this will not have an immediate impact on prison capacity, indicating that the prison population will continue to run above its CNA for the foreseeable future.

4.44 While some newly opened prisons have been designed for single occupancy, for example Bure and Oakwood, these establishments do have some double occupancy cells. Thameside (opened in March 2012) has mostly double occupancy cells, indicating that cell sharing will continue in the long term with the inherent risks of two prisoners sharing the same cell.

4.45 The CSRA process discussed in the previous section (4.34 to 4.40) aims to ensure that cell sharing is appropriately risk assessed and, as the Inquiry noted, there can be instances when prisoners benefit from sharing cells. The 2012 Littlehey inspection report noted that newly arrived adult prisoners were located in shared cells to provide support, subject to an appropriate CSRA being completed first. Reception and first night staff tried to match prisoners according to age, background, and whether they smoked. The 2013 Werrington report noted that four remanded and sentenced young people shared cells because it provided them with additional support.

Conclusion

4.46 Enforced cell sharing has not been eliminated and there are no plans for this to happen, with newly opened prisons including double occupancy cells. Population pressures and recent prison closures mean that over 20,000 prisoners are 'doubled up' and the prison population is above its CNA. There were examples of staff attempting to allocate prisoners and young people in shared cells to provide them with support.

Remand and convicted prisoners sharing cells and wings

4.47 ***Concern**: At the time he killed Zahid Mubarek, Robert Stewart had completed his sentence but was being held on remand for further offences. As Zahid Mubarek was sentenced, the Inquiry felt they should no longer have been sharing a cell at the time of the murder. Where a remand prisoner consented to share a cell with a convicted prisoner, the Inquiry recommended that this be with a particular prisoner rather than viewed as general consent.*

4.48 The HMIP remand thematic (2012) found that cell sharing between convicted and unconvicted prisoners was common, occurring at four of the five establishments that were inspected as part of the thematic[36]. The rule on cell sharing set out in the Prison Rules 1999 is unclear: it can be interpreted that convicted and remand prisoners must not share cells, or

---

[33] Hansard HC, 20 November 2012, c429W

[34] HM Chief Inspector of Prisons (2013) *Annual Report 2012-13*

[35] Howard League (2013) http://d19ylpo4aovc7m.cloudfront.net/fileadmin/howard_league/user/pdf/Prison_watch/Prison_Watch_29.11.2013.

[36] HM Inspectorate of Prisons (2012) *Remand prisoners: A thematic review*

that they must not be required to share cells. Even for the latter, we found that consent was often not obtained from the remand prisoner before putting them in a cell with a convicted prisoner. Our remand thematic recommended that 'except in exceptional circumstances, unconvicted prisoners should be located on discrete wings, separate from convicted prisoners. Unconvicted prisoners should have a status and regime that recognises and facilitates their entitlements, and that is distinct from the incentives and earned privileges scheme[37]'.

4.49 Cell sharing between convicted and unconvicted prisoners still takes place: at Eastwood Park (2012) a recommendation to stop the practice had been made in a previous report, but it had not been achieved; at Birmingham the 2012 report noted that cell sharing between convicted and unconvicted prisoners was taking place but there were plans to stop it.

Conclusion

4.50 Remand and convicted prisoners continue frequently to share cells and wings. The Prison Service interprets the Prison Rules as allowing for an unconvicted prisoner to share a cell with a convicted prisoner if they have given consent, which is viewed as general consent. While the Inquiry did state that remand prisoners could share with a convicted prisoner if consent was obtained, it recommended that the consent obtained only applied to a particular convicted prisoner, rather than convicted prisoners in general. Our remand thematic highlighted that prisoners were often not asked for their consent and went further than the Inquiry to recommend that remand prisoners should be held in discrete wings, separate from convicted prisoners except in exceptional circumstances.

Young adults and adults on the same wing

4.51 ***Concern****: The Inquiry recommended that the Prison Service should review whether the advantages of holding young offenders on the same wing as adult offenders outweigh the disadvantages and whether the practice should be extended to other prisons.*

4.52 Currently young adults can be held in dedicated young offender institutions (YOIs), split sites (those holding more than one type of distinct population), on a separate wing in an adult prison or integrated with adults. In November 2013 NOMS opened a consultation on 'Transforming Management of Young Adults in Custody'[38] to review the management of young adults in the prison estate, and to propose that young adults are held in adult prisons rather than in dedicated YOIs. As the Inquiry highlighted, the impact on young adults and how their needs can be met would have to be considered within this. As this report was being finalised, Ministers announced an independent inquiry into the deaths of young adults in custody and stated that the review of the young adult estate would be put on hold so it could be informed by the conclusions of the inquiry.

4.53 Our response to the consultation, based on our inspection evidence, highlighted that current outcomes for young adults are too often not good enough in whatever type of establishment they are held and we therefore welcomed a review of their management[39]. The picture was complex, with NOMS data showing that levels of violence, bullying and self-harm were higher at dedicated YOIs, although in our surveys young adults reported feeling safer in dedicated

---

[37] Ibid
[38] https://consult.justice.gov.uk/digital-communications/young-adults
[39] HM Chief Inspector of Prisons (2013) Response to the Ministry of Justice consultation: Transforming Management of Young Adults in Custody

establishments. Purposeful activity for young adults was poor across the different types of establishment they were held in, but particularly at dedicated YOIs. In contrast, respect and resettlement tended to be better at dedicated YOIs with the specific needs of young adults often being missed and therefore likely to be unmet when they were integrated with adults.

4.54 Inspections have raised some concerns about young adults and adults being accommodated on the same wings in some establishments. For example, at Woodhill (2012), some young adults were co-located on a specialist young adult wing while others were placed on a wing with adults. While risk assessments were carried out in advance, some vulnerable young adults were also held on the vulnerable prisoner wing. However, the inspection report notes that risk assessments did not address the risks of adult sex offenders being housed on a wing with young adults. Recommendations were made to review the safety on the vulnerable prisoner unit and to ensure that young adults received a suitable risk and vulnerability assessment.

4.55 Our consultation response concluded: 'No one model of provision will meet all young adults' needs. A range of different types of establishment are needed to meet young adults' different needs. Wherever they are held, specific regulations should ensure young adults' specific risks, needs and circumstances are identified and addressed. Effective staff training is required to ensure staff develop and demonstrate the appropriate competencies to respond to an integrated population.'[40]

Conclusion

4.56 In whatever type of establishment they are held, outcomes for young adults are not good enough. The government's recent announcement of an inquiry into deaths of young adults in custody and the implications of this for the review of the young adult estate provides a welcome opportunity to address the recommendation of the Zahid Mubarek Inquiry that the Prison Service should review whether the advantages of holding young offenders on the same wing as adult offenders outweigh the disadvantages and whether the practice should be extended to other prisons.

Personal officers

4.57 ***Concern**: Personal officer schemes allocate prisoners to a named member of staff who is meant to provide support, have regular contact with them and be a source of contact for any issues. The Inquiry was concerned that some establishments did not have a personal officer scheme and, in the ones that did, there was variation in the implementation of the scheme and the training that personal officers received.*

4.58 Personal officer schemes, of varying effectiveness, existed at all establishments inspected. The procedures for assigning personal officers and covering their work when they are on leave are important. Prisoners could experience a change in personal officer every time they move cell if officers are allocated to cells rather than to individuals. At Wetherby (2012), even though the personal officer allocation was cell based, a young person did not change his personal officer if he moved to another cell in the unit, but did experience a change if he moved to another unit. At Liverpool (2012) and Eastwood Park (2012) personal officers were allocated to cells, and at Canterbury (2012) there was no cover for personal officers. Reports on Dartmoor (2012), East Sutton Park (2012), New Hall (2012) and

[40] Ibid

Northumberland (2012) indicated that there was cover for personal officers if they were absent.

4.59 Some reports noted an effective personal officer policy with specified training requirements. A full inspection report on Glen Parva (2013) recommended that officers receive guidance and training on the role of a personal officer. The short follow-up inspection found that this had been partially achieved: the guidance was clear and understood by staff, but it did not appear to have effected significant improvement in practice, as the substance of the training was not reflected in personal officer entries. At the Keppel unit it was noted as good practice that new residential support officers were supported by an experienced mentor.

4.60 Prisoner surveys often disclose that unacceptable numbers of prisoners report having no personal officer, or not having contact with their personal officer. In some establishments, inspections found that the personal officer scheme existed on paper only and barely at all in reality. This was the case at several London prisons. From the recent Brixton inspection (2013), only half (52%) of prisoners said they had a personal officer and fewer prisoners than the national comparator said they had a member of staff they could talk to if they had problems.

4.61 Survey responses from adult and young adult prisoners during the annual reporting period 2012 to 2013 indicated that 61% of black and minority ethnic prisoners who said they had a personal officer felt that they were helpful or very helpful against 68% of white prisoners. This finding was reflected in the children's and young people's estate, with 64% of black and minority ethnic young people reporting that their personal officer tried to help them, compared with 78% of white young people.

Conclusion

4.62 All establishments inspected had personal officer schemes but the quality and training varied and some schemes existed only on paper. Prisoner surveys show a proportion saying that they either did not have a personal officer or had no contact with them. Survey responses on their helpfulness were poorer for black and minority ethnic prisoners.

Race and intolerance – position of Muslim prisoners

4.63 ***Concern****: The Inquiry's remit did not include an investigation of how Muslim prisoners were treated in prison. However, it did note that Zahid Mubarek's contact with the Muslim chaplain at Feltham was brief. This was not a criticism of the chaplain, but of the limited role that Muslim chaplains held at Feltham, which the Inquiry felt should be expanded as a valuable source of support.*

4.64 There has been an increase in the number of Muslim prisoners. In October 2000 there were 4,653 Muslim prisoners[41] whereas in June 2012, there were 11,248 Muslim prisoners, accounting for 13% of the prison population[42].

4.65 Survey responses from 2012 to 2013 showed that Muslim prisoners were more positive about access to a religious leader of their faith than their non-Muslim counterparts (see table 1 – statistically significant differences are highlighted).

[41] http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo050201/text/50201w21.htm#50201w21.html_wqn2

[42] www.parliament.uk/briefing-papers/SN04334.pdf

Table 1: The percentage of prisoners who said they could speak to a religious leader of their faith in private

	Muslim	Non-Muslim
Male adult	**65%**	**57%**
Female adult	**100%**	**66%**
Young adult	**75%**	**54%**
CYP	**76%**	**70%**

4.66 The HMIP thematic on Muslim prisoners in June 2010 considered the role of Muslim chaplains. At that time, it was apparent that their role had not been expanded, with some chaplains working for less than six hours a week[43]. Most of the Muslim chaplains interviewed felt that they did not have enough time to fulfil their roles. The large number of converts to Islam around the time of the thematic placed more demands on chaplains, who lacked the time to see all converts systematically.

4.67 Muslim chaplains felt that other members of staff lacked an understanding of Islam, or were influenced by media-inspired misconceptions. They thought that focused training on Islamic beliefs and culture was required, rather than the more general diversity training being delivered.

Conclusion

4.68 Since the Inquiry there has been an increase in the number of Muslims in prison. Our 2010 Muslim thematic found that the role of Muslim chaplains had not been sufficiently expanded to reflect this. Most Muslim chaplains did not feel they had enough time to fulfil their role and felt better staff training and understanding of Islamic culture was required. However, more recent inspection findings have found Muslim prisoners reported better access to a religious leader than non-Muslim prisoners.

Race and intolerance – addressing the key areas from 'Parallel Worlds'

4.69 ***Concern****: The Mubarek Inquiry highlighted that the issue of racism in prisons was now high on the agenda. This was a result of the murder of Zahid Mubarek and the recognition by the Prison Service that it was institutionally racist.[44] The Inquiry's remit did not extend to investigating race relations across all prisons and recommended that the Commission for Racial Equality and the Prison Service should incorporate the findings of this Inspectorate's review of race relations in prisons, and 'Parallel Worlds,' into their management of the action plan.*

[43] HM Inspectorate of Prisons (2010). Muslim prisoners' experiences: a thematic review.
[44] Home Office (2006) Report of the Zahid Mubarek Inquiry; London, The Stationery Office (p.413).

4.70 In 2003 the Commission for Racial Equality (CRE) worked with the Prison Service to produce an action plan 'Implementing Race Equality: A Shared Strategy for Change', to improve Prison Service performance on race equality. In 2005, HMIP published a review of race relations in prison, 'Parallel Worlds', which highlighted disconnection between staff who were not from a black and minority ethnic background and prisoners who were from that background, in particular over race relations.

4.71 Analysis of prisoner survey data[45] for Parallel Worlds identified two key findings and advised governors to develop mechanisms to deal with these differences in experiences and perceptions: Asian prisoners were more likely to report feeling unsafe than other black and minority ethnic categories and were more likely to report racist bullying by other prisoners. This was particularly true for women and young adults. Black prisoners were less likely than other minority ethnic prisoners to feel that they were treated with respect.

4.72 Analysis of 2012 to 2013 survey data indicates that, while some negative perceptions persist and a number of establishments during the reporting period were recommended to investigate and address the reasons for black and minority ethnic prisoners' negative perceptions, some changes can be seen in the perceptions of different ethnic groups that might indicate improvement. However, the picture is mixed and no clear overall conclusions can be drawn.

4.73 Table 2 provides a breakdown of survey responses to the question 'Have you ever felt unsafe here?' during 2012 to 2013. The table shows that, with a very few exceptions, prisoners from black and minority ethnic groups were generally more likely to report feeling unsafe than their white counterparts.

Table 2: The percentage of prisoners who said they had felt unsafe while in prison

	White	Black	Asian	Mixed	Overall
Male adult	**33%**	**35%**	**42%**	**37%**	**34%**
Women	**34%**	**26%**	**39%**	**14%**	**33%**
Young adult	**20%**	**36%**	**21%**	**29%**	**24%**
CYP	**28%**	**35%**	**36%**	**29%**	**30%**

4.74 Asian female prisoners continue to report more negative feelings of safety, as they did at the time of Parallel Worlds. In 2012 to 2013 39% reported having felt unsafe at some point during their time in the establishment, higher than any other ethnic group, although encouragingly no Asian female prisoners reported feeling unsafe at the time they completed the survey.

[45] Surveys were conducted between April 2003 and October 2004.

4.75 By contrast, Asian young adults (21%) were less likely than young adults from other black or minority ethnic groups to report feeling unsafe at some point at their establishment. At the time of Parallel Worlds, more than half the Asian young adults had reported feeling unsafe.

4.76 Parallel Worlds reported that 18% of black young adults said that they had felt unsafe, the lowest across all ethnic groups; whereas during 2012 to 2013, 36% reported having felt unsafe, the highest of all ethnic groups.

4.77 Parallel Worlds reported that racist bullying was particularly likely to be reported by Asian women and young adults. Table 3 provides a breakdown of survey responses during 2012 to 2013 to the question 'Have you been victimised by another prisoner here because of your race or ethnic origin?'. The table shows that, at 9%, the reporting of victimisation by young adult male Asian prisoners is higher than for most other ethnic groups. However, during 2012 to 2013, Asian women were less likely than other ethnic groups to report victimisation on grounds of race. Asian children and young people (5%) were more likely than any other ethnic group to report this in our children and young people surveys.

Table 3: The percentage of prisoners who said they had been victimised by another prisoner because of their race or ethnic origin

	Black	Asian	Mixed
Male adult	**6%**	**8%**	**7%**
Female adult	**14%**	**0%**	**0%**
Young adult	**7%**	**9%**	**9%**
CYP	**1%**	**5%**	**3%**

4.78 At the time of the Parallel Worlds report, black prisoners were less likely to say that they were treated with respect than prisoners as a whole. Table 4 provides a breakdown of 2012 to 2013 survey responses to the question 'Do most staff treat you with respect'. The data suggest that perceptions have changed somewhat, although in the women's estate black women prisoners were less likely to report being treated with respect by staff than any other ethnic group.

4.79 Table 4 shows that young adults were, across all ethnic groups, less likely to report being treated with respect by staff than either adults or children, and Asian young adults were particularly unlikely to report this, 45% doing so. This is of particular concern, suggesting that insufficient progress has been made since Zahid Mubarek's murder.

Table 4: The percentage of prisoners who said that staff treated them with respect

	White	Black	Asian	Mixed	Overall
Male adult	**79%**	**73%**	**71%**	**68%**	**78%**
Women	**77%**	**60%**	**78%**	**69%**	**75%**
Young adult	**70%**	**55%**	**45%**	**52%**	**64%**
CYP	**81%**	**65%**	**58%**	**70%**	**74%**

4.80 Inspection reports noted that most members of staff had received 'Challenge it, Change it' training[46], although making a judgement about the effectiveness of the training is beyond the scope of inspection reports. Parallel Worlds emphasised that governors and race relations liaison officers had a central role in promoting race equality. It was apparent from inspections that some governors took an active interest in equality and some reports referred to the governor chairing the equality committee. Most establishments had a diversity strategy, though not all addressed fully every protected characteristic listed in the Equality Act 2010.

4.81 Parallel Worlds recommended that there should be more effective consultation with prisoners to help bridge any racial divisions and tensions. Our inspections have found that prisoner consultation has improved, with, for example, prisoner equality and diversity representatives attending equality meetings. However, such positive reforms sometimes lapsed, for example when a strong focus on equality is diluted by other imperatives. Reports also note consultations and surveys conducted by the prison to canvass prisoners' opinions. Consultation findings should be fed into the equality meetings, but this did not always happen. Many inspection reports raise the need for prisoner representatives to be better trained for their role, and to be supported in their work.

4.82 Parallel Worlds found that the current tools to manage the racial and cultural dynamics of a prison did not always help governors identify or address race issues effectively. Race relations management meetings needed to be more frequent and better managed, ethnic monitoring needed expansion, and systems for investigating complaints about racism needed improvement.

4.83 Inspections have found that equality meetings were taking place in most establishments but their structure varied widely. Some took place monthly, bimonthly or even quarterly. Reports also refer to poor attendance at meetings in some establishments, and variations in the agenda. SMART (systematic monitoring and analysing of race equality treatment) data were regularly discussed but some meetings were insufficiently focused on outcomes for prisoners. It was often unclear if action points were followed up or prisoners were informed about how the issues they had raised would be addressed. Inspection reports also noted that other protected characteristics were not fully considered, and some received no attention.

---

[46] A staff training programme about diversity and equality that at one time NOMS required all prison and YOI staff to complete.

4.84 It should be noted that SMART monitoring encompasses all groups who are not white British, which reduces the capacity of the data to capture the significance of skin colour in determining the extent of discrimination. In March 2014, NOMS introduced a new equality monitoring tool in all establishments which draws equality data from P-NOMIS and collects information about outcomes for all protected characteristics.

4.85 Some inspections found that the system for identifying prisoners with a history of racist abuse is not always effective, with some prisoners being overlooked.

Conclusion

4.86 Parallel Worlds identified a range of areas that needed development, and the Inquiry recommended that they should be addressed by the Prison Service and Commission for Racial Equality in their action plan. These included the perceptions of black and minority ethnic prisoners about treatment, safety and respect. Inspection surveys indicated improvements in some areas of respect, but in safety black and minority ethnic prisoners still reported less favourably than white prisoners. These differences require further investigation. Asian young adults were particularly unlikely to report that they felt treated with respect by staff, which suggests that insufficient progress has been made since Zahid Mubarek's murder.

4.87 Although consultation with prisoners about equality has improved, using consultation findings to shape strategies and action plans remains a weakness. SMART monitoring remained focused on race and ethnicity, but not other protected characteristics, and it is often unclear if evidence of differential outcomes is addressed. SMART monitoring has recently been superseded by a new system with the potential to capture useful data about all protected characteristics.

Complaints

4.88 ***Concern****: The Inquiry determined that one of the key ways to improve race relations in prison was to improve the investigation of complaints so that prisoners would have more confidence in the complaints system, both in terms of fairness and effectiveness. This was also a finding in our Parallel Worlds thematic.*

4.89 The introduction of the race incident report form, now superseded by the discrimination incident report form (DIRF), has helped to improve the investigation of race-related complaints. Inspection reports indicate that most investigations into DIRFs were well conducted and, in some establishments, were quality assured by a community organisation. However, some reports indicated that quality assurance was not always effective. For example at Durham (2012), external assurance was just a 'perfunctory tick box' with no specific feedback. Not all community organisations contracted by prisons to scrutinise the investigation of complaints challenged the way that complaints were investigated or the outcomes. In some establishments we find that issues covered by DIRF forms were sometimes resolved through mediation, which if well conducted could be a positive experience for all parties involved in the incident that generated the complaint.

4.90 Responses to surveys from the annual reporting period 2012 to 2013 indicate that black and minority ethnic prisoners still have more negative perceptions of the fairness and effectiveness of complaints systems. Across the adult and young adult estate, 28% of black and minority ethnic prisoners who said that they had made a complaint felt that complaints were dealt with fairly compared with 41% of white prisoners, and 22% reported being prevented from making a complaint, compared with 15% of white prisoners. The quality of complaints investigations varied - inspection evidence shows that the prisons' complaints systems cannot be completely relied on to resolve complaints properly and this is a particular concern for prisoners who lack the competence to advocate for themselves, such as those who have learning difficulties. Some prisoners have told inspectors that they believe making a complaint would lead to victimisation and that they do not use the complaints system for fear of reprisals.[47]

Conclusion

4.91 The introduction of a specific discrimination reporting form has helped to improve the investigation of race-related complaints and these were often well conducted, although quality assurance procedures could be strengthened. Black and minority ethnic prisoners continued to report poorer perceptions of the complaints system than white prisoners, with almost a quarter reporting that they had been made to withdraw a complaint. Some prisoners continued to report a fear of reprisal and therefore said they did not use the complaints system.

Mentally disordered prisoners

4.92 ***Concern****: Although the Inquiry was cautious not to stray from its remit of investigating prisoner-on-prisoner in-cell attacks, the fact that Robert Stewart had a personality disorder led the Inquiry to look at the care and treatment of prisoners with mental disorders. It considered that there were issues in identifying prisoners with a mental illness and their potential risk, as well as how they were managed on the wings.*

4.93 Recent inspection reports show that all prisoners received health care screening on reception, including in some prisons the use of the learning disability screening questionnaire. However, a 2007 thematic report noted that screening on transfer to a new prison was not as comprehensive as on first entry to prison[48]. Some reception screens were missing from clinical records and information on mental health and self-harm was also missing in about half the cases examined. However, all prisons have now introduced SystmOne, an electronic system for the management of clinical information, which has improved information sharing between establishments.

4.94 Inspections have found that the number of staff who had received mental health awareness training ranged from almost 90% to less than 10% of uniformed officers. This is important to ensure that staff have the knowledge to identify and manage on the wing those with a mental illness.

[47] HM Chief Inspector of Prisons (2013) Submission to the Joint Committee on Human Rights - The implications for access to justice of the Government's proposed legal aid reforms.
[48]HM Inspectorate of Prison (2007) *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs.*

4.95 There are some differences among establishments in how mentally disordered prisoners fit into the regime. In some establishments we have found mentally disordered prisoners being held in health care, which should only happen if the prisoner has a clear clinical need. In some establishments, some prisoners with a mental disorder had been held in the segregation unit, including on one occasion, a prisoner who was held in segregation against the advice of health care and wing staff.

4.96 The Department of Health and NOMS have recently consulted on the offender personality disorder pathway implementation plan. This aims to provide a much more coordinated approach to managing prisoners with personality disorders and a more structured framework to ensure that prisoners are identified and referred to an appropriate intervention to address their risk. HMIP supports the principles behind the plan but it is too early to comment on progress.

Conclusion

4.97 Health care screening is conducted with prisoners on reception and information sharing had been improved by the introduction of SystmOne. The level of mental health awareness training that had been delivered to staff varied considerably across establishments and there were instances of prisoners with mental health issues being inappropriately held in health care or segregation. The Department of Health and NOMS are currently working on an offender personality disorder pathway implementation plan to improve the management of prisoners with personality disorders.

OASys assessments

4.98 *At the time of the Inquiry, the OASys (offender assessment system) was in its infancy[49]. OASys includes an assessment of the risk of harm a prisoner poses based on both dynamic (such as a prisoner's behaviour in prison and completion of courses) and static (such as offending history) risk factors and is used to inform the sentence planning process. The Inquiry felt that OASys should be used more often to alert staff to the risk that prisoners may pose and for that reason they felt that OASys should not be limited to prisoners serving more than 12 months.*

4.99 All adults serving sentences of more than 12 months and young adults with more than four weeks left to serve should have an OASys assessment[50]. Inspections frequently find a backlog of OASys assessments. Many reports make recommendations to clear backlogs and hold more timely reviews. For example, Stoke Heath (2012) had a backlog of 150 custody assessments, and Portland (2012) 110. As mentioned in 4.13, our POMI inspections point to numerous difficulties in sharing information between staff. Some information, particularly about risk, may be recorded elsewhere in security files.

4.100 Our joint POMI report[51] noted that, although objectives to address the risk to the public were often appropriate, risk management plans were often irrelevant to the period spent in custody and the risk a prisoner may pose to other prisoners or staff. The Channings Wood 2013 inspection report notes that risk management plans following OASys assessments failed to consider how risk to others would be managed while in custody. POMI inspections also

[49] HM Prison Service (2005) PSO 2205. Offender Assessment and Sentence Management – OASys.
[50] NOMS (2012) *PSI 14/2012 Implementation of the Service Specification for 'Manage the Sentence: Pre and Post Release from Custody' (transitional version).*
[51] Criminal Justice Joint Inspection (2013) *Third Aggregate Report on Offender Management in Prisons: Findings From a Series of Joint Inspections by HM Inspectorate of Probation and HM Inspectorate of Prisons*

found little evidence of risk being used when allocating a prisoner or in their re-categorisation process.

4.101 It is currently not a requirement for those serving less than 12 months to receive an OASys assessment, which the Inquiry recommended. In some cases such as Onley (2012) those serving less than 12 months received a 'resettlement sentence plan' but this was not the norm. At the time of writing, NOMS was planning to implement government plans whereby prisoners sentenced to less than 12 months will receive a basic custodial screening of their needs at the start of their sentence, and Community Rehabilitation Companies will be required to provide a resettlement plan which takes these needs into account.

4.102 Our joint POMI report raised concerns about the present offender management arrangements. We therefore recommended that 'a major policy review should be conducted by the Chief Executive of the National Offender Management Service, examining the execution and functioning of the offender management model in prisons, to ensure a better match between the requirements of the model and the resources and skills available in prisons to deliver it.'[52] This will be particularly timely in light of the proposed expansion and changes of services outlined in Transforming Rehabilitation.[53]

Conclusion

4.103 OASys assessments are currently only a requirement for prisoners serving 12 months or more and it was rare that those serving less than 12 months even received a resettlement plan. Inspections often found a backlog of OASys assessments and the need for more timely reviews. OASys was not routinely being used to manage or address a prisoner's risk to others while in custody. Considering the issues in current offender management provision outlined in our joint POMI report, we have recommended a major review of the offender management model, particularly in light of the expansion and changes in services that NOMS are being expected to implement.

MAPPA

4.104 *Multi-agency public protection arrangements (MAPPA) were created as a way of managing dangerous offenders. The Inquiry felt that MAPPA should be more commonly used throughout the prison estate to ensure that the risk posed by those subject to MAPPA was managed in custody and on release.*

4.105 MAPPA arrangements are in place at all prisons. Since the publication of the Inquiry report, most prisons have established an interdepartmental risk management team (IRMT) to review MAPPA cases and inspection reports found that these boards took place satisfactorily in most establishments. However, there were examples of prisons without an IRMT and at some prisons their role was unclear. IRMTs reviewed prisoners at the highest levels of MAPPA and there were examples of boards reviewing cell-sharing risk assessments of prisoners who may also be at risk. There was evidence of information being appropriately shared in Elmley (2012) where relevant departments received notifications of restrictions placed on prisoners. A recommendation made at the last full inspection of Eastwood Park, to make wing staff aware of women subject to risk management procedures, had been partially achieved by the follow-up inspection in 2012.

---

[52] Ibid
[53] Ministry of Justice (2013) Transforming rehabilitation: A strategy for reform

4.106 However, as with OASys assessments there was not always enough focus within MAPPA on the risk prisoners may pose to each other or to staff while in custody. In addition, MAPPA arrangements only start six months before a prisoner's release and not, if applicable, at the point of transfer to an open prison or at the start of release on temporary licence (ROTL) for work placements, which is of concern[54].

Conclusion

4.107 Most establishments had an IRMT to review MAPPA cases, although in some instances their role was not clear. MAPPA did not always include an appropriate focus on managing a prisoner's risk while they were in custody, at the point of transfer to an open prison or the start of ROTL.

[54] HMIP (forthcoming) Release on Temporary Licence (ROTL) failures: A review by HM Inspectorate of Prisons

Section 5. HMYOI Feltham – recent inspection findings

5.1 *Zahid Mubarek was murdered at Feltham in 2000. The Inquiry highlighted a range of failings across the prison estate and by individual officers but also with Feltham as an establishment. Key issues included staff shortages, overcrowding, lack of investment, poor industrial relations, and poor race relations.*

5.2 In March 2013 an unannounced full inspection took place of Feltham B young offender institution, which holds young adults and which is where Zahid Mubarek was murdered. It found that, against all healthy prison tests, outcomes for the young adults were either insufficient or poor. A summary of findings from the inspection report are reproduced below under the four healthy prison test headings.

Safety

5.3 The environment in reception and the first night unit offered a poor experience on arrival, but the support by staff was good. Induction did not ensure that prisoners were clear about what to expect. Levels of violence were high but some good work was developing to address this. Self-harm was also high but reducing. Care for the most vulnerable prisoners was inconsistent. Security was appropriately focused. Many prisoners did not feel the incentives and earned privileges scheme effectively rewarded good behaviour. The number of adjudications and use of segregation were high. The segregation regime was limited, relationships were good, and the special cell was rarely used. Use of force was high, and we were very concerned about the unprecedented frequency with which batons were drawn and used. Substance misuse treatment was good but psychosocial services needed development. Outcomes for prisoners were poor against this healthy prison test.

Respect

5.4 Conditions in residential areas were poor. Relationships between prisoners and many staff were distant and sometimes disrespectful, although we saw some that were good. The expectations that many staff had of prisoners were too low. The prison needed to do more to understand and meet the concerns of diverse groups. Prisoners lacked confidence in the complaints process, and legal services were underdeveloped. Health care provision was in transition but outcomes were reasonable. Prisoners disliked the food, which at lunchtime was served at cell doors. There was no catalogue ordering service. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Purposeful activity

5.5 Time out of cell and access to outside exercise were poor. Management of learning and skills provision was inadequate, and the education curriculum did not meet the needs of the population. There were not enough activity places, and those available were poorly used. The quality of teaching varied and too much was inadequate. Provision of English for speakers of other languages (ESOL) was insufficient and outcomes in the key areas of basic skills were inadequate. The quality of vocational training and achievements for those on a programme were generally good. The library was good but not well used. The gym provided

good opportunities for most prisoners. Outcomes for prisoners were poor against this healthy prison test.

Resettlement

5.6 There was a reducing reoffending strategy based on a needs analysis of the population, but resettlement services were in transition, which affected outcomes for prisoners. The quality of offender management work was mixed and there was only minimal contact with offender supervisors. The needs of many prisoners were not systematically identified on arrival or reviewed before their release. There was limited coordination and delivery of some reintegration work, although good support was offered in some resettlement pathways. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Conclusion

5.7 There were some examples of progress in implementing the Zahid Mubarek Inquiry recommendations at Feltham. For example, cell-sharing risk assessments were comprehensive and all new arrivals had a good quality first night risk interview. However, the inspection raised strong concerns and the HM Chief Inspector concluded that 'it was clear that Feltham B had deteriorated significantly and that there was a need for some radical thinking about its future'. [55]

5.8 The Inquiry noted 'the factors that had contributed to Feltham's degeneration into an establishment which was performing badly and in which prisoners were therefore more likely to be exposed to attacks by their cell mates. There are many lessons to be learned from Feltham's decline, but the most important is that population pressures and understaffing can combine to undermine the decency agenda and compromise the Prison Service's ability to run prisons efficiently.'[56] In light of this, the 2013 Feltham inspection findings are particularly disappointing.

5.9 Shortly after the publication of the report, NOMS announced that young adults on remand would no longer be held at Feltham to provide more stability in the population held. Ministers announced that a feasibility study would be conducted into replacing Feltham with a new facility on the existing and an adjacent site.

---

[55] HM Chief Inspector of Prisons (2013) Report of an unannounced full follow-up inspection of HMP/YOI Feltham (Feltham B – young adults) (p.5)
[56] Home Office (2006) *Report of the Zahid Mubarek Inquiry;* London, The Stationery Office (p. 552).

Section 6. Appendices

Appendix I: Recommendations made at the Mubarek Inquiry

	Inquiry recommendations
1	The elimination of enforced cell-sharing should remain the objective of the Prison Service, and the achievement of this goal should be regarded as a high priority.
2	The Prison Service should review whether the resources currently available to it might be better deployed towards achieving this goal, without compromising standards in other areas, and should set a date for realising this objective.
3	If the resources currently available to the Prison Service are insufficient to produce a significant decrease in enforced cell sharing, central government should allocate further funds to the Prison Service to enable more prisoners to be accommodated in cells on their own.
4	The Prison Service should retain its practice of placing prisoners who are at risk of suicide or self-harm, but who are not so vulnerable as to require being on suicide watch at all times or accommodated in a safer cell, in a cell with another prisoner who they can talk to in times of crisis. The practice should be extended to women's prisons to the extent that it is not already happening.
5	The Prison Service should retain the present practice of not asking new prisoners at reception or in the first night centre or during induction whether they would prefer to be in a cell on their own or to share a cell with another prisoner.
6	Subject to recommendation 7, the rule that an unconvicted prisoner should not be required to share a cell with a convicted prisoner should always be complied with.
7	The sole exception to that rule – namely when the unconvicted prisoner consents to share a cell with a convicted prisoner – should be regarded as applying only when the unconvicted prisoner consents to share a cell with a particular convicted prisoner, not with convicted prisoners in general.
8	All establishments should have a system for ensuring that immediate effect is given to a prisoner's change of status, by making certain that they do not share a cell with a prisoner of a different status.
9	The Prison Service should publish guidelines to assist officers in allocating cells to those prisoners who have to share a cell.
10	The guidelines should proceed on the assumption that the lack of privacy which cell sharing entails is more likely to be ameliorated if prisoners with a common ethnic and religious background share cells. But that should only be the starting point for the process. All prisoners should be interviewed on their arrival, either in the first night centre or during their induction, to enable them to explain their preferences for the type of prisoner they would prefer to share a cell with.
11	All decisions about whom a prisoner should share a cell with should be made, if possible, by a senior officer. If that cannot be done, the decision should be reviewed by a senior officer at an early opportunity. The suitability of the two prisoners to continue to share with each other should be reviewed at regular intervals, with the prisoners' personal officers being consulted over the issue.
12	The Prison Service should publish guidelines to assist officers in handling requests by prisoners to share a cell with a particular prisoner. Practical problems should not be treated as an insuperable hurdle preventing an otherwise suitable move of a prisoner from one cell to another.
13	The guidelines should require officers to keep prisoners informed of the progress of their requests, and if the request is refused, to notify prisoners of the reason for the refusal, unless security considerations or issues of confidentiality make that inappropriate.

14	The guidelines should contain guidance on how such requests should be recorded, but there is no need for such requests to be treated as formal applications under the requests and complaints procedures.
15	Wings holding convicted and unconvicted prisoners together should be kept to a minimum, and should only be used when there is no operational alternative.
16	The Prison Service should review whether the advantages of holding young offenders on the same wing as adult prisoners outweigh the disadvantages, and whether the practice should be extended to other establishments.
17	If the practice of holding young offenders on the same wing as adult prisoners is to continue, the law should be clarified to put its legality beyond doubt.
18	As soon as practicable, the Prison Service should assess the popularity of the bolted-down furniture made from white wood which is currently being trialled. It should then formulate a policy about the most appropriate form of furniture for use in cells, balancing the need to keep prisoners safe from their cell mates against the need for prisoners to live in cells which have a measure of homeliness, and taking into account prisoners' preferences and cost.
19	The Prison Service should consider whether dedicated searches of cells for concealed weapons would be tantamount to a full cell search.
20	In any event, the Prison Service should assess the resource and security implications of less frequent but random fabric checks against more frequent and more random full cell searches, bearing in mind that different strategies may be required for different establishments.
21	Senior officers should ensure that their staff know how to carry out fabric checks. They should ensure that officers realise that in order to check the walls of a cell, it will be necessary to look behind or under the furniture next to them. If that can only be done by moving the furniture, the furniture should be moved. If in the course of doing so they discover that the furniture is broken, they should check whether any parts of it could be used as a weapon.
22	An establishment's written cell-searching strategy should require each cell to be fully searched at least once in every three months. Senior officers should ensure that full cell searches are taking place as regularly as the strategy requires. Returns showing which cells have been fully searched, and when, should be submitted monthly. The department which is supposed to scrutinise the returns should do so speedily, and notify the senior officer of the unit and its principal officer if that is not happening.
23	The violence reduction strategy should be used as a vehicle to encourage prisoners to feel that they have a stake in making their prison safe – in particular, by encouraging prisoners to think that they have let other prisoners down if they resort to violence, and by letting prisoners have a say in the running of their prison through prisoner councils. Every prison should be required to have a functioning prisoner council made up of elected representatives which meets at regular intervals.
24	Information about a prisoner's convictions and outstanding charges held on P-NOMIS should include a short statement of the facts of each offence or charge.
25	If a convicted prisoner is not due to be released when they complete their sentence because they were remanded in custody awaiting trial on other charges, P-NOMIS should flag up the date on which their change of status is due to occur.
26	Although there are no plans for security information to be entered on to P-NOMIS in its first phase, security departments should enter any information which can be shared with the majority of staff when the first phase of P-NOMIS becomes operational.
27	P-NOMIS should include a facility for an alert to appear if information is held by the security department on prisoners which could affect their management but which is too sensitive for wider dissemination. An officer at the grade of senior officer or above should be able to ask for that information, and the request should be considered by the governor with line management responsibility for the security department. The governor should be able to refuse the request, or grant it on condition that the senior officer does not reveal the information to anyone, or on condition that the senior officer can tell their wing staff about it on the understanding that it is not to go any further.
28	Information overload should be avoided by enabling officers to get to the information they need quickly and to bypass the information they do not need. The technology should be up to date,

	and sufficient terminals should be provided to ensure that staff have ready access to P-NOMIS at all times.
29	The training which staff receive on P-NOMIS should not merely address how to log on, enter information and retrieve it. It should reinforce the need for any information which is to be entered to be accurate, comprehensive and unambiguous. It should also reinforce the need for all staff to be aware of the background and offending history of the prisoners in their charge, as well as their previous behaviour in prison. Staff should learn that the system will be useless if they do not use it properly.
30	To avoid prisoners leaving court without being accompanied by bail information reports or pre-sentence reports, the probation officer should ensure that a copy of the report is available for the escort contractor, and there should be someone in court whose responsibility it is to ensure that the dock officer gets it. Escort contractors should have a list of the documents which should accompany prisoners when they leave court, but if a prisoner leaves court without all the documents, the court should ensure that they are sent on to the prison without delay.
31	There should be someone in court whose responsibility it is to ensure that the dock officer gets copies of the warrant authorising the prisoner's detention, the list of their convictions, and the indictment or charge sheet.
32	When a judge asks for any remarks which they make to be brought to the attention of the Prison Service, the court should assume responsibility for commissioning a transcript of what has been said and sending a copy to the prison.
33	In the light of such legal advice as the Courts Service receives, it should publish a policy on the disclosure to the prison of medical or psychiatric reports on a prisoner submitted to the court.
34	The list of a prisoner's convictions sent to the prison should include a short statement of the facts of each offence and the charges the prisoner is facing.
35	The Police National Computer should be linked to the whole of the prison estate. In the meantime, any intelligence the police may have about prisoners which could affect their management in prison should be sent to the police liaison officers for the establishments at which the prisoners are being held. A decision can then be made whether the intelligence can be disseminated widely within the prison or given to a governor for their eyes only.
36	Whenever a prisoner is transferred to another establishment, the receiving establishment should be told what the reason for the transfer is. If the transferring prisoner is a particularly problematic one, the receiving establishment should be warned beforehand.
37	To ensure that all files accompany prisoners on their transfer to another establishment, they should be ticked off at the reception of the sending establishment against a checklist. Prisoners should not be allowed to leave unless all their files have been ticked as present, except with the permission of a governor. Staff on reception at the receiving establishment should notify the department responsible for chasing up files which do not arrive with a prisoner, entering the action they have taken in a "missing file book". Consequential action and the eventual receipt of the files should also be entered in the book.
38	Prisoners should not be admitted to a wing without their current wing file, save with the permission of a governor or the approval of the night orderly officer. Important entries in it should be made in red.
39	If prisoners arrive on a wing without a copy of the cell-sharing risk assessment form, they should be placed in a single cell until the form is found or a new one completed.
40	All establishments should have a procedure for notifying wings in writing that a prisoner is currently charged with, or has been convicted of, an offence under the Protection from Harassment Act 1997.
41	Each security department should establish a proper system for vetting security files to ensure that they are read by the end of the working day following their arrival, that any relevant information is relayed in writing to the wings, and that a record is kept of who vetted them, with the date and time.
42	Since security information is not to be included in the first phase of P-NOMIS, there remains a need for a national database for security information. Establishments should have their security intelligence systems upgraded if that has not already been done, and the systems should be networked across the prison estate.

43	Where prisoners have served a sentence before, the security department should always obtain their security files from the establishment from which they were discharged.
44	Documents held in an establishment's administrative section should be vetted by staff from the security department, and each establishment should have a protocol for that work along the lines of the system for vetting security files.
45	The senior officer on a wing should ensure that information arriving on the wing about a prisoner is recorded in the wing observation book. Particularly important information should be in red. When coming on duty, staff should read any entries in the wing observation book made since they were last on duty.
46	The discharge report which used to be prepared on prisoners on their discharge should be completed as a matter of course, and a copy included in their main prison file. It should be accessible on P-NOMIS when P-NOMIS becomes operational.
47	The Prison Service should publish a model procedure dealing with how establishments should bring Prison Service Orders and other instructions, whether national or local, which affect the management of prisoners to the attention of staff. The model procedure should be regarded as having been adopted by any establishment which does not produce one of its own.
48	Governors should ensure that any relevant comments or recommendations in external reports about their establishments which have implications for the safety of prisoners be brought to the attention of the workforce.
49	Every establishment should appoint an officer not below the grade of governor to be responsible for overseeing the flow of information. Such an officer should ensure that systems are in place for the transfer of information within an establishment and that the systems are being followed. They should take action when they find that they are not, and should review the arrangements periodically to ensure best practice is being maintained.
50	The handbook giving guidance on how to complete the prisoner escort record should be revised to make it clear that it is not merely of use while a prisoner is in transit, but it is also intended to inform the prisoner's management in the receiving establishment. It should give clear guidance to staff as to when a box should be ticked. Staff who are tasked with completing the form should be instructed on how to complete it by senior officers in their department. They should each be provided with a copy of the handbook, and they should be reminded of the need to spell out the reasons for a particular box being ticked.
51	Staff who are tasked with initially completing the cell-sharing risk assessment form should be instructed on how to complete it by a senior officer. In particular, they should be reminded that they are only assessing the risk prisoners pose to other inmates. They should not automatically assess prisoners as a high risk simply because they claim, for example, to be prone to lose their temper, but should ignore such claims if they believe them to be untrue, and they should guard against being over-defensive.
52	The instructions for completing the form should give duty governors guidance on how to exercise the options available to them when dealing with prisoners who are both at risk of self-harm and a risk to their cell mate.
53	The first review of the initial assessment should take place within one week of the initial assessment, and should take place in every case. It should be a multidisciplinary review, with representatives from the prisoner's wing, health care and the team responsible for implementing the establishment's violence reduction strategy all contributing to it. The documents set out in paragraph 59.15 of the report should be considered, and the participants should have been briefed on the contents of the prisoner's security file, if there is one.
54	The role of the duty manager or duty governor in the review process should be clarified.
55	Wing officers should be reminded of the need to call for a review of an assessment when the necessity for one is triggered by some occurrence which might affect the prisoner's emotional wellbeing.
56	The officer responsible for monitoring the processes for implementing measures outlined in risk minimisation plans should also be responsible for monitoring their actual implementation.
57	The register of prisoners assessed as high or medium risk should identify what proportion of the establishment's population those prisoners represent.
58	OASys should be used by all establishments to identify the risks posed by prisoners to staff and

	other inmates, and the risks which are identified should be fed back to the wings.
59	OASys assessors should have access to information relating to prisoners' behaviour while serving previous sentences and to information held in security files.
60	All adult prisoners serving sentences of less than 12 months' imprisonment who had an OASys assessment before being sentenced should have that assessment reviewed during the induction process. The review need only address the risk of harm which the prisoner poses to staff and other inmates. If resources permit, adult prisoners serving sentences of less than 12 months' imprisonment who did not have an OASys assessment before being sentenced should have one during the induction process.
61	The risk management model for the management of prisoners to whom MAPPA applies and who have been identified as posing the greatest risk to the public should be adopted by all establishments. Prisoners who have been identified as being a high risk to their cell mate on any review of the cell-sharing risk assessment, or posing a very high or high risk to staff and other inmates on the OASys assessment, should be referred to the inter-departmental risk management team envisaged by the model.
62	It is neither necessary nor desirable to introduce a risk classification, similar to the security classification, which identifies the degree of risk which a prisoner poses to staff and other inmates.
63	That part of the basic training course for new prison officers which focuses on the development of their interpersonal skills should be reviewed in the light of this report and the lessons to be learned from Zahid's murder. In particular, two of the key attributes required of the prison officer should be stressed. They are the ability to pick up on what is happening on the wing, which prisoners pose a risk to other inmates, and what prisoners might be worried about, and the ability to earn the respect of the prisoners on the wing so that they are prepared to confide in them without fear of it getting out.
64	Ex-offenders should be used to give trainees an insight into prison life from the perspective of prisoners.
65	It should be mandatory for all establishments to have a personal officer scheme. That includes busy local prisons, although if time for personal officer work is limited, it should be used constructively.
66	Personal officers should be assigned to individual prisoners, not to a group of cells. They should be members of a small team, so that when a prisoner's personal officer is not on duty, the prisoner can approach another member of the team.
67	The role of the personal officer should be clearly defined in each establishment's personal officer scheme. The Prison Service should publish a model scheme, which should be regarded as having been adopted by every establishment which does not produce one of its own.
68	Before officers begin personal officer work, they should receive training locally on what the work involves.
69	The Prison Service's policy on whistle-blowing should identify the most appropriate way for staff, in an exceptional case, to get confidential advice from an independent outsider and to raise their concerns outside the Prison Service. It should also ensure that the members of staff of companies who contract with the Prison Service, such as escort contractors and those responsible for the running of the contracted out establishments, have access to the Prison Service's whistle-blowing policy.
70	Making a false and malicious allegation that wrongdoing has taken place should be expressly stated to be a disciplinary offence, for which dismissal from the Prison Service may be an appropriate sanction.
71	Research should be conducted on how effective the obligation to report wrongdoing – and the designation of a failure to do so as a disciplinary offence – has been. This should be done by comparing the number of instances of reported wrongdoing before and after these measures were implemented.
72	A comprehensive review of the quality of care provided to prisoners with mental health problems and its effectiveness should be conducted once the changes introduced since Zahid's murder have had a chance to work.
73	The first reception health screen questionnaire should be revised so as to trigger a referral to a

	mental health professional on the health care team even if the prisoner has only self-harmed in prison. A referral should also be triggered where the prisoner's behaviour is such that the health care officer completing the questionnaire considers it desirable.
74	When prisoners are referred for a mental health assessment, the assessment should address the risk which they pose to staff and other inmates.
75	The responses of those members of staff who have attended the mental health awareness training course should be analysed to determine whether the course can be improved. The number of frontline staff attending the course should be increased, resources and staff deployment permitting.
76	Profiled time should be set aside for staff to read the booklet explaining the main components of the mental health awareness training course. The booklet should include advice given on the course about how prisoners with particular disorders should be managed on the wing. That advice should be published and made freely available.
77	The measures which should be taken to minimise the risk which a mentally disordered prisoner on ordinary location poses to staff and other inmates includes: • not placing such a prisoner in a shared cell • if such a prisoner is to share a cell, carefully selecting their cell mate • ensuring that, whatever difficulties there may be in operating a proper personal officer scheme, such a prisoner has a personal officer who is fully aware of their background and who makes a particular effort to get to know them and keeps an eye on their state of mind •checking the correspondence and searching the cell of such a prisoner more frequently and carefully than would otherwise have been the case • ensuring, again regardless of the difficulties which might be faced in providing a good regime for all prisoners in the establishment, that such a prisoner is appropriately occupied with, for example, work, education or offending behaviour programmes • keeping a closer watch over material such as films, to which such a prisoner has access, and exercising control over their suitability • checking on P-NOMIS or with the security department about the existence of any useful intelligence about such a prisoner and what is known about their previous behaviour in prison.
78	The Prison Service should prepare a readable guide, which explains the circumstances in which personal information about a prisoner should be disclosed by health care staff to officers on the wing. The guide should contain practical examples of situations where disclosure should or should not be made.
79	The Prison Service and the CRE should address the key areas for development identified by the Inspectorate in Parallel Worlds, its recent review of race relations in prison, in managing the action plan, Implementing Race Equality: A Shared Agenda for Change, which the Prison Service has produced in partnership with the CRE and is the blueprint for the progress which the Prison Service needs to achieve.
80	The diversity training which prison officers receive as part of their basic training should stress the need for them to put themselves in the position of black and minority ethnic prisoners and see things from their point of view. They should be told about the techniques they can use to develop that skill.
81	The training of any officer responsible for investigating complaints of racism should stress that corroborative evidence of a complaint, though desirable, is not essential. Officers should be reminded of the need to guard against falling into the trap of seeing as decisive the existence of a possible racially neutral reason for treatment which would otherwise be discriminatory.
82	Prisoners should not be used under any circumstances to assist in the investigation of complaints of racism, or to act as an intermediary between the complainant and the investigating officer.
83	The definition of a racist incident adopted by the Stephen Lawrence Inquiry should be used to identify what constitutes a complaint of racism, so that a complaint of racism is one where the action complained of is perceived to be racist by the victim or any other person.
84	The Prison Service, the Inspectorate and the CRE should consider whether there is a need for the investigation of complaints of racism and other serious complaints to be carried out by an

	independent body, or at least to be carried out with a strong independent element built into the process.
85	The Prison Service and the CRE should investigate the desirability and feasibility of race relations liaison officers being recruited from outside the Prison Service.
86	Without suggesting in any way that the Prison Service should be regarded as institutionally infected with religious intolerance, thought should be given by the Home Office to recognising the concept of institutional religious intolerance, along the lines of the definition of institutional racism adopted by the Stephen Lawrence Inquiry.
87	The Muslim Adviser to the Prison Service should consider how the role of prison Imams can be expanded – without in any way compromising their religious role – so as to make them readier to assist with the non-religious needs of Muslim prisoners.
88	The Home Office should promote legislation to add each prison to the list of bodies required to publish race equality policies or race equality schemes under the Race Relations Act 1976.

Appendix II: Methodology

Survey analysis

Surveys were conducted across the reporting year (between April 2012 and March 2013) at all establishments that received a full announced, full unannounced and full follow-up inspection. In total, data from 48 prison/YOI surveys were analysed (see table 5 below). Depending on the size of the establishment, researchers distributed questionnaires to all or a randomly selected sample of prisoners or young people. Every effort was made to speak to each person individually to explain the purpose and confidentiality of the survey and to make participants aware of the independence of the Inspectorate. Interviews were conducted with those who said they would have problems completing the survey due to literacy or language difficulties. All completed questionnaires were placed in sealed envelopes and collected by Inspectorate staff. Each survey that was handed out at children and young people establishments was numbered to ensure that child protection issues were followed up. Respondents were made aware of what would happen to the information they were providing.

Selecting the sample

A statistical formula[57] was used to calculate the baseline sample size needed to ensure that the survey was representative of the population held. The sample selected was greater than the baseline sample size to ensure the baseline was met. The samples were designed to be a general reflection of the establishments from which they were taken in terms of the number of prisoners from white backgrounds and the number from black and minority ethnic backgrounds.

Treatment of data

Throughout this report data are weighted to mimic the whole population at each establishment so that the overall responses reflect the entire prison estate. All the figures in the comparator tables are weighted data.

Missing data, where respondents have not answered a question, have been excluded from the analysis. This means that percentages may have been calculated from different totals where there are different response rates across questions.

The majority of figures quoted in this report have been rounded.

Inspection report analysis

All 55 reports of inspections of adult prisons and children and young people establishments published between 4 April 2012 and 27 March 2013 were analysed. The table below lists all inspection reports analysed for this review. Inspections that included a survey are indicated by a tick in the fourth column.

[57] The formula was provided by a Ministry of Justice statistician and has a 95% confidence level with a standard error margin of 3% either way.

Table 5: Inspection reports included in this report

Establishment	Inspection type	Date published	Survey conducted
Dartmoor	Full announced	4 April 2012	✓
Durham	Full announced	17 April 2012	✓
Cookham Wood	Full announced	18 April 2012	✓
Littlehey	Full follow-up	25 April 2012	✓
East Sutton Park	Full announced	27 April 2012	✓
Hollesley Bay	Short follow-up	3 May 2012	✓
Liverpool	Full follow-up	4 May 2012	✓
Standford Hill	Full announced	8 May 2012	✓
Whatton	Full announced	12 June 2012	✓
Norwich	Full follow-up	13 June 2012	✓
Birmingham	Full announced	21 June 2012	✓
Woodhill	Full announced	22 June 2012	✓
Hull	Short follow-up	27 June 2012	
Eastwood Park	Short follow-up	4 July 2012	
Thorn Cross	Full announced	6 July 2012	✓
Spring Hill	Short follow-up	13 July 2012	
Stoke Heath	Full follow-up	18 July 2012	✓
Ranby	Full announced	25 July 2012	✓
Elmley	Full announced	27 July 2012	✓
Portland	Short follow-up	1 August 2012	
Wetherby	Full announced	3 August 2012	
Wetherby (Keppel Unit)	Short follow-up	3 August 2012	
Buckley Hall	Full announced	21 August 2012	✓
Wolds	Full follow-up	22 August 2012	✓
Everthorpe	Short follow-up	28 August 2012	✓
New Hall	Full follow-up	29 August 2012	✓
Preston	Short follow-up	4 September 2012	
Garth	Short follow-up	6 September 2012	
North Sea Camp	Short follow-up	7 September 2012	
Reading	Short follow-up	20 September 2012	
Leyhill	Full announced	3 October 2012	✓
Wakefield	Full follow-up	12 October 2012	✓
Isle of Wight	Announced full follow-up	16 October 2012	✓
Dorchester	Short follow-up	1 November 2012	
Northumberland	Full unannounced	6 November 2012	✓
Onley	Full announced	7 November 2012	✓
Hindley	YJB Survey	13 November 2012	✓
Canterbury	Full announced	14 November 2012	✓
Gloucester	Full unannounced	21 November 2012	✓
Stocken	Full follow-up	27 November 2012	✓

Bullingdon	Full unannounced	30 November 2012	✓
Lincoln	Full unannounced	11 December 2012	✓
Ford	Announced full follow-up	13 December 2012	✓
Parc (under 18 site)	Full announced	21 December 2012	✓
Bullwood Hall	Full announced	11 January 2013	✓
Highpoint	Full announced	16 January 2013	✓
Glen Parva	Short follow-up	23 January 2013	
Eastwood Park (Mary Carpenter Unit)	Full follow-up	1 February 2013	✓
Hatfield	Announced full follow-up	6 February 2013	✓
Channings Wood	Full announced	12 February 2013	✓
The Verne	Full announced	19 February 2013	✓
Wetherby	YJB Survey	5 March 2013	✓
Keppel Unit	YJB Survey	5 March 2013	✓
Forest Bank	Full unannounced	6 March 2013	✓
Werrington	Full follow-up	12 March 2013	✓
Foston Hall	Short follow-up	19 Mar 2013	
Winchester	Full announced	20 March 2013	✓
Lewes	Full unannounced	27 March 2013	✓
Feltham	YJB Survey	6 January 2014	✓
Warren Hill	YJB Survey	6 January 2014	✓
Rivendell	YJB Survey	Unpublished[58]	✓

[58] At the time of the inspection there were only three young women at the unit, two completed a survey. Due to the low number of participants the results were not published.

HM Inspectorate of Prisons is a member of the UK's National Preventive Mechanism, a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.