Report on an announced thematic follow-up inspection of the

Close supervision centre system

by HM Chief Inspector of Prisons

4–8 December 2017

Glossary of terms

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Introduction

This report is a follow-up of the inspection of the close supervision centre (CSC) system thematic inspection conducted in March 2015. Over 50 of the most dangerous men in the prison system are held in the CSC system, all under prison rule 46. A further 20 (or so) men are managed centrally under the managing challenging behaviour strategy (MCBS), sometimes in special units or more normally in a mainstream location in a high security prison. The MCBS is used for men who do not meet the threshold for the CSC, but who nevertheless present with challenging behaviour in custody.

Men are selected because of the serious risk of harm they present to prisoners and staff, demonstrated by their exceptionally problematic custodial behaviour. Many have been convicted of serious further offences committed in prison. CSCs reflect arguably the most restrictive custodial conditions in the England and Wales prison system. Men are held in small specialist units or in individually designated rule 46 cells to ensure the safety of others and themselves. Both the CSC and MCBS systems are run by a central team operating in the Prison Service's high security and long-term directorate. However, day-to-day management of the men is the responsibility of the host prison. The statement made in the introduction to our last inspection report remains relevant: 'This is extreme custody and its management raises complex operational challenges and profound ethical issues.'

At our inspection in March 2015, we reported that CSCs were run on sound psychological principles with humanity and good care. Strategic management was reasonably good overall, but the role of the central MCBS was unclear and we were also concerned that there was no independent input to key decision-making. We considered then that the regimes and progression opportunities offered in units, and particularly in designated cells, needed to be improved. Despite the potential and real risk of serious assaults, we reported that men were held safely and in generally decent conditions. This follow-up aimed to review progress in the key areas highlighted at our last visit.

At this inspection, we found tangible progress had been made in all our healthy prisons tests for CSCs. Strategic management was stronger than previously and the relationship between the central MCBS and CSCs was now clear. Care and management planning had been improved, and the tiered approach to target setting motivated men to demonstrate their progress. Key decision-making was structured, systematic and evidence-based. The collection of data had improved, but more analysis would have helped managers identify trends and patterns in outcomes. Units were psychologically informed, and all were on their way towards achieving Royal College of Psychiatry Enabling Environment accreditation. The focus on giving men hope and persevering even with those who were the most difficult to reach was impressive.

However, there was still no independent scrutiny of key decisions. This meant the systems lacked external assurances on the robustness and fairness of assessment, selection and deselection decisions, and CSC managers missed out on potentially helpful constructive criticism. In addition, we remain concerned about the treatment and conditions of men held in designated cells who generally experienced impoverished segregation-like regimes, limited care planning and a lack of progression opportunities often for months, and in a few cases, years.

Regimes had improved at most of the units, although staffing shortages hampered efforts, particularly at Woodhill. They also contributed to the inconsistent delivery of regular individual personal development (IPD) and group supervision sessions.

It was positive that far more men than previously had progressed out of the CSC and central MCBS systems, often to less restrictive special units and sometimes to mainstream prison wings. Transition arrangements for those moving between units remained good, and planning for the small number of men released each year from CSCs was also good. Fewer men subject to the central MCBS were now in special units and most lived on mainstream prison wings. Support to help men maintain

contact with children and families had improved, but the lack of privacy during visits remained a problem.

The serious risk of harm presented by the men held should not be underestimated and we were impressed by staff's proportionate and nuanced approach to managing them. Responsive risk management arrangements meant that the units were generally safe, but on the relatively rare occasion when incidents occurred, they tended to be quite serious. There had been two self-inflicted deaths since our last visit. The central team had responded appropriately and were monitoring an action plan to address the issues raised.

Staff-prisoner relationships remained a key strength. It was impressive how staff could be subject to verbal and sometimes physical assault, yet retain a focus on men's well-being and progression. The units were mostly clean and decent, but exercise yards needed improvement to offset the units' claustrophobic environment. Excellent work had been undertaken to better understand why Muslim men were over-represented in the CSC system. Processes for managing and responding to complaints had improved. Health care provision was better overall, but despite excellent links with high security special hospitals, men continued to wait too long for mental health hospital beds.

Our assessments of prisoner outcomes at this inspection were more positive than at the last inspection in three of the four healthy prison tests. Managers were determined to move the CSC and central MCBS systems forward, and saw our CSC expectations as a key driver for doing so. Well over 80% of the recommendations made in 2015 had been fully or partially achieved. Given the severity of CSC custody, we were impressed by staff's focus on giving men hope, working with them as individuals, and their determination to help some men who were unamenable to interventions. Some significant issues still needed to be addressed, and the CSC system was under increasing strain from the rise in serious violence across the prison estate and the resulting number of referrals for assessment. Nevertheless, we commend the progress made to help men reduce their risks to others and to lead more purposeful and productive lives.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons February 2018

The close supervision centre and managing challenging behaviour strategy systems

Task of the close supervision centre system

The overall aim of the close supervision centre (CSC) system is to remove the most significantly disruptive, challenging and dangerous prisoners from the ordinary prison location, and to manage them within small and highly supervised units. This facilitates an assessment of individual risks, followed by individual and/or group work to try to reduce the risk of harm to others, enabling a return to a normal or more appropriate location as risks decline. CSC prisoners may also be held in designated cells in segregation units in high security prisons for a range of operational and management reasons. Wherever they are held, these men are held subject to prison rule 46 as quoted in *Prison Rules 1999*:

- Where it appears desirable, for the maintenance of good order or discipline or to ensure the safety of officers, prisoners or any other person, that a prisoner should not associate with other prisoners, either generally or for particular purposes, the Secretary of State may direct the prisoner's removal from association accordingly and his placement in a close supervision centre of a prison.
- A direction given under paragraph 1 shall be for a period not exceeding one month, but may be renewed from time to time for a like period, and shall continue to apply notwithstanding any transfer of a prisoner from one prison to another.
- The Secretary of State may direct that such a prisoner as aforesaid shall resume association with other prisoners, either within a close supervision centre or elsewhere.
- In exercising any discretion under this rule, the Secretary of State shall take account of any relevant medical considerations that are known to him.

Task of managing challenging behaviour strategy centrally managed system

The managing challenging behaviour strategy (MCBS) was launched in 2008 to manage men who do not meet the threshold for the CSC system but who nevertheless require central management because their behaviour is dangerous, disruptive or otherwise particularly challenging. Most men subject to the MCBS were managed locally by the host prison with advice available from the CSC central team, but a few were managed centrally by the central management group (CMG). The aim is to provide structured interventions in small units so men can be moved back to a more mainstream prison environment, or to provide support and central oversight of men already in more mainstream locations. The men are managed by the CSC system central management team but are not subject to prison rule 46. This inspection was only concerned with centrally managed men, particularly those held in small units.

Background

The control review committee (CRC) report (1985) marked the first attempt by the England and Wales Prison Service to develop a more strategic and systematic way of managing prisoners with very serious behaviour problems. They were accommodated in small secure self-contained units operating relatively unstructured regimes. However, some prisoners found it difficult to cope and ended up in long-term segregation or were managed through the continuous assessment scheme, which meant they were transferred from segregation unit to segregation unit in different high security prisons. When the CRC system was wound up in 1995, 20 men were in specialist units and 20 were in segregation units or on continuous assessment.

The CSC system was established in April 1998 following the Woodcock[1] and Learmont[2] reports (1994), which recommended more managed regimes for high security prisons. The CSC system was established in April 1998 in the wake of reports on high profile escapes, which recommended more managed regimes for high security prisons. A more structured approach was developed involving a staged 'progression' system, which rewarded cooperative behaviour. In February 1998, units at Woodhill, Durham and Hull prisons were opened. At the same time, designated cells were identified in the segregation units of several high security prisons where CSC prisoners could be held for a temporary period for a range of operational and management reasons.

In 1999, HMIP published its first thematic review *Inspection of close supervision centres*. The system as it then stood had a capacity of 48 prisoners and held 41. We were broadly supportive of the approach adopted but made a number of recommendations, including that prisoners in designated cells should be covered under prison rule 46; that the monitoring group should have greater independence and that ministerial endorsement should be required for long-term segregation. We also recommended better training and support for staff working in the units, and more specialist mental health and psychological input. Some, but not all, of these recommendations were implemented.

We looked again at CSCs in our *Extreme custody* thematic report in June 2006, in which we discussed the balance between isolation and engagement in the regimes of the various units as they had evolved. As of August 2005, the number of men in the system was 30 and units were now based at Woodhill, Wakefield, Whitemoor and Long Lartin prisons. In general, we supported the approach adopted: we agreed with the closure of punishment units, the introduction of mental health support, particularly at Woodhill, and opportunities for progressive moves within and out of the system. However, we were critical of poor management information systems, which impeded the development of a clear understanding of how the system was operating, the limited nature of the regimes offered, and the use of designated cells for indefinite periods. We repeated our call for better external oversight of the system.

For a number of years from 2006 we inspected CSC units only when we inspected a prison that hosted one, outlining our findings about the individual unit in the overall report. In March 2015, we chose to inspect the CSC system (including men managed by the central CSC team under the MCBS) thematically using a specially designed methodology and a draft set of bespoke expectations, which we refined and published in 2016[3]. At that inspection, we concluded that the system was based on sound security and psychological principles and that men were being cared for safely, decently and humanely. However, a number of weaknesses we identified in 2006 remained. We also had concerns about the number of Muslim men in the system and considered the role of the central MCBS to be unclear.

Description of CSC and MCBS units

HMP Full Sutton – Management unit

The Full Sutton unit was the newest addition to the system opening in January 2014. The management unit accommodated prisoners selected for the CSC system who needed to undertake one-to-one and group work to reduce their risks and enable them to progress within and from the CSC system.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272031/2741.pdf
[2] http://hansard.millbanksystems.com/lords/1995/oct/16/prison-security-learmont-report
[3] www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/02/CSC-Expectations-WEB.pdf

HMP Manchester E wing – Special interventions unit (SIU)
The SIU aimed to provide individual, time-bound and risk-based care and management for prisoners allocated to the CSC system. Their needs were considered to be more suitably addressed and managed within a small and highly supervised environment. The SIU provided a range of individual assessment and treatment options and both clinical and forensic psychology services were available.

The SIU had up to four cells designated for CSC prisoners held under prison rule 46, which enabled them to participate in one-to-one work in a supervised environment with high levels of staff support. Prisoners subject to central case management under the MCBS might also be allocated to the unit but would not be subject to rule 46.

The SIU had between two and six places for centrally managed MCBS prisoners (depending on how many CSC prisoners were there) for whom it was not suitable to carry out specific care and management targets within a mainstream prison. Prisoners subject to central case management under the MCBS were allocated to the unit alongside CSC prisoners. Unlike CSC prisoners, they could, subject to a risk assessment, access mainstream prison regimes.

HMP Wakefield F wing – Management and assessment unit
The Wakefield unit provided a secure and highly supervised environment for CSC prisoners who were unsuitable for other CSC units as a result of their behaviour. The regime focused on work to reduce short-term high risks and providing a decent regime for those for whom a return to a less controlled and restrictive CSC unit required a greater amount of intervention and supervision.

The assessment part of the unit aimed to carry out assessments of prisoners' risks and needs relating to their referral to the CSC, using past information to inform future care and management options.

HMP Whitemoor F wing – Management unit
Whitemoor was a progressive unit within the CSC system providing a more open regime, an integrated environment and better opportunities to test prisoners' progress towards deselection. Prisoners were normally allocated to the unit where compliance and a reduction in risks were evident; however, prisoners could also be allocated to Whitemoor, where individual risk levels indicated that the prisoner could mix more freely with others.

Prisoners who were disengaged from the regime or who had become problematic could continue to be managed at Whitemoor, where attempts were made to re-engage or stabilise them. Where prisoners' behaviour had become too destabilising for the unit they might be transferred to another unit or temporarily to a designated cell.

HMP Woodhill House unit 6, A wing – Assessment and management unit
The unit aimed to carry out assessments of prisoners' risks and needs relating to their referral to the CSC, using past information to inform future care and management options, and to manage those prisoners post-selection who required a more controlled regime.

HMP Woodhill House unit 6, B wing – Management unit
This unit sought to take forward action relating to risks and behaviour management identified during the CSC assessment period and work towards a reduction in prisoners' risk of harm, enabling them to progress through the CSC system.

HMP Woodhill House unit 6, E wing – MCBS unit
The unit held up to eight centrally managed MCBS prisoners (usually 10 but capped during the inspection due to building work) who were considered not to meet the threshold for the CSC system, but who would benefit from management on a small discrete unit with intensive staff

support. Unlike CSC prisoners, they could, subject to a risk assessment, access the mainstream regime in the prison.

Designated cells

Designated rule 46 cells in high security prisons' segregation units were available for the temporary management of CSC prisoners outside the units listed above. The CSC management committee (CSCMC) authorised a prisoner's removal to a CSC designated cell under prison rule 46 at the monthly CSCMC meeting. For more detail, see Appendix III.

Fact page

Units' status
Public

Department
Long-term and high security estate

Accommodation
Close supervision centre (CSC) prisoners were held in a variety of discrete units under prison rule 46 or in cells in ordinary segregation units that had been designated as rule 46 cells. Managing challenging behaviour strategy (MCBS) prisoners were not held in rule 46 accommodation but in a range of accommodation, including small units, such as segregation, personality disorder units (PDU) and psychologically informed planned environment (PIPE) units, or other mainstream locations.

CSC locations and capacity

Location of unit	Maximum capacity of unit	Number of prisoners held at the start of the inspection (at 4.12.17)
Wakefield	12	11
Woodhill – A wing	10	10
Woodhill – B wing	8	5
Manchester	4	2
Full Sutton	10	5
Whitemoor	10	9
Total places	54	42

Designated cell locations and capacity

Location of designated cells	Maximum capacity	Number of prisoners held at the start of the inspection
Wakefield	2	2
Whitemoor	2	2
Full Sutton	2	3 (including one temporarily designated cell)
Manchester	0	1 (including one temporarily designated cell)
Long Lartin	2	2
Frankland	2	1
Belmarsh	2	2
Total	**12**	**13**

Total CSC population: 55

Capacity: 66

MCBS units and MCBS prisoners located in segregation units

Location of unit/segregation unit	Number of central MCBS prisoners held at the start of the inspection
Woodhill central MCBS unit (C wing)*	7
Manchester SIU (joint CSC/MCBS unit)**	3
Manchester segregation unit	1
Frankland segregation unit	0
Whitemoor segregation unit	1
Belmarsh segregation unit	1
Wakefield segregation unit	0
Long Lartin segregation unit	1
Normal location (including PIPEs, PDUs, main wings)*	9
Total	**23**

* Normal capacity on C wing was 10 beds but, due to maintenance work on the wing, men were located on E wing, which had a capacity of eight spaces.
** maximum capacity: 6 beds

Total central MCBS population: 23

Name of director
Richard Vince

Name of central team governor
Kirsty Tempest

Escort contractor
Long-term and high security estate

Health care and substance misuse service providers
Service providers at the host prison

About this inspection and thematic report

A1 Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

A2 All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

A3 All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. The tests are adapted for different custodial settings.

The tests for the close supervision centre (CSC) system are:

CSC strategic management: prisoners are appropriately selected for CSCs and receive individual support to reduce their risk of harm and work towards deselection.

Progression and reintegration: prisoners benefit from a purposeful regime which supports efforts to address problematic behaviour, and clearly focuses on progression and reintegration.

Safety: prisoners, particularly the most vulnerable, are held safely.

Respect: prisoners are treated with respect for their human dignity.

A4 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by HM Prison and Probation Service (HMPPS).

- **outcomes for prisoners are good.**
  There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

- **outcomes for prisoners are reasonably good.**
  There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

- **outcomes for prisoners are not sufficiently good.**
  There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

- **outcomes for prisoners are poor.**
  There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

A5 Our assessments might result in one of the following:

- **recommendations**: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

- **examples of good practice**: impressive practice that not only meets or exceeds our expectations, but could be followed by other similar establishments to achieve positive outcomes for prisoners.

A6 Five key sources of evidence are used by inspectors: observation; prisoner surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments. The inspection methodology will be adapted for different custodial settings.

CSC inspection methodology

A7 This inspection looked at outcomes for prisoners who had been selected for formal assessment or for management within the CSC system and who therefore were being held under prison rule 46. We also looked at a small number of prisoners who were being managed in small discrete units by the CSC central management under the managing challenging behaviour strategy (MCBS), but who had not been selected for the CSC system and who were not subject to prison rule 46. References to the CSC system in this inspection report also apply to the MCBS unless explicitly stated otherwise.

A8 This follow-up inspection aimed to measure progress since the 2015 inspection. We employed a simpler methodology than previously, but completed the inspection in one rather than two weeks. Prisoners had an opportunity to contribute via a simple qualitative questionnaire, rather than the full survey and individual interviews we used last time. We also met many of the men during the inspection. Questionnaires were posted to the 52 prisoners in the CSC system, and 21 were returned to us, a response rate of 40%. Similar questionnaires were sent to the 27 centrally managed MCBS men (also on 30 October 2017), and eight were returned to us, a response rate of 30%. These response rates were low and when interpreting the data, we did not assume that the views expressed were representative of the men held.

A9 We used the same confidential and anonymous online survey for staff that we used at the previous inspection. It was available to staff working in CSC units for two and a half weeks in November 2017. The 74 responses received formed part of the inspection evidence. We have not published the results of the staff survey because we could not be sure that it reached all CSC staff. We were therefore not able to determine the response rate or be

confident that the views expressed were representative of all CSC staff. The responses were used by inspectors to provide broad indications of the views and concerns of staff.

This report

A10 This explanation of our approach is followed by a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing an account of the main changes in the CSC system since our previous inspection. Section 5 collates all recommendations and examples of good practice arising from the inspection.

A11 We have made relatively few recommendations, concentrating on what we considered to be the main issues needing to be addressed (see concerns and recommendations).

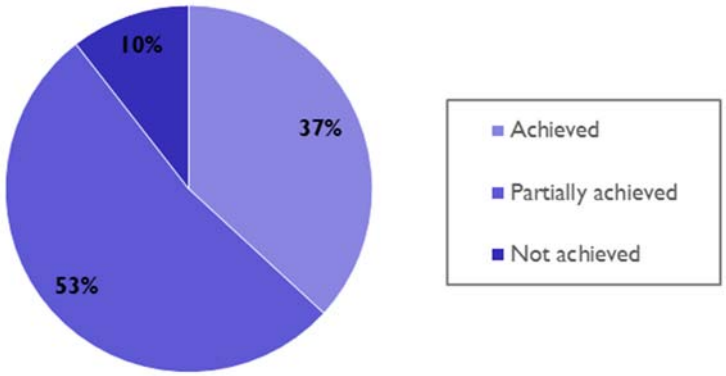
A12 Details of the inspection team can be found in Appendix I. A small number of anonymised case studies have been included in Appendix IV. They illustrate the complexity of the men held in the CSC and central MCBS systems.

Summary

S1 We last inspected the close supervision centre system in 2015 and made 19 recommendations overall. 17 of our recommendations were fully accepted, and two were partially (or subject to resources) accepted.

S2 At this follow up inspection we found that seven of those recommendations had been achieved, 10 recommendations had been partially achieved and two recommendations had not been achieved.

Figure 1: Close supervision centre system progress on recommendations from last inspection (n=19)



S3 Since our last inspection outcomes for prisoners improved in all healthy prison areas apart from Safety which remained the same. Outcomes were good for Respect and Strategic management, and outcomes were reasonably good for Safety and Progression and reintegration.

Figure 2: Close supervision centre system healthy prison outcomes 2015 and 2017

Close supervision centre strategic management

S4 *Strategic management of both the close supervision centre (CSC) and central managing challenging behaviour strategy (MCBS) systems had improved. However, there continued to be a lack of independent scrutiny of decision-making. There was more clarity about the role of the central MCBS, which was being used to manage men who did not meet the threshold for the CSC. Data collection had improved, and treatment pathways were clearer and more flexible. Some progress had been made in ensuring the provision was consistent. All the men had up-to-date care and management plans and reviews were regular and meaningful. The tiered approach to target setting was impressive. Men were managed by a multidisciplinary team and psychological support was very good. Staff's persistence in interacting with men who were difficult to reach was commendable.* ***Outcomes for prisoners were good against this healthy prison test.***

S5 *At the last inspection in 2015 we found that outcomes for prisoners in the CSC system were reasonably good against this healthy prison test. We made four recommendations in the area of CSC strategic management. At this follow-up inspection, we found that one of the recommendations had been achieved and three had been partially achieved.*

S6 The CSC and MCBS operating manuals had been further refined and outlined the role of each system and how they worked in conjunction with each other. However, there was still a lack of robust or independent scrutiny of key decision-making processes. There was a strategic commitment to delivering a cohesive and consistent service across the estate, but we continued to find some variation in the planned provision, often caused by staff shortages. Treatment pathways were now much clearer. They were more flexible and properly focused on reducing individuals' risk of harm. All units had made progress towards Royal College of Psychiatry Enabling Environment accreditation. Governance structures continued to include several layers of formal meetings, which were appropriate for the management of this extremely complex population. We were satisfied that the system was only used for those demonstrating the riskiest behaviour. Despite a rising number of referrals and admissions, managers were resisting further increasing the capacity of the CSC system. The central MCBS system was being used more as an alternative to long-term segregation and to prevent men from being admitted to the CSC system. The collation and use of data to inform the management of the system was developing. Individual professional development (IPD) for staff was still too inconsistent.

S7 All prisoners had an individual care and management plan and most understood what was required of them to progress. The process was multidisciplinary and care and management plans were generally good. Monthly and quarterly multidisciplinary reviews took place consistently, although interactions with individual prisoners continued to be variable. The tiered approach allowed managers to focus on all aspects of individuals' well-being and involvement in constructive, enhancing and risk-reducing activities. Men under assessment and in designated cells were, however, not as clear about what was happening to them and needed more active care planning. We were impressed by continuing efforts to find ways of working with men who were extremely challenging or disengaged. The continuing problems with delivering appropriate regimes and support for men in designated cells needed further attention to ensure the operational requirements of the CSC were being delivered.

Progression and reintegration

S8 *Time out of cell varied greatly depending on the risks presented by individual men. Most regimes had improved but were being negatively affected by staffing shortages, particularly at Woodhill. Access to fresh air for those who wanted it was reasonable. The yard at Full Sutton had been transformed, but others remained stark. There was a much better focus on progressing prisoners through the system and a significant number of men had been deselected. Children and families work had improved overall but there was still more to do.* ***Outcomes for prisoners were reasonably good against this healthy prison test.***

S9 *At the last inspection in 2015 we found that outcomes for prisoners in the CSC system were not sufficiently good against this healthy prison test. We made three recommendations in the area of progression and purposeful activity. At this follow-up inspection, we found that all three of the recommendations had been partially achieved.*

S10 Despite shortages of psychology staff across the estate all units continued to deliver a psychologically informed approach, which had developed and improved since the last inspection. A wide range of interventions was available, underpinned by a comprehensive needs assessment. Most interventions were delivered on a one-to-one basis.

S11 Time out of cell varied. At Woodhill A it was consistent with a basic segregation regime but at Wakefield, where men were also on 'single unlock' (where they can only be unlocked one at a time), opportunities for time out of cell were better. At Manchester, Woodhill B and Woodhill E, time out of cell was reasonable and at Full Sutton and Whitemoor it was good. Generally, regimes were delivered consistently but there were some unplanned curtailments as a result of staffing shortages.

S12 Regimes had improved and been enriched. Progress was particularly notable at Wakefield. Access to off-wing facilities for MCBS men was risk assessed and men could use them relatively consistently at Manchester.

S13 Prisoners in units could spend at least one hour in the open air every day, but many did not take advantage of the opportunity. Since the last inspection, some exercise yards had been improved, particularly at Full Sutton, but otherwise they remained cage-like and offered no outlook. Physical education continued to be good and library services were reasonable. Most central MCBS prisoners were now held with the general population and could access a mainstream regime.

S14 The rate of deselections from CSCs and the central MCBS had increased following evidence of risk reduction and the possibility of progression, which helped motivate prisoners and staff. Transfer arrangements between units continued to be managed well. Some deselected men had to wait many months for a transfer out of the CSC system and the individual needs of some deselected men, particularly those held in ordinary prisons' MCBS locations were not always well understood or met by staff.

S15 We saw some good examples of staff supporting prisoners to maintain or re-establish contact with their families and partners. It was positive that some families and supporters were involved in the care and management plan process. More men could now have visits in open conditions, which was positive. Most visits rooms were small, which meant supervising staff were close by. We were concerned that visits were consequently not sufficiently private. Accumulated visits (where prisoners are allowed several visits over a few days) were well used.

Safety

S16 *Support on arrival was good and induction processes had improved. The potential for harm in the population was significant and there had been some recent serious assaults. There was a clear and effective focus on keeping men and staff safe, and despite the risks presented, levels of violence were low. Staff had a good awareness of what triggered men's behaviour. Designated cells were still used frequently, and we remained concerned about the length of stay and the regime offered to some men. Use of force was low and well managed. Care for men vulnerable to self-harm was generally very good, but some aspects of one self-inflicted death were worrying. Adult safeguarding arrangements had improved. Most security arrangements were proportionate.* ***Outcomes for prisoners were reasonably good against this healthy prison test.***

S17 *At the last inspection in 2015 we found that outcomes for prisoners in the CSC system were reasonably good against this healthy prison test. We made six recommendations in the area of safety. At this follow-up inspection, we found that three of the recommendations had been achieved, two had been partially achieved and one had not been achieved.*

S18 Pre-transfer arrangements were generally good and handcuffing and other restrictions during escorts were proportionate and based on risk assessments. Induction arrangements had improved and were good across all units. The restricted regimes for new prisoners at Whitemoor had now been discontinued.

S19 Levels of violence were low. However, there had been some serious assaults on staff and prisoners and the level of risk presented by the men held meant there was potential for very serious harm. There were good links with the host prison's safer custody and violence reduction teams. Weekly multidisciplinary dynamic risk assessment meetings were effective at managing day-to-day risks. Care and management plan target-setting and reviews to manage behaviour in the longer term were good and showed that prisoners were managed according to their individual risks. The incentives and earned privileges scheme was used imaginatively at some sites to promote good behaviour. Overall, staff had a good insight into men's behaviour and used it effectively to avoid triggers and de-escalate situations when necessary. Unlocking protocol levels were assessed and assigned every day and personal protective equipment was rarely used.

S20 High control cells were not used frequently. Governance arrangements had improved since the last inspection and were good in most locations. However, we were not confident high control cells were being used or authorised appropriately at Long Lartin.

S21 As at the last inspection, some men remained in designated cells for too long. The environment and regime for most prisoners in designated cells was poor – they were treated as if they were being segregated for disciplinary reasons. Access to basic amenities, such as showers and telephones, was too limited at some sites.

S22 Management and monitoring arrangements for the use of force were good and the number of incidents was low. Spontaneous and planned interventions we reviewed were well organised and properly carried out. The use of special accommodation was low. The routine use of strip-clothing in the special cell at Manchester was inappropriate.

S23 There had been three deaths in custody since the last inspection. Action plans showed that most issues had been addressed. The death of one prisoner at Woodhill was the most worrying, as there were serious deficits in how events leading to his death were managed. They were being addressed. Levels of self-harm were low. Assessment, care in custody and teamwork documents for prisoners at risk of suicide or self-harm showed good

multidisciplinary planning and support. Strip-clothing was now only used as a last resort for those at risk of self-harm, following an individual risk assessment.

S24 All units now applied the host prison's adult safeguarding policy and most had received a visit from the local adult safeguarding board. Staff had a good understanding of who could be considered at risk.

S25 Security measures were well managed and systems for identifying and managing prisoners' risks were effective. Procedural security was generally proportionate and dynamic security arrangements were good. Intelligence was very well managed. Security-led meetings were well attended.

S26 CSC and central MCBS residents continued to make use of host prison substance misuse services. There had only been one positive mandatory drug test and two residents were suspected of having taken Spice (a man-made drug that mimics the effects of cannabis but is much stronger with no discernible odour). All had been referred to appropriate services.

Respect

S27 Some improvements had been made to the units, although the atmosphere remained claustrophobic, and cleanliness at Woodhill required improvement. Staff-prisoner relationships were very good. Attention to equality and diversity issues was good, and staff now had a better understanding of the ethnic and religious mix of men in the system. There had been improvements in the management of complaints and arrangements were appropriate. Legal services were adequate. Health provision was now better than previously and reasonably good overall. There were still some unacceptable delays in transfers to secure hospital beds. ***Outcomes for prisoners were good against this healthy prison test.***

S28 At the last inspection in 2015 we found that outcomes for prisoners in the CSC system were reasonably good against this healthy prison test. We made six recommendations in the area of respect. At this follow-up inspection, we found that three of the recommendations had been achieved, two had been partially achieved and one had not been achieved.

S29 Units had better communal areas and cells were clean, except at Woodhill, where the units were grubby and some cells were dirty. Some units still had too little natural light. Prisoners could wear their own clothes and all had access to laundry facilities. Clean bedding was readily available. Access to showers and telephones was good apart from for those in designated cells. Applications were managed well, particularly those relating to unit matters, which reflected the positive relationships between staff and prisoners.

S30 All prisoners in units could collect their meals from serveries and food was reasonable, although meals were served too early in some units. Some units had self-catering facilities so prisoners could cook their own meals, which was good. Canteen arrangements were reasonable and we saw no inappropriate restrictions on purchases.

S31 Staff knew the men in their care well and spoke about and to them in a compassionate, considered and supportive way. They praised even small, but incremental, changes in behaviour and appropriately challenged poor behaviour.

S32 A comprehensive review into the number of black and minority ethnic and Muslim men in the CSC system had been carried out. The evidence indicated that the proportion of black and minority ethnic men in the system was similar to the general prisoner population. The

fact that a large number of Muslim men were subject to the system had also been explored and an impact assessment carried out to provide assurance that biases in processes and decision-making were not contributing to the disproportionate number held. The impact assessment also examined the other protected characteristic groups, finding no adverse outcomes. The findings had been discussed at CSC management meetings, and the situation needed to be reviewed periodically.

S33 Equality and diversity in all units was managed using the host prison's policies and procedures. There was evidence to show that prisoners' individual needs were addressed through care planning and one prisoner had an adapted cell. The number of discrimination incident reporting forms submitted was very low and all had been dealt with well. Faith provision was good across all units and some central MCBS prisoners at Manchester and Woodhill could attend religious services with the main prison population.

S34 The number of complaints had declined. Complaints were managed locally and responses were generally timely and focused. Complaints were now centrally monitored. Prisoners had adequate access to legal services and restrictions on legal aid funding, enabling CSC prisoners to challenge decisions to place them in the CSC system, were soon to be eased.

S35 Access to primary health services was very good and staff were well prepared for medical emergencies. Dental services were responsive to men's need. Multidisciplinary working was strong and there had been some progress in information-sharing between health services and the CSCs, although practices were more advanced in some units than others. Medicine management had improved and was generally good. There was good access to well-integrated mental health services with better provision at Manchester. However, transfers under the Mental Health Act still took far too long.

Concerns and recommendations

S36 Concern: Strategic arrangements were strong and key decisions were well thought through and based on the information available. However, there remained no independent scrutiny, and key assessment, selection and deselection decisions for the CSC system were not challenged.

Recommendation: An independent member of the CSC management group and/or committee (who is not an employee of HM Prison and Probation Service or the Ministry of Justice) should challenge robustly the CSC decision-making process.

S37 Concern: The CSC operating manual stipulates that staff in CSC and central MCBS units should be specially trained and receive regular IPD and group supervision sessions. This is an essential support mechanism for staff managing some of the most challenging men in the prison system. We met staff who had not been trained and others who had not received IPD for many months. We also heard that group supervision sessions were sometimes cancelled.

Recommendation: Staff should receive support in line with the CSC operating manual.

S38 Concern: Staffing shortages were undermining the effectiveness of regimes because they could not always be delivered as advertised. Men subject to a 'single unlock' on Woodhill A wing had very limited time out of cell and access to a reasonable regime, much less than men at Wakefield who presented similar risks.

Recommendation: Regimes should ensure men have maximum opportunity to be involved in enriching and progressive activities, which should be delivered as advertised.

S39 Concern: Most exercise yards remained cage-like, stark and poor. They did not provide an outlook, or offset the oppressive environment of the units. Men had very limited opportunities to experience more natural surroundings, such as greenery, plants and natural light unencumbered by cages. In contrast, the yard at Full Sutton had been transformed.

Recommendation: Further improvements should be made to the environment of the units, and particularly the exercise yards.

S40 Concern: Although the children and families provision and some visits rooms had improved, there was still often little privacy during visits. Family visits were run in some, but not all, units.

Recommendation: Opportunities for the men to contact their families, children and friends should be enhanced, and privacy during visits assured.

S41 Concern: There were still significant problems with the way designated cells were being used and managed. The CSC operating manual set standards for the regime men should receive in these cells, but they were often not being achieved. Despite host prisons being given additional resources to deliver a better regime for CSC prisoners in designated cells, men too often experienced a poor, segregation-like regime, with limited, if any, care planning and progression opportunities. Men often stayed in these cells for several months.

Recommendation: Operational managers of the CSC system should hold host prisons to account in ensuring that men in designated cells have a reasonable regime and appropriate support and care planning. Stays in designated cells should be as short as possible.

S42 Concern: Men in special accommodation at Manchester were routinely strip-searched and placed in strip-clothing.

Recommendation: Prisoners should only be strip-searched and placed in strip-clothing if an individual risk assessment warrants it.

S43 Concern: Communal areas and many cells at the Woodhill units were grubby or dirty.

Recommendation: Communal areas and cells in the Woodhill units should be clean and decent.

S44 Concern: Despite excellent partnership work with NHS high security special hospitals, transfers to mental health beds were still often delayed for long periods of time.

Recommendation: Transfers to secure hospital beds should be prompt and within current transfer guideline.

Section 1. Close supervision centre strategic management

Strategy, selection and review

Expected outcomes:
Prisoners are only held in dedicated close supervision centre (CSC) units as a last resort. Governance processes are strong and prisoners have clear rights of appeal. Prisoners are allocated to units that meet their individual needs.

1.1 At our 2015 inspection we found a lack of clarity about the relationship between the CSC and the managing challenging behaviour strategy (MCBS) systems and some inconsistencies between the approaches of different units. We were also concerned that decision-making lacked independent scrutiny. At this inspection, we found greater clarity of purpose, but still considered there was insufficient independent scrutiny (see recommendation S36 and paragraph 1.5).

1.2 The CSC operating manual had been revised in April 2017 and a separate MCBS policy had been published in July 2017. These documents clarified the role of each system and how they were related. We found that most staff and prisoners now understood how the two systems worked in conjunction with each other.

1.3 Although the central team did not have direct management responsibility for units in host prisons, or for their operational managers, we saw a commitment to delivering a cohesive and consistent service across the estate. Relationships between central and local managers were generally cooperative and supportive and the approach to managing men was more consistent than previously. However, we continued to find some variation in the planned provision, often caused by staff shortages, which were particularly acute at Woodhill.

1.4 Managers had prepared a clinical review in March 2015, which had led to some service developments, for example a more individual approach to assessment for selection, clearer treatment pathways that more consistently focused on reducing the risk of harm and a more flexible use of the CSC estate to meet individual needs. All units were now working towards the Royal College of Psychiatry's Enabling Environment accreditation. This process had created a positive dynamic of constructive peer criticism and improvement. As a result, there was now a much clearer focus on progression, creating a new sense of hope among prisoners that did not exist at our previous inspection.

> *'The most beneficial thing I've found is that engaging fully and honestly with the process is helpful and encouraging and it does work; meaning to engage fully it is very possible to come off CSC and take a lot away from it.' Prisoner testimonial to CSC managers*

1.5 Governance structures continued to include several layers of formal meetings, which were appropriate for managing the extremely complex population. Arrangements for selection and deselection for the CSC and the central MCBS continued to be robust. We were broadly satisfied that the system was only used for men demonstrating the riskiest behaviour in prison. Although an independent advisory group continued to meet, its role did not include providing external scrutiny of individual decisions. Given the highly restrictive nature of custody in these units, we therefore continued to consider that more independent external scrutiny of decision-making was necessary to ensure that men were always selected for the CSC as a last resort, and deselection happened at the earliest point it was safe to facilitate

(see recommendation S36). In addition, there was still no formal process other than by judicial review that allowed prisoners to appeal selection decisions.

1.6 The CSC system had capacity for 66 men and during our inspection 55 places were in use – an 15% increase since our 2015 inspection. Despite this pressure and sharp increase in referrals for the CSC and the central MCBS since April 2017, managers had refrained from increasing the capacity of the CSC system. However, the central MCBS was now being appropriately used more frequently as an alternative to long-term segregation and to prevent admission to the CSC.

1.7 During the inspection, 23 men were subject to the central MCBS, a 64% increase since our previous inspection. There were plans to relocate the Woodhill MCBS unit to Long Lartin, reinforcing the distinction between the CSC and MCBS systems.

1.8 The central team now collected more management information, which was considered quarterly by the CSCMC. Data on complaints had proved useful, but it was often difficult to extract data from the individual prisons and trend analysis was not yet well developed. Managers were now much clearer about the number of referrals being made, where they came from, and data on deselections.

1.9 Regular CSC staff continued to be carefully selected and benefited from good training (but see also paragraph 4.8). Psychologists offered weekly group supervision and support. Managers also aimed to provide each officer with an individual personal development (IPD) session every six weeks, but sessions did not take place consistently everywhere and we still found a few staff were reluctant to participate in the process (see recommendation S37).

Individual care and management

Expected outcomes:
All CSC prisoners have a robust individual assessment of their risk and need, which is regularly reviewed and implemented. Prisoners, together with all relevant staff, are involved in drawing up and reviewing plans. Progression and reintegration are clearly promoted and processes are rigorously applied.

1.10 All prisoners except those under assessment now had an up-to-date care and management plan. They had improved since the last inspection and were generally good. Plans were now simpler, genuinely multidisciplinary and included short-, medium- and long-term targets which most prisoners understood. Real efforts were made to encourage men to be meaningfully involved with their multidisciplinary team, and many were.

1.11 Monthly, quarterly and annual multidisciplinary reviews of progress took place consistently. Staff understood that changing the behaviour of the men held was a long process that required patience. We were generally impressed by continuing efforts to find ways of working with men who could be extremely challenging and frequently chose to disengage from the support available.

1.12 However, men under assessment and those in designated cells were not sufficiently clear about what was happening to them. Although men in designated cells had care and management plans, they were less meaningful than those for men in the CSC units and the prisoners did not have the same access to specialist staff as men located in units. Both groups needed more active care planning to ensure that efforts to manage them, particularly to prevent psychological deterioration, were as determined and creative as in the CSC units (see paragraphs 3.8–3.10 and main recommendation S41).

1.13 A regime and environment review in March 2016 had led to the development of a five-tiered approach to individual care and management designed to support progression pathways. We welcomed the new approach, which helped staff identify what activities might be most appropriate for individual men and encouraged a focus on well-being as well as risk reduction and purposeful activity. The approach also helped prisoners view simple activities, such as taking medication, as part of their progression.

Section 2. Progression and reintegration

Progression and purposeful activity

Expected outcomes:
There are a range of interventions and purposeful activities to ensure the psychological and emotional wellbeing of prisoners. Prisoners are able, and expected, to engage in activity that is likely to benefit them and support their progression and reintegration.

2.1 Some progress had been made in all locations towards providing a broader range activities to encourage progression and keep prisoners purposefully occupied.

2.2 The focus on risk assessment, management and reduction remained strong. Many prisoners continued to value one-to-one psychology sessions, but a chronic shortage of psychologists caused problems with the consistency and the availability of staff. Some additional resources had been made available and work was being carefully prioritised to minimise the impact on prisoners.

2.3 Staff had conducted a comprehensive needs assessment and psychologists delivered a wide range of appropriate interventions, mostly on a one-to-one basis. As at our previous inspection, the motivation and engagement modules from the Chromis accredited offending behaviour programme for violent offenders had proved useful with some men. The Hopes manual was a new intervention originally developed by Mersey Care NHS Foundation Trust for use at Ashworth high security hospital. The model aimed to reduce long-term segregation by helping staff identify and address factors that were preventing progress. Managers had modified it for use in prisons where it had been used with four close supervision centre (CSC) men.

2.4 Time out of cell varied considerably and often on a day-to-day basis, and was largely driven by the assessed risks the men presented, and whether they could safely associate with other prisoners. On most wings, time out of cell had to be divided between two or more 'association groups' because not all the men could be unlocked simultaneously. The more association groups there were, the less time out of cell was available to each man. All units were locked up occasionally so that staff could support the host prison but a lack of data meant we could not be assured the process was always managed fairly. (See recommendation S38.)

2.5 In Woodhill A, time out of cell was consistent with a basic segregation regime, because none of the men could associate with each other. If men took up the opportunity to have one hour's exercise, a shower and a phone call, they would have had one to two hours out of their cell every day. Many chose not to use the exercise yards and therefore had less than this. The regime was in contrast with that at Wakefield, where men presented similar risks, but could have three to four hours out of their cells each day. (See recommendation S38.)

2.6 Arrangements for time out of cell at Manchester, Woodhill B and Woodhill E were reasonable, but varied depending on risks, which evolved from day to day. During our inspection men on Woodhill B wing had up to three hours if they took all the opportunities offered and men at Manchester could have up to five hours. (See recommendation S38.)

2.7 At Whitemoor and Full Sutton, prisoners had a good amount of time out of their cells, often over six hours per day until 6.30pm Monday to Thursday. In the MCBS units, time out of cell varied between three and five hours per day.

2.8 Managers had commissioned a regime and environment review in March 2016. Each site now had a regime action plan, which demonstrated the work being undertaken to provide appropriate activities. Regimes were mostly delivered consistently, but at Woodhill acute staff shortages in the host prison had resulted in a restricted regime at weekends in B and E units and too many unplanned periods of lock-up, further reducing time out of cell. (See recommendation S38.)

2.9 The regime at Full Sutton was full and varied and inspectors found it impressive. Staff at Wakefield had enriched the regime through a games room and in-cell activities. It was good that Woodhill now had a dedicated teacher who worked in the unit every day. Prisoners could receive regular support with functional skills and distance learning, and teachers encouraged men to write poems for an anthology. On occasion, it was still necessary for this support to take place through a cell door and teaching was still undertaken in the area where other prisoners were associating, which was distracting. Elsewhere, there was less formal education provision, but prisoners received support to study independently in their cells. Woodhill had also provided two men on A wing with some meaningful in-cell work, which enabled them to earn money. In all units, most men also had a small cleaning task to complete every day.

2.10 Overall, exercise yards remained poor, particularly at Woodhill, Manchester and Wakefield. They were cage-like, views of the sky were obscured and there was no outlook (see recommendation S39). However, the yard at Full Sutton had been improved, with seating, plants and poly-tunnels. The previously little used garden area at Whitemoor had been very productive during the summer and prisoners had enjoyed cooking the produce.

2.11 The library provision remained similar to our previous inspection. Prisoners could request books, and there was a small well-stocked library in each unit. Men appreciated the gym facilities at all sites. At Full Sutton, a physical education instructor provided support three times a week, which was excellent. During association, staff often played pool, table football or board games with prisoners. Men appreciated the craft rooms at Whitemoor and Full Sutton.

2.12 It was very positive that, in contrast to the last inspection, most prisoners subject to the central MCBS were now located in the general population of the host prison, and therefore had access to a mainstream regime. Those in the MCBS units were more restricted. Men at Manchester could access off-wing activities in the category A unit. At Woodhill, men could use mainstream facilities subject to a risk assessment. During our inspection, only one man benefited from this. We understood that the new Long Lartin unit (see paragraph 1.6) would not have in-unit facilities for visits or a gym, which would encourage central MCBS men to participate in the wider regime.

Good practice

2.13 *Prisoners at Full Sutton could choose from a structured timetable of activities ranging from work and domestic duties and therapy sessions to craft classes, gardening and horticulture. The activities rewarded the progress prisoners had already made and encouraged continuing engagement.*

Reintegration and resettlement planning

Expected outcomes:
Prisoners are supported when they are moved to other units within the CSC system, to mainstream prison locations or to secure NHS facilities. At the point of release, adequate support is provided.

2.14 Transfer arrangements continued to be managed well. It was hugely significant that the rate of deselection from both CSC and the central MCBS had increased, following evidence of risk reduction and the possibility of progression, which helped motivate prisoners and staff. Since June 2014, 21 men had been deselected from the CSC (although two were later reselected). Two of them were transferred to high security hospitals and the remainder were split between the central MCBS and other specialist units. Since October 2016, 12 men had been deselected from the central MCBS. Many of the prisoners we spoke to had been deselected from either the CSC and central MCBS directly or through the central MCBS following progression from the CSC. A number said staff in their new location did not always understand their needs, and therefore did not provide the support they needed to progress. This was especially true for men held in ordinary prison locations, rather than small specialist units. Some deselected prisoners had to wait many months for a transfer out of the CSC system because of difficulties securing onward placements.

Children, families and contact with the outside world

Expected outcomes:
Prisoners are encouraged and supported to maintain contact with family and other supporters in the community, and to involve them in key decisions.

2.15 Efforts had been made to involve families more proactively in the care of the men held, but visiting facilities remained poor at most sites (see recommendation S40).

2.16 Many of the men held had very little contact with the outside world. However, staff had organised events for those who had supportive partners, which helped prisoners maintain or re-establish these relationships. Prisoners now had an opportunity to invite family members or friends to care and management plan or assessment, care in custody and teamwork (ACCT) case management reviews for prisoners at risk of suicide or self-harm. Although few took up the opportunity, it had been very positive in some cases.

2.17 Staff continued to arrange inter-prison visits, phone calls and video-links for men with close relatives in prison. We were pleased to see that a father had been able to cook a meal for his son during one such visit.

2.18 Visiting facilities at Whitemoor and Woodhill remained unchanged. In these locations and at Wakefield, prisoners described oppressive supervision, which meant they could not hold a private conversation (see recommendation S40). However, there had been some good progress. At Wakefield staff now conducted better risk assessments, which meant more men could have visits in open, albeit cramped conditions. At Full Sutton, the visits room was small but comfortable and the proximity of staff was offset by background noise. Staff had held two extended visits in the main visits hall when prisoners had enjoyed a meal and games with their family and friends. Accumulated visits (where prisoners are allowed several visits over a few days) continued to be well used.

2.19 Access to phones was good but often lacked sufficient privacy. Prisoners at Woodhill continued to complain about time limits on calls. However, they could arrange to make calls in the evening, when they would otherwise have been locked up.

Section 3. Safety

Escorts and early days in custody

Expected outcomes:
CSC prisoners transferring to, between and from CSC units are treated safely, decently and efficiently.

3.1 Pre-transfer and transfer arrangements remained generally good and handcuffing and other restrictions during escorts were proportionate and based on risk assessments. Induction arrangements had improved and were now good in all units. All men received a thorough induction over two days, which included a comprehensive health care screening. The restricted regimes for new prisoners at Whitemoor had been discontinued. Except for men in designated cells, most prisoners could have a shower and a phone call on their day of arrival.

Behaviour management

Expected outcomes:
Prisoners feel safe from bullying and victimisation (which includes verbal and racial abuse, theft, threats of violence and assault). Prisoners at risk or subject to victimisation are protected through active and fair systems known to staff, prisoners and visitors, and which inform all aspects of the regime. Appropriate and proportionate disciplinary processes and methods of managing refractory behaviour are in place. The use of designated and high control cells is proportionate.

3.2 There had been 23 violent incidents in the six months prior to the inspection, similar to the number recorded at the last inspection. Sixteen of them (73%) had been against staff, four of which had been so serious that staff had required hospital treatment. The level of risk presented by the men held meant there was potential for very serious harm.

3.3 Violent incidents were recorded and analysed so patterns and trends could be identified and senior staff investigated each incident well. Links with host prisons' security, safer custody and violence reduction teams were very good and there was an unrestricted flow of intelligence and security reports to the units.

3.4 Weekly multidisciplinary dynamic risk assessment meetings (DRAMs) were generally effective at managing day-to-day risks. Target setting and reviews in care and management plans, which managed behaviour in the longer term, had significantly improved since the last inspection and were now good. The plans we examined showed that prisoners were managed according to their individual risks.

3.5 The incentives and earned privileges scheme was well managed and used imaginatively at some sites to promote and reward good behaviour and reviews took place every week. At Whitemoor, prisoners who behaved exceptionally well could earn rewards.

3.6 Staff used their knowledge of the men and their behaviour to avoid triggers and de-escalate situations and we continued to be impressed by the calm way staff dealt with abuse and poor behaviour. Most men in units were assessed as safe to be unlocked by two staff. Unlocking protocols and personal protective equipment (PPE) for unlocking prisoners were based on a dynamic risk assessment and discussed every week at the multidisciplinary DRAM. PPE was used rarely.

3.7 Governance of the use of high control cells (cells with furniture, bedding and sanitation as well as a hatch in the cell door to assist in managing high risk behaviour) had generally improved and the cells were not used frequently. Logs were kept and the paperwork we examined showed that their use had been properly authorised and justified for short periods. However, at Long Lartin, governance of these cells was weak and we found prisoners had been in these cells without proper authority.

3.8 Governance arrangements for prisoners held in designated cells remained weak. There was still a lack of clarity about who was responsible for them and what regime and support should be provided (see also paragraph 1.12). As at our previous inspection, men in designated cells had limited contact with or support from close supervision centre (CSC) staff (see recommendation S41).

3.9 During our inspection, of the 13 men in designated cells, seven had been there for longer than three months, but others were held for much longer. In the two-year period from October 2015, one man had been in four different designated cell locations for a total of seven and a half months, interspersed with short periods in three different units. Another, who was waiting for a secure hospital bed (see also paragraph 4.23), had been held in a series of designated cells for over 20 months (see recommendation S41). While we recognised the complexity of the men involved, and the work being done by the central team to address their problems, such prolonged periods of time in designated cells were unacceptable and detrimental to the psychological well-being of the men involved.

3.10 Men in designated cells generally had a poor regime consistent with mainstream segregation. Some men in designated cells could not shower or make a phone call every day. At Full Sutton, men were not always offered a shower daily. Most men were offered exercise every day, but many declined and few had access to a gym. This meant men had very little time out of their cells and for most the regime amounted to prolonged solitary confinement[4]. Prisoners' isolation was exacerbated by the fact that some had no TV or radio and very limited access to education (see recommendation S41).

Use of force

Expected outcomes:

Disciplinary procedures are applied fairly and for good reason. Prisoners understand why they are being disciplined and can appeal against any sanctions imposed on them.

3.11 The use of force remained low. There had been more incidents than at our previous inspection – 79 in the previous six months but 51% of them only involved the use of handcuffs. Force was still used more frequently with individuals in designated cells.

3.12 Use of force management and monitoring arrangements were conducted by host prisons and were good. All incidents were discussed, associated paperwork was examined and samples of video recordings were scrutinised. Both spontaneous and planned interventions were well organised and properly carried out. We saw de-escalation routinely used to good effect, force was justified and proportionate and proper authority was recorded. In most cases, the application of handcuffs was subject to a risk assessment and properly recorded, but this was not always the case at Long Lartin.

3.13 Special accommodation was used infrequently, but the routine use of strip-clothing in the special cell at Manchester was inappropriate (see recommendation S42).

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[4] Solitary confinement' is when detainees are confined alone for 22 hours or more a day without meaningful human contact (United Nations Standard Minimum Rules for the treatment of prisoners. Rule 44).

Self-harm and suicide prevention

Expected outcomes:
The CSC unit provides a safe and secure environment which reduces the risk of self-harm and suicide. Prisoners are identified at an early stage and given the necessary support. All staff are aware of and alert to individual vulnerability issues, are appropriately trained and have access to proper equipment and support.

3.14 There had been three deaths in CSCs since the previous inspection, two of which had been self-inflicted (one at Manchester and one at Woodhill). The death at Woodhill was a particular concern because there had been serious deficits in how events leading to it were managed. All recommendations from Prisons and Probation Ombudsman (PPO) reports into deaths in custody were included in an action plan and most had been met. However, the staffing situation at Woodhill (see paragraph 4.8) meant that not all staff working in the units had received the full 'Working with Challenging Behaviour' programme as recommended in the PPO's report.

3.15 Given the complexity and vulnerabilities of many of the men in CSCs, the number of self-harm incidents remained reasonably low, as did the number of assessment, care in custody and teamwork (ACCT) case management documents opened. In the six months prior to our inspection there had been 18 incidents of self-harm involving eight prisoners and 26 ACCTs, which was double the number at our previous inspection.

3.16 ACCT procedures were generally good. In the cases we reviewed, care maps were detailed and updated properly. Case reviews were timely, multidisciplinary and well attended. During our inspection, we saw staff who knew and cared about the personal circumstances of men in crisis and helped them to deal with their problems. We saw them interact positively with vulnerable men on a day-to-day basis, demonstrating an appropriate interest in their welfare and responding maturely, patiently and calmly to challenging behaviour.

3.17 As at our previous inspection constant supervision was not used frequently. Strip-clothing was now only used as a last resort for those at risk of self-harm, following an individual risk assessment.

Safeguarding (protection of adults at risk)

Expected outcomes:
The CSC promotes the welfare of all prisoners, particularly adults at risk, and protects them from all kinds of harm and neglect.[5]

3.18 There were now safeguarding policies at most host prisons, which also related to the CSC and MCBS units. Links had been made with adult social services except at Whitemoor. Although staff had not received formal safeguarding training, they had a good understanding of men in their care who were at risk and we continued to be satisfied that men's safeguarding needs would be identified and met through the regular multidisciplinary case reviews and the DRAMs.

[5] We define an adult at risk as a vulnerable person aged 18 years or over, 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. 'No secrets' definition (Department of Health 2000).

Security

Expected outcomes:
Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence as well as positive staff-prisoner relationships. Prisoners are safe from exposure to substance misuse while in prison.

3.19 Because the CSC units were in high security prisons, physical security was extensive. Nevertheless, units felt reasonably relaxed and the security procedures in place were generally proportionate. Risk management systems were comprehensive and any restriction placed on prisoners' movements or the regime was usually justified. However, as at our last inspection prisoners were strip-searched too often without an individual risk assessment, for example before moving around within the prison (see recommendation S42).

3.20 CSC managers attended their host prison security meetings and information-sharing was effective. Good intelligence gathering and assessment supported dynamic security. Intelligence continued to be managed well and action was always taken promptly to avert any threats against staff or prisoners. Supervision when prisoners were unlocked was effective.

3.21 Closed visits were rarely used in CSC units but were sometimes used in designated cells, without prisoners receiving an individual risk assessment to justify their use.

Substance misuse

Expected outcomes:
Prisoners with drug and/or alcohol problems have access to clinical and psychosocial services that are equitable to the services offered to non-CSC prisoners

3.22 Prisoners continued to be screened for substance misuse problems on arrival and make use of the host prison's substance misuse services. In the rare cases when it was required, treatment could be delivered within the unit. During the inspection, three men were receiving appropriate support, one following a positive mandatory drug test and two others suspected of having taken Spice (a man-made drug that mimics the effects of cannabis but is much stronger with no discernible odour).

Section 4. Respect

Daily living arrangements

Expected outcomes:
Prisoners live in a safe, clean and decent environment within which they are encouraged to take personal responsibility for themselves and their possessions. Prisoners are offered varied meals to meet their individual requirements and food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations. Prisoners can purchase a suitable range of goods at reasonable prices to meet their diverse needs.

4.1 Since the last inspection, efforts had been made to brighten the units, although some still lacked natural light. Units were mostly clean and well maintained, but at Woodhill communal areas were grubby and many cells were dirty and smelled (see recommendation S43). Art work and quotations from close supervision centre (CSC) residents were on display in some units.

4.2 Prisoners could wear either their own clothes and all had access to laundry facilities, mostly in the units. All prisoners received clean bedding every week. Access to showers and phones was good for most but poor for men in some designated cells (see paragraph 3.1).

4.3 Prisoners could make applications every day. Those relating to unit matters were dealt with promptly reflecting the positive staff-prisoner relationships. Prisoners reported that staff were helpful and we observed that most staff were quick to respond to requests. At Manchester, prisoners had a computer terminal without an internet capability, which gave them access to their spending account information and enabled them to make applications to other departments in the prison.

4.4 All prisoners in units could collect their meals from the servery areas and the food was reasonable. However, some meals were served too early – lunch was often served before midday. Manchester and Full Sutton all had cooking facilities for prisoners ranging from toasters and microwaves at Manchester to full facilities at Full Sutton. A new kitchen at Wakefield was due to open soon enabling men to cook for themselves and use their time constructively.

4.5 All units used the canteen list provided by the host prison and there were no unnecessary restrictions on what prisoners could purchase. Prisoners could buy newspapers and magazines and had access to catalogues for larger items.

Staff-prisoner relationships

Expected outcomes:
Prisoners are treated with respect by staff throughout the duration of their time in custody, and are encouraged to take responsibility for their own actions and decisions. Staff facilitate an environment which supports safe and supportive relationships.

4.6 We continued to see strong staff-prisoner relationships. Staff spoke to and about men in a compassionate, considered and supportive way and demonstrated an impressive knowledge and understanding of men's circumstances, behaviour, risk factors and triggers. Staff praised small but incremental positive behaviour change and consistently challenged poor behaviour

appropriately. They spoke often of the importance of providing compassionate support to encourage hope in the possibility of progression.

4.7 Multidisciplinary working remained strong and operational managers were clear about their roles and the purpose of the units, which was further underpinned by strategic direction and leadership.

4.8 Most staff understood the ethos of the system, were well-trained and skilled in supporting prisoners using a psychologically informed approach. However, there were some staff shortages, which were covered by officers from the host prisons or detached duty staff. They were not necessarily appropriately trained, placing additional burdens on regular staff, which prisoners recognised. The problem had an impact on Woodhill in particular, where only 27 out of 44 CSC officer posts on A and B wings were filled. The shortfall did not yet substantially affect prisoner outcomes but regular staff felt under pressure and there was a growing risk that the culture and ethos of the units could be undermined.

Equality and diversity

Expected outcomes:

Staff demonstrate a clear and coordinated approach to eliminating discrimination, promoting equitable outcomes and fostering good relations, and ensure that no prisoner is unfairly disadvantaged. This is underpinned by effective processes to identify and resolve any inequality. The distinct needs of each protected characteristic are recognised and addressed.

4.9 Managers had conducted a thorough investigation into the number of black and minority ethnic and Muslim prisoners held in the CSC system. The research indicated that the proportion of black and minority ethnic prisoners was similar to the general prison population in December 2015 and December 2016 when data were collected. However, the Muslim population as a proportion was higher than the general prison population. An impact assessment had been carried out to understand why this was the case, and to ensure there was no bias in processes or decision-making that had contributed to this situation. This reassured us that selection and deselection processes were based on risk assessments of prisoners' behaviour and risks to others, rather than ethnicity or religion. The issues raised were discussed at various CSC management boards. Nevertheless, managers needed to continue to routinely monitor equalities data and investigate where necessary to ensure that processes were fair.

4.10 Equality and diversity in all the units were managed under host prison policies and procedures and unit managers attended strategic prison meetings. Prisoners received individual care and support specific to their needs. Few prisoners had disabilities and there was little need for additional support, but one prisoner had been provided with adaptations to his cell. The impact assessment had also considered the other protected characteristics, finding no evidence of adverse outcomes or bias. The number of discrimination incident reporting forms submitted was low in all the units. They were managed well.

Faith and religious activity

Expected outcomes:
All prisoners are able to practise their religion fully and in safety. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and resettlement.

4.11 Faith support was still very good. Prisoners in the MCBS units at Manchester and Woodhill could attend religious services in the main prison subject to an individual risk assessment.

Complaints

Expected outcomes:
Effective complaints procedures are in place for prisoners, which are easy to access, easy to use and provide timely responses. Prisoners feel safe from repercussions when using these procedures and are aware of an appeal procedure.

4.12 The complaints procedures continued to be effective and the number of complaints had decreased from an average of 39 per month at the last inspection to about nine per month at this inspection. All prisoners knew how to make a complaint and there was no evidence that prisoners came under pressure to withdraw complaints or were victimised for making a complaint. A few men remained unconvinced that the system was objective or fair. We saw no evidence to support this view, and we continued to see an emphasis on local face-to-face resolution.

4.13 The central CSC management team now monitored trends and themes in complaints on a quarterly basis so lessons could be learned. Staffing and the regime at Whitemoor and Woodhill and property were the key issues in 2017.

Legal rights

Expected outcomes:
Prisoners held in CSCs have access to legal advice and receive visits and communications from their representatives without difficulty.

4.14 At our previous inspection, legal services were adequate but restrictions in access to legal aid could have had an impact on the ability of some prisoners to obtain legal assistance to challenge key decisions. In April 2017, the Court of Appeal ruled that certain cuts to legal aid for prisoners were unlawful. As a result, the government introduced changes to the law to specify that prisoners challenging certain decisions are eligible for legal aid, including decisions about placement in a CSC. The law came into force in late February 2018.

4.15 There was sufficient access through prison libraries to legal texts, CSC manuals and Prison Service publications. Legal visits arrangements were generally adequate, but the facility at Whitemoor was not private. Access to Justice laptops (laptop facilities for eligible prisoners to progress legal proceedings) were available on application.

Health services

Expected outcomes:
Prisoners have access to health services that are equitable to the services offered to non-CSC prisoners.

4.16 At this inspection, CSC managers and unit staff continued to meet regularly with NHS representatives to review individual cases and pursue a strategic approach to treatment pathways. All prisoners were seen on admission by a health care professional (HCPs) and there were good visiting arrangements for HCPs. Prisoners could access health care outside the CSC and, if required, clinicians contributed to case review meetings.

4.17 At this inspection, patients had good access to clinical HCPs, at least as promptly as in host prisons and a nurse visited the units each day. There had been some problems with access to visiting GPs at Wakefield, which were offset by using nurse prescribers. More GPs had been recruited to address the problem and were due to start in January 2018. Dental services were responsive to men's needs.

4.18 A small number of men with long-term medical needs had appropriate access to specialist HCPs. No men required personal care as defined under the Care Act.

4.19 Access to internal clinics and external appointments was good despite logistical challenges and we saw how the NHS had worked hard to ensure the dignity of CSC patients receiving care in general hospitals.

4.20 Most clinical consultations were undertaken in private in a suitable setting. However, for a small number of men one-to-one HCP assessment was not considered appropriate because of the risks presented. Some units lacked suitable treatment rooms. HCPs regularly attended the units and contributed to most enhanced case review meetings. This was particularly the case for mental health HCPs who offered valued support to men in the units.

4.21 There remained some issues related to sharing medical information, but most pertinent information about treatment was shared appropriately between professionals. Protocols covering this important aspect of care were being developed but had still not been implemented in full.

4.22 Medicine management arrangements had improved and were generally good. Confidentiality and security were now good, medication now came in named patient supplies and staff were prepared in a medical emergency.

4.23 Mental health support was now timely and effectively integrated – Manchester had made particular progress. The care programme approach (mental health services for individuals diagnosed with a mental illness) was being appropriately used and reviews were taking place. Despite greater collaboration with NHS commissioners, and significant efforts by CSC managers to expedite transfers, prisoners still waited far too long to be transferred to secure hospital beds under the Mental Health Act with most waiting several months when the guideline was 14 days (see recommendation S44).

Section 5. Summary of recommendations and good practice

The reference number at the end of each recommendation or example of good practice refers to its paragraph location in the main report.

Recommendations

5.1 An independent member of the CSC management group and/or committee (who is not an employee of HM Prison and Probation Service or the Ministry of Justice) should challenge robustly the CSC decision-making process. (S36)

5.2 Staff should receive support in line with the CSC operating manual. (S37)

5.3 Regimes should ensure men have maximum opportunity to be involved in enriching and progressive activities, which should be delivered as advertised. (S38)

5.4 Further improvements should be made to the environment of the units, and particularly the exercise yards. (S39)

5.5 Opportunities for the men to contact their families, children and friends should be enhanced, and privacy during visits assured. (S40)

5.6 Operational managers of the CSC system should hold host prisons to account in ensuring that men in designated cells have a reasonable regime and appropriate support and care planning. Stays in designated cells should be as short as possible. (S41)

5.7 Prisoners should only be strip-searched and placed in strip-clothing if an individual risk assessment warrants it. (S42)

5.8 Communal areas and cells in the Woodhill units should be clean and decent. (S43)

5.9 Transfers to secure hospital beds should be prompt and within current transfer guideline. (S44)

Good practice

5.10 Prisoners at Full Sutton could choose from a structured timetable of activities ranging from work and domestic duties and therapy sessions to craft classes, gardening and horticulture. The activities rewarded the progress prisoners had already made and encouraged continuing engagement. (2.13)

Section 6. Appendices

Appendix I: Inspection team

Sean Sullivan	Team leader
Ian Dickens	Inspector
Karen Dillon	Inspector
Jeanette Hall	Inspector
Kellie Reeve	Inspector
Gordon Riach	Inspector
Michelle Bellham	Researcher
Catherine Shaw	Researcher
Joe Simmonds	Researcher
Steve Eley	Health services and substance misuse inspector
Paul Tarbuck	Health services and substance misuse inspector
Kathleen Byrne	Care Quality Commission
Jan Fooks-Bale	Care Quality Commission
Dr Paul Gilluley	Independent consultant in forensic psychiatry

Appendix II: Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made, organised under the four tests of a healthy prison. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Strategic management

Prisoners are appropriately selected for CSCs and receive individual support to reduce their risk of harm and work towards deselection.

At the last inspection, in 2015, the aims of the close supervision centre (CSC) system were clearly described, although there were inconsistencies between units and some management arrangements lacked clarity. The role of managing challenging behaviour strategy (MCBS) units needed to be clearer. Risk assessments were robust but decision-making lacked independent input or scrutiny. Selection followed a clear path and was based on a wide range of information but there was no formal appeals process. The approach was psychologically informed and prisoners and staff received some good support. All prisoners had individual care and management plans but the quality was too variable. Staff knew the men in their care well. Outcomes for prisoners were reasonably good against this healthy prison test.

Main recommendations

The central team needed to have a greater level of input into the recruitment of managers and staff and the day-to-day running of the CSC units to ensure the system was delivered consistently. (S40)
Partially achieved

Key decisions regarding the selection and deselection of prisoners and the need to continue to hold them in the CSC system should be open to robust, independent scrutiny and meaningful challenge from outside the prison system; they should also be subject to a formal appeals process that prisoners can easily access. (S41)
Partially achieved

Data across a range of key areas should be collated for specific CSC units and the CSC management team should use it centrally to identify and address any emerging trends or patterns. (S42)
Partially achieved

Recommendations

The purpose, processes and regimes to support the centrally managed MCBS prisoners should be clear; they should support the strategy's main aim of diverting prisoners away from the CSC system back to mainstream prison units. (1.10)
Achieved

Progression and reintegration

Prisoners benefit from a purposeful regime which supports efforts to address problematic behaviour, and clearly focuses on progression and reintegration.

At the last inspection, in 2015, good group and individual work was facilitated. The addition of the Full Sutton unit had enhanced prisoners' opportunities for progression. Access to interventions was developing but a broader range was required. Time out of cell was too variable; for some it was poor. Access to purposeful activity was not sufficient and staffing issues reduced this further. Education opportunities were particularly poor. The lack of activity was detrimental for some and meant prisoners did not have sufficient opportunities to support their progression. The library provision was very limited but there was reasonable access to physical education. Reintegration was mainly related to moves within the system, which appeared to be well managed. Children and families provision was poor. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Main recommendations

Prisoners should be able to fill their time out of their cell with activities likely to benefit them and support progression. They should be encouraged to use time locked up as constructively as possible. (S43)
Partially achieved

Communal areas and exercise yards in all units should be improved to make them less oppressive and austere. (S45)
Partially achieved

Recommendation

There should be a CSC-wide strategy to encourage and support prisoners to maintain contact with family and others in the community, and to involve them in key decisions. (2.30)
Partially achieved

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2015, early days arrangements were generally well managed. Despite the risks presented, most prisoners felt safe and behaviour management work appeared measured and proportionate. Levels of violence and self-harm were low, although some incidents were extremely serious. The management of prisoners in designated cells was poor. Formal disciplinary procedures were rarely used. Use of force, high control cells and personal protective equipment (PPE) was also low, although some oversight arrangements needed to improve. Security was generally proportionate, although there was some disproportionate searching and use of handcuffs. Substance misuse support was provided when needed. Outcomes for prisoners were reasonably good against this healthy prison test.

Main recommendation

Designated cells should only be used for the shortest possible period and only in exceptional circumstances. Rule 46 prisoners in designated cells should receive equivalent care to those held in units. (S44)
Not achieved

Recommendations

Induction arrangements should be improved and the restricted regime at Whitemoor should be reviewed. (3.6)
Achieved

Governance and oversight of the use of high control cells should be improved. (3.18)
Achieved

Strip-clothing should only be used as a last resort and subject to a risk assessment. (3.28)
Achieved

Arrangements for initiating contact with the local director of adult social services (DASS) and the local safeguarding adults board (LSAB) to develop local safeguarding processes should be implemented for all men held within the CSC system. (3.31)
Partially achieved

Strip-searching, the use of handcuffs and closed visits should only be applied subject to an individual risk assessment. (3.37)
Partially achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2015, living conditions were mixed; some units were cramped, which was a significant issue, and more needed to be done to make them less austere, improve the outlook from the prison and enhance outside exercise areas. Otherwise units were clean and decent. Relationships were very good and staff knew the men very well and worked constructively with them. The reasons for the large number of black and minority ethnic and Muslim men held needed to be better understood. Complaints processes were reasonable and legal services were adequate. Health services overall met prisoners' needs but better information-sharing was required. Outcomes for prisoners were reasonably good against this healthy prison test.

Main recommendation

The reasons why the number of black and minority ethnic and Muslim prisoners in the CSC system was so high needed to be better understood to ensure there was no discriminatory practice. (S46)
Achieved

Recommendations

All staff working in the CSC system should be offered regular individual professional development sessions. (4.17)
Partially achieved

Health care practitioners undertaking medicines management and administration in the CSCs should comply with their respective professional guidance and not secondarily disperse medications. (4.45)
Achieved

There should be an information-sharing protocol to ensure the prompt exchange of prisoner information, and provide a mechanism for resolving disagreements. (4.46)
Partially achieved

The care programme approach should be continued wherever the patient is in the prison system until such time as a documented multi-disciplinary review concludes otherwise. (4.47)
Achieved

Patients requiring mental health services should be transferred expeditiously in line with transfer guidelines. (4.48)
Not achieved

Appendix III: Extracts from *Close Supervision Centres Operating Manual* (April 2017)

Referral to the CSC (page 17)

Prisoners referred to the CSC system would normally be those who have carried out a single serious act of violence, or those demonstrating (or threatening to demonstrate), behaviours that are significantly dangerous to others, and as such they are deemed unsuitable to be managed on normal location or in a segregation environment. The decision whether to refer a prisoner to the CSC will take into account the need to protect others from the risk of serious harm posed by some prisoners. Previously he may have demonstrated violence and/or other control problems, and not responded sufficiently to alternative methods of control. Attempts to manage problematic prisoners using existing processes are usually required to evidence compliance with the requirements of PSO 1810, paragraph 2.5 and section 8. But all cases are judged on their individual merits, and there can be circumstances where CSC referral is appropriate without a history of such behaviours or failure to respond to other measures. Whilst a referral is initiated or ongoing, local managers should consider management under Local MCBS or CVMM.

Referral criteria:
A prisoner may be referred to the CSC if any one or more of the following are evident:

- Demonstrating repeated or escalating violence towards others;
- Carried out, or orchestrated, a single serious or significant act of violence or disorder, e.g. hostage taking, murder, attempted murder, serious assault, concerted indiscipline etc.;
- Causing significant day-to-day management difficulties by undermining the good order of the establishment i.e. through bullying, coercion, intimidation, threats, regime disruption and subversive activity. Involvement in such activities may not always be overt but be supported by significant intelligence indicating that individual's involvement;
- Seriously threatening and/or intimidating behaviour, directed at staff and/or prisoners;
- A long history of disciplinary offences indicative of persistent problematic behaviour;
- Repeated periods of segregation under Prison Rule 45 - Good Order or Discipline;
- A continuous period of segregation exceeding six months (3 months for non-high security prisons) due to refractory behaviour;
- Failure to respond to attempts to manage his risk and behaviour using existing processes, or under MCBS / CVMM (Long Term and High Security Estate only), and his risk to others or the safe operation of an establishment is deemed to be significant.
- Threatening to demonstrate behaviours that are significantly dangerous to others, and where there is evidence that deems that risk / threat credible, and as such they are unsuitable to be managed on normal location or long term in a segregation environment.

Referral to the CSC does not bypass the use of appropriate existing management tools already available in all establishments. The prisoner must be informed of the referral and provided with a copy of the referral document no later than 14 days prior to CSCMC, (subject to redaction only where necessary). Personal or Legal representations may be submitted for CSCMC.
The referral should be sent to the CSC functional mailbox, and will first be considered by CMG [central management group], with a recommendation being made to CSCMC where the final decision will be established. If the CSCMC selects a prisoner for assessment within the CSC system he will be notified of the decision in writing with reasons for the decision, and will transfer to a CSC assessment location as soon as is operationally possible to commence his assessment to determine suitability for placement under Prison Rule 46. Where operational or other factors determine that the prisoner cannot transfer at that time, he will remain in a designated cell awaiting assessment under Rule 46 and be reviewed monthly by the CSCMC.

When considering the referral at CSCMC, alternatives to CSC management will also be considered, and may be decided upon, including management on a normal location, or management under Local or Central MCBS. The criteria for MCBS can be found within the MCBS Policy, and are available on

request from Local MCB Managers or CMG. Prisoners are informed via the CSC Referral documents that their case will also be considered for such management strategies and can access the criteria and policy on request. A prisoner may appeal the CSCMC decision, via the complaints system or via correspondence for the attention of the PSSUM, who will raise this at next CSCMC.

Designated cells (page 11)
Designated cells (DCs) are a resource available to the CSCMC and must only be used for CSC prisoners to ensure adequate Rule 46 cells are available across the High Security and Long Term Estate. Such locations are appropriate when it becomes necessary to temporarily remove prisoners from the main CSC units. These cells are termed Designated Cells as they are designated by the Director with the delegated authority of the Secretary of State for the purpose of holding Rule 46 prisoners only. The aim of the system is to accommodate CSC prisoners within the main units to carry out the work identified for them, however there are a range of circumstances for which a DC would be appropriate;

- For prisoners within CSC units, either through disruptive, subversive, manipulative, or violent behaviour, who refuse to comply with any regime or intervention offered to them, including passive refusal, and/or is disrupting the regime to the detriment of other prisoners located on the unit;
- For whom a move would be in the best interests of their, or another prisoner's physical and/or mental well-being;
- For an adjudication hearing (although as a last resort, as Video link should be attempted first);
- To facilitate an adjudication award;
- For compassionate reasons;
- To facilitate the reasonable management of prisoners within the system (see below)*;
- To enable a period of accumulated or inter-prison visits;
- As contingency accommodation in the event that a unit has to be decanted to facilitate maintenance work, or is evacuated following an incident.

*Facilitating the 'reasonable management' of prisoners may include the need to transfer a prisoner due to conflicts with individual prisoners, or to enable another prisoner to be brought into the CSC system for assessment, treatment, or progression, to address staff well-being, to enable cells to be allocated to another prisoner where a priority need is identified, pending allocation to a CSC unit, or to manage witness conflicts where an offence has been committed within the CSC.

Appendix IV: Case studies

Case study 1 – Mr A
Mr A was convicted of murder while already on life licence, and given a whole life tariff to reflect the violence used. While in custody Mr A committed several serious assaults on prisoners, all of which demonstrated a decline in behaviour and increased willingness to use violence.

Five years after the second conviction for murder, Mr A received a further indeterminate sentence for a serious assault on a fellow prisoner where extreme violence was used. The assault resulted in referral and ultimate selection to a CSC.

Following selection to the CSC system, Mr A has often displayed periods of challenging behaviour such as non-engagement with staff, destroying property and aggressive or violent episodes. He also has a further conviction for attempted murder within a special unit setting.

Mr A appears more stable when able to follow a set regime with focus on the use of available fitness equipment. Incidents of violence or destruction of property have often followed any limitations to his set regime or uncertainty around his immediate future.

Despite the risk of significant violence towards other prisoners, the CSCMC has attempted two progressive moves since 2014 and continues to encourage Mr A to engage with multidisciplinary support to address the risks of repeated violent behaviour.

Case study 2 – Mr B
Mr B was given an indeterminate sentence for conspiracy to murder and threats to kill. He received a tariff of four years. Mr B's custodial behaviour was poor and included bullying, intimidation, maintaining gang-related links and engaging in illicit activity within prison.

Mr B had been involved in several assaults on staff that included a serious assault on two officers. Following selection to a CSC for his poor custodial behaviour and increased use of violence, multidisciplinary teams identified key triggers that could cause further incidents of violence. Mr B worked with many professionals within the CSC system to address the identified risks and, following completion of intensive psychological intervention to address violence risks, was recommended for deselection.

Following due consideration, the CSCMC felt that further consolidation of improved behaviour from Mr B was required and he was moved to a CSC unit where he could access this opportunity. While there Mr B continued to engage well with staff and other prisoners, often acting as a calming influence to his peers in addition to making improvements to the unit regime by engaging in positive consultation. When setbacks occurred Mr B demonstrated an ability to manage his frustration in an appropriate way without the use of violence.

Mr B was deselected from the CSC while located within this unit and began a process of gradual reintegration into the mainstream population. Mr B continues to engage with multidisciplinary teams with hopeful progression to a specialist unit, while continued support is provided via managing challenging behaviour system protocols.

Case Study 3 – Mr C
Despite a close-knit family, Mr C had a problematic schooling and left before taking any formal qualifications. Mr C's social circle was involved in sophisticated crime and he was attracted to the potential financial benefits of crime from an early age. Mr C was convicted of murder and firearms offences following a drive-by shooting. He was given a life sentence with a tariff of over 20 years.

Mr C is well-built prisoner and prison entries indicate that he could often seem intimidating due to his size. While the frequency of his violent incidents in prison were limited, when they did occur they often resulted in high risk of harm. Mr C seriously assaulted six members of staff following warnings in relation to his poor behaviour. The staff involved suffered serious injuries, including a fractured jaw and broken nose. Mr C was selected into the CSC system and received a further three-year prison term to run consecutively with the life tariff.

Mr C engaged with intensive psychological intervention to address violence risks but was not selected for the second phase of this work due to disruptive behaviour. Mr C was subsequently transferred to another CSC unit, to facilitate weekly clinical sessions to inform a further full case assessment. Mr C engaged positively while at this unit and was deselected to central MCBS two years later.

Mr C was initially managed under central MCBS and following successful reintegration he completed further offending behaviour work. Mr C continued positive engagement, gaining a trusted role within the main kitchen and working as a peer culture champion.

Mr C was discharged to local MCBS management a year later and was discharged from local management into mainstream population recently.