Report on an independent review of progress at

HMP Isle of Wight

by HM Chief Inspector of Prisons

7–9 January 2020

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Contents

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

About this report

A1 Her Majesty's Inspectorate of Prisons (HMI 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 visits 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 Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations in between inspections. IRPs will take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny, and will focus on a limited number of the recommendations made at the inspection. IRPs will therefore not result in assessments against our healthy prison tests.[1]

A4 The aims of IRPs are to:

- assess progress against selected key recommendations
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our main concerns at the full inspection.

A5 This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in April/May 2019 for further detail on the original findings.[2]

IRP methodology

A6 IRPs will be announced at least three months in advance and will take place eight to 12 months after the full inspection. When we announce an IRP, we will identify which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

A7 During our three-day visit, we will collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence will include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

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1 HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

2 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/08/Isle-of-Wight-Web-2019.pdf.

A8 Each recommendation followed up by HMI Prisons during an IRP will be given one of four progress judgements:

- **No meaningful progress**
  Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

- **Insufficient progress**
  Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken had not yet resulted in any discernible evidence of progress (for example, better systems and processes) or improved outcomes for prisoners.

- **Reasonable progress**
  Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better systems and processes) and/or early evidence of some improving outcomes for prisoners.

- **Good progress**
  Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.

A9 When Ofsted attends an IRP its methodology will replicate the monitoring visits conducted in further education and skills provision.[3] Each theme followed up by Ofsted will be given one of three progress judgements.

- **Insufficient progress**
  Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

- **Reasonable progress**
  Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

- **Significant progress**
  Progress has been rapid and is already having considerable beneficial impact on learners.

[3] Ofsted's approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook* at paragraphs 25 to 27, available at https://www.gov.uk/government/publications/further-education-and-skills-inspection-handbook

Key findings

S1 At this IRP visit, we followed up 11 of the 35 recommendations made at our most recent inspection and made judgements about the degree of progress achieved to date.

S2 We judged that there was good progress in three recommendations, reasonable progress in two recommendations, insufficient progress in one recommendation and no meaningful progress in five recommendations.

Figure 1: Progress on recommendations from 2019 inspection (n=11)

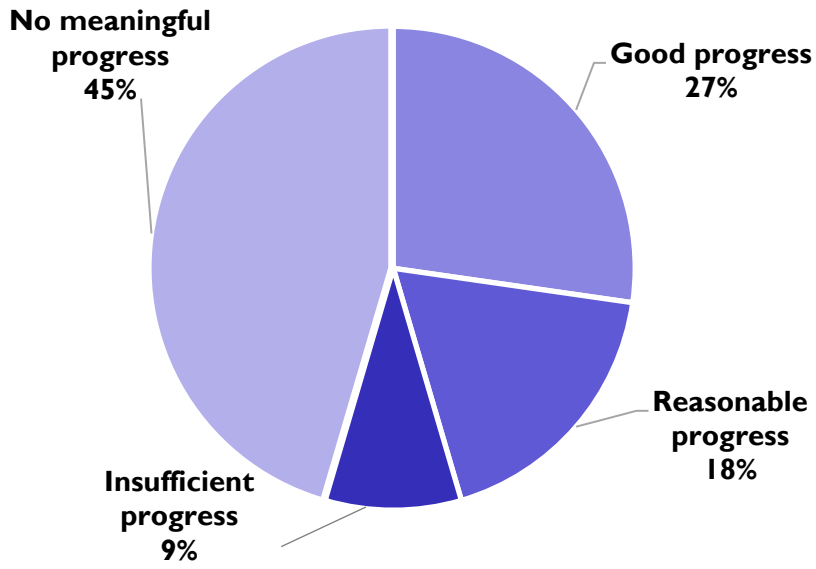


Figure 2: Judgements against HMI Prisons recommendations from April/May 2019 inspection

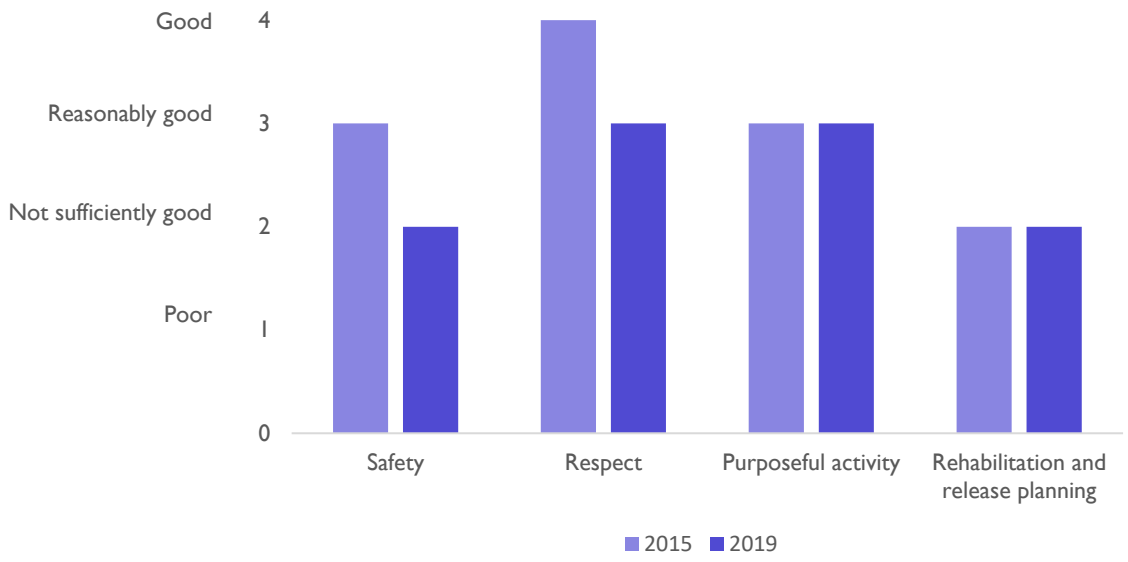
Recommendation	Judgement
The prison should investigate all violent incidents thoroughly to understand the drivers of violence and implement a strategy to reduce it. (S45)	Reasonable progress
The incentives and rewards policy should be reviewed to ensure meaningful differences between the levels and effective oversight arrangements should be put in place. (S46)	No meaningful progress
The governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including communication of the correct medical code and calling an ambulance immediately. (S47)	Good progress
Single cells should only be used to accommodate one prisoner. (S48)	No meaningful progress
All prisoners should have effectively screened in-cell toilets. (S49)	No meaningful progress
Systems for application and redress should be managed effectively to ensure that prisoners receive a timely response. (S50)	Good progress

A memorandum of understanding should be formally agreed between the social care provider, the prison and the local authority, to ensure that social care needs are consistently met. (S51)	Good progress
Patients requiring hospital admission under the Mental Health Act should be assessed and transferred expeditiously within the current transfer guidelines. (S52)	No meaningful progress
Prisoners should have regular face-to-face contact with an offender supervisor and an up-to-date OASys assessment to help them address their offending behaviour and to ensure that their progression is monitored effectively. (S57)	Insufficient progress
Prison offender supervisors should receive specific training in working as offender supervisors with sex offenders and receive regular professional supervision. (S58)	Reasonable progress
Remand prisoners should be held in an establishment that can meet their needs. (S59)	No meaningful progress

Section 1. Chief Inspector's summary

1.1 At our inspection of HMP Isle of Wight in 2019 we made the following judgements about outcomes for prisoners.

Figure 3: HMP Isle of Wight healthy prison outcomes 2015 and 2019.



1.2 HMP Isle of Wight is a training prison holding about 1,000 prisoners across two separate sites. Almost all of them were serving long sentences for sexual offences, but the prison was also used to hold a small remand population from the Isle of Wight. The prison was last inspected in April/May 2019. While Ofsted judged the overall effectiveness of education training and work to be good, outcomes for prisoners had declined in the areas of safety and respect and continued not to be sufficiently good in rehabilitation and release planning.

1.3 At this visit, we reviewed progress against 11 key recommendations. Taken as a whole, progress had not been good enough in the majority of areas. There had been good progress in three, reasonable progress in two, insufficient progress in one and no meaningful progress in five areas. However, there was a significant difference between how work had progressed in areas local managers had responsibility for and those that required national support from HM Prison and Probation Service (HMPPS).

1.4 Local managers had made reasonable or better progress in five out of seven recommendations. This included important work to determine the causes of violence and challenge or support individuals involved in violent incidents. The safety team had used information from this work to inform a strategy to reduce overall levels of violence, but it had been implemented too recently for us to see any impact on outcomes. Managers had also ensured that staff understood their roles and responsibilities in the event of a medical emergency and that an ambulance was called when an emergency code was used. However, there continued to be significant weaknesses in the operation of the incentives and rewards policy.

1.5 In the area of respect, managers had worked well to improve systems for applications and redress. Social care had also been improved by the implementation of a memorandum of understanding with the local council.

1.6 In rehabilitation and release planning, there had been some work to improve oversight of the department and train prison offender managers (POMs). However, there continued to be a large backlog of assessments of prisoners' risks and needs, and infrequent contact between POMs and prisoners.

1.7 In contrast to the progress made by local managers, all four recommendations that required external support from HMPPS had been rejected and so no progress had been made. These recommendations included taking steps to ensure basic standards of decency by reducing overcrowding and ensuring all prisoners had access to a toilet overnight. During this visit, we found that about 160 prisoners continued to live in overcrowded cells. In addition, most prisoners on the Albany site continued to live in cells without a toilet or sink. Instead they relied on night sanitation, an electronic system that allows prisoners out of their cells individually to use communal facilities overnight. Prisoners, including older and disabled people, were allowed seven minutes to use the facilities, which many said was not long enough. It was not uncommon for prisoners to face a wait of an hour. This meant that many resorted to using a bucket in their cell and effectively 'slopping out' in the morning. This was not an acceptable situation.

1.8 HMPPS also rejected a recommendation intended to ensure sick prisoners were transferred to a mental health facility in line with national guidelines. I accept that this recommendation requires working in partnership with NHS commissioners, but the continued lack of action means patients remain in facilities that are unable to meet their needs for significant periods of time. One patient who had been waiting too long for a hospital bed during our inspection was still waiting at the time of this visit eight months later.

1.9 Finally, HMPPS rejected a recommendation that remand prisoners should be held at an establishment that could meet their needs. As a consequence, there continued to be no release planning for this group and none of them were participating in education or activities during our visit. In addition, the small remand population was prevented from exercising its voting rights in the general election of December 2019.

1.10 This was a mixed review. Local managers had worked well and made progress in some important areas. However, HMPPS needs a change of approach to ensure accommodation meets basic standards and all prisoners receive appropriate support and health care.

Peter Clarke CVO OBE QPM January 2020
HM Chief Inspector of Prisons

Section 2. Progress against the key concerns and recommendations

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2019. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Managing behaviour

Key concern: Prisoners had very poor perceptions of safety. The prison did not have a grasp of the drivers of violence which had increased since our last inspection. Violent incidents were not always investigated thoroughly and the quality of some of those investigations was poor. Management of violent prisoners was weak and plans in place did not provide helpful and consistent advice to staff on lowering risk.

Recommendation: The prison should investigate all violent incidents thoroughly to understand the drivers of violence and implement a strategy to reduce it. (S45)

2.1 The safety team had experienced some staff changes since our inspection. There was a new operational manager in the team and three additional supervising officers on each site who collated data and investigated most incidents of violence.

2.2 Prison managers had worked hard to cleanse local data to ensure it was accurate. Incidents of violence were now reported and referred for local investigation promptly. Most incidents were being investigated in less than four days, which was a notable improvement from the last inspection. Investigations into incidents had also improved, however their quality varied and some investigations continued to require deeper enquiry to establish the root cause of the incident.

2.3 The prison had successfully implemented challenge support and intervention plans (CSIPs)[4] and most staff we spoke to were aware of the process and knew how to make a referral. CSIPs were impressive. The prison had ensured that reviews of plans took place and were multidisciplinary. The weekly safety intervention meeting was also well attended and discussed prisoners with more complex needs. It was positive that, where the prison had identified concerns about mental health, the mental health team was pivotal in advising on the management of the prisoner. The prison had also used CSIPs twice recently to support victims. Although the plans for victims were not as robust as those for perpetrators, managers assured inspectors that they intended to improve support for victims of violence further.

2.4 The prison had received good support from managers at the long-term high security estate and had conducted an evaluation to understand the causes of violence at HMP Isle of Wight in November 2019. This piece of work underpinned a strategy that was drawn up in December 2019, which outlined many laudable objectives, such as upskilling staff, rolling out CSIPs and improving the prison's physical environment. However, given its recent implementation very few had been achieved and there had yet to be an impact on the overall level of violence, which had risen since our inspection.

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[4] Challenge, support and intervention plans are used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Some prisons also use the CSIP framework to support victims of violence.

2.5 We considered that the prison had made reasonable progress against this recommendation.

Key concern: The difference between the standard and enhanced levels of the incentives and rewards policy (IRP) was marginal. Management of the IRP was poor and reviews were not always conducted on time. Some prisoners remained on basic for more than two months. Not all prisoners on basic level we spoke to knew how to appeal against decisions to downgrade them to basic level.

Recommendation: The incentives and rewards policy should be reviewed to ensure meaningful differences between the levels and effective oversight arrangements should be put in place. (S46)

2.6 As at the last inspection, the prison had about 70% of its prisoner population on the highest level of the scheme and less than 5% on the basic level. The policy had been reviewed recently, however sanctions for prisoners on the basic regime had become more punitive and there had been no improvements to ensure there was a distinction between the standard and enhanced levels. Managers had consulted the population, but no additional incentives had been added to the enhanced regime.

2.7 At our inspection, reviews were not being held on time for those on the basic level of the scheme and this remained the situation in most cases. The lack of oversight also meant prisoners with several warnings were not demoted on time. It was a concern that staff we spoke to were not aware of the entitlements of prisoners on the basic level and there was confusion about when prisoners could access a basic regime. The responses from staff were mixed across all wings, but they unanimously believed that the new policy delivered less time out of cell for those on the basic level than before.

2.8 Prisoners we spoke to were unsure about how long they would be on the basic level and said their regime varied from one day to the next, depending on which staff were on duty. No prison records were held to document prisoners being unlocked, how long they were out of their cells, or if they had been given the opportunity to have a shower, make a phone call or spend time with other prisoners during association. Prisoners we spoke to remained unsure about how they could appeal against decisions to downgrade them and there was no evidence in prison records of staff informing them about how to do so.

2.9 We considered that the prison had made no meaningful progress against this recommendation.

Safeguarding

Key concern: Not all recommendations from the Prisons and Probation Ombudsman following deaths in custody had been implemented.

Recommendation: The governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including communication of the correct medical code and calling an ambulance immediately. (S47)

2.10 Prison managers had worked very hard to address this recommendation. Notices had been distributed to remind staff of this responsibility and were being reissued at regular intervals. Staff had been given pocket guides to advise them of the correct code to call and inform them of their obligation to call an emergency code without delay if they had a concern. Most staff we spoke to were aware of what to do in the event of a medical emergency.

2.11 The prison control rooms had started keeping records of when the emergency codes were called, what time an ambulance was requested and what time it arrived at the establishment. They also captured records of when the ambulance was cancelled and had management checks in place to ensure that this was only ever initiated by a medical professional.

2.12 The control room operators on both sites were largely aware of their obligation to call an ambulance when an emergency code was called and the governor took action to address a misunderstanding on the Parkhurst site when inspectors raised it with him.

2.13 We considered that the prison had made good progress against this recommendation.

Living conditions

Key concern: About 200 prisoners were sharing in cells that were designed for one prisoner. Most of these cells had toilets which were poorly screened.

Recommendation: Single cells should only be used to accommodate one prisoner. (S48)

2.14 Since the inspection, the operational capacity of the prison had been reduced, however at the time of our visit, there were about 160 prisoners sharing cells designed for one.

2.15 Curtains had been provided for the overcrowded cells on the Parkhurst site, although in house block 18, the proximity of the toilet to the beds meant that this arrangement did not provide prisoners with privacy or decent conditions.

2.16 We considered that the prison had made no meaningful progress against this recommendation.

Key concern: Night sanitation was in place for most prisoners on the Albany site. This system was unsatisfactory and it had broken down in the past. Prisoners on these wings had a chemical toilet in their cells, but we found that many lacked access to the chemicals that would make them function properly.

Recommendation: All prisoners should have effectively screened in-cell toilets. (S49)

2.17 The night-sanitation system on the main Albany unit allowed one prisoner on each wing out of their cell for seven minutes at a time to use the toilet. Prisoners who needed to use the toilet overnight joined an electronic queue to be unlocked. A maximum of eight prisoners could join the queue, which meant a potential wait of 56 minutes. Control room staff told us it was not unusual for there to be eight people waiting, which meant no one else could join the queue. The waiting time for these prisoners could be more than an hour.

2.18 Many prisoners, particularly those with reduced mobility, told us they had difficulty using the system within the allotted time. Those failing to return to their cell within seven minutes were unable to use the system for the rest of the night and had to ask the control room to be allowed out to the toilet. We spoke to one prisoner who used a walking stick, who told us he had recently been locked out of the system because he had returned late and had been unable to arrange permission to access the toilet for the rest of the night. He had wet himself in his cell.

2.19 Due to these restrictions many prisoners chose not to use the system and instead used a bucket, which could subsequently be emptied during morning domestic time.

2.20 Prisoners were offered the option of a 'portaloo', and a small number had accepted them, although these were not chemical toilets, and the contents had to be emptied in the same way as the buckets.

2.21 There was little space in the cells for the portaloos or buckets, and most of those we saw were beside prisoners' beds. Some of the buckets were stained and smelt, and there were no hand-washing facilities in the cells. The prison had recently begun to trial the use of a simple cloth and Velcro strip that could be fixed to the cell observation panel so that those using a bucket or portaloo had some privacy.

2.22 The prison had not used information about the system to assess whether the arrangements met the needs of the population. However, a survey of prisoners' views of the arrangements had been carried out during the inspection.

2.23 We considered that the prison had made no meaningful progress against this recommendation.

Prisoner consultation, applications and redress

Key concern: Systems for application and redress were poorly managed and most prisoner applications were responded to late. This resulted in too many complaints made following unanswered applications. Many complaints were also responded to late resulting in understandable frustration among prisoners.

Recommendation: Systems for application and redress should be managed effectively to ensure that prisoners receive a timely response. (S50)

2.24 There had been a sustained focus on improving the application and redress systems since the inspection, which had resulted in a significant reduction in the number of applications and complaints that received a delayed response.

2.25 The systems for applications and redress had not been changed, although the target time for responding to applications had been increased from three to five days. This was specifically to allow those areas that usually operated within traditional business hours enough time to respond to applications submitted over the weekend.

2.26 There had been a notable and sustained increase in management oversight. The prison had a sophisticated database that provided an overview of applications yet to be resolved, along with the target date. Details of those that were overdue were shared every day with managers, and, during our visit, there were only 12 that had not been dealt with on time.

2.27 Details of complaints approaching the target date for resolution were forwarded to the member of staff assigned to investigate the matter, as well as the relevant manager. As a result, in the six months before the visit very few complaints were resolved after the due date, with the most overdue being seven days. During the inspection, we saw complaint responses that were late by three weeks and more.

2.28 We considered that the prison had made good progress against this recommendation.

Social care

Key concern: Despite efforts by the prison and health care, strategic links with the Isle of Wight Council were underdeveloped. No memorandum of understanding was in place to support the delivery or development of services and to ensure that the social care needs of prisoners were met.

Recommendation: A memorandum of understanding should be formally agreed between the social care provider, the prison and the local authority, to ensure that social care needs are consistently met. (S51)

2.29 A memorandum of understanding between Isle of Wight Council and the prison was now in place and supported the implementation of social care provision at the prison. The head of equality had clear oversight of the social care process and integrated working. There were now four disability liaison officers (DLOs) working across both sites who had time dedicated to implementing the action required to improve social care. The DLOs had all undertaken a trusted assessor's qualification, which allowed them to undertake initial assessments of prisoners' needs, which expedited the process. The assessment reduced the number of referrals to the council that were below the threshold for social care and enabled prisoners to access some equipment more promptly.

2.30 A prisoner buddy scheme was in place, where 19 prison buddies, supervised by the DLOs, provided non-intimate care for 74 prisoners. Buddies had a clear understanding of their role, and tasks were organised on a rota system. However, there was a need for some additional formal training for the buddies, but most had evidence of training in areas such as first aid, and biological cleaning certificates to enable them to undertake their role.

2.31 The registered care provider Care First, commissioned by the local authority, delivered care packages to six prisoners during our visit. Each prisoner had a comprehensive care plan and notes were recorded. Carers attended the prison up to four times a day across both sites, and prisoners were complimentary about the care they received.

2.32 There remained some delays in social worker assessments that fell outside the agreed 28 days for assessments to take place and the final reports for these prisoners often arrived weeks later, with the total process sometimes taking months. There was evidence that Care UK, although not responsible for social care, ensured that those with obvious unmet needs received care until the local authority provided support.

2.33 We considered that the prison had made good progress against this recommendation.

Mental health care

Key concern: None of the nine patients transferred to hospital under the Mental Health Act in the six months to the end of March 2019 had been transferred within the guideline of 14 days and some had waited several months.

Recommendation: Patients requiring hospital admission under the Mental Health Act should be assessed and transferred expeditiously within the current transfer guidelines. (S52)

2.34 Timescales for transferring prisoners under the Mental Health Act continued to be too long. Two patients from our last visit were still awaiting a transfer, one of whom had been waiting 15 months. There had been three transfers under the Mental Health Act since our last inspection, all of which breached the transfer guidelines by several weeks.

2.35 Care UK, the health provider had recently published national guidance on the late transfer of patients under the Mental Health Act and sent weekly updates of patients whose cases had breached the national transfer target to its health and justice commissioners.

2.36 We considered that the prison had made no meaningful progress against this recommendation.

Reducing risk, rehabilitation and progression

Key concern: The levels of regular, meaningful contact between offender supervisors and prisoners was low and largely reactive. About a third of prisoners did not have an up-to-date OASys assessment which undermined the ability to provide these prisoners with the appropriate interventions to reduce their risk.

Recommendation: Prisoners should have regular face-to-face contact with an offender supervisor and an up-to-date OASys assessment to help them address their offending behaviour and to ensure that their progression is monitored effectively. (S57)

2.37 At the time of our review, the offender management unit (OMU) was in the middle of a significant transition as managers implemented the offender management in custody (OMiC) process.[5]

2.38 Under this new model, it was positive that prison offender managers (POMs) within the OMU were co-located in a way that allowed them to provide informal support to one another and share knowledge within the team.

2.39 Each POM now held a caseload of approximately 65 prisoners, a reduction since our inspection. In addition, there were improvements in managerial oversight of contact between prisoners and POMs. Despite this, not all prisoners received regular face-to-face contact with their POM. Where contact was achieved, it remained mostly reactive and was based on processes rather than motivational or sentence progression work.

2.40 Managers had recently implemented processes to improve their oversight of outstanding offender assessment system (OASys) documents and subsequent reviews. It was promising that fewer prisoners were now without an initial assessment of their risks and needs – 10% of the population compared to 16% at our inspection. However, 43% of prisoners had not received a review of their OASys document within the last year, more than double the number compared with our inspection.

2.41 Initiatives such as POM drop-in sessions on the house blocks had the potential to work well. However, prisoners were not sure of the purpose of these sessions and the service had not yet been implemented consistently across the prison. POMs' attendance at segregation reviews also had the potential to work well; however, it was disappointing that attendance varied.

2.42 We considered that the prison had made insufficient progress against this recommendation.

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[5] Following a review of offender management in 2015, HMPPS began to introduce a new offender management model from 2017. The new model is being implemented in stages, starting with new prison officer key workers. The second phase, core offender management, and the introduction of prison offender managers is being introduced gradually, from 2019.

Key concern: Prison offender supervisors were not adequately trained or supervised to work as offender supervisors or with prisoners convicted of sexual offences. This affected their ability to deliver sufficient one-to-one interventions and progress prisoners through their sentence plan.

Recommendation: Prison offender supervisors should receive specific training in working as offender supervisors with sex offenders and receive regular professional supervision. (S58)

2.43 Since our inspection, most POMs had completed a workbook on working with prisoners who commit sexual offences. Those who had completed it found it helpful for their practice. However, during our review, no refresher sessions were planned to revisit lessons learned and establish ongoing training needs for POMs in this area, for example working with prisoners who were maintaining their innocence.

2.44 Due to the mostly reactive nature of POM contact with prisoners on their caseload, there was little evidence on P-Nomis (a database used in prisons for the management of offenders) of POMs undertaking any focused one-to-one work with prisoners to help them progress through targets set in their sentence plan.

2.45 Although at the time of our visit, POMs did not receive professional supervision, there were plans in place for this to start imminently. The senior probation officer had scheduled nine supervision sessions per year with each POM. The sessions were detailed to include observations of practice as well as reflective learning and training. POMs stated that this would enable them to better structure their work.

2.46 We considered that the prison had made reasonable progress against this recommendation.

Interventions

Key concern: The prison was ill suited to meeting the needs of the remand population. Accommodation was poor, access to legal help and advice was underdeveloped and preparation for release was inadequate.

Recommendation: Remand prisoners should be held in an establishment that can meet their needs. (S59)

2.47 Remanded prisoners continued to be held at HMP Isle of Wight. At the time of our review, 11 prisoners were held in the designated remand unit in the prison. The regime there was limited; most prisoners spent all their time in one unit. Some prisoners were held on remand for extended periods of time.

2.48 In addition, prisoners remanded for sexual offences were not located in the designated remand unit, which further complicated access to the limited remand-specific services that were available.

2.49 Some attempts had been made to improve the physical conditions in the remand unit, for example, by introducing wall murals and improving the floor in some cells.

2.50 Resettlement provision and advice for prisoners on remand who were released from HMP Isle of Wight remained poor. Nine prisoners (31%) held on remand had been released since our inspection. Five went home, two to hostels and two were homeless. Due to the lack of provision for this population, release planning support was unable to meet prisoners' needs.

2.51 Although remanded prisoners now had better access to legal help, the prison did not enable them to exercise their right to vote in the 2019 election and none did so.

2.52 It remained the case that, overall, remand prisoners had little access to education or other purposeful activity.

2.53 We considered that the prison had made no meaningful progress against this recommendation.

Section 3. Appendix

Review team

Peter Clarke	Chief Inspector
Angus Mulready-Jones	Team leader
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Esra Sari	Inspector
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