



**REPORT ON  
A FULL ANNOUNCED  
INSPECTION**

**OF**

**HM PRISON WEALSTUN**

**27-31 OCTOBER 2003**

**BY**

**HM CHIEF INSPECTOR OF PRISONS**

Crown copyright 2003  
ISBN 1 84473 159 6  
Printed and published by:  
Her Majesty's Inspectorate of Prisons  
1st Floor, Ashley House  
Monck Street  
London SW1P 2BQ  
England

## INTRODUCTION

HMP Wealstun is a large and complex establishment: half of it is a category C training prison and the other half a category D open prison. At the time of the inspection, it held around 600 prisoners, but this was set to increase to 950, when all wings were operative and new units completed.

Unlike some other training prisons we have inspected recently, Wealstun offered employment or education to nearly all its prisoners. It was genuinely a working prison and it is to be commended on that. However, much of the work did not lead to qualifications and some was not suitable to the prison's changed population, as it absorbed the effects of the population pressure in the prison system.

Like other low security and open prisons, Wealstun was feeling the effects of this pressure. It was receiving different and more difficult prisoners: arriving earlier in sentence, some without having undertaken essential preliminary work, and some unsuitable for the low secure conditions. In order to accommodate even more of them, much of the prison was a building site, placing additional strains on security and staffing.

But Wealstun also had pressures of its own. It was still feeling the aftershock of a serious disturbance four months ago on the closed side, which had resulted in the loss of one unit, still under repair. As a consequence, the previously relaxed regime had been considerably tightened: with greater security during movements, and a great deal less association and time out of cell for prisoners. Staff were understandably anxious about preserving control and stability; but prisoners were understandably frustrated with a regime that was considerably more restrictive than in other category C prisons. It is to the credit of staff and managers that staff-prisoner relationships remained reasonably good, and indeed in some places excellent. The task now is to support staff to gradually relax controls, engage fully with prisoners and regain the dynamic security that is necessary to run a training prison, particularly as it is about to double in size.

We had even more serious concerns about the open side of the prison. Over half the prisoners, including those new to the establishment, lived in wholly unacceptable conditions: in dormitories which lacked fire and smoke alarms, were open to vermin infestation, and in a state of disrepair, with broken windows, damp and mould, in spite of some pre-inspection cosmetic repairs. These dormitories were due to be demolished when new units were built, but they should not have been in use at all. They were unfit for habitation.

Added to this was the fact that we found staff on the open side were sometimes not present at all – for example during evening association or at night – and when present had little active engagement with prisoners, except for lifers. As a result, a more difficult and short-term population was being managed without any effective dynamic or physical security. Although all prisoners had theoretically signed up to be drug-free, 95% of them told us that drugs were freely available: and indeed some dormitory doors had notices saying ‘no salesmen’ in order to discourage dealers. Finally, opportunities for working out were too few, and those that existed were restricted to prisoners living within fifty miles of the prison, on the grounds that they might be able to retain those jobs on release. Some prisoners were, however, released on license to undertake offending behaviour programmes outside the prison.

In order to create an effective open prison at Wealstun, it will not be enough to replace the unsafe and insanitary dormitories. Staff, from governors downward, will need to engage actively with prisoners. And all suitable prisoners should have opportunities for the paid work that will make their resettlement easier. Prisoners should not be penalised because it is impossible for the Prison Service to hold them close to home.

Wealstun shows the effects of population pressure on a previously stable and settled prison. That is a message that needs to be heard and understood at every level, as more and more prisoners, earlier in sentence, are decanted into low security and open prisons. And there can be no excuse, whatever the pressure, for holding prisoners in conditions which breach basic health and safety requirements. But there is also a task for local managers. Wealstun will inevitably be a more difficult and less settled

prison than it was: with an increased population of more short-term and volatile prisoners. This will require active management and staff engagement, on both sides of the prison, if it is to provide a stable and secure environment where prisoners have the opportunities they need to reduce re-offending.

**Anne Owers**

**HM Chief Inspector of Prisons**

**December 2003**



# CONTENTS

	Paragraph	Page
<b>INTRODUCTION</b>		3
<b>FACT PAGE</b>		11
<b>HEALTHY PRISON SUMMARY</b>	HP.01-HP.50	13
<b>1 ARRIVAL IN CUSTODY</b>		25
Reception	1.01-1.05	
First night	1.06-1.08	
Induction	1.09-1.11	
Conclusion and recommendations	1.12-1.17	
Legal rights	1.18-1.20	
<b>2 RESIDENTIAL UNITS</b>		31
Accommodation and facilities	2.01-2.18	
Clothing and possessions	2.19-2.26	
<b>3 DUTY OF CARE</b>		37
Anti-bullying	3.01-3.11	
Preventing self-harm and suicide	3.12-3.25	
Race relations	3.26-3.46	
Foreign national prisoners	3.47-3.57	
Substance use	3.58-3.70	
Maintaining contact with family and friends	3.71-3.91	
Applications, requests and complaints	3.92-3.101	
<b>4 HEALTHCARE</b>		61
Introduction	4.01	
Environment	4.02-4.05	
Records	4.06-4.07	
Staffing	4.08-4.11	

Delivery of care	4.12-4.32	
Mental healthcare	4.33	
Conclusion and recommendations	4.34-4.56	
<b>5 ACTIVITIES</b>		<b>71</b>
Employment	5.01-5.11	
Education and work skills training	5.12-5.41	
Library	5.42-5.49	
Physical education	5.50-5.60	
Faith and religious activity	5.61-5.68	
Time out of cell	5.69-5.80	
<b>6 GOOD ORDER</b>		<b>87</b>
Security and rules of the establishment	6.01-6.09	
Prisoner disciplinary procedures	6.10-6.17	
Use of force	6.18-6.27	
Segregation unit	6.28-6.45	
Vulnerable prisoners	6.46-6.50	
Incentives and earned privileges	6.51-6.66	
Categorisation	6.67-6.72	
<b>7 RESETTLEMENT</b>		<b>103</b>
Management of resettlement	7.01-7.05	
Re-integration planning	7.06-7.25	
Sentence planning	7.26-7.33	
Offending behaviour work	7.34-7.41	
Public protection	7.42-7.50	
Life sentenced prisoners	7.51-7.56	
Key workers (personal officers)	7.57-7.66	
<b>8 SERVICES</b>		<b>121</b>
Catering	8.01-8.10	
Prison shop	8.11-8.20	



## **9 RECOMMENDATIONS AND GOOD PRACTICE**

127

<i>Recommendations</i>	9.01-9.103
<i>Housekeeping points</i>	9.104-9.135
<i>Examples of good practice</i>	9.136-9.143

### **APPENDICES**

<b>I</b>	Inspection team	i
<b>II</b>	Prisoner population profile	ii
<b>III</b>	Summary of prisoner questionnaires - closed side	iv
<b>IV</b>	Summary of prisoner questionnaires - open side	xxii



## **FACT PAGE**

### **Role of the establishment**

HMP Wealstun is a prison with a site split between a category C training prison and category D training/resettlement. It receives prisoners predominantly prisoners from West Yorkshire and County Durham.

### **Area organisation**

Yorkshire and Humberside.

### **Number held**

At 27 October 2003: 603.

### **Certified normal accommodation**

663.

### **Operational capacity**

712.

### **Last inspection**

14-18 July 1997.

### **Brief history**

HMP Wealstun opened on 1 April 1995 following an amalgamation of HMPs Thorp Arch and Rudgate, creating a category C (closed) side and a category D (open) side within one establishment. Wealstun's whole-establishment approach aims to enable the progressive transfer of suitable prisoners from the closed to the open side. In March 1996 a new wing was completed on the closed side, increasing the operational capacity by 120 to 573. In 1998, E and F wings were constructed on the open side, providing 100 single rooms as the first stage in the replacement of the old dormitory accommodation. In 2002 two ready-to-use units, K and L wings, were erected on the open side, providing 80 additional places.

### **Description of residential units**

- A – Closed category C mixed, standard and enhanced status prisoners (voluntary testing unit/drug treatment).
- B – Closed category C mixed, standard and basic status prisoners (induction and first night).
- C – Closed category C mixed, standard and enhanced status prisoners .
- D – Closed category C enhanced status prisoners (voluntary testing unit).
- E – Open category D (largely resettlement and long-term population, single rooms).
- F – Open category D (single rooms).
- K – Open category D (modular unit, single rooms).
- L – Open category D (modular unit, single rooms).
- N – Open category D (dormitory accommodation, induction).
- S – Open category' D (dormitory accommodation, induction).

# HEALTHY PRISON SUMMARY

## Introduction

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

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

HP.02 HMP Wealstun is split between a closed Category C training prison and an open Category D prison; though it is managed as a whole prison. There had been considerable expansion at HMP Wealstun since the last inspection in 1997. On the open side two ready-to-use units had been erected, accommodating an additional 80 prisoners, and on the closed side an additional accommodation block housed 120 prisoners. At the time of this inspection further expansion was under way: two new wings on the open side were nearing completion, and the old dormitory accommodation was due to be vacated and demolished when these were ready. There were plans for two further wings to be constructed on the side of the demolished dormitories. An 180-place cellblock was also under construction on the closed side, and numerous ancillary projects were either under way or planned and funded. The certified normal accommodation of the prison would rise from 712 to 952 by the end of the expansion programme.

HP.03 In June 2003 there had been a serious incident of concerted indiscipline. As a result C wing, on the closed side, was out of use and undergoing repairs and refurbishment. The incident itself had made a considerable impact on the establishment and, in particular, controls on prisoners' movements had been strengthened significantly.

HP.04 In common with most category C and open prisons, Wealstun had suffered the effects of population pressures and had begun to receive more criminally sophisticated and custodially experienced offenders, earlier in sentence.

## **Safety**

HP.05 Wealstun provided a reasonably safe environment for both staff and prisoners, although the degree of safety varied according to location. It was to the credit of management and staff that this level of safety had been maintained during the widespread construction activity, and with a more demanding and volatile prisoner population than previously. Potential threats to safety were manifest, and some improvement in systems and development of dynamic security was necessary to ensure stability and safety.

HP.06 The reception process was well managed by a friendly and respectful staff team who provided helpful information and assistance in a clean and organised environment. There was careful management and separation of reception and discharge procedures for category C and category D prisoners, and the necessary searches were conducted sensitively. Selected prisoners were used to provide peer support and information for new arrivals.

HP.07 On both the open and the closed side, new receptions were initially accommodated in the least desirable units, those without in-cell electricity. A telephone call was provided for new prisoners, but there were no first night arrangements on the closed side and those on the open side were insufficient. On the closed side the supportiveness of staff went some way to offset this omission.

HP.08 The dormitories on the open side were without adequate alarm systems and prisoners had serious difficulty in locating staff, especially at night. These arrangements were intrinsically unsafe and the accommodation itself was unfit for habitation.

HP.09 Prisoners arriving on either side received an induction: a formalised four-day induction programme was delivered on the closed side, and there was a less formal, but equally effective, 1.5-day programme on the open side. Information provided was

good, and was well supported by attractively presented induction leaflets. The programme on the closed side began every Monday and was not able to accommodate new arrivals on a rolling basis. Some prisoners were, therefore, locked in their cells for most of the day for up to four working days.

HP.10 A revised anti-bullying scheme had been introduced in July 2003. It was very well publicised and was well understood by both staff and prisoners. There was a process for identification of bullying, and appropriate documentation was completed properly. The anti-bullying committee minutes did not, however, indicate that it had been active in driving forward the development of the scheme, or in checking quality, monitoring trends or identifying gaps in practical implementation.

HP.11 Searching targets were being met, but searching staff admitted that they were sometimes pre-occupied with the number of cell searches to be completed, to the detriment of their quality. Where security information reports warranted a targeted search, these were always completed. Although the percentage of positive mandatory drugs tests was just under the target figure of 20%, this target was unacceptably high. Prisoners acknowledged that there was a considerable amount of drugs in the prison and, in the prisoners' survey, 95% of respondents on the open side and 64% on the closed side said that it was easy or very easy to get drugs in Wealstun.

HP.12 The segregation unit was clean and well managed, and relationships were good, but prisoners could shower only three times per week. All prisoners received into the unit were strip searched and all cells were fitted with cardboard furniture, without any risk assessments being carried out. Daily entries in wing files were not always made, and documentation relating to use of the unfurnished room was not always fully completed. We observed the removal of a prisoner from normal location to the segregation unit; this was carried out professionally and with proper regard for the care of the prisoner.

HP.13 A new incentives and earned privileges (IEP) policy had been introduced a month before the inspection, but was not fully operational on the closed side. On the open side it had not been implemented at all, and decisions about privilege levels were made with very little supporting information. On both sides there was little

differential between standard and enhanced levels, and prisoners were more concerned about which wing they were on than their privilege level.

HP.14 There was a comprehensive suicide and self-harm policy, and the safer prisons suicide prevention management team minutes showed that trends were monitored and issues identified for action. Notices advising prisoners of available support were clearly displayed throughout the establishment, and monitoring of prisoners on self-harm measures, F2052SH, was thorough. Listeners were available on both sides of the prison, and there was good support from the Samaritans.

### **Respect**

HP.15 Although Wealstun was not an overtly disrespectful establishment, the level of respect shown to prisoners, both in their living conditions and their relationships with staff, was variable. Prisoners living on the open side were less well served in both regards than those on the closed side.

HP.16 On the open side, the old dormitory accommodation, which all new receptions occupied, was unsuitable for habitation. The fabric of the building was poor, with ill-fitting or broken windows, and showers and toilets were dirty. Rats were seen frequently around the building and, anecdotally, inside it. There were no fire, smoke or general alarms in the dormitory accommodation. On the closed side the accommodation was generally clean, if well worn. There was no in-cell electricity supply to most cells on B wing. There were good laundry facilities on both sides, and the clothing issued was satisfactory, but prisoners did not have access to coats or rainwear, even in inclement conditions.

HP.17 The personal officer system was operating, but with variable levels of contact on the closed side. Wing staff knew the prisoners on their wings and there was some positive interaction, particularly on D wing. On the open side, the personal officer scheme was completely ineffective, and there was very little interaction of any kind between staff and prisoners. There were few entries in wing files, and prisoners often experienced difficulties in even finding a member of staff.



HP.18 General applications were not always recorded before they were passed on for response, and there was no system to monitor or record replies. Prisoners had no confidence that they would receive replies to their applications. Complaints forms were removed from the boxes and sifted by wing senior officers, to identify and deal with those complaints that could be resolved at wing level. Prisoners were aware of this process and perceived it as a means of preventing their complaints from getting to senior managers. Those complaints that were logged and answered by senior managers were polite and helpful. Although there was a prisoner representative forum, which could have been used to resolve some of these issues, it was seen to lack decision-making power and consequent action. On the open side, in particular, it was seldom attended by a governor grade.

HP.19 There was a good induction programme for kitchen workers. While the processing of food was not unhygienic, areas of the kitchen had not been adequately cleaned. The quality of food was good, as were the size of the portions, and few prisoners complained about the meals. On the open side prisoners waited in a long queue outside the dining room to collect their meals and, as there was no pre-select menu, those at the end of the queue received little choice of food.

HP.20 The visitors' centre was appreciated by prisoners' families, but was too small to serve the needs of both sides of the prison. Its opening times did not coincide with the arrival schedule for public transport, and so visitors had to wait outside until it opened. Prisoners' visitors were treated in a friendly and respectful way by staff, and the visiting rooms were reasonably comfortable, if in need of some redecoration. There were supervised crèche facilities and refreshment bars on both sides. Prisoners in the segregation unit or on the basic privilege level did not receive their statutory visiting entitlement, being restricted to half-hour visits. Many prisoners complained that they had difficulty in getting to use telephones, and that the times available for domestic calls were unduly restrictive.

HP.21 A combined equal opportunities, race relations and diversity committee met quarterly. Comprehensive ethnic monitoring statistics were kept, but they were presented in a way that made it difficult to identify any emerging trends immediately. Racial incident report forms were investigated satisfactorily, although minority ethnic

prisoners expressed little faith that their complaints were taken seriously. There was no formalised provision for foreign national prisoners.

HP.22 Prisoners' healthcare needs were met by a part-time general practitioner service, but prisoners on both sides complained about the treatment they received from the doctor. By contrast, the nurses were seen to be professional and caring. There was minimal mental healthcare provision and no nurse-led clinics for chronic diseases, even though it would have been possible to provide some within existing resources.

### **Activity**

HP.23 The prison operated a policy of full employment, which was understood and accepted by prisoners. Much of the employment available did not lead to qualifications, and the range of activities was not tailored to the needs of the changed population, although there were plans to address both of these issues.

HP.24 The published core day was adhered to, so that time out of cell, association and exercise were consistent and predictable. On the closed side, association had been reduced since the riot in June 2003, and was only available on alternate days - much less than would be expected in a category C Prison. In the week prior to the inspection the prison had begun unlocking some non-associating prisoners so that they could shower or make a telephone call. This remained restrictive, and did not allow these prisoners a shower every day.

HP.25 Allocation to employment was well structured and ensured that all prisoners had employment. Ample employment was available on the closed side, with a reduced number of prisoners, but on the open side it was sometimes necessary to over-subscribe workplaces.

HP.26 There was an extensive range of work on both sides and, although some of it was repetitive and mundane, other work offered opportunities to gain employment skills. The workshops were adequately resourced and provided safe environments, with protective equipment available as necessary.

HP.27 There was also a good range of skills training but, again, there was little accreditation that would be recognised by employers. Where accreditation was taking place it was well planned. Standards of achievement in both industrial cleaning and catering training were very high. The construction industry training was well resourced and effective, and there was some excellent community project work, which benefited both the prisoners and community groups. Conditions for the forklift truck training were poor, as broken pallets and overhanging loads constituted potential hazards.

HP.28 There were few prisoners in education, although some outreach education was provided to the workshops. Little use was made of part-time education, and prisoners were not keen to undertake full-time basic skills courses, with the added disincentive of wages lower than in the workshops. Those prisoners who were in education were well motivated, and professional, respectful relationships were in evidence.

HP.29 The libraries on both sides were located in small, unsuitable buildings, and there was little integration between the libraries and the education department. Statutory texts, legal reference books and some foreign language books were available. On the open side the library had been used imaginatively to provide attractive displays of leaflets, application forms and health promotion material.

HP.30 The physical education department provided good teaching and training, and achievements on courses were high. On the open side activities were restricted by the limited facility and the recreational emphasis was on weight training, which did not meet the needs of many of the prisoners. The PE department worked in conjunction with other departments and outside agencies to provide smoking cessation support and auricular acupuncture, and to support the drug rehabilitation programme.

HP.31 Ministers were available for all the main faiths. On the closed side the chapel was inadequately heated during the refurbishment of C wing, and this discouraged attendance. The multi-faith room was very small and accessible only through the chapel, which was disrespectful to other faiths wishing to use it. The chaplaincy provided a wide range of evening classes, although since the riot these had been

suspended on the closed side because of restrictions on outside movements during the evening. Prisoners did, however, move outside to the gym in the evenings.

### **Resettlement**

HP.32 Resettlement was regarded as a priority by the prison, and significant resources had been devoted to it, but this area was not co-ordinated to meet individual prisoners' needs in a manner that was timely or facilitated movement through the system.

HP.33 There was an efficient system for recategorisation reviews. Prisoners were given dates for the reviews, which were multi-disciplinary and provided written or verbal feedback on the outcomes. However, recategorisation to open conditions was not seen as a progressive move for prisoners at Wealstun because of the poor living conditions on the open side.

HP.34 Parole, release on temporary licence (ROTL) and home detention curfew (HDC) were all well administered and the quality of documentation was good. The rate of ROTLs on the closed side was very low. This may have been partly, but not totally, explained by the recategorisation to open conditions of those who became eligible for ROTL. Some prisoners, particularly on the open side, arrived within days of their HDC eligibility date, and were fast-tracked through the system so that they were released on time, wherever possible.

HP.35 Prisoners' needs for advice in relation to debts, benefits and housing were identified on induction, but the responsibility to seek help was then left with the prisoner. Agencies, including SOVA (a charity working on offender rehabilitation), were available to provide advice and support, provided that prisoners approached them. Some prisoners were being discharged with unresolved problems, including a few without accommodation. On the open side, twenty prisoners with home areas in Yorkshire and Humberside were working out in paid employment, with the aim to retain that employment after release. Other prisoners whose homes were further away could not access paid employment because they would not be able to continue it after release.

HP.36 Dedicated sentence planning officers were sometimes redeployed to other duties, with the result that some sentence plans were not up-to-date. Plans were not always sufficiently tailored to individual needs, and the targets set were not always achievable. Targets often included completion of offending behaviour programmes, but there were long waiting lists both for the accredited reasoning and rehabilitation (R&R) programme and the range on non-accredited courses on offer. Links had been forged with Yorkshire probation areas to enable some prisoners to attend accredited programmes in the community, and there were plans to develop this further.

HP.37 There was a good policy document to support public protection cases, together with a system to identify prisoners posing a potential risk to the public. The prison was represented at the local multi-agency public protection panel (MAPP).

HP.38 There was little specific provision for life sentenced prisoners, all of whom were on the open side of the prison. There was, however, good personal officer support for this group. Some life sentenced prisoners had been received with outstanding offending behaviour issues which had not been addressed at sending establishments; this created considerable difficulties at Wealstun, where there was no provision to meet these needs.

HP.39 All of the prisoners on the open side, and most on the closed side, had signed a voluntary drug testing compact. Tests were on target, but the system allowed prisoners to present themselves for testing at any time during the identified day, and a significant proportion of samples showed evidence of dilution. The CARAT (counselling, assessment, referral, advice and throughcare) team provided initial assessments, some individual work and a three-day drug awareness course, and ADAPT (Alcohol and Drug Addiction Prevention and Treatment) ran an eight-week rehabilitation programme. In a prison with a high incidence of drug use, these programmes could only be provided for a small proportion of prisoners, and there was no effective provision for those who were ineligible or unsuitable for the ADAPT programme.

## **Conclusion**

HP.40 Wealstun provided a mainly safe and respectful environment, although the standard of some of the accommodation on the open side was neither safe nor respectful. The quality of relationships between prisoners and staff varied considerably: there was some positive interaction on the closed side, but negligible contact, and therefore little positive work or dynamic security, on the open side. The recent disturbance had resulted in increased constraints on prisoner movements and activities, and the influx of more challenging prisoners on both sides had, to some extent, destabilised the regime. There was full employment of prisoners, although this did not focus sufficiently on the acquisition of employment skills. The resettlement strategy was well resourced, but was not always directed at meeting the individual needs of the current population.

## **Main recommendations**

**HP.41 The North and South dormitory units should be taken out of commission immediately.**

**HP.42 All cells in B wing should be equipped with in-cell electricity.**

**HP.43 The induction programme should run on a rolling programme so that all prisoners can join it on the day following reception.**

**HP.44 The target for positive mandatory drug testing should be reduced, and there should be a review to identify methods of reducing the supply of drugs into the establishment.**

**HP.45 The new incentives and earned privileges scheme should be fully implemented on both sides of the prison.**

**HP.46 Staff on the open side of the prison should be deployed to maximise their interaction with prisoners.**

**HP.47 Observations and notes of contact between staff and prisoners should be made in wing files and be monitored by managers.**

**HP.48 The restrictions on prisoner movement, association and activities, imposed following the June 2003 riot, should be regularly reviewed and gradually relaxed as soon as it is safe to do so.**

**HP.49 Work and training should, wherever possible, lead to qualifications recognised by outside employers.**

**HP.50 The resettlement provision should be based on a needs analysis of the population; it should offer all eligible prisoners opportunities to work outside the prison.**





# CHAPTER ONE

## ARRIVAL IN CUSTODY

### Reception, first night and induction

#### Expected outcomes

The expected outcomes for arrival in custody procedures (reception, first night and induction) are:

- **Safety:** Everything reasonable is done to help prisoners feel safe on their reception into prison; prisoners' needs are identified, including physical and mental healthcare, in order that they may be cared for and supported by competent trained staff
- **Respect:** The way in which entry procedures are conducted and the approach of competent staff preserves the personal identity of prisoners, respects their privacy and dignity and is responsive to their individual needs
- **Respect:** Prisoners are made aware of prison routines, how to access available services and cope with imprisonment
- **Purposeful activity:** Prisoners are constructively occupied during their first days in prison, preferably as part of a comprehensive induction programme
- **Resettlement and reducing re-offending:** Prisoners' welfare needs are identified and appropriate help offered to deal with them

#### Reception

1.01 The reception department was in a single-storey building close to the main gate, and provided easy access for escorting vehicles. The facilities were clean, well ordered and displayed many informative notices, including information for non-English speakers. We observed the department during early morning routines to discharge prisoners, and at other times when receiving prisoners transferred from other prisons. One senior officer and three officers were regularly deployed to these duties. The staff were experienced and knowledgeable, displayed in their courteous and respectful treatment of prisoners. They paid particular attention to prisoners who were experiencing their first custodial sentence, for whom they were reassuring and

informative. In our prisoner survey, more than 60% of respondents on both sides said that they had been treated 'well' or 'very well' in reception.

1.02 Searches of prisoners were carried out sensitively in appropriate privacy, and with clear explanations of the process. Separate holding rooms were provided for category C and category D prisoners; these contained magazines and leaflets. When new prisoners for both closed and open sides arrived on one vehicle, reception staff managed the reception process carefully to ensure that the two categories did not mix. We found the escort vehicles to be in clean condition, and escort staff had a positive rapport with those in their charge. Many prisoners complained of discomfort during the journey, but most felt that escorting officers had catered well for their personal safety and well being.

1.03 Prisoner escort record (PERs) were carefully checked, and we observed good professional exchanges of information, both verbal and written, between prison staff and escort contractors. A member of nursing staff conducted preliminary health checks of all new arrivals in private during the reception process. Cell sharing risk assessments were completed on all category C prisoners, but not for those entering the open side.

1.04 Good use was made of orderlies who were trained as 'Insiders', who offered first-hand advice about the establishment; this appeared to add to the positive atmosphere of the department. Insiders also issued prison clothing and a range of leaflets giving local details, including one that focused on a prisoner's first 24 hours in the establishment. Arrangements for property storage in a locked room were managed efficiently, and there was an application system for prisoners to access or exchange property. A relatively large volume of property belonging to absconders was awaiting removal to a national store.

1.05 There were no shower facilities in the reception area, but all new arrivals could shower on arrival in B wing (closed) or the dormitory units N and S (open). The facilities for prisoners in this part of the open prison were wholly unacceptable (see paragraph 2.04). Prisoners were not able to use a telephone in reception, but they were told the arrangements to use a telephone on arrival in wings. A new PINphone

system had been introduced just before this inspection, and prisoners, including new arrivals, reported serious difficulty in accessing telephones.

### **First night**

1.06 Newly arrived prisoners were allocated to B wing (closed) or to the dormitory area (open). B Wing also housed prisoners on the basic level of the incentives and earned privileges (IEP) scheme, and we were told by B wing staff that cells here sometimes served as an extension of the segregation unit (though records indicated only one such use in a period of two years). Prisoners were not issued with pens routinely and were advised that these could be borrowed from the wing office.

1.07 The dormitories were unfit for habitation, and the toilet and shower provision in this area was a health hazard. While transfer to category D conditions was ostensibly a positive move for prisoners, new arrivals in Wealstun open, including some life sentenced prisoners, were shocked by what they found, and rightly questioned whether this was a progressive transfer.

1.08 There were no effective first night arrangements on either side. However, prisoners entering open conditions were usually seen on the day of arrival by a senior officer (resettlement) who explained routines and general arrangements. We observed one such session, which was dominated by prisoners' reactions to, and disbelief at, what they had found in the dormitory block. In our survey, a third of all new category D prisoners said they felt unsafe on their first night.

### **Induction – closed side**

1.09 The recently introduced induction programme commenced each Monday. A regular team of induction officers operated a rota to deliver basic information about the overall regime. A dedicated induction group room was available. Specific speakers from relevant departments supplemented the input of the designated induction officers.

1.10 Prisoners started the programme on the Monday following their arrival. In the meantime, their waiting period was largely inactive, as they could not start work until they had completed the preparation for work module of the induction programme

(which operated from Wednesday through to the following Tuesday). Only 19% of prisoners – those who arrived on a Friday – could start the programme without undue delay. In our survey, 64% of category C respondents said that the programme was sufficiently comprehensive, but some told us that they suffered 'information overload' in the first two days. We also learned that not all sessions were fully covered, despite the published programme.

### **Induction – open side**

1.11 Induction generally began on the day of the prisoner's arrival in the category D side with an interview with a senior officer. On the next day there were group and individual interviews with probation, education and drugs workers, and prisoners were allocated to work. An introduction to the gymnasium also included elements of emergency aid training and techniques for safe lifting in readiness for work or other physical activities. More than half the category D prisoners in our survey said the induction programme was inadequate for their needs.

### **Conclusion**

1.12 The reception and discharge of prisoners was managed efficiently by experienced staff who treated them with courtesy and respect. The effective use of trained orderlies added to the positive level of service in the department. First night accommodation in both closed and open sides was unsatisfactory, albeit for different reasons, and in each case tended to negate some of the benefits of a positive reception experience. The induction programme for category C prisoners was comprehensive and covered a range of important topics, including bullying, which was the only major issue not covered in the information leaflets issued at reception. The group room was well equipped and always available, and the detailing of trained and experienced staff was reliable. Many prisoners had to wait several days to start the programme (see recommendation HP.42). Recently transferred category D prisoners were preoccupied by the shock of unacceptably poor living conditions in the dormitories and associated facilities. This detracted from the benefits of the induction programme, which was in itself minimal, but adequate.

### **Recommendations**

1.13 **Prisoners should have ready and free access to telephones in reception.**

1.14 Newly arrived prisoners on the closed side should not be accommodated alongside those on the basic regime or held under segregated conditions.

1.15 Newly arrived prisoners on the open side should be accommodated in conditions of decency, which reflect the progressive nature of their transfer to a category D prison.

1.16 There should be specific first night accommodation and arrangements for both closed and open sides.

### Housekeeping point

1.17 The published induction programme should be followed to ensure that all prisoners receive full and essential information.

### Legal rights

#### Expected outcomes

The expected outcomes for legal rights procedures are:

- **Safety** Prisoners are safe from repercussions or recrimination in making any application, request or complaint
- **Respect:** Prisoners are told their rights of access to due process in relation to bail, legal aid, legal representation and appeals and can exercise those rights while in prison
- **Respect:** Unconvicted prisoners are treated as innocent, unsentenced as not having a custodial sentence, and both are given the same opportunities and activities as convicted or sentenced prisoners
- **Purposeful activity:** The regime provides reasonable opportunity to seek release on bail and prepare for trial
- **Resettlement and reducing re-offending:** The regime provides reasonable opportunity to preserve accommodation and employment and to pursue legitimate business and social interests

1.18 Two trained legal services officers were available on each side, and prisoners could see them by application on each wing. Detailed time was not always available. Most prisoners reported ready access to legal books. In our prisoner survey, the majority of category C respondents said it was easy to get help with legal matters, whereas only 24% of those in open conditions found the service good – almost half reported that help was difficult or very difficult to obtain. Prisoners to whom we spoke in the open side said that the legal service via staff was 'a joke'.

### **Conclusion**

1.19 Although we were told that the provision of legal services was equal across the two sides, prisoners in the closed sector reported a better service than those in open conditions.

### **Recommendation**

1.20 **The provision of legal services across the prison should be reviewed to ensure that an equitable service is available to all prisoners.**

## CHAPTER TWO

### RESIDENTIAL UNITS

#### **Expected outcomes**

The expected outcomes for accommodation and facilities, clothing and possessions, and hygiene are:

- **Safety:** Prisoners live in a safe and hygienic environment
- **Safety:** Prisoners are risk and needs assessed before being placed with other prisoners in shared cells
- **Respect:** Prisoners have their dignity and privacy of life respected while in prison
- **Respect:** Prisoners are encouraged, enabled and expected to maintain an acceptable level of personal hygiene in appropriate, decent residential accommodation
- **Purposeful activity:** Suitable space and facilities on residential units are available and used to permit association activities that meet prisoners' needs

#### **Accommodation and facilities**

2.01 Wealstun was split into two sides (open and closed), accommodating up to 332 category C and 380 category D prisoners.

2.02 A total of 352 category D prisoners were accommodated in the open side during our inspection. Of these, 174 were in old-style dormitory accommodation (North and South unit). These units consisted of four-person dormitories, communal bathing and toilet facilities, association rooms, a laundry, a prayer room, and office accommodation that served all of the open side.

2.03 Four further units (E, F, K and L wings) made up the remainder of the open prison, and housed prisoners in single rooms in modern accommodation. For administration purposes, prisoners housed on K and L wing used the North office and prisoners housed on E and F wing used the South office for general enquiries and applications.

2.04 Plans to demolish the old-style North and South dormitories were scheduled for spring 2004. However, this accommodation was totally unfit for habitation at the time of our inspection and had been for some considerable time. There was no alarm system in these units, basic repairs had been neglected, windows were smashed or missing, mould was evident in the toilet and shower areas, and the building was damp and totally neglected. In addition there was considerable evidence that the building was infested with rats.

2.05 The newer-type accommodation (E, F, K and L wings) was clean and airy, with adequate baths. However, some of these buildings also suffered from an inadequate alarm system, with no audible cell call systems on two wings and there was little evidence of staff presence. In particular, prisoners were justly concerned about how to contact staff in the case of an emergency during the evening or night period when offices were not routinely staffed.

2.06 Four wings (A-D) made up the accommodation on the closed side, although at the time of our inspection C wing was closed for refurbishment. Accommodation consisted of a majority of single cells, with a small number of double cells on A and B wing. D wing was all single cells and was reserved for enhanced prisoners. All cells had integral sanitation, but none had privacy screens. Both A and D wings had in-cell electricity, and there were plans to install it in B wing as part of an ongoing development programme.

2.07 Each wing had communal showers, toilets and baths, all of which were well cleaned and maintained. Colour-coded cleaning equipment was in use, but there was some evidence of cross-contamination.

2.08 Prisoners could shower at least every other night on A and B wing during association periods; they were not routinely offered the opportunity to take a shower each day.

2.09 Although there had been some effort to increase prisoners' time out of cell in the week prior to the inspection (by allowing one landing out for telephone calls and



showers if not on association), this was still below the expected outcomes for prisoners.

2.10 The number of telephones available for prisoners' use was limited and prisoners complained of limited access, particularly on A and B wings. On B wing, only two telephones were available for up to 80 prisoners. Many of the telephones that were available in the prison did not have acoustic/privacy hoods.

### **Conclusion**

2.11 The old-style dormitory accommodation on the open side of Wealstun was unfit for habitation. Conditions were extremely poor and posed a potentially serious health and safety risk to prisoners accommodated there. Newer category D accommodation was better structurally, but also posed safety threats, as prisoners could not raise any alarm in the event of an emergency. Accommodation on the closed side was clean and tidy, although in need of some basic maintenance.

### **Recommendations**

2.12 **An alarm system should be installed urgently in the open side units so that prisoners can obtain assistance in an emergency during the evening and night period.**

2.13 **Privacy screens should be installed in all cells with integral sanitation.**

2.14 **Prisoners should be offered the opportunity to shower and make a telephone call each day if they wish.**

2.15 **There should be a review of the number of telephones on each wing.**

### **Housekeeping points**

2.16 Privacy/acoustic hoods should be installed on all telephones.

2.17 Colour-coding of cleaning equipment should be adhered to.

2.18 Basic maintenance work should be carried out on A and B wings.

## **Clothing and possessions**

2.19 All prisoners at Wealstun were allowed to wear their own clothing, unless they were on the basic regime of the incentives and earned privileges scheme.

2.20 Both the open and closed sides had good arrangements for the laundry of private clothing. Access to these facilities was at least once a week, under a rota system organised by prisoner orderlies. Irons and ironing boards for prisoners' use were available on wings.

2.21 Despite the privilege of being able to wear their own clothing, many prisoners chose to wear prison-issue clothing. Exchanges of kit were regular, and the quality of prison clothing was generally good.

2.22 A local ruling stated that only prisoners on the resettlement scheme or working on outside parties could have coats in their possession, either prison-issue or privately purchased and sent in through reception. There seemed little rationale for this ruling, which resulted in many prisoners walking on the open prison side in inclement weather without appropriate coats to protect them.

2.23 Prisoners were allowed 12 items of personal clothing in possession at any one time and the system of exchanging these items had recently been reviewed. They were allowed to send up to three items out and receive three items in each month. Prisoners complained that this system was time-consuming and unnecessarily bureaucratic.

## **Conclusion**

2.24 There were adequate facilities for prisoners to maintain a high standard of cleanliness, and access to laundry facilities was good. Prison clothing was of generally decent quality, and exchanges were predictable and frequent. Prisoners could gain access to stored property, although the system was in need of refinement.

## **Recommendations**

**2.25 The number of items of personal clothing that prisoners are allowed in possession should be reviewed, alongside a review of the current arrangements for exchanging personal items through reception.**

## **Housekeeping point**

2.26 There should be a review of the facilities list, particularly in regard to allowing all prisoners to have outer garments in possession.

.



## CHAPTER THREE

### DUTY OF CARE

#### Anti-bullying

##### Expected outcomes

The expected outcomes for creating an environment safe from bullying are:

- **Safety:** Prisoners are as safe as possible from bullying behaviour and bullied prisoners are always given full support in any bullying incident
- **Respect:** Neither staff nor prisoner uses their position or power to bully others
- **Respect:** Bullying and bullied prisoners are treated fairly and are aware of the systems that operate to prevent bullying behaviour
- **Purposeful activity:** Activities take place to develop self-esteem within an environment which discourages bullying and assists those who are or might be bullied
- **Resettlement and reducing re-offending:** Street and prison cultures are challenged through effective anti-bullying measures and programmes for all who are involved

3.01 Wealstun had an anti-bullying policy, which had been reviewed and re-launched in July 2003. The changes to the policy were mainly procedural. All the wings had anti-bullying folders that gave guidance on how to use the policy and all the necessary documentation required to apply the policy.

3.02 The policy was overseen by an anti-bullying committee, which should have met quarterly. The committee was chaired by a senior manager and was multi-disciplinary; members included the anti-bullying co-ordinator, probation, chaplaincy, education, wing liaison officers and security. In 2003 the committee had met only three times, in February, July and August. Examination of the minutes showed that the committee was not driving the policy, or doing quality checks of anti-bullying documentation, looking for 'hot spots', analysing statistical information and checking for gaps in the system. For example, action points were not followed up. In the

segregation unit we found records of prisoners who had been segregated on rule 45 at their own request because they had been bullied; not all these prisoners had been brought to the attention of the anti-bullying co-ordinator or, subsequently, to the committee.

3.03 The anti-bullying co-ordinator fulfilled this role in addition to his other duties; he was also in charge of two wings and had other general duties to perform. He was enthusiastic and had a good knowledge of anti-bullying issues.

3.04 The policy was very well publicised in the prison and at the time of the inspection included some eye-catching notices. All new prisoners were told about the policy on induction and were given an information booklet about bullying. Prisoners we spoke to knew and understood the policy. Staff who we spoke to all knew about the policy, could describe what action to take when they suspected bullying was taking place, and could produce their anti-bullying folders.

3.05 Bullying was dealt with in three stages. The first stage for a prisoner suspected of bullying was a verbal warning by a senior officer, an entry in his wing history sheet, and his name put in the central anti-bullying log. If a prisoner was confirmed as a bully he would be placed on stage two, with a formal written warning and logged monitoring via an anti-bullying observation booklet. He would be given a form describing his bullying behaviour and informing him that he would be monitored for a set period of time, usually 28 days. After the monitoring period the prisoner would be reviewed. If a prisoner continued to bully he would be placed on stage three, and informed in writing of the reasons for this. In addition to monitoring, as at stage two, further sanctions included a cell search, a prison shop order form check, and a ban on association with other prisoners in their cells. The prisoner would be reviewed weekly and given verbal feedback on his behaviour. After 28 days there would be a formal review, and he would either be taken off the measures or given another period of time on the regime. There was an appeals procedure, which prisoners were informed of at each of the three stages.

3.06 In 2003 to the time of the inspection, there had been one recorded incident of bullying on the open side, and 17 on the closed side. There was one prisoner who was

on stage two of the regime, and the relevant documentation had been completed properly. The prisoner was aware of why he was on anti-bullying measures. There was no intervention to challenge or change his behaviour. Although the policy document mentioned interventions for both bullies and victims, in reality there were none.

3.07 In our survey, 66% of respondents on the open side and 74% on the closed side said they had never felt unsafe while at Wealstun.

### **Conclusion**

3.08 There was an up-to-date anti-bullying policy, which was understood by both staff and prisoners. The anti-bullying committee did not meet at the published times: it was not geared to quality check or look for gaps in the policy, and it was not driving the policy. Anti-bullying was given a high priority and the staff involved were enthusiastic about their work. The three-stage regime was appropriate, but there were no interventions to challenge bullies or support victims, despite this being stated in the policy.

### **Recommendations**

3.09 **The anti-bullying committee should meet on its published dates.**

3.10 **There should be standing agenda items on the anti-bullying committee that follow up action points, quality-check anti-bullying documentation, examine statistics, look for trends and identify gaps in the systems.**

3.11 **The anti-bullying committee should ensure that there are interventions to challenge bullies and support victims.**

## Preventing self-harm and suicide

### Expected outcomes

The expected outcomes for preventing self-harm and suicide are:

- **Safety:** Prisoners are held in an environment in which all reasonable steps are taken to protect prisoners from self-harm and suicide honouring the prison's duty of care to every prisoner
- **Safety:** Significant information about individual prisoners at risk of self-harm or suicide is communicated effectively by those who hold it to those who need it and integrated into the support plan
- **Respect:** Prisoners know where to find help and access it in times of crisis or need
- **Respect:** Raising and maintaining prisoners' self-esteem, especially in times of transition or change, should be inherent in the prison's culture, management, regimes and activity
- **Respect:** The treatment of those at risk of self-harm or suicide shall always maintain confidentiality, preserve or enhance the dignity of the prisoner and shall not itself be dehumanising
- **Purposeful activity:** Those prisoners at risk of self-harm or suicide are encouraged to participate in appropriate purposeful activities including specific programmes for their needs in this respect

3.12 A residential governor led the suicide prevention work for both the open and closed sides of the prison. A comprehensive policy document had been produced in November 2002, and updated in July 2003 to take account of emerging best practice. A multi-disciplinary safer prisons suicide prevention management team (SPSP) met quarterly and was attended by staff and prisoner representatives from both sides of the prison, as well as the local Samaritans. A principal officer had undertaken the role of suicide prevention co-ordinator, and a senior officer from both sides acted as liaison officer for the Samaritans-trained Listener scheme.

3.13 There had been two deaths in custody on the closed side during August 2002. One inquest had been held in October 2003 and the other was scheduled for later in 2004. Areas of concern identified at the inquest included the poor collation of evidence – memoranda and logs submitted stated the basic facts, but were poor quality. There were no



recommendations that needed to be addressed. An action plan had been prepared and submitted to the area manager following the internal investigation.

3.14 Between September 2002 and October 2003 17 incidents of self-harm had been recorded for the whole prison; only one incident was from the open side. On the closed side, 51 F2052SH (prisoners at risk) forms had been opened during 2002 and 64 during 2003. One incident had been recorded for the open side; the prisoner was subsequently moved to the closed side of the prison. The review board saw all prisoners on F2052SHs within 72 hours.

3.15 There were graphs on the numbers of F2052SH forms opened by location, the different areas of the establishment, and the reasons for opening them. The location and graphs by area indicated that the majority of prisoners (six and 13 respectively) self-harmed by cutting in the segregation unit. Graphs indicating reasons for opening the F2052SH forms listed depression, followed by family problems and poor coping strategies as the main reasons for self-harm. Of these figures, only one prisoner repeatedly self-harmed, and two had F2052SH forms opened on two occasions.

3.16 New arrivals were seen by a member of the healthcare team and assessed for risk of suicide and self-harm as part of the healthcare screening procedure.

3.17 Since the beginning of January 2003, F2052SH forms had been opened on 60 prisoners who were felt to be at risk of self-harm or suicide. There were two open F2052SH forms at the time of the inspection. Some prisoners had been transferred to other prisons with open F2052SH forms. We read the files of these cases and the six most recently closed forms. The quality of the daily entries in the supervision and support record varied, but contained some caring comments from the co-ordinator and wing staff. Overall, the content and adherence to procedures were satisfactory. All files recorded that the level of observations and support plans had also been observed.

3.18 Analysis of the self-harm monitoring showed that support plans targeted individual services and ensured that few prisoners were subject to F2052SH procedures for long periods. For example, there was provision for in-reach mental health provision (counselling), support from the chaplaincy, Listeners and the personal officer.

3.19 There were no Listener suite or inpatient health facilities; however, there were plans to build a Listener suite as part of the extensive building work in the establishment. There were double cells on A and B wings that were used to accommodate prisoners who self-harmed with other prisoners who were not Listeners. Listeners reported that they preferred to operate a rota system, rather than themselves being 'doubled up' with prisoners needing support.

3.20 Listeners operated a rota system at night times and saw prisoners during the day if they were available. There were 10 Listeners from the open side and 13 from the closed side of the prison. We met four Listeners from the closed side, including one who took the role of Listener co-ordinator. The Listener groups included minority ethnic prisoners and they assisted prisoners with a range of problems, including family, relationships, recategorisation, bullying, and parole issues. Reception orderlies (Insiders) also gave an input to the induction for new prisoners, briefing them on what to expect on the first night. The groups recorded the number of hours they spent in supportive contact with other prisoners, meetings with the Listener co-ordinators and the Samaritans.

3.21 Listeners reported that they were well supported by each other through the Listeners' forum (including prisoners from the open side), and through staff and local Samaritans monthly meetings. Each Listener had a 'Listener's cell' leaflet posted on his door. There were various posters with the telephone number of the Samaritans and staff in the prison whom both prisoners and visitors could notify if they felt a prisoner was at risk of self-harm. These posters were displayed on each wing and in the visitors' centre on both sides of the prison. A telephone line to the Samaritans had been installed recently on every wing and on the segregation unit on the closed side. Cordless digital phones to contact the Samaritans were also available in each wing office, on both sides of the prison.

3.22 Staff working at night had access to emergency response kits on each wing on both sides. The inspectors who conducted a night visit were impressed with a senior officer on the open side who carried ligature shears in a holster attached to his belt, to enable immediate response to serious incidents of self-harm. We were told that 130 staff had been trained in suicide awareness to date, and that normal operations in the prison were curtailed on the third Wednesday of every month for staff training in this area.

## **Conclusion**

3.23 Prisoners who were identified as being at risk of self-harm or suicide were supported by the F2052SH system. There was a well-used and supported Listener scheme on both sides of the prison but there was no care suite.

## **Recommendations**

3.24 **More staff should be trained in suicide awareness as a matter of urgency.**

3.25 **A Listener care suite should be provided and its use managed according to an agreed protocol.**

## Race relations

### Expected outcomes

The expected outcomes for race relations are:

- **Safety:** Prisoners live in an environment in which they are safe from physical, verbal or emotional abuse, intimidation or victimisation or any discrimination on the grounds of race or culture
- **Respect:** Prisoners experience a culture that values diversity and actively promotes, maintains and monitors good practice in race relations
- **Respect:** Foreign nationals and those for whom English is not their first language are enabled to understand and communicate successfully
- **Respect:** Prisoners, regardless of their ethnic cultural background, have equal access to all appropriate facilities and activities within the establishment. Eligibility for benefits and privileges, e.g. risk assessments, are made without regard for race, ethnicity or culture
- **Purposeful activity:** Prisoners and staff are able to recognise and acknowledge the cultural diversity of the prison population

3.26 Race relations and equal opportunity work at Wealstun were subsumed under the umbrella of diversity. There was no race relations policy, but there was an equal opportunities policy that covered both sides of the prison. The updated policy was in its final draft stage and included a race relations statement. At the time of the inspection the combined population for the open and closed sides by ethnicity was 86.1% white, 6.5% Pakistani, 1.8 % Asian other, 1.8% Caribbean, 1.1% Indian, 0.9% African, 0.9% Black other and 0.9% other.

3.27 Wealstun had a 19-person multi-disciplinary race relations/diversity management team (RR/DMT), chaired by the deputy governor, that covered the whole prison. The meetings were quarterly, with representation from the various departments, Independent Monitoring Board, four prisoner representatives, the chaplain and imam, and a black offenders' support group (Partners of Prisoners Support Group, POPS).

3.28 There was a race relations liaison officer (RRLO), who had received both race relations and diversity training. There were also two assistant RRLOs, one for each side of the prison. Photographs of members of the RR/DMT were displayed on notice boards around the establishment. The RR/DMT minutes recorded that the RRLO carried out many aspects of his duties in his own time.

3.29 The equal opportunities committee (EOC) usually met a few days prior to the main RR/DMT, but had not met in the most recent quarter, due to training commitments. The diversity committee meeting always followed the RR/DMT and picked up on issues arising from the EOC. Policy statements on race relations were displayed around the prison. A total of 137 staff from both sides of the prison had attended the diversity training prescribed by the Prison Service; just under two-thirds of prison staff were still waiting to be trained.

3.30 The RRLO provided quarterly ethnic monitoring statistics to the committee. The statistics were assessed using range settings that indicated whether individual figures were higher or lower than the range. However, the statistics were not presented in a user-friendly way, and only problematic areas were discussed at the RR/DMT meetings. We found evidence of positive action in terms of proportionately more minority ethnic prisoners being on the enhanced regime and attending education courses. There was also evidence to show that negative trends had been addressed.

3.31 There was some celebration of diversity at Wealstun. The prisoners' handbook was available in languages other than English. Each month a group of up to 20 minority ethnic prisoners, mainly from the closed side of the prison, participated in discussion workshops with representatives from POPS. Prison staff did not attend these meetings; any issues that arose from them were raised by the prisoner representatives and discussed at the RR/DMT meeting for resolution. Three Muslim prisoners cooked the meals for Ramadan, and prisoners taking these meals reported that they made a welcome change from the usual curries. The prison had held religious and cultural diversity days in the chapel in October 2002 and 2003, and we were told that this would be repeated in future years.

3.32 The system for making racial complaints was secure and confidential throughout the prison. Racial incident forms were displayed and easily accessed by prisoners. Secure complaint boxes were conveniently placed on each wing. The RRLO or his assistants emptied the boxes regularly. Complaints were referred to the RRLO, and were logged, investigated, resolved fairly quickly and quality-checked by the governor. The RRLO had also produced a guide for staff on reporting racist incidents, as well as a multi-faith guide on the searching of prisoners and their religious artefacts. However, the guides were not displayed in the wing offices on either side of the prison.

3.33 The RRLO had received only six complaints from February to October 2003, and we were concerned that this low level might reflect a lack of confidence in the system. There had been 11 investigations in the previous year. Some complaints had required detailed investigation. We looked at all the racial incident forms and these had been completed satisfactorily. There were no outstanding investigations.

3.34 We spoke to 35 minority ethnic prisoners from both sides of the prison; they reported that they had little confidence in the complaints procedure. Typical remarks from prisoners were: ‘complaints are not dealt with promptly - some of us are too scared to make complaints’; ‘your cards are marked if you complain. It has a knock-on effect. If we complain we’ll get shipped out.’ It should be noted that white prisoners, too, largely distrusted the general complaints system (see para 3.97). However, most of these prisoners on the closed side knew the RRLO, said that he had been helpful and that they respected him.

3.35 Minority ethnic prisoners on both sides of the prison conveyed a mixed picture of race relations at Wealstun. Overall, they agreed that the majority of officers and prison staff were pleasant and treated them well, and that only a few were viewed negatively. A few officers on the closed side were singled out for special praise. Others were criticised for using inappropriate language and for ‘talking down’, shouting at – and ‘belittling’ black and minority ethnic prisoners.

3.36 Prison food was another area of contention for some minority ethnic prisoners, who complained about the quality and limited variety of available dishes. Asian prisoners complained that they were given reheated curries every day. Minority ethnic prisoners also complained about the price and variety of black products from the prison shop.

## **Conclusion**

3.37 Wealstun had many of the components of a race relations strategy in place, including a good and well-respected Race Relations Liaison Officer. Monitoring statistics were available, and acted upon. However, black and ethnic minority prisoners had little confidence in the race complaints procedures and that, together with the few complaints registered, was a cause for concern. Two-thirds of the staff had not received race and diversity training. Prisoners reported inappropriate language and behaviour from a minority of officers; though a few were also highly praised. There were some criticisms of the range of food and shop products.

## **Recommendations**

3.38 **The race relations/diversity management team should meet monthly.**

3.39 **Facility time for the race relations liaison officer (RRLO) should be increased to carry out tasks and promote positive race relations.**

3.40 **All staff should receive diversity training, which should address issues such as unacceptable use of inappropriate language and behaviour towards prisoners.**

3.41 **Strategies to improve prisoner confidence in the racial complaints procedure should be developed.**

3.42 **The prison should work more closely with the black prisoner support group, Partners of Prisoners Support Group, to promote regular cultural diversity celebrations.**

### **Housekeeping points**

3.43 Ethnic monitoring data should be presented in a more user-friendly format.

3.44 The guide for staff on reporting racist incidents, and the multi-faith guide on the searching of prisoners and their religious artefacts, should be readily available in the wing offices.

3.45 The catering department should be more creative in offering minority ethnic prisoners a broader range of meals.

### **Good practice**

3.46 *The establishment issued a multi-faith guide on the searching of prisoners and their religious artefacts.*

### **Foreign national prisoners**

3.47 There were 13 foreign national prisoners at Wealstun, who came from Africa, the Caribbean, Eastern Europe, India, the Middle East and Pakistan. Only one prisoner was subject to a deportation order. Wealstun was unaware of the honest number of its foreign nationals, and had described some prisoners incorrectly, simply because they were born abroad, even though they were British citizens.

3.48 Wealstun had no foreign nationals policy, liaison officer or consultative committee. There were no proper procedures to support foreign national prisoners' contact with their families, friends or external support groups, or facilities to meet as a group. Foreign national prisoners could apply for a monthly phone card, or airmail envelopes; however, most were unaware of this.

3.49 We met a group of five foreign nationals, from both sides of the prison, from different countries. They shared the same difficulties as other prisoners, and echoed similar criticisms about the food, poor relations with a minority of officers, poor feedback from applications, and lack of confidence in the complaints procedure. However, communication proved to be the most significant barrier to coping with custody.



3.50 Notices in foreign languages were not evident around the prison. Wealstun had access to translation services, although this had been used only once. However, there was an informal arrangement for the imam to translate letters into various languages. The prisoners' handbook had been translated into different languages.

3.51 A strategy for the care and support of foreign nationals was proposed at the time of the inspection. During reception they would be given an information sheet about their entitlements, and officers would have to complete a foreign national prisoner contact sheet on their behalf, covering any need for assistance with translation, level of language skills required, assistance with telephone calls, networking with embassies, immigration, and outstanding concerns and issues.

### **Conclusion**

3.52 There were 13 foreign national prisoners at Wealstun, only one of whom was subject to a deportation order. There was no foreign nationals policy, or proper support services to maintain their contact with families, friends or external support groups. There was a language support service, but this was underused. The imam translated letters for prisoners on an informal basis. Most prisoners were unaware that they could apply for an extra phone card or airmail envelope. Some foreign national prisoners complained about the food, poor feedback on their applications and the inappropriate manner of a minority of prison officers. A support strategy for foreign nationals had been proposed.

### **Recommendations**

**3.53 The proposed support strategy for foreign national prisoners should be put into place as a matter of urgency. Good practice elsewhere on the treatment of foreign national prisoners – such as the model in use at HMP Wandsworth – should be adapted for use at Wealstun.**

**3.54 A foreign national prisoners' policy should be produced as a matter of urgency.**

3.55 **There should be appropriate provision for foreign national prisoners to maintain contact with their families, friends and external support groups.**

3.56 **Notices and information displayed to prisoners should also be available in foreign languages.**

### **Housekeeping point**

3.57 The availability of interpreting services should be widely publicised to prisoners.

### **Substance use**

#### **Expected outcomes**

The expected outcomes regarding substance use are:

- **Safety:** All prisoners are as safe as possible from exposure to and the effects of substance use while in custody
- **Respect:** Prisoners with substance related needs are identified at reception and throughout their time in custody
- **Purposeful activity:** All prisoners receive effective drug and alcohol education interventions to meet their needs
- **Resettlement and reducing re-offending:** Prisoners, according to their individually assessed needs, are provided with the necessary support and treatment both in prison and after release to maintain healthy lifestyles and avoid the harmful effects of drug use

3.58 Drug treatment provision at Wealstun consisted of CARAT (counselling, assessment, referral, advice and throughcare) services, a drugs course, and voluntary and mandatory drugs testing.

3.59 The CARAT service was provided by COMPASS. The COMPASS team comprised a manager, who divided her time between Wealstun and HMP Northallerton, and two workers for each side of the prison. Each team worker had a caseload of prisoners. COMPASS staff took part in the prisoner induction programme, undertook structured intervention work with prisoners, and also ran a

three-day drug awareness course. The team, which had plans to expand, was supported by a full-time administrative officer. COMPASS staff received referrals from sending prisons for prisoners transferred into Wealstun, and also from the voluntary testing unit if a prisoner tested positive. Some out-working prisoners held on the open side of the prison were not always able to access drugs services due to the incompatibility of CARAT office hours with their work commitments.

3.60 CARAT workers referred prisoners to the ADAPT course, or on to other establishments if they were not suitable for that course. CARAT workers arranged for prisoners to receive hepatitis B vaccinations from healthcare centre staff, and also organised follow-up care with outside agencies, such as housing providers and further treatment programmes. Such provision included going on to Naltrexone (a drug used to support relapse prevention) when needed. COMPASS workers arranged formal agreements with outside agencies for the treatment to be continued after release, and the drug was administered to prisoners by healthcare staff one week prior to release. The administrative officer followed up the effectiveness of this arrangement four and eight weeks after release.

3.61 ADAPT had been based at Wealstun since August 2003; the team consisted of a manager and five drugs workers. It provided an eight-week drugs rehabilitation core programme. The programme, which took 10 prisoners per course, was not accredited at the time of the inspection and ran on the closed side of the prison only. Prisoners were assessed for their suitability for the course after self-referral or referral as part of their sentence plan. To ensure that the course was accessible to prisoners on both sides of the prison, category D prisoners agreed to be temporarily relocated in the closed side for the duration of the course. However, there were plans to run the course in the open prison. The course took a holistic approach, and included yoga, auricular acupuncture and sessions in the gym to promote a healthy lifestyle. It was flexible; sessions could be repeated at the request of participants. Prisoners told us that they had found the course useful. All participants were interviewed at the end of the course and referred back to the COMPASS workers for continuity of service provision. There was no provision or relapse prevention course or for prisoners serving short sentences.

3.62 No detoxification programmes were offered, although this was not explicit in the drug strategy document. Healthcare centre staff assessed prisoners on arrival to the establishment, and did not accept those who either required or who had yet to complete a detoxification programme.

3.63 The open prison operated a voluntary drug testing unit (VTU) on A wing, and all prisoners there signed a compact to this effect. In addition, a voluntary testing programme was available to all category D prisoners. All but 50 prisoners on the closed side had also agreed to voluntary testing. Prisoners either signed a voluntary testing compact at induction or prior to arrival if they were transferring to Wealstun for the drugs course. However, our survey of prisoners showed that 95% of respondents on the open side felt that drugs were freely available. This was confirmed by prisoners to whom we spoke; indeed some had posted on their doors ‘no salesmen’ in order to discourage drug dealers.

3.64 Prisoners were selected for the VTU the evening prior to the day they were required for testing and were given a notice to attend. They attended the VTU when they were ready to urinate. They were warned about providing a diluted sample. Both waiting areas were small and not ideal but, in practice, they were rarely used. Prisoners were given a certificate each time they provided a negative sample, and there was a system of accumulating certificates for a bronze, silver or gold award. Prisoners appreciated this system. The target for voluntary testing was 900 prisoners per month. This was being met, and there was an agreement with the governor that the staff detailed for this work would not be moved to other duties.

3.65 Prisoners who responded to the prisoner survey complained that positive VTU results resulted in punitive disincentives. However, we were shown evidence that the incentives and earned privilege scheme (IEP) had recently been revised to avoid this. For example, a first positive test or dilution resulted in a referral to CARAT services and, for category D prisoners, a deferment of community visits. Prisoners agreed to these arrangements as part of their compact.

3.66 The prison's multi-disciplinary drug strategy team met monthly. The drug strategy document for 2003-04 had been devised in line with the Yorkshire area drug strategy 2003-06.

### **Conclusion**

3.67 The drug strategy at Wealstun was developing, and the introduction of a new principal officer to manage the overall approach, including the ADAPT service, was beginning to show dividends. The drug strategy was clear, and voluntary testing targets were being met. However, particularly on the open side, there were problems with the supply of drugs.

### **Recommendations**

3.68 **The working times of the CARAT (counselling, assessment, referral, advice and throughcare) workers should be reviewed to ensure that they are accessible to prisoners on the open side of the prison.**

3.69 **The provision of a short drugs course as relapse prevention, or for prisoners serving a short sentence, should be considered.**

3.70 **The drug strategy should be explicit that prisoners who require, or who are still completing, a detoxification programme are not accepted for transfer to Wealstun.**

## Maintaining contact with family and friends

### Expected outcomes

The expected outcomes on maintaining contact with family and friends are:

- **Safety:** Prisoners and visitors feel safe in their time together and visitors feel safe within the establishment
- **Respect:** The rights of prisoners to maintain contact with family and friends are upheld and practical arrangements are in place to provide for them with special consideration being given to children and partners
- **Respect:** Visitors are welcome to the establishment, supported within the prison and recognised as free members of society in order that they may contribute positively to the prisoners' progress
- **Resettlement and reducing re-offending:** Prisoners are encouraged to build and maintain family and social networks and relationships that contribute to their well-being and help reintegrate them into the community

### Mail

3.71 In our survey, 45% of respondents from the closed side of the prison and 32% from the open indicated that they had problems either sending or receiving mail, but we found no evidence to support this. Mail was censored appropriately and delivered by wing staff on the closed side over the lunchtime period, and was available for collection at both lunchtime and teatime for prisoners on the open side.

### Telephones

3.72 Wealstun had recently transferred to the PIN telephone system and had experienced some initial problems, which had been rectified at the time of our inspection. However, prisoners on both the open and closed sides still complained about access to telephones. On B wing, for example there were only two telephones, neither with acoustic/privacy hoods, for up to 80 prisoners. Unsurprisingly, the telephones were extremely busy during association periods.

### Visits

3.73 Domestic visits were available in both side of the prison each afternoon, except for Wednesdays and Fridays. Visitors to prisoners on the closed side were

required to book their domestic visits on the visits booking line, which was open for two hours each weekday morning. The booking line was staffed by the prison movements officer, and was often unanswered while he/she attended to other duties. The limited time the line was open, coupled with the frustration of the telephone ringing out, led to visitor dissatisfaction.

3.74 A small leaflet available to visitors provided good information on travel directions to the prison and basic information on the visits procedure.

3.75 On arrival at Wealstun all visitors were required to book in at the visitors' centre. Staff working there dealt with visitors in a professional and friendly manner. The centre had a drinks machine, a television and a few chairs. However, it was too small for the number of visitors it served, and the opening hours did not coincide with the timings of public bus services arriving at the prison, which resulted in many visitors waiting outside.

3.76 Visitors for the closed side were called across in groups of five and were searched by operational support grade staff in the gate area of the main prison. While the searching itself was sensitive, the area used was not appropriate, as general visitors were booking in and out of the prison while searching was under way. Visitors were then escorted to the visits hall, allocated a seat number and the prisoner was called. This process was time-consuming, with some visits not beginning until approximately 45 minutes after the published visits start time.

3.77 Prisoners located in the segregation unit or on the basic level of the incentives and earned privileges scheme were not allowed the statutory entitlement of one-hour visits. Wealstun policy was to limit such visits to a half-hour.

3.78 Wealstun did not have a drug dog, but had access to the area team of dogs and their handlers co-ordinated through HMP Leeds. In practice drug dogs were not used routinely on domestic visits at Wealstun.

3.79 The visits halls on both the open and closed sides needed redecoration.

3.80 The hall on the closed side was cramped, and the seating extremely close together. There was little opportunity for prisoners and their friends and family to have private conversations without being overheard by other prisoners and their visitors.

3.81 There was a small crèche, staffed by volunteers. This facility offered adults the opportunity to talk without the children being present, and was well used by children of all ages.

### **Conclusion**

3.82 Prisoners had limited access to telephones, and they complained that they could not use a telephone with reasonable ease or regularity (see recommendation 2.16). The visiting arrangements were generally satisfactory, and visitors were treated sensitively. However, the booking phone line often went unanswered as a result of the bookings officer being deployed to other duties. The searching area, the visitors' centre, and the layout of the closed side visits hall needed attention.

### **Recommendations**

**3.83 The visits booking line should be open for a longer period; its availability out of office hours should be considered.**

**3.84 A larger visits centre to accommodate the expected number of visitors should be provided.**

**3.85 The visitor centre opening hours should be reviewed to be in line with the timing of public transport to the prison.**

**3.86 All prisoners, including those on the basic IEP level, should receive their statutory entitlement to one-hour visits, with immediate effect.**

**3.87 Passive drug dogs should be used during domestic visits to help promote a safe environment for prisoners.**



## Housekeeping points

3.88 There should be a review of searching procedures for visitors to identify alternative, private searching areas.

3.89 There should be a review of visits procedures to speed up the process from booking-in to the start of visits.

3.90 The visits halls on both sides of the prison should be redecorated.

3.91 The layout of the visits hall on the closed side should be reviewed to allow greater privacy for prisoners and their visitors.

## Applications, requests and complaints

### Expected outcomes

The expected outcomes for applications, requests and complaints are:

- **Safety:** Prisoners are safe from repercussions or recrimination in making any application or request or complaint
- **Respect:** Prisoners know and are given appropriate help to exercise their right of access both to applications, and requests and complaints; they receive a prompt, courteous and fair response from staff
- **Resettlement and reducing re-offending:** Sentence plans are normally implemented without a prisoner needing to use applications or request and complaints

3.92 A significant number of prisoners complained to inspectors that their applications were misplaced or were not answered. We were unable to follow these complaints through, as there was no system of recording applications or tracking progress to the reply stage. The system varied from wing to wing: for example, D wing recorded all applications, but not the responses to them; other wings recorded nothing other than governor's applications. However, prisoners were well informed about the system, and had free access to applications on both the open and closed sides.

3.93 Prisoner representative meetings took place each month on both sides of the prison. They were attended by a cross-section of prisoners from each wing, and by staff representatives. However, a review of minutes showed that no governor had attended the meetings on the open side for at least the previous seven months. Category D prisoners said that the forum was not used to its full benefit, and that it had 'no teeth'. The absence of a governor grade to make decisions at the forum undoubtedly fuelled this opinion.

### **Complaints**

3.94 Complaints forms were widely available, and complaints boxes were in prominent positions. Senior officers were responsible for opening the complaints box each morning, logging the complaints and forwarding them to the relevant department for responses. A copy of the original complaint was made on the daily log sheet and forwarded to the complaints clerk for future reference.

3.95 In our survey, 93% of respondents on the open side and 74% on the closed side said that they did not believe the complaints system at Wealstun was fair. Senior officers said that they checked the nature of a complaint and would not always log it if they felt they could deal with it at wing level. This practice may have contributed to prisoners' lack of faith in the system.

3.96 Prisoners also said that they were afraid to submit complaints about staff as they felt these would result in their transfer to a different establishment. These fears appeared largely unfounded however, and we found specific examples of prisoners who had recently submitted complaints and were still located at Wealstun.

3.97 In our survey, 89% of respondents on the open side and 65% on the closed side said that responses to complaints were not prompt. However, complaints that were recorded were dealt with efficiently, and a senior manager checked the log regularly to ensure timeliness of responses. The quality of responses was good, offering prisoners full and detailed explanations.

## **Conclusion**

3.98 Prisoners at Wealstun had little faith in the application and complaints system. There was no formal system to log applications, and there was evidence of some screening of complaints at senior officer level, which undoubtedly contributed to the negative perception of the system.

## **Recommendations**

3.99 **All applications should be logged and tracked through to the reply stage.**

3.100 **A governor grade should attend the prisoner forum and follow up action points.**

## **Housekeeping point**

3.101 The screening of complaints at senior officer level should cease and all complaints should be logged formally.



## CHAPTER FOUR

### HEALTHCARE

#### **Expected outcomes**

Inspectors will make judgements about healthcare against the following outcomes:

- Prisoners receive a full range of primary healthcare, health promotion and disease prevention services in an environment that is clean, safe and conforms with the standards that operate in the NHS
- NHS and prisoner records are available to those responsible for the care of the patient
- Prisoners receive healthcare from appropriately trained staff and support and care in meeting their health needs from all prison staff. Their right to refuse treatment is recognised
- Prisoners with physical or mental health problems are identified and assessed promptly, receive appropriate treatment and care and, where appropriate, are referred without delay to appropriate secondary care providers
- Prisoners' access to health promotion in primary care is equivalent to that in the community
- Prisoners are encouraged to maintain healthy lifestyles while in prison and on release and are linked to community services including GPs prior to release
- Prisoners receive inpatient healthcare that meets NHS standards in an environment that is clean, safe and meets NHS standards
- Inpatients receive opportunities for purposeful, therapeutic occupation according to their assessed needs and care plan
- Patients requiring specialist healthcare are identified promptly and referred to visiting specialists or the NHS
- Continuity of treatment and care is not impeded by transfer between prison and the NHS or by inappropriate security precautions

4.01 Wealstun had a type two healthcare centre providing primary healthcare services between 7.00am and 5.00pm daily. The healthcare centre had a green rating under the Prison Service healthcare traffic light system. Leeds North East Primary Care Trust (PCT) had undertaken a comprehensive health needs assessment, published in August 2003. It had been compiled using prisoner questionnaires and focus groups (four prisoner and two staff groups). It provided a thorough assessment, identifying the healthcare needs at Wealstun for the following 12 months. A clinical governance action plan had also been agreed.

### **Environment**

4.02 The main healthcare centre was situated in the closed part of Wealstun, adjacent to A wing. There was a large waiting area with an extensive range of health promotion posters and literature, and a treatment room with access to a doctor's office. Other accommodation included offices, a dental suite and an optician's room. There was a small treatment room and a doctor's office in the open side of the prison, situated in the main corridor of the dormitory accommodation. Although there was a small waiting area for prisoners this was unfurnished and, as a consequence, prisoners waited in the corridor.

4.03 Basic emergency equipment was stored in both treatment areas; a defibrillator was also available in the main healthcare centre. The defibrillator was taken to the gate lodge when the healthcare centre was closed. However, neither nursing nor discipline staff had received training in its use.

4.04 The healthcare facilities in the reception area were basic, consisting of one room.

4.05 There were plans to expand the healthcare facilities on the open side in line with the expansion of the prison.

### **Records**

4.06 Current inmate medical records (IMRs) for prisoners held in the closed side were stored in an office in the main healthcare centre. Those for prisoners on the

open side were kept in the smaller treatment room on that side of the prison. Both rooms were accessible by healthcare centre staff only.

4.07 Old IMRs were stored in the prison's administrative area. There were attempts to amalgamate the IMRs of prisoners who had previously been at Wealstun. Entries in the IMRs were clear and well written by Wealstun staff, and pharmacy charts were filed in the IMRs when completed.

### **Staffing**

4.08 The healthcare manager was a G grade registered general nurse (RGN) who had been in post for approximately two months. She was supported by a total of four whole-time equivalent (wte) nurses, two of whom were RGN, one a registered mental nurse (RMN) and one who was dual qualified; a further 0.5wte E grade was due to start duties. Agency nurses (RGNs) were used regularly.

4.09 The staff had a range of experience, including the independent and supplementary prescribing course and counselling qualifications. They could access relevant training and courses, including basic resuscitation training from the local ambulance service. They had access to a good range of reference materials and a variety of policies and protocols that were being revised at the time of the inspection. Clinical supervision was organised by staff in their own time. Staff were supported by an administrative officer who worked 25 hours a week.

4.10 Two recently retired GPs, employed by Primecare, delivered both the GP clinics and out of hours cover. A consultant psychiatrist provided one session per fortnight, and pharmacy services were carried out by HMP Leeds.

4.11 A local dentist attended for two sessions per week, an optician provided two sessions per month and a chiropodist ran one clinic per month. Each practitioner divided their time equally between the open and closed sides of the prison.

### **Delivery of care**

4.12 Prisoners arriving at Wealstun were seen by a nurse, who undertook a review of their medical history. If they were felt to be unsuitable for Wealstun because of

their medical status, arrangements were made to transfer them out again that day. Nurses discussed with prisoners how medications would be administered, and completed a disability questionnaire which, with the prisoner's consent, was shared with discipline staff. Prisoners were given a leaflet advising them of the healthcare facilities available, and those who were to be located on the open side and who needed to see a doctor were advised to attend the treatment room the following morning. Prisoners for the closed side were called to the main healthcare centre on the morning after arrival.

4.13 In our survey, 91% of respondents on the open side and 85% on the closed side said they saw a member of the healthcare team on arrival. Healthcare staff participated in the induction course for all prisoners, outlining the services available.

4.14 Arrangements for prisoners to access the primary care team varied between the open side, the closed side, and the segregation unit.

4.15 On the open side, prisoners queued at 8.00am outside the treatment room to be seen by a nurse, who either treated them or gave them an appointment time for the doctor that day. They returned at the appointed time and saw the doctor. This system meant that prisoners were often late for work, or missed breakfast to keep their appointment. Treatment by the nurse was not guided by any triage protocols.

4.16 Prisoners on the closed side reported to discipline staff on their wing if they wished to see the doctor. Appointments were allocated by healthcare staff to a maximum of 15 prisoners per day; divided between the wings.

4.17 The doctor saw prisoners in the segregation unit daily.

4.18 In our survey, 33% of respondents on the open side and 46% on the closed side said the overall quality of healthcare was good or very good. However, 63% on the open side and 47% on the closed side said that the care provided by the doctor was bad or very bad, compared with 63% and 80% respectively who said that the care provided by nursing staff was good or very good.



4.19 There were no clinics for chronic disease management; staff advised patients to attend the healthcare centre regularly for their condition to be monitored. However, there was an influenza vaccine clinic and hepatitis B vaccination clinics. Smoking cessation clinics were organised by gym staff, who devised a suitable programme for individuals; there was good liaison with healthcare staff for the provision of nicotine replacement patches.

4.20 On the open side of the prison, the majority of prisoners had their medications in possession, either weekly or monthly. They queued outside the treatment room at 7.30am for their medications. On the closed side of the prison, prisoners went to the main treatment room at the end of the morning and were given their medication daily, weekly or monthly in possession. Not all prisoners had secure facilities in which to store their medications. Prisoners in the segregation unit were given their medications daily in possession. Nursing and medical staff decided whether a prisoner could have their medications in possession after assessing them for at least a fortnight, and considering their medical condition and type of medications. There was no formal follow-up system if prisoners failed to attend for their medications. Prisoners could also speak to a nurse to obtain a variety of over-the-counter medications.

4.21 HMP Leeds provided the pharmacy services. The pharmacist responsible for the service had recently visited Wealstun and had produced a report with recommendations for improvements, most of which had already been implemented. He attended the medicines and therapeutics committee meetings, but did not visit Wealstun regularly. There was no facility for the pharmacist and the patients to interact.

4.22 Medicines were sent from HMP Leeds to Wealstun as named patient supplies, dispensed in response to faxed prescriptions. Stock for special sick medication was obtained via a faxed requisition sheet. There were no systems to audit either type of supply. Medicines were normally received at Wealstun on the same day that the fax was sent, for supply to the patient the following day. All prescribed in-possession medicines were for one, seven or 28 days treatment. A few medicines were provided as pre-packs for immediate supply; these were properly dual labeled so that audit was possible. Most medicines were supplied in conventional containers, but some patients

received Venalink cassettes; the rationale was for the use of this system was not clear. Patient information leaflets were provided only when medicines were supplied in original packs.

4.23 Prescription and administration charts were used to authorise medicine supplies. We looked at a number, and all were properly written. The 28-day treatment period was adhered to, and healthcare staff completed the records of supplies.

4.24 There was a special sick policy whereby a small range of medications could be administered by nursing staff. There were plans to widen this range once the pharmacist had provided training to the staff. Medications issued under the special sick policy were correctly recorded on the front of the patient's prescription and administration record sheet. There was no formal system to audit records to highlight possible abuse. No medicines were available for supply outside the opening hours of the healthcare centre, unless an out of hours doctor was called. An out of hours policy had been drafted and was awaiting implementation. There was an out of hours cupboard in the treatment room, which could only be accessed by the on-call doctor. Although a record book was available, there were no records as yet.

4.25 All medicines were stored in the treatment rooms, one on each side of the prison; both rooms were clean and tidy. All medicines were stored in locked metal cupboards in an orderly and secure manner, and were labelled in accordance with Medicines Act requirements. Medicine cupboards were checked weekly for stock levels and expiry dates, but there was no documentation of such checks. There were fridges with built-in thermometers in both treatment rooms for storage of temperature-sensitive medicines. A record was kept of daily maximum and minimum temperature readings.

4.26 There was a medicines and therapeutics committee which met approximately every three months; however, the membership did not include any representatives from the local PCT. No formulary for prescribed medication was available.

4.27 A local practitioner provided the dental services for both the open and closed sides of the prison. There were separate sessions for the different categories of

prisoners. The waiting times for treatment were four weeks on the closed side and five weeks on the open side; however, urgent cases were seen within a maximum of seven days. A full range of treatments under NHS general dental services was available to the prisoners. It was understood that the practitioner was remunerated on an item of service basis.

4.28 The dental surgery was of old design and needed refurbishment and some redesign. A new dental surgery was due to be provided on the open side of the prison. Positive pressure oxygen, emergency drugs, mercury spillage kit and a satisfactory number of instruments were present. The sharps and clinical waste disposal were satisfactory. There was also a protocol for the management of medical emergencies in the dental surgery.

4.29 The waiting lists for other allied health professionals were minimal.

4.30 Arrangements for prisoners who had outside hospital appointments were made with the security department. Prisoners from the open side were often granted a licence to attend appointments on their own; other prisoners were escorted. We were told that there had been problems with arranging escorts, but this had been addressed and there were now minimal delays. Nursing staff liaised directly with outside hospitals if a prisoner was admitted as an inpatient; they made clear notes of all enquiries in the prisoner's IMR.

4.31 Prior to release, prisoners had to make an appointment with nursing staff for pre-release papers to be signed. Prisoners with ongoing medical or psychiatric problems were advised to make the appointment at least five days prior to discharge, so that arrangements could be made for their continuing healthcare. There was evidence of good nursing staff liaison with outside agencies.

4.32 Facilities for elderly and/or disabled prisoners were minimal. Nursing staff had some aids to daily living that could be lent to prisoners as required.

## **Mental healthcare**

4.33 Psychiatric support was provided by Leeds Mental Health Trust. Support consisted of one consultant psychiatrist session per fortnight and two sessions with a G grade nurse. The service was rudimentary and there was no evidence of the care programme approach. The G grade nurse saw a few patients and kept separate notes about them, but it was not clear whether these were amalgamated with the IMR. A report on the mental health in-reach services, written by the manager of the service in September 2003, identified the shortcomings of the provision.

## **Conclusion**

4.34 The healthcare centre at Wealstun had a new and enthusiastic healthcare manager and the nurses were professional and caring. Prisoners had reasonable access to the services of a GP. While there was evidence of some structured clinics, staff needed to be creative in arranging nurse-led clinics for chronic disease management. There was a lack of mental health provision, although this had been recognised and was being addressed.

## **Recommendations**

- 4.35 **A suitable waiting area should be provided for prisoners attending the healthcare centre facilities on the open side of the prison.**
- 4.36 **Staff should have time profiled for clinical supervision.**
- 4.37 **There should be an annual skill mix review to ensure that nursing staff are able to meet the healthcare needs of the expanding population at Wealstun.**
- 4.38 **All staff who may need to use the automated external defibrillator should be trained to use it.**
- 4.39 **GP clinic times should be set in conjunction with the core day to ensure they do not disadvantage prisoners who work.**
- 4.40 **Triage protocols should be developed to ensure consistency of advice and treatment to all prisoners.**

**4.41 There should be a chronic disease register, and nurse-led chronic disease clinics.**

**4.42 A primary care trust representative should be encouraged to attend medicines and therapeutics committee meetings. The committee should consider the following:**

- **system and clinical audit arrangements**
- **development of a local prescribing formulary**
- **ratification of all medication-related policies and patient group protocols**
- **development of a policy for the use of Venalinks**
- **introduction of risk management systems, such as error logging and significant event recording, in line with clinical governance**
- **an increase of pharmacy hours at Wealstun**
- **the introduction of pharmacist-led clinics.**

**4.43 The mental health in-reach services should be extended to meet the requirements at Wealstun.**

### **Housekeeping points**

4.44 In the dental suite on the closed side, the dental chair should be moved to a more appropriate position, and two more sinks should be provided.

4.45 Other methods of remuneration for the dentist should be investigated, such as a sessional fee.

4.46 Information about prisoners seen by the mental health in-reach team should be amalgamated with their main inmate medical record.

4.47 All prisoners should have suitable secure facilities to store in possession medications.

4.48 Patient information leaflets (PILs) should be supplied with all prescribed medications, or a notice displayed to advise patients that PILs are available on request.

4.49 Weekly expiry date checks of medicine stock should be documented.

4.50 Systems to allow supply of simple remedies when the healthcare centre is closed should be considered.

4.51 A mercury spillage tray should be provided in the dental suite.

4.52 The dentist should record medical histories of dental patients.

### **Good practice**

4.53 *Both prisoners and staff were involved in the compilation of the health needs assessment.*

4.54 *Healthcare staff had adopted the concepts of clinical governance; the protocol for reporting errors related to the administration of medications was good practice.*

4.55 *Healthcare centre staff completed a disability questionnaire with new prisoners that was shared with discipline staff.*

4.56 *There was an inventory of instruments at the end of each dental session.*

## CHAPTER FIVE

### ACTIVITIES

#### Employment

The expected outcomes for prisoner employment are:

- **Safety:** Prisoners work in a safe, suitable environment
- **Respect:** The range, type and availability of work activity meets the needs of the prison population and prisoners are treated fairly in all aspects of their work, its allocation and pay
- **Purposeful activity:** Prisoners are engaged in well-organised employment; work programmes are integrated fully with residential units and other departments
- **Resettlement and reducing re-offending:** Prisoners are occupied in realistic work that prepares them for employment on release and helps to reduce re-offending

5.01 The head of inmate activities was responsible for all prisoner activities on both the open and closed sides of the prison. Each side had its own activities manager, who took responsibility for the day-to-day running of activities on their side, and managed allocation to work and applications for changes of labour. All prisoners were interviewed by their respective activities manager during their induction period, and their work preferences were sought. Prisoners also underwent educational needs assessments at induction, but those who opted out of education were not listed – regardless of need.

5.02 The prison operated on the basis of full employment, and every prisoner was allocated work at the end of his induction. On the closed side, employment was plentiful for the reduced number of prisoners held at the time of the inspection, and there was generally no difficulty in allocating prisoners to an activity of their choice. On the open side, work places were generally full, but work parties were oversubscribed, as necessary, to ensure that every prisoner was occupied.

5.03 If a prisoner could not be allocated initially to the occupation of his choice, he was encouraged to complete a labour change form and meet the prospective party supervisor. It was not normal practice to place prisoners on waiting lists, but they were told to reapply in the future when vacancies might have occurred. All applications to change occupation were processed by the activities managers and, if it was not possible to effect the change, there was a message to the wing indicating either that the prisoner should reapply, or that he was not suitable. Prisoners were not informed directly in writing of the outcome of their application.

5.04 The management of programmes at workshop level was satisfactory. Day-to-day communication was good, and managers issued weekly bulletins, supported by frequent visits to the training areas. In most areas instructors felt well supported by their immediate management. Staff were trained in instructional techniques, and some had higher teaching qualifications.

5.05 There was an extensive range of employment on both sides of the prison, including land-based activities, industrial cleaning, data entry, laundry, construction, tailoring, catering, and light assembly work

5.06 Some of the work available in these workshops was repetitive and mundane. However, in some workshops there were opportunities for prisoners to gain a good range of skills to carry out their tasks, and the training was generally good. The workshops were appropriate areas for prisoners to gain skills in a realistic working environment.

5.07 Resources on the open side were generally good. Training areas were spacious and well lit. This was not the case in some closed side workshops. The sewing machine repair and contracts department workshops were cramped and not designed to accommodate a full complement of prisoners. There was little natural light and conditions were drab and untidy.

5.08 Purposeful activity took place in the workshops, and the conditions were generally safe. If required, prisoners were supplied with, and used, appropriate personal protective equipment.



## Conclusion

5.09 There was a wide range of work available and, although some of it was repetitive and mundane, there were opportunities for prisoners to gain work skills. Management of the areas was good, the conditions were safe and the working environment and resources were generally satisfactory, although less so in the sewing machine repair and contract services workshops.

## Recommendations

5.10 **Prisoners should be informed in writing of the outcome of a labour change application and, if assessed as suitable for the work sought, they should be placed on a waiting list.**

5.11 **The conditions in sewing machine repair and contracts workshops should be improved.**

## Education and work skills training

### Expected outcomes

The expected outcomes for education are:

- **Safety:** Prisoners receive education and work skills training in a safe, suitable environment in which they are enabled to participate fully
- **Respect:** Prisoners are offered opportunities in education and work skills training that meet their identified needs and different levels of ability, and promote and respect personal responsibility; education is facilitated and valued by the establishment and reflects a sensitivity to equality of opportunities issues
- **Purposeful activity:** Prisoners have the opportunity to engage in a range of education and work skills training that provides constructive and meaningful activity and potential for self-expression
- **Resettlement and reducing re-offending:** Prisoners are involved in education and work skills training specifically to enhance their employment opportunities

## **Education**

5.12 The contract for providing education and training had been held by City College Manchester since January 2000. The contract was managed by the education manager, and responsibility for the day-to-day management of education was delegated to a number of co-ordinators.

5.13 Since the closure of C wing, and the consequent reduction in the prison roll, the number of prisoners enrolled on full-time foundation programmes had been low, with classes running at approximately half their capacity. In response to this, managers had merged classes under one teacher, rather than run sessions with only one or two learners. Staff teaching such classes rarely knew in advance who was to attend the class, and were often unable to plan whole group learning effectively.

5.14 The curriculum was geared to full-time classes, and there was comparatively little use of part-time attendance, even for basic skills. Prisoners were disinclined to attend for basic skills full-time, not only because of difficulties in maintaining concentration, but also because the rates of pay were better in workshops. Prisoners were also removed from classes to attend half-day offending behaviour programmes, depleting the classes still further.

5.15 Where prisoners did choose to attend education, achievement of their personal goals was good. Many learners on the programmes had had poor experiences of formal education, and many had left school with few, if any, qualifications. They were clear about the value of improving their literacy and/or numeracy, and the benefits that this would bring them on release. In one class, for example, a prisoner who started with very weak reading and writing skills had improved sufficiently to be able to write letters home unaided, and to read the replies with confidence.

5.16 While the current ICT (information and communications technology) programmes met the needs of many learners, insufficient attention had been given to developing the curriculum further to become more attractive to a wider range of prisoners. For instance, there were no courses in computer installation and maintenance, programming, or web page design.

5.17 On the open side of the prison there were good European computer driving licence (ECDL) facilities. The room was attractively laid out, accommodated 14 prisoners and provided a very good learning environment. There was a network of modern computers and up-to-date software. Learners had immediate access to all the ECDL learning and assessment resources when they logged on to the network. Instant feedback was given to them on the accuracy of their coursework and the results of their assessments. ICT students had good opportunities to obtain externally awarded qualifications at elementary and intermediate levels. Where they were unable to obtain a complete qualification, they could receive accreditation for the modules or units they completed.

5.18 The ICT resources on the closed side of the prison were inadequate, as recognised in the self-assessment report. The computers were old and unreliable and frequently broke down.

5.19 No retention and achievement rates were set in the education department, apart from the number of achievement targets required for a given period. There was also no systematic recording of the number of starters on programmes. This made it difficult for managers to determine how well the department was performing. There were inadequate arrangements to assess the quality of the teaching taking place.

## **Conclusion**

5.20 Learners were justifiably proud of their achievements, especially if they had left school early without any formal qualifications. Activities were focused and clearly maintained the learners' motivation and interest throughout the sessions. There was a very professional and respectful attitude between the learners and the teaching staff. However, the pay structure provided a disincentive which adversely affected the levels of attendance.

## **Recommendations**

5.21 **Consideration should be given to introducing part-time courses into the curriculum.**

**5.22 The information and communications technology curriculum should be broadened to provide a range of courses to suit the interests of a wider group of prisoners.**

**5.23 The quality of the ICT resources should be improved, particularly on the closed side of the prison.**

**5.24 The education department should use management information on retention and achievement rates to improve its strategic and operational focus.**

**5.25 The rigour and frequency of the quality assurance system for assessing the teaching and learning arrangements should be improved.**

**5.26 Prisoners attending basic skills education should not be subject to a pay disincentive.**

### **Work skills training**

5.27 Although there was a range of activities on both sides of the prison in which prisoners could gain employment skills, there was a lack of accredited training programmes leading to NVQ (national vocational qualification) qualifications. Qualifications at NVQ level 2 and laundry competence certificates were being developed, which would enable the majority of prisoners to achieve a nationally recognised qualification. However, there were insufficient trained personnel with the expertise to develop appropriate supporting materials.

5.28 Training was of a good standard; there were several examples of high quality work produced, particularly in clothing and cleaning programmes. However, there were no arrangements to ensure observation of training throughout the workshops to continually improve the quality of that training.

5.29 Where accredited training was taking place it was well planned. The fabric cutting workshop had designed particularly effective systems to meet the requirements of NVQ delivery. Thorough lesson plans and course structuring had been developed to support the delivery of short programmes. Individual learning

plans were well utilised and provided accurate information on the progress of learners. A thorough evaluation of the course content and quality of delivery was provided through a feedback questionnaire completed by learners.

5.30 Three areas were equipped to deliver NVQ qualifications, in fabric cutting on the open side, and contracts assembly and sewn products on the closed side. Two learners were working towards NVQs at level 2 in the cutting section, and one in electrical assembly. There had been more than 20 previously successful candidates in the sewing section, and three new learners were registered for the NVQ level 2.

5.31 There had been efforts to identify appropriate qualifications for prisoners who were on short-term sentences or were likely to be transferred. The planning of individual training in these cases was incomplete, and there was a low retention rate.

5.32 Construction programmes were well resourced. There was an excellent programme of project work taking place outside the prison, in which learners received great benefit from working in the community. Learners and employers spoke highly of the opportunities that were available to them on these projects.

5.33 Forklift truck training conditions were poor. There were broken pallets and overhanging loads during training, which were potential hazards to safe training conditions.

5.34 Industrial cleaning courses were well resourced with programmes meeting industrial standards. Learners undertaking industrial cleaning training developed a wide range of skills and expertise. The provision was highly regarded and had gained awards in recent competitions.

5.35 There were no catering programmes on the open side. However, on the closed side prisoners developed high levels of skills on catering courses. Learners were well motivated, took pride in their work and had a sense of achievement. They developed good personal and practical skills in the kitchens. Many learners had realistic ambitions to work in the industry, and most achieved a competence and capability of

industry standards. Ninety per cent of learners who started on the catering programme had successfully achieved the qualification.

### **Conclusion**

5.36 A range of training was available for prisoners to develop employment skills, and the quality of teaching and learning was generally good. Where learning was accredited, the planning was thorough, but few programmes led to NVQs. There were plans to increase the level of accreditation, although there were insufficient trained personnel to support this. Only in forklift truck training were conditions poor, and potentially unsafe.

### **Recommendations**

**5.37 Staff should be trained to develop their expertise in producing appropriate support materials for national vocational qualifications.**

**5.38 Short courses leading to qualifications should be developed for short-term prisoners.**

**5.39 Conditions for forklift truck training should be improved.**

**5.40 The provision of catering programmes should be developed on the open side of the prison.**

**5.41 There should be quality assurance of training through regular and rigorous observation of workshop sessions.**

### **Library**

5.42 Library services were provided through a service level agreement with the local library authority. There were two library facilities at the prison, one on the closed side and one on the open side. They were mainly used for recreational reading, and there were few technical books and magazines suitable to support prisoners on educational and training courses. A full range of legal reference books and Prison Service orders were stocked in both libraries, as were a small number of foreign language books.

5.43 There was poor integration between the libraries and the education service. Prisoners were not encouraged to use the libraries, and complained that they were not resourced to meet their learning needs. Many of the books were unsuitable for prisoners with basic skills needs, and there was a limited range of ICT books.

5.44 There were some language audiotapes and some audio books for prisoners with reading difficulties. Children's books were available for prisoners to take to the visitors' centre to read to their children when they visited. There was also a range of games that prisoners could borrow.

5.45 On the open side there was an attractive display of health books and a stand containing new paperbacks. A variety of informative leaflets were on display, and three daily newspapers were available.

5.46 There were extensive plans to provide new facilities to be opened during 2004. These would include computers and learning areas for prisoners.

## **Conclusion**

5.47 There were small libraries on both sides of the prison, but they were used primarily for recreational purposes. They were not stocked with texts to support prisoners' learning, and there was little formal integration between the libraries and the education department, although there were plans to improve this when they were relocated into new accommodation.

## **Recommendations**

5.48 **The stock of technical books should be increased to support the education and training of learners.**

5.49 **Communication between the education department and the libraries should be improved.**

## Physical education

### Expected outcomes

The expected outcomes for physical education are:

- **Safety:** Prisoners are safe during physical education activities
- **Respect:** The range, type and availability of physical education activities meet the needs of the prison population; prisoners are treated fairly in all aspects of physical education
- **Respect:** Physical education is part of the provision of a healthy lifestyle in promoting personal health, fitness and co-operative and team skills
- **Purposeful activity:** Prisoners are engaged in suitable physical education programmes that are fully integrated with other purposeful activities

5.50 A senior officer and five physical education instructors organised and delivered the physical education activities across both sides of the prison. Over 240 prisoners used the sports facilities each week for recreational PE. All new receptions received an induction to the PE programme to ensure safe participation, including instruction in emergency first aid and manual handling.

5.51 At the time of inspection 12 learners were studying for the treatment of sports injuries certificate.

5.52 The sports courses were intensive programmes operating over four weeks. Other courses included first aid, sports leadership, weight training, fitness instruction and specific sports coaching awards. A recreational PE programme took place during some periods of the day, evenings and at certain times at the weekend.

5.53 There was good teaching and training in all aspects of physical education. Prisoners received particularly good support from instructors during their sessions. Staff were experienced and appropriately qualified, and displayed a good level of competence.

5.54 Teaching on sports courses was delivered in an informative and motivational style and at a level and pace appropriate to the needs of the learners. Learners carried



out a detailed and thorough training programme and produced high standards of work. Portfolios contained good quality evidence. Learners' experience and competence were enhanced through organising and leading activity sessions.

5.55 Sports facilities on the open side consisted of a gymnasium containing weight training equipment and an open space for general activities. There were insufficient vocational sports courses offered on the open side of the prison. The choice of recreational activities on the open side was very limited, and consisted mainly of weight training, which did not suit many of the prisoners.

5.56 There were good links with healthcare on a smoking cessation programme (see paragraph 4.19). There were also productive links with community groups working with disadvantaged people where prisoners provided coaching and training using the prison sports facilities.

### **Conclusion**

5.57 The physical education department provided an effective induction to all prisoners, and offered a good range of vocational and recreational activities on the closed side. On the open side the programme was restricted by the limited facilities available, and did not meet the needs of all of the prisoners. PE instructors were integrated into other work within the prison and in work with community groups.

### **Recommendations**

5.58 **The sports facilities on the open side should be extended.**

5.59 **More vocational sports courses should be introduced on the open side.**

5.60 **The range of recreational activities on the open side should be extended to meet the needs and interests of the prisoners.**

## Faith and religious activity

### Expected outcomes

The expected outcomes for faith and religious activity are:

**Safety:** Prisoners can safely take part in spiritual activities

**Respect:** Prisoners of all faiths are able to practise their faith in suitable accommodation with sufficient appropriate facilities

**Purposeful activity:** Prisoners have ready access to a range of appropriate spiritual activities

**Resettlement and reducing re-offending:** Prisoners and groups of prisoners are able to be involved with their faith ministers from the community

5.61 There was one Church of England chaplain who was responsible for both sides of the prison. He was assisted by a number of sessional ministers and volunteers. All faiths could worship and have a minister to lead them.

5.62 There was a chapel with interview rooms and an activity room on both the open and closed sides. The chapel on the closed side was spacious, while the one on the open side, which had been built by prisoners, was comparatively small. There were multi-faith rooms on both sides. The room on the closed side was small and had to be accessed through the chapel. Some faiths found this to be disrespectful and used the activities room, as this was larger and outside the chapel. The multi-faith room on the open side was small but accessible. However, no ablutions area was provided.

5.63 The timings of religious services were advertised around the prison. Prisoners did not have to make an application to attend services, and prison officers did not supervise any religious activity. There were additional activities available for prisoners including, on the open side, the Alpha course, Bible study and open discussions. These activities took place mainly in the evenings. Bible studies were offered each Tuesday afternoon on the closed side only. Prisoners were not allowed to move outside the main prison areas in the evening and, therefore, prisoners from D wing could not attend the chapel. This was an inconsistent rule, as prisoners could move outside the main prison in the evening to attend the gymnasium.

5.64 The chaplain interviewed all new receptions and informed them of the activities available and how they could see a minister. Ministers could meet prisoners in private, and often did. In our survey, 77% of respondents on the open side and 73% on the closed side said their religious beliefs were respected. Ministers were involved in the broader aspects of prison life, sitting on various committees and providing written reports for sentence planning and parole.

5.65 The chaplain was consulted whenever there was bad news to be passed to a prisoner. There were good relations between the ministers and other staff. The chaplain felt able to visit the governor whenever he needed to, without making an appointment.

### **Conclusion**

5.66 The provision of ministers for all faiths was good. There were sufficient places of worship. The multi-faith rooms were too small; one was accessed via the chapel, and the other had no provision of ablutions. Prisoners on the closed side could not go to the chapel in the evening.

### **Recommendations**

5.67 **The multi-faith rooms should be relocated to accommodation that is more suitable to meet the needs of different faiths.**

5.68 **Prisoners should be allowed to use the chapel on the closed side in the evenings.**

## Time out of cell

### Expected outcomes

The expected outcomes for time out of cell, including hours unlocked, association and exercise, are:

**Safety:** Prisoners are safe when participating in out of cell activities

**Respect:** All prisoners have fair access to out of cell activities, opportunities for which meet the needs of the prison population

**Purposeful activity:** Varied and appropriate activities are supported by well-run wing routines and staff involvement

5.69 Information on the core day was displayed in residential wings and was included in the induction booklet issued to all prisoners on arrival. Inspectors monitored activity movements and found that published times were generally followed.

5.70 Following the serious incident that occurred in June 2003, the regime had been significantly restricted. Management needed to monitor this situation carefully and review these arrangements at the earliest opportunity.

5.71 Association for prisoners on A and B wings was provided on alternate evenings. On the evening that these units were not scheduled for association, prisoners on a designated landing were unlocked to use the showers and telephones. Prisoners on the same wing were also given an opportunity to attend PE. These arrangements did not guarantee prisoners daily access to showers, and were below the provision expected for a category C establishment (see recommendation 2.15).

5.72 During their designated association periods, prisoners in A and B wings used a large room off the connecting corridor. This was well equipped with a large Sky television/video, full-size snooker table, five pool tables, table football and darts. Access to the snooker table was pre-booked through a member of staff; for all other games it was on a first come, first served basis. On D wing there were four pool tables, table tennis and darts. All equipment on the closed side was generally in good condition.

5.73 Prisoners on the open side were allowed to associate on their own unit or could use shared facilities on the old-style dormitories. The main shared association room had with two pool tables, one snooker table and table tennis. The majority of equipment needed some repair. There was also a separate television room. On E wing the only association equipment available was a damaged pool table. This was also the case for prisoners on F wing, but they also had access to table football and darts. K and L wings both had two very small association rooms with a pool table in each. The level of provision and state of equipment on the open side was impoverished and had not been supported by the general purpose fund.

5.74 During our evening visit we saw some staff involved in limited engagement with prisoners on the closed side. On the open side, however, we did not come across a single member of staff. We spoke to a number of prisoners who were walking around looking for staff to help them with queries because the office was locked and unstaffed. On the open side prisoners had to return to their own wings by 8.00pm when the external doors were locked.

5.75 Daily exercise was available for prisoners on the closed side in a recently constructed exercise yard adjacent to D wing. Prisoners received 30 minutes each midweek day and up to 45 minutes at the weekends. The yard was mainly grassed with a narrow concrete path around the outside. It was relatively small and inadequate for the number of prisoners using it. There was no seating and prisoners were not issued with suitable clothing for cold or wet weather.

5.76 The establishment was meeting its target for prisoners' time unlocked, but it was not calculating these figures correctly, as they did not include time unlocked figures for the weekends and prisoners held in the segregation unit,

## **Conclusion**

5.77 A restricted regime had been introduced since the serious incident in June 2003. This needed close monitoring by management, as the regime on the closed side of the establishment was no longer meeting the expected standard for category C prisoners (see main recommendation HP.47). There was good provision of

association equipment on the closed side, and it was generally in good condition. On the open side the level of provision and the condition of association equipment were extremely poor. No staff were available to engage with prisoners on the open side during evening association (see main recommendation HP.45). Prisoners on the closed side received daily exercise, but the temporary exercise yard was unsuitable for the numbers involved. There was no seating provided and prisoners were not issued with suitable clothing for inclement weather. Time out of cell figures were not accurately recorded by the establishment.

### **Recommendations**

**5.78 Local management should urgently review the association equipment provided to prisoners on the open side. This equipment should be fully supported by the general purpose fund.**

**5.79 Time unlocked figures should be calculated correctly taking into account figures for weekends and prisoners held in the segregation unit.**

### **Housekeeping point**

5.80 Seating should be provided in the temporary exercise yard.

## CHAPTER SIX

### GOOD ORDER

#### **Expected outcomes**

The expected outcomes for good order are:

- **Safety:** Prisoners' safety is protected by clear rules necessary for the maintenance of good order and discipline and enforced by the properly exercised authority of prison staff
- **Respect:** Prisoners understand the rules of the establishment and are treated fairly; they are able to appeal against decisions
- **Respect:** Segregation, the use of force and application of category and status are used for their proper purposes and not as punishments
- **Respect:** Every opportunity is taken to encourage good behaviour even when enforcing boundaries of control
- **Purposeful activity:** Good order is supported through activities for prisoners which are challenging and well-organised

#### **Security and rules of the establishment**

6.01 The establishment had experienced a very serious incident in June 2003, when prisoners broke out of an association room and scaled the roof of C wing. As a result of continuing works, C wing was still closed at the time of inspection. The establishment had not received any prior intelligence relating to the incident. It appears that there might well have been a spontaneous element; however, the Independent Monitoring Board had identified increasing problems leading up to this event. It was, therefore, a real concern that the establishment's own security systems had failed to recognise these problems.

6.02 The security department received approximately 15 security information reports (SIRs) from the closed side of the establishment and around eight from the open side each week. These levels appeared relatively low in view of the number of prisoners held at Wealstun, and called into question the effectiveness of the

establishment's dynamic security arrangements, including the quality of staff and prisoner relationships. Staffing levels were extremely low on the open side, making it impossible for appropriate relationships to develop.

6.03 The establishment had a target of searching all cells and dormitories every three months. These targets were being met, but staff told us that an unrealistic number of searches were often expected. As a result, searches were not always completed to the required standard. Target searches authorised by a governor following analysis of SIRs were always completed. There was a monitoring system for managers to periodically check on the quality of searches and other security procedures.

6.04 A total of 5% of the population received a random mandatory drug test (MDT) each month. The establishment's target for positive tests was not to exceed 20% of those tested. This target was met but was excessive, particularly given the significant number of prisoners held in closed conditions. The list maintained by the security department of unauthorised items found in the establishment highlighted prisoners easy access to drugs. In our prisoner survey, 95% of respondents on the open side and 64% on the closed side said it was easy or very easy to get drugs into Wealstun. There had also been a number of finds on the open side relating to alcohol misuse.

6.05 The security department had been waiting for some while to gain access to the computerised '4 x 4' information system, which was known to save staff time and produce effective analysis of intelligence reports.

6.06 Copies of local rules were issued to prisoners on the closed side, as part of the induction process on B wing. There was no similar arrangement on the open side, and local rules were not comprehensively published in any other format.

## **Conclusion**

6.07 The establishment had experienced a serious incident in June 2003. No related intelligence had been received prior to that incident, which gave cause for concern, particularly relating to the quality of dynamic security within Wealstun. Targets for searching were being met, but staff told us that they were sometimes given unrealistic



targets, resulting in poor quality searches. The random mandatory drug testing target of 20% was also being met, but this appeared high in view of the significant number of prisoners held in closed conditions (see main recommendation HP.43). Local rules had not been published to prisoners on the open side.

### **Housekeeping point**

6.08 Local rules should be published to prisoners on the open side.

6.09 The security department should have the benefits of the computerised '4 x 4' system for processing and analysing information.

### **Prison disciplinary procedures**

6.10 Adjudicating governors were listed on the weekly bulletin; the governor in charge completed adjudications at least once per week. The establishment held adjudication standardisation meetings, and agreed tariffs had been published to both staff and prisoners.

6.11 The adjudication room was situated in the segregation unit and fully met requirements. There was a fixed alarm point, and the table provided for the prisoner was secured to the floor. There was also an evidence cabinet and a television/video for reviewing evidence provided via CCTV footage.

6.12 The process appeared well organised, with the adjudicating governor having individual laminated sheets for each charge. These sheets provided a user-friendly means for adjudicators to check the required burden of proof.

6.13 The prisoner was rub down searched prior to entering the hearing and then escorted in by two officers. The escort staff sat behind the prisoner, and there was no attempt to intimidate him at any stage during the proceedings.

6.14 The governor put the prisoner at ease and made sure he fully understood the process. The hearing was conducted at a pace to suit the individual's needs, and the prisoner was given every opportunity to question the evidence. He was also

encouraged to provide a full explanation of the events leading up to the incident. Following hearings where guilt was established and an award made, the prisoner was issued with written details, which included outlining the avenues of appeal.

6.15 A review of completed documentation confirmed that proceedings were conducted in a clear, fair and open manner. Prisoners were given every opportunity to call witnesses and seek advice from their legal advisers. There were also many excellent examples where pleas of mitigation were taken into account by the adjudicator, although this was not 100% consistent. Documentation was completed comprehensively.

6.16 The average weekly number of adjudications for 2003 was 24; this was an increase on the previous year.

### **Conclusion**

6.17 Adjudication tariffs had been published to prisoners, and hearings were completed in a clear, fair and open manner. Prisoners were given every opportunity to call witnesses and request legal advice. Documentation was completed to a high standard, and there was good evidence that pleas of mitigation were taken into account before awards were made.

### **Use of force**

6.18 The establishment was required to deliver basic control and restraint refresher training to uniformed staff annually, and maintain a minimum of 21 trained to control and restraint advanced level three. Both these targets were being met. There had been a total of 19 use of force incidents in 2003 up to the time of inspection. While this was relatively low, it was still a significant increase on the previous year.

6.19 Relevant documentation was completed to a good standard and provided evidence that use of force was only used as a last resort, and that only legitimate and approved control and restraint methods were deployed. When appropriate, handcuffs had been applied during use of force incidents on the closed side. This had reduced the level of discomfort to the prisoner and assisted in his safe transfer to the segregation unit. There were examples of use of force documentation certified by the

authorising officer. This was inappropriate; certification should have been completed by a manager who was not directly involved in the incident.

6.20 We observed a use of force incident from B wing to the segregation unit. Throughout the incident staff acted professionally and every effort was made by the supervising office to de-escalate the situation. A member of nursing staff was also present to monitor the prisoner during the removal. The level of care continued in the segregation unit, where the prisoner was seen by the medical officer and an F2052SH (self-harm monitoring) document was opened.

6.21 Forms for authorising use of unfurnished accommodation and mechanical restraints were filed with the relevant use of force documentation. As a result these forms had not been issued with a unique number and were difficult to locate. There were also several occasions where unfurnished accommodation had been used without completion of the relevant authorisation forms. This had already been identified through local self-audit, and appropriate arrangements had been put in place to address it. Some of the completed authorisation forms that we examined were of poor quality, with many sections not completed. Much of the missing detail was relatively minor, but omissions included time of removal from the accommodation and confirmation that the documentation had been copied to the medical officer and IMB. Some entries did not give assurance that the monitoring arrangements, as specified on the authorisation, were being completed.

6.22 Unfurnished accommodation had been used nine times so far in 2003. On two of these occasions a body belt was also used. The figures relating to unfurnished accommodation were an increase on the previous year.

## **Conclusion**

6.23 Use of force incidents, although relatively low, were increasing. The establishment was meeting its control and restraint training targets, and use of force documentation was generally completed to a good standard. There were occasions, however, where certification had been completed by the authorising officer, which was inappropriate. Authorisation forms for use of unfurnished accommodation were not always completed, although local audit had identified this matter, which had

recently been addressed. Where these forms had been completed, the documentation was not filed appropriately and was of poor quality.

### **Recommendations**

**6.24 Use of force documentation should be certified by an appropriate manager not involved in the actual incident.**

**6.25 Authorisation forms for use of unfurnished accommodation should be completed on every occasion.**

**6.26 Authorisation forms for use of unfurnished accommodation should be completed comprehensively, and also provide assurance that the levels of monitoring specified were maintained.**

### **Housekeeping point**

6.27 Authorisation forms for use of unfurnished accommodation should be given a unique serial number and maintained in their own secure file.

### **Segregation unit**

6.28 The accommodation in the segregation unit consisted of 10 normal cells and one unfurnished cell. There was also a wing office, an adjudication room, prisoner toilets and showers, and separate toilet and shower facilities for staff. All accommodation was on the ground floor. There was an exercise yard immediately adjacent to the unit, which had been divided to provide two smaller yards. In the event of the segregation unit being full, cells on B1 landing were used as an overflow facility.

6.29 The unit was well managed and organised, with high levels of cleanliness and well ordered notice boards.

6.30 The normal cells in the unit had recently been painted and were free of graffiti; there was plenty of natural light from a reasonable sized window. Toilets had no privacy screening, but they had been positioned away from the observation port. Each cell had a bed, which was secured to the floor, and a cardboard table and chair.

Cardboard furniture was provided routinely, with no subsequent risk assessment to determine whether it could be replaced safely with normal furniture.

6.31 On arrival into the unit, prisoners were strip searched in the unfurnished cell, before being relocated into a normal cell. A strip search was always given and there was no form of risk assessment of whether that level of search was necessary. Cells were prepared for new receptions with clean bedding, cup, knife, fork, spoon, and a laminated sheet explaining wing rules and routines.

6.32 Prisoners received only three showers per week rather than a daily shower. In addition, those serving punishments or segregated under rule 45 (good order and/or discipline) were restricted to half-hour visits. The provision in both areas was well below the expected level.

6.33 Education was provided, but only to prisoners who were attending full-time education while on normal location. A reasonable range of library books was held on the unit, and prisoners could change their books each day. Prisoners were not allowed to attend church services, but services were arranged on the unit if requested. While dietary needs were catered for, no pre-selection of menus was offered in the segregation unit; this appeared unnecessarily punitive.

6.34 On the day we inspected the unit roll was five – two prisoners were serving awards of cellular confinement and three were segregated under rule 45 ((good order and/or discipline). We spoke to all prisoners. The only complaint made was on the temporary loss of heating due to ongoing work on C wing. Staff had issued additional blankets and temporary heaters to enable prisoners to keep warm but these measures were inadequate.

6.35 From our observations it was evident that staff had a sound knowledge of all the prisoners held in the unit. In addition, staff-prisoner relationships were very good.

6.36 Prisoners were moved out of the segregation unit at the earliest opportunity. There had been only two recent occasions when segregated prisoners had remained in the unit for longer than 28 days. In each of these, a governor grade had chaired

reviews, which had appropriate attendance from other departments and which were well documented.

6.37 We reviewed all rule 45 documentation and found that it had been completed comprehensively. This included the occasions where continued segregation had been authorised by the Independent Monitoring Board.

6.38 The governor, medical officer and chaplain made daily visits to the unit, which were recorded in the wing register. In addition to wing history files, staff also kept an occurrence sheet on each prisoner. Entries were not made every day however, and the quality of the entries in both documents did not provide sufficient evidence that the physical, emotional and mental well being of prisoners was being monitored effectively.

### **Conclusion**

6.39 The segregation unit was well managed, with good systems and high levels of cleanliness. Staff knew the prisoners in their charge, and there was evidence of good relationships between them. There were some gaps in the regime available to prisoners, with restricted access to showers, reduced visits and, for the majority, no education provision. Cardboard furniture was provided routinely, and there was no risk assessment system to determine the appropriate level of search on location into the unit. Documentation was generally completed to a good standard. However, entries in wing history files were not made daily and did not demonstrate the necessary levels of monitoring.

### **Recommendations**

**6.40 There should be a risk assessment of prisoners on their location into the segregation unit to determine the level of search required.**

**6.41 Prisoners in the segregation unit should receive daily access to showers and be allowed domestic visits of one hour's duration.**

**6.42 Staff from the education department should visit the segregation unit regularly and provide appropriate work for all prisoners held there.**

6.43 **Daily entries should be made in the wing history files of all prisoners held in the segregation unit, to monitor their physical, emotional and mental well being effectively.**

### **Housekeeping point**

6.44 Prisoners held in the segregation unit should be able to pre-select their meals.

6.45 The provision of cardboard furniture in the segregation unit should be reviewed after a prisoner has been there for a few days, with a view to replacing it with normal furniture.

### **Vulnerable prisoners**

6.46 There were no special arrangements for dealing with vulnerable prisoners on either the closed or open side of the establishment. Though the prison had a Safer Prisons Policy with instructions for managing vulnerable prisoners, in practice the segregation unit was often used to accommodate vulnerable prisoners.

6.47 In 2002, a total of 45 prisoners had been segregated at their own request; the figure for 2003, up to the time of inspection, showed a reduction by a third to 30 such requests. Once segregated at their own request, these prisoners received the same regime as others in the segregation unit, except that they were allowed a normal one-hour visit rather than the restricted 30-minute visit allowed to other prisoners held there.

6.48 We were told that the reduction in prisoners segregated under own request was due to staff trying to manage these prisoners on normal location. This was an informal arrangement, which was not supported by published guidance or appropriate support plans.

### **Conclusion**

6.49 In spite of guidance on the means of identifying and supporting vulnerable prisoners on normal location, there was still an over-reliance on the use of own request segregation.

## Recommendation

6.50 Staff should be encouraged to use the written guidance for dealing with vulnerable prisoners; and to develop individual support plans.

## Incentives and earned privileges

### Expected outcomes

The expected outcomes for incentives and earned privileges are:

- **Respect:** Prisoners understand the rules of the establishment and are treated fairly; they are able to appeal against decisions
- **Respect:** Every opportunity is taken to encourage good behaviour even when enforcing boundaries of control

6.51 The incentives and earned privileges (IEP) system had been recently revised, with a comprehensive policy document issued in August 2003. The new system was an updated version of the original one operating at Wealstun. There were three incentive levels: enhanced, standard and basic. The same system for assessing performance applied to both sides of the establishment, although some of the available privileges varied.

6.52 On arrival in the establishment all prisoners signed a compact and were allowed a copy of it. Prisoners would normally enter the scheme on standard level, unless there was evidence that they had been on the higher level at their previous establishment. They could apply for enhanced status after a minimum qualifying period of three months and had to meet the following criteria: no formal warnings for two months; no proven adjudications for three months; and drug-free for at least three months. They also needed the support of the wing senior officer and personal officer, had to demonstrate that they had made a positive contribution to the establishment or a significant personal achievement (such as achieving an NVQ or being a Listener forum representative), and that they had complied fully with their sentence plan targets.



6.53 Under the system, the wing senior officer and identified personal officers were required to discuss each individual prisoner's recent behaviour on a monthly basis, together with any current issues. Following this meeting a monthly contact sheet was completed and inserted in the prisoner's wing history file. The personal officer had to comment on this sheet about the individual's level of compliance with routines, attitude to staff/prisoners, attitude towards employment, level of participation in sentence planning process, and his general behaviour.

6.54 The senior officer made recommendations to the regime assessment panel (RAP) about prisoners who needed to be considered for a change of incentive level. The panel met monthly, but convened outside scheduled times if there was an urgent need to review an individual case.

6.55 The RAP consisted of a principal officer, wing senior officer and personal officers. Prior to the panel meeting the wing was responsible for requesting and collating written contributions from the personal officer, work supervisor and other departments in the establishment. Prisoners were required to be considered by the panel every three months as a minimum, except for those on the basic level who were reviewed every 28 days. Recommendations by the RAP had to be endorsed by a residential governor grade.

6.56 There had been attempts to implement the revised system on the closed side and there were good examples of where this had been achieved, although there were still many gaps where documentation was not in place. On the open side, no attempt had been made to introduce the new system, and decisions relating to IEP status had been made routinely without appropriate supporting documentation. Entries in wing history files were extremely poor. There were many examples across the establishment where the minimum stipulated three-monthly review had not taken place.

6.57 Where the RAP had met and made a decision to demote a prisoner, he was issued with written details explaining the reasons, improvement targets and appeal arrangements. We saw excellent examples where this form had been used.

6.58 On the closed side, D wing was used solely to accommodate prisoners on the enhanced level; they had televisions in-cell and received association every evening. Enhanced prisoners were also held on A and B wing where they received association on alternate nights only. A wing had in-cell televisions, which were available to both enhanced and standard level prisoners. On B wing, in-cell television was only in eight enhanced cells. As a result, location on the closed side was, in many respects, more important to prisoners than their IEP status.

6.59 Variance between the standard and enhanced levels was negligible for prisoners on the closed side. Additional privileges that could be earned were restricted to: additional private cash; one extra visit a month; the right to purchase £4 extra pin phone credit; own duvet/quilt cover; one extra weekly PE session; and the opportunity to be considered for orderly jobs. In addition, enhanced prisoners on the open side could achieve resettlement leave, subject to risk assessment.

6.60 Prisoners on the basic level were located on B1 landing. There were no basic prisoners at the time of inspection, and there had been no recent examples for us to review relevant documentation. There was a published routine for basic prisoners, which included restricting them to the final 30 minutes of association periods to use the telephone and shower; visits were also restricted to 30 minutes.

6.61 Appeals were conducted by the senior manager in charge of residential. There had been only three recent appeals and none of the prisoners involved were still at the establishment. We were unable to review the related documentation, but published arrangements for appeals appeared thorough.

## **Conclusion**

6.62 Wealstun's published incentives and earned privileges system was comprehensive, but it had not been successfully introduced (see main recommendation HP.44). There were good examples of completion of documentation on the closed side, but the level of implementation was, at best, variable. On the open side the published system had not been adopted. Decisions about a prisoner's IEP level were made routinely without appropriate supporting documentation, and the minimum requirement of three- monthly reviews, as stipulated in the policy

document, often did not take place. Prisoners saw location on the closed side as more important than achieving enhanced status. There was also little variance between standard and enhanced levels in the range of incentives available to prisoners on the closed side.

### **Recommendations**

**6.63 Frequent entries should be made in wing history files to support decisions made under the incentives and earned privileges scheme.**

**6.64 The range of incentives available to enhanced prisoners should be standardised across the prison, regardless of their location.**

**6.65 The variance in incentives available at the standard and enhanced levels should be reviewed to make the enhanced level more attractive.**

### **Good practice**

*6.66 The regime assessment panel completed a form explaining to prisoners the reasons for any demotion, improvement targets and appeal arrangements.*

## Categorisation

### Expected outcomes

The expected outcomes for categorisation are:

- **Safety:** Prisoners are held in accommodation which is appropriate for their own and others' safety
- **Respect:** Prisoners are located in an establishment that is as close to home as possible and able to meet their identified needs
- **Respect:** Criteria for determining security categorisation and allocation procedures are clear, open and fair, and rules governing transfer arrangements are fairly and consistently applied without discrimination
- **Purposeful activity:** Security conditions do not unnecessarily restrict prisoners' access to purposeful activity

6.67 Re-categorisation of prisoners to category D status was co-ordinated effectively through the sentence planning unit. During their initial sentence plan, all prisoners were advised of the month in which their recategorisation would be considered. This review date was based on individual circumstances and was linked intrinsically to targets set in sentence plans. The process was initiated by the sentence planning team and progressed by the wing senior officer, who obtained written contributions from the prisoner's personal officer, seconded probation staff, drug workers, security and the prisoner's current employer.

6.68 Each wing senior officer (SO) reviewed all paperwork, which included reports of the prisoner's compliance with sentence planning targets, his wing file and core record. The SO then completed the reclassification documentation with a recommendation to the residential governor, and they assessed each prisoner together for recategorisation to category D.

6.69 Prisoners were not requested to make any contribution to the review process and were not present on the board itself. They received written responses from the residential governor, which were explained by either the wing senior officer or their personal officer. Responses were polite and courteous, and prisoners were advised of the appeals process.

6.70 Successful applications for category D status resulted in prisoners transferring from the closed side of Wealstun to the open side. Prisoners did not see this as a progressive move due to the poor induction accommodation and facilities that were offered on the open side compared to the closed side. (See accommodation and facilities.)

### **Conclusion**

6.71 Re-categorisation was well ordered and controlled, and review dates were set appropriately on the basis of individual cases.

### **Recommendations**

6.72 **Prisoners should be invited to make representations, either written or verbal, when their categorisation status is reviewed.**



# CHAPTER SEVEN

## RESETTLEMENT

### Expected outcomes

The expected outcomes for resettlement are:

- **Safety:** Prisoners are able to trust staff to deal with details of their offending and personal circumstances responsibly
- **Respect:** Sentence planning, offending behaviour and substance misuse programmes and re-integration planning are effective and meet prisoners' assessed needs
- **Respect:** The approach of all staff encourages responsible behaviour and supports prisoners working on their offending, substance misuse and other problems and preparing for release
- **Purposeful activity:** Access and allocation to purposeful activity is linked to prisoners' assessed needs and their planned targets
- **Resettlement and reducing re-offending:** Prisoners address their offending behaviour and related problems and prepare for release while in custody

### Management of resettlement

7.01 Wealstun had a resettlement policy committee (RPC) that met bi-monthly under the chairmanship of the deputy governor, who was also head of resettlement. The prison saw this level of leadership as an indicator of the priority afforded to this area of work under the Prison Service's Yorkshire area strategy. Minutes of the meetings recorded comprehensive discussion and relevant representation of internal departments and services, but there were no regular places on the committee for external representatives from employers' associations or similar bodies.

7.02 The policy document of the resettlement scheme had been updated in November 2002 and drew together a number of rehabilitative strands: sentence planning, a job club, community work (unpaid) and paid employment. The resettlement unit itself was sited on the open side of the prison and was available to

category D prisoners in their final year before parole eligibility date (PED) or with at least six months left to serve.

7.03 Resettlement opportunities for category C prisoners were less clearly defined and revolved around the principle of progressive transfer to the category D side of the prison. Unfortunately, the poor state of induction accommodation on that side of the prison was a disincentive and contradicted the notion of progression (see induction and paragraph 6.71). There was very low use of release on temporary licence, and virtually no expectation of this among the prisoners in closed conditions. In addition, many targets related to offending behaviour programmes, for which there had been very long waiting lists until relatively recently, and prisoners described increasing levels of frustration on that account.

### **Conclusion**

7.04 Resettlement had an appropriately high profile in the area strategy, and much of the establishment's future planning focused on the creation of an integrated and progressive regime to reach into the post-release phase of offender management. However, current opportunities were not equitable across the prison or within the two component regimes.

### **Recommendation**

7.05 **The resettlement policy committee should review policy in order to increase ROTL benefits to both category C and category D prisoners.**

### **Re-integration planning**

7.06 The prison's plans were guided by the area policy and the regional publication *Pathways for Resettlement*, which underpinned the work of all Yorkshire prisons. In addition to providing employment training and experience, Wealstun targeted housing and debt advice in re-integration planning. Housing advice was provided by Foundation Housing under the umbrella of the SOVA (Society of Voluntary Associations) project which was well established. As a result of an undiscovered administrative error, the current housing advice provider was not eligible to bid for a new contract. Despite significant recognition of its successes with prisoners, it would



not be carrying forward its work in the Yorkshire area under the Custody to Work initiative.

7.07 The housing adviser was closely involved in the induction process for all prisoners and, in particular, identified homeless prisoners for early intervention. A check of discharges showed that only about 6% of prisoners left without a known address. Although staff felt that some of these had made informal, but undeclared arrangements, they were classified as of no fixed abode (NFA) on release. This level of NFAs was a significant achievement compared with national statistics, which show that over 40% of prisoners are discharged homeless from prison.

7.08 In the year ending March 2003, 482 prisoners had been assessed for housing needs; of these, 446 needed significant help. Almost a quarter of these men were helped to retain existing housing, and a similar number referred for rehousing through local authorities and housing associations.

7.09 The induction process also identified financial problems, and prisoners so affected were referred to a debt adviser provided by West Yorkshire probation area who visited monthly. This assistance had led to a number of structured plans for prisoners to manage their individual situations prior to release, and had successfully launched plans that continued after release.

7.10 The preparation for work and other employment advisory services were available on both sides of the prison, but SOVA's access to category C prisoners had been severely restricted since the serious incident in June 2003, and it was estimated that the next preparation for work course would be disrupted until January 2004 as a result of building works and limited group room space. (For the community work scheme and paid work opportunities see paragraphs 7.18, 7.19.)

## **Parole**

7.11 The workload at Wealstun arising from parole cases was the highest in the Prison Service area; 20 eligible cases a month were identified. Information given to prisoners was clear and helpful. In the year preceding the inspection this translated

into 186 actual applications (65 category D and 121 category C), and resulted in 46 (71%) and 38 (31%) releases on parole licence respectively.

7.12 During the previous year there had been some slippage leading to a number of late submissions of dossiers to the Parole Board. Some of this was due to the heavy workload, and some to external factors – such as delayed interviews by visiting board members, and seriously delayed submissions by outside probation officers. For its part, the prison had recently provided additional clerical support, and there were indications that the earlier record of prompt submissions was about to be restored.

7.13 Parole dossiers contained good quality assessments, which were reflected in the decision notes sent out by the Parole Board.

#### **Home Detention Curfew (HDC)**

7.14 The HDC department was very busy and working under added pressure because prisoners were frequently transferred to Wealstun within days of their HDC eligibility date and with little or no preliminary HDC work completed. Representations had been made to the sending prisons but to little avail. The affected prisoners were fast-tracked through the system so that they were released on time, wherever possible. This was a creditable performance and showed strong commitment to the principles of early release under this scheme. Despite the tight time-scales imposed on Wealstun, the quality and thoroughness of risk assessment and public protection considerations were commendable.

#### **Release on temporary licence (ROTL)**

7.15 Temporary release was available, theoretically, to all prisoners in both category C and category D sides of the prison, subject to risk assessment, and information about release on temporary licence (ROTL) was given to all prisoners. In practice, it appeared that opportunities for ROTL on the closed side were severely restricted. The record showed that only two prisoners from that part of the prison had benefited from ROTL in the year preceding the inspection, and this was low by comparison with other parts of the category C estate. However, we were told that suitable prisoners were sometimes re-categorised and relocated in the open side before temporary release occurred.

7.16 In total, 305 applications for ROTL had been made from the open side in the past year of which 212 (69.5%) were granted. However, local statistics did not show the numbers of prisoners who benefited, since some were granted more than one period of temporary release. Our survey showed that, despite the relatively high use of temporary release for category D prisoners, only 24% of respondents said they had access to it. The available records did not detail ROTL statistics for the closed side, except to reveal that only two applications had been granted. Boards were held weekly under the chairmanship of a senior manager.

7.17 A conscientious clerk administered the ROTL system efficiently, and all required internal and external communications were appropriately managed and tracked. Risk assessment within the prison was thorough, but we learned of occasions when evaluations by home probation areas were either insubstantial or late.

7.18 We noted the significant use of ROTL to enable category D prisoners to participate in the accredited enhanced thinking skills (ETS) programme under the auspices of probation areas. This provided access to courses not currently available in the prison, as well as targeted participation in specific courses, such as one addressing domestic violence.

7.19 Category D prisoners in the resettlement unit were eligible to apply for unpaid community work for 20 days as a prerequisite for participation in the paid employment scheme. This was available for up to 50 prisoners, but at the time of the inspection only 20 prisoners were involved. Those who had taken part described with enthusiasm the benefits of involvement in local charitable and community ventures, and the obvious mutual benefits.

7.20 The paid work scheme was in line with the strategy that prisoners should acquire jobs and retain them during a smooth transition from prison to community on their release. Paid work was also under-subscribed at the time of the inspection, with only a further 20 prisoners engaged in this scheme. It was available only to those whose home area was within 50 miles of the prison – about 60% of prisoners. This

disqualified 40% of prisoners whose claim on employment training and experience was arguably the same as those from the more immediate locality.

## **Conclusion**

7.21 Good working relationships had been fostered between prison staff and those providing specialist re-integration services. This work took account of the regional framework for Yorkshire and Humberside, and the principles outlined in the regional publication, *Pathways for Resettlement*. The success of the housing advisory scheme was notable. The parole system was well managed to the benefit of significant numbers of prisoners. There had been some temporary slippage in prompt submission, which had been addressed appropriately. Release on temporary licence was well administered, but focused on prisoners on the open side; it was our impression that prisoners on the closed side did not benefit fully from this provision. The community work and paid work schemes were beneficial but could only benefit 60% of prisoners.

## **Recommendations**

7.22 **The resettlement policy committee should review the operation of the release on temporary licence (ROTL) scheme and ensure that all prisoners have a fair and equal opportunity to benefit.**

7.23 **The outworker scheme should be expanded to provide experience and training for a wider group of prisoners, while making every attempt to secure employment for prisoners beyond release.**

## **Housekeeping point**

7.24 ROTL statistics should provide detailed information to managers, clearly differentiating between open and closed sides and indicating which categories of ROTL are applied for and granted as a proportion of applications from eligible prisoners.

## **Good practice**

7.25 *The housing advisory service provided by Foundation Housing contributed positively to the resettlement of the 46% of prisoners in serious housing need, and resulted in only 6% of prisoners being discharged without accommodation.*

## **Sentence planning**

7.26 There were designated sentence planning officers on both sides of the prison. Known as the 'report writers', it was their primary responsibility to prepare the sentence planning documentation and incorporate contributions from a range of internal and external sources. However, these officers were often redeployed to other duties. This had a disruptive effect and led to some delays in reviews, particularly for category C prisoners. These delays had adversely affected the flow of referrals to offending behaviour programmes, and caused some prisoners to feel disadvantaged and frustrated.

7.27 Sentence planning boards were held weekly on each side of the prison, and were chaired by a senior manager. In the closed side, most prisoners to whom we spoke were aware of their sentence plan and its contents. In our survey, 54% of respondents said they were involved or very involved in the development of their plan, but this left a significant number who were indifferent to or not involved in the process. This appeared connected to weaknesses in the personal officer scheme, which had the potential for more significant and positive impact on sentence planning. Of the 85% of category D prisoners who qualified for sentence plans, only half had an active sentence plan at the time of the inspection.

7.28 The sentence plans we looked at suggested that some content had become standardised, and many of the targets were not sufficiently precise or time-bounded – despite the assertion by managers that these should be specific, measurable, achievable, relevant and time bounded (SMART).

7.29 There were relevant links to the incentives and earned privileges scheme, and to consideration of release on temporary licence and home detention curfew issues. However, in the closed prison, category C prisoners had very low levels of ROTL (see

paragraph 7.14). Prisoners attended boards and were helped to present their views and to understand the process.

7.30 Education, healthcare and drug services staff made important and informative contributions to sentence plans, and prisoners on the open side reported positive influences from the work experience and community work which had formed part of their planned progress. Sentence plans for category D prisoners dealt primarily with resettlement issues, but the process also revealed substantial areas of need which had not been met prior to recategorisation.

7.31 There was a low level of attendance at review boards by outside probation officers, and we noted that a growing number of prisoners had no nominated link with their home probation area. We were told that this affected 40% of prisoners at the time of the inspection. However, it was positive to see that sentence plan targets sometimes extended beyond the bounds of the custodial period and pointed towards post-release work or collaborative work during sentence; the probation areas in Yorkshire, in particular, could offer offending behaviour programmes not available in the prison.

## **Conclusion**

7.32 Sentence planning ostensibly occupied a central position in the whole of the custodial experience at Wealstun. Appropriate resources were identified, but not always deployed, to reflect the importance of this work. There was a danger that the process could become mechanistic and perceived as an exercise in completing documents, rather than an indispensable part of the rehabilitation process which dealt with prisoners as individuals.

## **Recommendation**

**7.33 The staff detail should properly reflect the importance attributed to sentence planning, and designated staff should not be readily redeployed.**

## **Offending behaviour work**

7.34 One accredited programme, reasoning and rehabilitation (R&R) was provided, and this was on the closed side of the prison only. The delivery of this programme

achieved an implementation quality rating (IQR) of 100% in 2002-03 in the audit by the Prison Service offending behaviour unit. An effective tripartite management group supported the programme to manage the three key elements – programme delivery, quality of treatment and links to external agencies.

7.35 The in-year target for completions of this programme was 90, and required the delivery of nine courses per year. This provided a very heavy workload for the tutor group of four prison officers and three probation staff, whose combined efforts went well beyond the normal call of duty to achieve the reported results. This work was undertaken against a waiting list which had reached 70 at one point in the summer of 2003, but which had reduced to about half of that figure at the time of the inspection. To achieve their targets, the programmes team had, on occasion, run three separate groups simultaneously with no substantial reserves of staff.

7.36 Delays in sentence planning had led to frustration for prisoners who wished to start the programme, having had their needs identified and targets set prior to transfer to Wealstun. The targets from the earlier prison were not implemented automatically, and had to be reviewed by a fresh sentence planning board at Wealstun. This was difficult for prisoners to understand when they had been sent to Wealstun expressly to undertake the R&R programme. We learned that delays of six to eight weeks had been experienced, which adversely affected the motivation of prisoners who then joined an already lengthy waiting list. At the time of the inspection the maximum waiting time for R&R was 16 weeks for those who had been assessed as suitable for the course.

7.37 A range of non-accredited courses was on offer. Most notably, a short course called Choices for Change was delivered on both sides of the prison and had also attracted long waiting lists – especially in the closed side, where it had reached 80 at the time of the inspection. This course had been submitted for accreditation. Other groups addressed drugs issues and preparation for work, while specialists from the voluntary sector tackled gambling and alcohol problems.

7.38 The enhanced thinking skills (ETS) programme was not available in the prison, but was operated by West Yorkshire probation service in the community.

There were arrangements to enable prisoners to attend this course through temporary release.

## **Conclusion**

7.39 Management and staff demonstrated a commitment to providing offending behaviour programmes, but the success to date was largely due to the extraordinary efforts of the frontline staff. This was commendable, but not sustainable in the long term. The quality of output and the imaginative local planning to link with other providers in the community was worthy of substantial support and appropriate resources.

## **Recommendations**

**7.40 Where sentence planning targets identifying a programme need have been set for a prisoner at a sending prison, these should be speedily referred to appropriate staff.**

**7.41 The complement of trained tutors should be reviewed in the light of current waiting lists and in anticipation of expanding demand from an increased roll.**

## **Public protection**

7.42 The seconded senior probation officer (SPO) was effectively the operational lead in public protection matters, although the deputy governor was the accountable senior manager. The SPO brought considerable experience and knowledge to this area of work, having been instrumental in developing policies in other settings.

7.43 When the system was introduced, initially in 2001, there was an early management assumption that Prison Service order 4400<sup>1</sup> would not apply to any prisoners allocated to Wealstun, but this was quickly disproved. The SPO's contribution went beyond that indicated in the resettlement business plan 2002-03 agreed between the governor and the West Yorkshire probation area, and this was

---

<sup>1</sup> Prison Service order 4400 is in two parts: Chapter One deals with the protection of child visitors to prisoners who are assessed as posing a potential threat to their safety and well-being; Chapter Two seeks to prevent prisoners from harassing a member of the public by any means.



reflected in the current, comprehensive public protection policy document published and signed in November 2002.

7.44 A system was in place to identify high-risk cases and, where required, full referral was made to a multi-agency public protection (MAPP) meeting. We saw an example of just such a case involving non-parole conditional release. The difficulties and anomalies encountered by those operating public protection measures were highlighted by the fact that the prisoner in question had been variously described as a 'model prisoner', and had attained significant positions of trust in the establishment. Notwithstanding this, the potential risks to the public were properly identified and managed.

7.45 This latter point underlined the need for supportive training for prison staff who have day-to-day contact with prisoners so that they might more fully understand the dangers which sometimes lie behind institutional compliance. All seconded probation staff had undergone mandatory training.

7.46 Conversely, some prisoners arrived at Wealstun wrongly identified as presenting risks. The system at Wealstun had successfully removed these labels from men whose reputation would otherwise have been damaged.

7.47 Particular attention was paid to inform the relevant authorities of any listed prisoner who was on the outworking scheme. While this initially generated anger and concern for some prisoners, the outcome was usually positive in that it paved the way for a more open and honest approach after final release.

7.48 At the time of the inspection there were 17 Schedule One offenders<sup>2</sup> in closed conditions, and a further five, including one life sentenced prisoner, on the open side. In addition there were six prisoners to whom PSO 4400 (Chapter Two) applied. West Yorkshire probation area had been extremely co-operative in establishing local

---

<sup>2</sup> Prisoners convicted of an offence listed in Schedule One of the Children Act 1989 against a child or young person under the age of 18 years.

protocols, but much work remained to achieve similar standards across all the areas served by Wealstun.

### **Conclusion**

7.49 Public protection policy and practice were properly supported by senior management, and effectively implemented through the informed leadership of the seconded senior probation officer.

### **Good practice**

7.50 *Public protection practice and protocols at Wealstun provide a model for the Prison Service in its new duty as a 'responsible authority' in public protection matters.*

## Life sentenced prisoners

### Expected outcomes

The expected outcome for provision for life sentenced prisoners are:

**Safety:** Lifers trust that details of their offences and personal circumstances are treated responsibly by staff

**Safety:** Potential lifers on first entering custody, and newly sentenced lifers returning from court, are given close attention and support from trained staff

**Respect:** All lifers are able to address their risk factors and prepare for release within the timescale of their tariffs

**Respect:** Recalled lifers and licence revokees are dealt with promptly, openly, consistently and fairly and a regime provided for them

**Respect:** Staff working with lifers understand the lifer system and encourage lifers to maintain a positive approach to their sentence and work towards their eventual release

**Purposeful activity:** Lifers experience balanced regimes with opportunities for work, education, leisure and social interaction which afford them choice and require them to take increasing responsibility for themselves

**Resettlement and reducing re-offending:** Lifers are able to access help which assists them in coming to terms with their sentence and to take responsibility for their offending

**Resettlement and reducing re-offending:** Lifers experience a phased re-integration into the community supported by a resettlement team in the discharging prison which includes input from the home probation officer

7.51 At the time of the inspection the prison held 16 lifers; all were located in open conditions. A nominated senior manager took overall responsibility and was supported by two principal officers as lifer managers. Collectively they brought considerable experience to this work. They were well supported by a conscientious clerk, whose attention to detail was reflected in the readiness with which we could locate and identify key information.

7.52 It quickly became clear from discussions with key staff and with lifers themselves that some of them had arrived in open conditions with significant issues not addressed prior to transfer. These included an absence of specific group work,

which in some cases had been identified as a target earlier in sentence. Understandably, this was distressing to prisoners who, having 'progressed', were faced with the prospect of reverting to earlier issues. In addition, like other new arrivals in the open prison, life sentenced prisoners had to cope with the deplorable state of their induction accommodation (see paragraph 2.04).

7.53 It was a credit to staff at Wealstun that they tackled this in a professional and responsible manner, and in ways that minimised the potential damage to the prisoners themselves. Clearly a category D prison was not resourced or programmed to meet these outstanding needs, and it was commendable that two seconded probation officers, in conjunction with other staff, were seeking to make up the deficits through demanding one-to-one work. The possibility of enabling lifers to attend accredited courses via the Yorkshire probation areas was also being explored. With senior management support, the seconded probation staff and lifer managers had organised a successful 'lifer day' in July 2003. This was to become an annual event and there were efforts to sustain a lifer forum, which had suffered some slippage.

7.54 Personal officers attached to individual lifers provided good support, including the organisation of accompanied town visits and other re-integration aids. Prisoners appreciated this, and personal officer views were well represented in contributions to life sentence plans. We also noted good quality psychological assessments, which accounted for a substantial portion of the senior psychologist's workload. The psychologist was operating solo at the time of the inspection as a result of staff movements, although there were contingency plans to provide some assistance from the area.

## **Conclusion**

7.55 Life sentenced prisoners were well managed and, unlike many other prisoners, they received consistently effective support and advice from skilled and committed personal officers. Administrative support was thorough and reliable, and led to the prompt submission of dossiers and timely reviews. Wealstun staff made every effort to offset any potential damage which might arise from earlier inadequacies of the system.

## Recommendation

7.56 Management should strongly support lifer days, which should become regular events.

### Key workers (personal officers)

#### Expected outcomes

The expected outcome for key workers are:

- **Safety:** Key workers provide a first line level of care promoting safety in the prison environment
- **Respect:** Prisoners experience relationships with their key workers that are based on mutual respect, high expectations and affirmation
- **Respect:** Prisoners know that their key worker will support them fully in their involvement in the prison system and throughout the progress of their sentence, based on sound knowledge of the prisoner, including any special needs
- **Purposeful activity:** Key workers encourage the best use of their prisoners' time out of cell
- **Resettlement and reducing re-offending:** Key workers ensure that prisoners start and maintain the process of resettlement from the beginning of the sentence and in each new location

7.57 All prisoners on both sides of the prison had nominated personal officers. In our survey, 64% of respondents on the closed side had met their personal officer during the first week and, overall, 74 % felt that personal officers were either helpful or very helpful.

7.58 On the open side the position differed in that more than half the respondents to our survey said they had not met their nominated officer for more than a week, and 55% had not yet met their officer at all. However, most of the minority who were in contact with a personal officer said this was helpful to them.

7.59 These research findings supported our observations and findings that the operation of the scheme was variable across the whole prison. On the closed side there was more positive interaction, and particularly good examples were noted on D wing.

Management checks of wing files were in evidence, and there were contributions by personal officers in sentence plans.

7.60 In the open prison there was little positive staff contact with prisoners, and many officers appeared to have little or no working knowledge of prisoners' individual circumstances. Examination of wing files revealed cases in which no entries had been made for several months, and others contained scant information – often in a negative vein. The actual operation of the personal officer scheme in the open side, as observed by us, fell below the minimal expectations of local managers who acknowledged that 'only significant events were recorded in history sheets' because of low staffing levels in that part of the prison.

7.61 Prisoners were urged to take the initiative to seek out their personal officers and introduce themselves. This proved difficult and prisoners, like inspectors, found it difficult to locate *any* staff on the open side during the evening association period.

7.62 The exception to this limited performance lay in personal officer work with life sentenced prisoners, all of who were located in open conditions (see paragraph 7.54).

## **Conclusion**

7.63 A structured personal officer scheme was allegedly in place across the whole prison, but its implementation was inconsistent. While the best performance was on the closed side, there was still room for improvement. On the open side the scheme was largely ineffective for most prisoners. The few who had a personal officer link felt this was helpful. These views confirmed the scheme's value, but also highlighted the disadvantage to many prisoners who did not have this link. There was effective personal officer work with life sentenced prisoners.

## **Recommendations**

7.64 **An effective personal officer scheme should be available to all prisoners.**

7.65 **Personal officers should be supported by appropriate training.**

**Housekeeping point**

7.66 Personal officers should be required to be pro-active in introducing themselves to prisoners.





# CHAPTER EIGHT

## SERVICES

### Catering

#### Expected outcomes

The expected outcomes for catering are:

- **Safety:** Prisoners' food is prepared and served safely in accordance with environmental health regulations and religious requirements
- **Respect:** Prisoners receive a fair portion of healthy, balanced, nutritious and varied meals to meet their physical, gender, health, religious, ethnic and medical needs
- **Respect:** Prisoners have a choice and are encouraged to eat healthily to help them create and maintain healthy lifestyles

8.01 The kitchen was located on the open side of the prison and was due to be replaced by a new building in 2004. It was supervised by a manager and nine staff; all were civilian grades. The kitchen was dirty. On our night visit we found vegetable and meat waste in internal drainage channels, dirty mops and buckets leaning on worktops, and leaking waste pipes flooding floors. When we visited during the day we found it to be generally dirty, but not unhygienic; all the various food preparation areas were clean and tidy, and food was properly separated and stored.

8.02 There were 30 prisoners working in the kitchen. All were given an induction and provided with a useful booklet, which gave good information for anyone working in that environment. The prison was just starting to offer prisoners training leading to qualifications.

8.03 The menu was on a three-week cycle and was pre-select for prisoners on the closed side, offering five choices at lunch and dinner. The menu choice was varied,

with vegetarian, vegan, and halal option. For halal eaters there was always more than one option, and often three or four. There was also a healthy eating option.

8.04 We observed meals being served. They were hot, well presented and the portions were generous. On all the occasions we saw meals being served we did not receive a single complaint about the food. A member of the kitchen staff was on duty at the serverys when meals were served. There were food complaints books on all the wings and in the libraries; a member of the kitchen staff checked these weekly. The complaint books we checked contained few complaints, and were noted each week by kitchen staff. Prisoners were surveyed twice a year for their views of the food.

8.05 Meals were served at the published times. Prisoners on the closed side ate their meal in their cells. Prisoners on the open side could use a dining hall. The dining hall was shabby and looked distinctly tired. With seating for about 200, it was not large enough to accommodate all the prisoners. Prisoners did not always remove waste from their table after they had eaten, which was unhygienic and uninviting for the next person to use it. There were large queues of prisoners waiting outside the dining room for all meals. The queues were outdoors and there was no covering; in inclement weather waiting for meals would be very uncomfortable.

## **Conclusion**

8.06 The kitchen was dirty but not unhygienic. Food was prepared in distinct areas and properly stored. The menus were varied and catered for the needs of all prisoners. The food was appetising and the portions generous. There were various avenues for prisoners to complain or comment about the food. The dining facilities for prisoners on the open side were shabby. Some prisoners had to eat at tables with food waste left by the last diner. It was not good practice for prisoners to queue for their meals in the open.

## **Recommendations**

8.07 **The senior manager carrying out daily visits to the kitchen should ensure that levels of cleanliness are monitored and maintained.**

8.08 **The dining room should be redecorated.**

8.09 **Prisoners' arrival for meals should be managed to eliminate queuing outside the dining hall.**

### **Housekeeping point**

8.10 Cleaners should be employed in the dining room to wipe down tables after they have been used.

### **Prison shop**

#### **Expected outcomes**

The expected outcomes for the prison shop are:

**Safety:** Arrangements to enable prisoners to purchase goods minimise opportunities for bullying

**Safety:** Items held in the prison shop and store are stored and served according to the requirements of food safety, hygiene, religion and security

**Respect:** Prisoners have a suitable range of affordable goods available for purchase at reasonable prices to meet their ethnic, cultural and gender needs

8.11 The operation of the prison shop had been contracted out to Aramark. Prisoners were provided with a weekly order form on Wednesdays; this showed the amount of money they had available to spend, and they could choose their purchases from a product list of 332 goods. A total of nine toiletry items, three skincare products, and two grocery items were aimed at minority ethnic prisoners. Updated copies of the product list and catalogues were kept in the wing offices on both sides of the prison.

8.12 Prisoners were concerned that the goods were expensive compared to the level of wages they received. The range of foodstuffs also attracted some criticism. There was a limited amount of fresh fruit available. Products for Asian prisoners were limited to a jar of mixed pickles, and for Caribbean prisoners a Jamaican bun. In the prisoner survey, 61% of respondents did not feel that the shop sold a wide enough range of goods to meet their needs.

8.13 The service was, however, predictable and accessible. Prisoners collected their purchases on Fridays and were given a receipt with full details of their purchases. On the open side, officers supervised prisoners when they collected their purchases from the visits building. On the closed side, Aramark staff set up a table on each wing and dispensed the goods to prisoners. Aramark staff also carried a supply of popular goods to rectify any mistakes on the spot. When this was not possible, prisoners were given an IOU receipt and their goods were delivered the next day.

8.14 Prisoners in the segregation unit, and those with authorised absences, completed an order form in the same way, and collected their goods from the wing office. New arrivals received a £5 or £10 reception pack, with tobacco included for smokers.

8.15 Aramark also managed the catalogue service. Prisoners had access to five different catalogues from which to choose items of clothing, recreational goods, vitamin supplements and other purchases. They paid a 50p administration charge per order, if the goods were in stock, and generally received their purchases within a month. However, there could be delays of up to three months. A local company supplied daily newspapers and magazines at normal shop price.

8.16 A prisoners' forum met monthly to discuss product availability, standard of product delivery, and the 10 most and least popular products. There was representation from Aramark, prison managerial staff and prisoners from both sides of the prison.

## **Conclusion**

8.17 There was a predictable prison shop service to all prisoners. A reasonable range of goods was available, but this was particularly limited for Asian prisoners. Where there were mistakes with orders, these were rectified on the spot or the next day. Some prisoners experienced delays of up to three months for their catalogue goods. Prisoners' views on product availability and standard of product delivery were represented through the monthly prisoners' forum.

## **Recommendations**

**8.18 The Prison Service should ensure that the range of goods sold in prison shops is wide enough to meet the reasonable expectations of prisoners, and that the needs of different populations are provided for.**

**8.19 The price of goods should be looked at in future contract negotiations with Aramark, particularly in view of their monopoly position and the low wages of prisoners.**

**8.20 The delays in the processing of prisoners' catalogue orders, particularly from Argos, should be reduced.**



## CHAPTER NINE

### RECOMMENDATIONS AND GOOD PRACTICE

*(Numbers in brackets refer to paragraph in main report)*

#### **Main recommendations**

##### **To the Governor**

9.01 **The North and South dormitory units should be taken out of commission immediately. (HP.41)**

9.02 **All cells in B wing should be equipped with in-cell electricity. (HP.42)**

9.03 **The induction programme should run on a rolling programme so that all prisoners can join it on the day following reception. (HP.43)**

9.04 **The target for positive mandatory drug testing should be reduced, and there should be a review to identify methods of reducing the supply of drugs into the establishment. (HP.44)**

9.05 **The new incentives and earned privileges scheme should be fully implemented on both sides of the prison. (HP.45)**

9.06 **Staff on the open side of the prison should be deployed to maximise their interaction with prisoners. (HP.46)**

9.07 **Observations and notes of contact between staff and prisoners should be made in wing files and be monitored by managers. (HP.47)**

9.08 **The restrictions on prisoner movement, association and activities, imposed following the June 2003 riot, should be reviewed to determine the extent to which they can be safely relaxed, and when. (HP.48)**

9.09 **Work and training should, wherever possible, lead to qualifications recognised by outside employers. (HP.49)**

9.10 **The resettlement provision should be based on a needs analysis of the population; it should offer all eligible prisoners opportunities to work outside the prison. (HP.50)**

### **To the Director General**

9.11 **The Prison Service should ensure that the range of goods sold in prison shops is wide enough to meet the reasonable expectations of prisoners, and that the needs of different populations are provided for. (8.18)**

### **Other recommendations**

#### **To the governor**

#### ***Arrival in custody***

9.12 **Prisoners should have ready and free access to telephones in reception. (1.13)**

9.13 **Newly arrived prisoners on the closed side should not be accommodated alongside those on the basic regime or held under segregated conditions. (1.14)**

9.14 **Newly arrived prisoners on the open side should be accommodated in conditions of decency, which reflect the progressive nature of their transfer to a category D prison. (1.15)**

9.15 **There should be specific first night accommodation and arrangements for both closed and open sides. (1.16)**

9.16 **The provision of legal services across the prison should be reviewed to ensure that an equitable service is available to all prisoners. (1.20)**



### ***Residential units***

9.17 **An alarm system should be installed urgently in the open side units so that prisoners can obtain assistance in an emergency during the evening and night period. (2.12)**

9.18 **Privacy screens should be installed in all cells with integral sanitation. (2.13)**

9.19 **Prisoner should be offered the opportunity to shower and make a telephone call each day if they wish. (2.14)**

9.20 **There should be a review of the number of telephones on each wing. (2.15)**

9.21 **The number of items of personal clothing that prisoners are allowed in possession should be reviewed, alongside a review of the current arrangements for exchanging personal items through reception. (2.25)**

### ***Duty of care***

9.22 **The anti-bullying committee should meet on its published dates. (3.09)**

9.23 **There should be standing agenda items on the anti-bullying committee that follow up action points, quality-check anti-bullying documentation, examine statistics, look for trends and identify gaps in the systems. (3.10)**

9.24 **The anti-bullying committee should ensure that there are interventions to challenge bullies and support victims. (3.11)**

9.25 **More staff should be trained in suicide awareness as a matter of urgency. (3.24)**

9.26 **A Listener care suite should be provided and its use managed according to an agreed protocol. (3.25)**

- 9.27 **The race relations/diversity management team RR/DM should meet monthly. (3.38)**
- 9.28 **Facility time for the race relations liaison officer (RRLO) should be increased to carry out the tasks to promote positive race relations. (3.39)**
- 9.29 **All staff should receive diversity training, which should address issues such as unacceptable use of inappropriate language and behaviour towards prisoners. (3.40)**
- 9.30 **Strategies to improve prisoner confidence in the racial complaints procedure should be considered. (3.41)**
- 9.31 **The prison should work more closely with the black prisoner support group, Partners of Prisoners Support Group, to promote regular cultural diversity celebrations. (3.42)**
- 9.32 **The proposed support strategy for foreign national prisoners should be put into place as a matter of urgency. Good practice elsewhere on the treatment of foreign national prisoners – such as the model in use at HMP Wandsworth – should be adapted for use at Wealstun. (3.53)**
- 9.33 **A foreign national prisoners' policy should be produced as a matter of urgency. (3.54)**
- 9.34 **There should be appropriate provision for foreign national prisoners to maintain contact with their families, friends and external support groups. (3.55)**
- 9.35 **Notices and information displayed to prisoners should also be available in foreign languages. (3.56)**
- 9.36 **The working times of the CARAT (counselling, assessment, referral, advice and throughcare) workers should be reviewed to ensure that they are accessible to prisoners on the open side of the prison. (3.68)**

- 9.37 **The provision of a short drugs course as relapse prevention, or for prisoners serving a short sentence, should be considered. (3.69)**
- 9.38 **The drug strategy should be explicit that prisoners who require, or who are still completing, a detoxification programme are not accepted for transfer to Wealstun. (3.70)**
- 9.39 **The visits booking line should be open for a longer period; its availability out of office hours should be considered. (3.83)**
- 9.40 **A larger visits centre appropriate for the expected number of visitors should be provided. (3.84)**
- 9.41 **The visits centre opening hours should be reviewed to be in line with the timing of public transport to the prison. (3.85)**
- 9.42 **All prisoners, including those on the basic IEP level, should receive their statutory entitlement to one-hour visits, with immediate effect. (3.86)**
- 9.43 **Passive drug dogs should be used during domestic visits to help promote a safe environment for prisoners. (3.87)**
- 9.44 **All applications should be logged and tracked through to the reply stage. (3.99)**
- 9.45 **A governor grade should attend the prisoner forum and follow up action points. (3.100)**

### ***Healthcare***

- 9.46 **A suitable waiting area should be provided for prisoners attending the healthcare centre facilities on the open side of the prison. (4.35)**
- 9.47 **Staff should have time profiled for clinical supervision. (4.36)**

**9.48 There should be an annual skill mix review to ensure that nursing staff are able to meet the healthcare needs of the expanding population at Wealstun. (4.37)**

**9.49 All staff who may need to use the automated external defibrillator should be trained to use it. (4.38)**

**9.50 GP clinic times should be set in conjunction with the core day to ensure they do not disadvantage prisoners who work. (4.39)**

**9.51 Triage protocols should be developed to ensure consistency of advice and treatment to all prisoners. (4.40)**

**9.52 There should be a chronic disease register, and nurse-led chronic disease clinics. (4.41)**

**9.53 A primary care trust representative should be encouraged to attend medicines and therapeutics committee meetings. The committee should consider the following: (4.42)**

- **system and clinical audit arrangements**
- **development of a local prescribing formulary**
- **ratification of all medication-related policies and patient group protocols**
- **development of a policy for the use of Venalinks**
- **introduction of risk management systems, such as error logging and significant event recording, in line with clinical governance**
- **an increase of pharmacy hours at Wealstun**
- **the introduction of pharmacist-led clinics.**

**9.54 The mental health in-reach services should be extended to meet the requirements at Wealstun. (4.43)**

### **Activities**

**9.55 Prisoners should be informed in writing of the outcome of a labour change application and, if assessed as suitable for the work sought, they should be placed on a waiting list. (5.10)**

**9.56 The conditions in sewing machine repair and contracts workshops should be improved. (5.11)**

**9.57 Consideration should be given to introducing part-time courses into the curriculum. (5.21)**

**9.58 The information and communications technology curriculum should be broadened to provide a range of courses to suit the interests of a wider group of prisoners. (5.22)**

**9.59 The quality of the ICT resources should be improved, particularly on the closed side of the prison. (5.23)**

**9.60 The education department should use management information on retention and achievement rates to improve its strategic and operational focus. (5.24)**

**9.61 The rigour and frequency of the quality assurance system for assessing the teaching and learning arrangements should be improved. (5.25)**

**9.62 Prisoners attending basic skills education should not be subject to a pay disincentive. (5.26)**

**9.63 Staff should be trained to develop their expertise in producing appropriate support materials for national vocational qualifications. (5.37)**

**9.64 Short courses leading to qualifications should be developed for short-term prisoners. (5.38)**

- 9.65 **Conditions for forklift truck training should be improved. (5.39)**
- 9.66 **The provision of catering programmes should be developed on the open side of the prison. (5.40)**
- 9.67 **There should be quality assurance of training through regular and rigorous observation of workshop sessions. (5.41)**
- 9.68 **The stock of technical books should be increased to support the education and training of learners. (5.48)**
- 9.69 **Communication between the education department and the libraries should be improved. (5.49)**
- 9.70 **The sports facilities on the open side should be extended. (5.58)**
- 9.71 **More vocational sports courses should be introduced on the open side. (5.59)**
- 9.72 **The range of recreational activities on the open side should be extended to meet the needs and interests of the prisoners. (5.60)**
- 9.73 **The multi-faith rooms should be relocated to accommodation that is more suitable to meet the needs of different faiths. (5.67)**
- 9.74 **Prisoners should be allowed to use the chapel on the closed side in the evenings. (5.68)**
- 9.75 **Local management should urgently review the association equipment provided to prisoners on the open side. This equipment should be fully supported by the general purpose fund. (5.78)**

**9.76 Time unlocked figures should be calculated correctly taking into account figures for weekends and prisoners held in the segregation unit. (5.79)**

***Good order***

**9.77 Use of force documentation should be certified by an appropriate manager not involved in the actual incident. (6.24)**

**9.78 Authorisation forms for use of unfurnished accommodation should be completed on every occasion. (6.25)**

**9.79 Authorisations forms for use of unfurnished accommodation should be completed comprehensively, and also provide assurance that the levels of monitoring specified were maintained. (6.26)**

**9.80 There should be a risk assessment of prisoners on their location into the segregation unit to determine the level of search required. (6.40)**

**9.81 Prisoners in the segregation unit should receive daily access to showers and be allowed domestic visits. (6.41)**

**9.82 Staff from the education department should visit the segregation unit regularly and provide appropriate work for all prisoners held there. (6.42)**

**9.83 Daily entries should be made in the wing history files of all prisoners held in the segregation unit, to monitor their physical, emotional and mental well being effectively. (6.43)**

**9.84 Staff should be encouraged to use the written guidance for dealing with vulnerable prisoners; and to develop individual support plans. (6.50)**

**9.85 Frequent entries should be made in wing history files to support decisions made under the incentives and earned privileges scheme. (6.63)**

**9.86 The range of incentives available to enhanced prisoners should be standardised across the prison, regardless of their location. (6.64)**

**9.87 The variance in incentives available at the standard and enhanced levels should be reviewed to make the enhanced level more attractive. (6.65)**

**9.88 Prisoners should be invited to make representations, either written or verbal, when their categorisation status is reviewed. (6.72)**

### ***Resettlement***

**9.89 The resettlement policy committee should review policy in order to increase ROTL benefits to both category C and category D prisoners. (7.05)**

**9.90 The resettlement policy committee should review the operation of the release on temporary licence (ROTL) scheme and ensure that all prisoners have a fair and equal opportunity to benefit. (7.22)**

**9.91 The outworker scheme should be expanded to provide experience and training for a wider group of prisoners, while retaining the vision of securing employment for prisoners beyond release. (7.23)**

**9.92 The staff detail should properly reflect the importance attributed to sentence planning, and designated staff should not be readily redeployed. (7.33)**

**9.93 Where sentence planning targets identifying a programme need have been set for a prisoner at a sending prison, these should be speedily referred to appropriate staff. (7.40)**

**9.94 The complement of trained tutors should be reviewed in the light of current waiting lists and in anticipation of expanding demand from an increased roll. (7.41)**

**9.95 Management should strongly support lifer days, which should become regular events. (7.56)**



9.96 **An effective personal officer scheme should be available to all prisoners.**  
(7.64)

9.97 **Personal officers should be supported by appropriate training.** (7.65)

### **Services**

9.98 **The senior manager carrying out daily visits to the kitchen should ensure that levels of cleanliness are monitored and maintained.** (8.07)

9.99 **The dining room should be redecorated.** (8.08)

9.100 **Prisoners' arrival for meals should be managed to eliminate queuing outside the dining hall.** (8.09)

9.101 **The Prison Service should ensure that the range of goods sold in prison shops is wide enough to meet the reasonable expectations of prisoners, and that the needs of different populations are provided for.** (8.18)

9.102 **The price of goods should be looked at in future contract negotiations with Aramark, particularly in view of their monopoly position and the low wages of prisoners.** (8.19)

9.103 **The delays in the processing of prisoners' catalogue orders, particularly from Argos, should be reduced.** (8.20)

## Housekeeping points

### ***Arrival in custody***

9.104 The published induction programme should be followed to ensure that all prisoners receive full and essential information. (1.17)

### ***Residential units***

9.105 Privacy/acoustic hoods should be installed on all telephones. (2.16)

9.106 Colour-coding of cleaning equipment should be adhered to. (2.17)

9.107 Basic maintenance work should be carried out on A and B wings. (2.18)

9.108 There should be a review of the facilities list, particularly in regard to allowing all prisoners to have outer garments in possession. (2.26)

### ***Duty of care***

9.109 Ethnic monitoring data should be presented in a more user-friendly format. (3.43)

9.110 The guide for staff on reporting racist incidents, and the multi-faith guide on the searching of prisoners and their religious artefacts, should be readily available in the wing offices. (3.44)

9.111 The catering department should be more creative in offering minority ethnic prisoners a broader range of meals. (3.45)

9.112 The availability of interpreting services should be widely publicised to prisoners. (3.57)

9.113 There should be a review of searching procedures for visitors to identify alternative, private searching areas. (3.88)

9.114 There should be a review of visits procedures to speed up the process from booking-in to the start of visits. (3.89)

9.115 The visits halls on both sides of the prison should be redecorated. (3.90)

9.116 The layout of the visits hall on the closed side should be reviewed to allow greater privacy for prisoners and their visitors. (3.91)

9.117 The screening of complaints at senior officer level should cease and all complaints should be logged formally. (3.101)

### ***Healthcare***

9.118 In the dental suite on the closed side, the dental chair should be moved to a more appropriate position, and two more sinks should be provided. (4.44)

9.119 Other methods of remuneration for the dentist should be investigated, such as a sessional fee. (4.45)

9.120 Information about prisoners seen by the mental health in-reach team should be amalgamated with their main inmate medical record. (4.46)

9.121 All prisoners should have suitable secure facilities to store in possession medications. (4.47)

9.122 Patient information leaflets (PILs) should be supplied with all prescribed medications, or a notice displayed to advise patients that PILs are available on request. (4.48)

9.123 Weekly expiry date checks of medicine stock should be documented. (4.49)

9.124 Systems to allow supply of simple remedies when the healthcare centre is closed should be considered. (4.50)

9.125 A mercury spillage tray should be provided in the dental suite. (4.51)

9.126 The dentist should record medical histories of dental patients. (4.52)

### **Activities**

9.127 Seating should be provided in the temporary exercise yard. (5.80)

### **Good order**

9.128 Local rules should be published to prisoners on the open side. (6.08)

9.129 The security department should have the benefits of the computerised '4 x 4' system for processing and analysing information. (6.09)

9.130 Authorisation forms for use of unfurnished accommodation should be given a unique serial number and maintained in their own secure file. (6.27)

9.131 Prisoners held in the segregation unit should be able to pre-select their meals. (6.44)

9.132 The provision of cardboard furniture in the segregation unit should be reviewed after a prisoner has been there for a few days, with a view to replacing it with normal furniture. (6.45)

### **Resettlement**

9.133 ROTL statistics should provide detailed information to managers, clearly differentiating between open and closed sides and indicating which categories of ROTL are applied for and granted as a proportion of applications from eligible prisoners. (7.24)

9.134 Personal officers should be required to be pro-active in introducing themselves to prisoners. (7.66)

### **Services**

9.135 Cleaners should be employed in the dining room to wipe down tables after they have been used. (8.10)

## Examples of good practice

9.136 *The establishment issued a multi-faith guide on the searching of prisoners and their religious artefacts. (3.46)*

9.137 *Both prisoners and staff were involved in the compilation of the health needs assessment. (4.53)*

9.138 *Healthcare staff had adopted the concepts of clinical governance; the protocol for reporting errors related to the administration of medications was good practice. (4.54)*

9.139 *Healthcare centre staff completed a disability questionnaire with new prisoners that was shared with discipline staff. (4.55)*

9.140 *There was an inventory of instruments at the end of each dental session. (4.56)*

9.141 *The regime assessment panel completed a form explaining to prisoners the reasons for any demotion, improvement targets and appeal arrangements. (6.66)*

9.142 *The housing advisory service provided by Foundation Housing contributed positively to the resettlement of the 46% of prisoners in serious housing need, and resulted in only 6% of prisoners being discharged without accommodation. (7.25)*

9.143 *Public protection practice and protocols at Wealstun provide a model for the Prison Service in its new duty as a 'responsible authority' in public protection matters. (7.50)*

