REPORT ON

AN UNANNOUNCED FOLLOW-UP INSPECTION OF

HM PRISON HOLLOWAY

11 – 15 December 2000

BY

HM INSPECTORATE OF PRISONS

PREFACE

This is the fourth time that we have inspected HMP & YOI HOLLOWAY in the past five years, this time as a follow-up to our previous announced inspection in 1997. I am conscious that, being the only women's prison in London, within easy reach of a multiplicity of political and other visitors, and in view of past inspection reports, it is more in the public eye than almost any other prison in the country. This inevitably impacts on both the Governor and his staff, who must feel at times that they are living and working in a goldfish bowl. I am conscious too of the effect on their morale of what must seem like an endless stream of criticism, when many of both the causes and the solutions must seem outside their ability to influence. Therefore, in presenting what must seem like another critical report I must emphasise that it contains evidence not only of some excellent work by many people, demonstrating their commitment to their task, often against the odds, but also evidence that there has been a great deal of positive and creative thinking about the treatment of and conditions for the many different ages and types of prisoner who are sent there, and it is with the prisoners that I want to begin this preface.

In planning any operation it is essential to establish first the characteristics of the target that has to be tackled, in this case the prisoner population. Only when this has been done can you establish, with any degree of certainty, what resources are needed for the task. One member of staff, when asked to describe the population contended that it contained a large number of alcoholic drug abusers, caring for numerous siblings, 9 out of 10 of whom have suffered sexual as well as physical and emotional abuse. This does not describe an advantaged cross section of the national population, but, as a generalisation, it is endorsed by some of the statistics contained in the report:

> 53% said that they had problems needing immediate attention at the moment of reception:
>
> > 38% said that these were to do with health, including medication.
> >
> > 31% said that these were to do with their use of drugs.

31% said that these were to do with housing.

23 % said that these were to do with family issues.

Many had more than one problem, so these figures are individual rather than collective indicators.

75% were found to be suffering from some form of identifiable mental disorder.

45% of new receptions were in need of immediate drug detoxification, 75% of whom were injecting drug users.

50% were serious alcohol abusers.

90-95% were using benzodiazapenes, indicating the need to help with sleep or stress.

The 62 new receptions seen by the admirable Bourne Trust First Night in Custody Project in October, and the 74 seen in November, each had 95 children for whom they were responsible. This included a 15-year-old girl with a 10-month-old baby.

2052 SH suicide watch procedures were open on 52 prisoners, or 10% of the population.

24% had no fixed abode at the time of reception, and 37% said that they did not know where they would be going on release.

73% had no job to go to on release.

37% get no visits.

What were the staff at HOLLOWAY able to do about this, and how well were they meeting these and other needs?

The capacity of the Health Care Centre had been reduced from 92 to 27.

59% of the current inpatients, at the time of our inspection, should have been in NHS secure psychiatric care. 30% of hospital appointments were cancelled because of lack of escorts.

The current detoxification programme was in no way capable of meeting the need, only being able to offer 10 as opposed to 21-day programmes.

There were insufficient follow–on or voluntary drug testing arrangements in the prison, or links with inadequate follow-on in the community. I was told a number of harrowing stories about young prisoners who had died soon after resuming their abuse very soon after release, as a result of this latter deficiency, which staff felt distressed about because of their powerlessness to prevent what they saw as a horrible inevitability.

45% said that they had been offered no help with their housing problems, and we found this most important requirement, particularly for women prisoners, to be woefully under-resourced.

76% said that they had not been given courses to help them to get a job. 59% said that they had not been involved in any activities likely to encourage positive change in them.

40 % of possible education provision was being lost because prisoners were not being got to the excellent education centre on time. Far too many individual students were in education for only 33% of the time that they should have been there, for a variety of reasons.

Only 20% of the staff had received up to date mandatory training in suicide prevention.

In other words, needs are not being met, which means the treatment of and conditions for prisoners in HOLLOWAY are not satisfying the aim of the Criminal Justice System, namely to protect the public by preventing of crime, through engaging offenders in programmes designed to tackle the likelihood of re-offending. The questions that then have to be asked are why, and what can be done about it.

Throughout the inspection we gained the distinct impression that, rather than being able to concentrate on the needs, treatment and conditions for prisoners, the Governor, and therefore staff, were under competing direction, which, because it came from political and Prison Service masters, was seen as being of greater importance. The Minister of Prisons was taking a very personal interest in Health Care, making frequent visits to the prison to be briefed, and, naturally, a considerable amount of attention was being paid to his personal demands. We were impressed with the plans put forward by the Camden and Islington NHS Trust for improvements in primary care. But primary care is but one aspect of the life of this very complex establishment, faced with a multiplicity of problems, and I must be concerned at the impact on the overall treatment and conditions of prisoners of having so much managerial time diverted from their attention, in order to deal with but one issue.

Furthermore, we gained the distinct impression that Prison Service Headquarters was far more concerned about Key Performance Indicators, Key Performance Targets, accreditation and budgetary matters, than with identifying and satisfying the criminogenic needs of prisoners. In every previous report I have drawn attention to the fact that HOLLOWAY cannot solve all its problems by itself, and needs the active involvement of line management. Of course there is a need to monitor targets and expenditure, but these requirements are assuming an unhealthy dominance in the running of prisons, in direct contrast to their purpose, which is the treatment and conditions of prisoners, in line with the Prison Service's Statement of Purpose. I have lost count of the number of times that I have made this point, but it makes no sense to

go on monitoring inadequate provision, for the sake of monitoring it, when that does not result in improvements to outcomes for prisoners, enabling a prison to satisfy the prime task required of the Service. The whole process is not helped if Prison Headquarters are fed inaccurate information, such as thousands of wrongly recorded regime hours uncovered by my inspectors. Real improvement can only be made based on fact and not on fudge. This is why it is so important to ensure that Ministers are only provided with accurate information.

So what? The Prison Service has now established a Women's Policy Group, which has done some excellent work in many areas, and also appointed an Operational Manager of the Women's Prisons. I hope that these two, separately and together, will examine this report in detail, and note the number of activities that we suggest require needs assessment to enable improvement. These include such essentials as:

Establishing offending behaviour needs, and developing suitable treatment programmes for both adult and young women.

Educational needs assessments in every women's prison.

Analysis of the changing pattern of drug use, and so determining the most suitable forms of treatment. In this connection I am interested in a proposed pilot of a treatment programme involving young drug abusers and their young children, developed, and proving successful, in Canada.

Custody planning for unsentenced prisoners.

Reviewing sentence-planning procedures and ensuring that prisoners are only held where appropriate and required treatment programmes are available.

Establishing proper arrangements for the treatment and conditions of unsentenced as well as sentenced children and young prisoners.

On this last point I must condemn, in the strongest terms that I can, the continued practice of holding unsentenced children with sentenced adults, only

moving them to join their peers when they are themselves sentenced. The stupidity of putting impressionable children in dormitories with hardened criminals is beyond my comprehension. Common sense, never mind the law, should dictate that this is wholly inappropriate, and I am surprised that the Prison Service has not taken action to eliminate the practice, without attention having to be drawn to it in an inspection report. I made the point to the Minister immediately following the inspection, and I hope that the practice will now cease.

Of course there are things that the Governor must consider and put right, attention to which are drawn in the report. At the same time I must emphasise that one of my prime concerns about HOLLOWAY, because it impacts on the treatment of and conditions for prisoners, is the treatment of and conditions for staff. Unless these are right, nothing will be right for prisoners, and HOLLOWAY is particularly troubled by a number of factors that need urgent attention, as three examples show:

> I am disturbed at the simultaneous exit, for a variety of reasons, of so many female Governor grades. It stands to reason that there must be a proper gender balance in the management of a female prison, particularly one as complex as HOLLOWAY, and there are many very competent female Governor grades in the system who could replace those who have left. But such an exodus suggests a lack of sensible career planning.
>
> The Governor told me that, on average, one member of staff leaves each week, again for a variety of reasons. No organisation can survive such a constant drain on its most important resource, trained staff, and hope to deliver all that is required of it. It is essential that all staff working with women prisoners are suitably trained, another deficiency that we noted. Traditionally other women's prisons take trained staff, particularly middle managers, from HOLLOWAY, which does not help. Stability must be brought to staffing arrangements acknowledging the constant pressures of maternity leave,

sickness, training courses and other factors. Stress was frequently mentioned, brought about by the demands of the population, and inadequate staff numbers. Stressed staff are not efficient staff, and the reasons for it should be examined and ameliorated.

Nursing staff in particular pose a very real problem. The financial situation in any establishment is bound to be distorted if it faces an overtime bill of £40,000 per month for Agency nurses, required to replace full time staff who cannot be recruited. With budgetary compliance being afforded such high importance by senior management, note must be taken of this situation.

Our concerns about the lack of a Throughcare Committee, the inadequate Personal Officer scheme, the need for permanent staff permanently available to provide Bail Information, the need to carry out proper risk assessment before allocating anyone, particularly children, to shared accommodation, and many other aspects that require attention are mentioned in the report. I must draw attention too to the final paragraph, 4.09, which catalogues the very serious concerns to which we drew the attention of the Governor and the Operational Manager during the debrief that we conducted at the end of the inspection.

Set against that are a number of very good things, listed as examples of good practice, to which I must add the excellent interventions with those with emotional needs, listed in paragraphs 3.55 – 3.61 and the running of the young offenders wing by a recently departed, and not replaced, APS Principal Officer. These confirm that there are foundations on which necessary improvements can be based, because people have thought through what is required.

But none of these can happen unless there is a serious attempt to produce a viable strategic plan for HOLLOWAY, based on satisfying the needs of the many types of prisoner it is called upon to contain. 28% of all female prisoners come from London,

and therefore, however unsatisfactory, there will always be a need for at least one large prison in London, to serve the London courts, and from which women should be resettled back into their communities. This last cannot be done from DRAKE HALL in Staffordshire, in which many prisoners from HOLLOWAY find themselves.

The nature and needs of the women's prison population is changing, as the remark with which I began this preface indicates. All to many, who are already primary carers for children, abuse drugs, alcohol and medication in large quantities, possibly in response to the economic and social pressures with which they are faced, which include horrific levels of domestic violence and other abuse. Like it or not, more and more children are themselves having children, for whom they must be prepared to be responsible. This is not to excuse the commission of the crime for which females end up in prison, but to describe a reality that has to be recognised and tackled if they are not to return, or, more hopefully, not come in in the first place. It is a sad fact that you have to assume that every female in prison has been subject to abuse in some form or another, which must condition the way in which they are treated, particularly by male staff.

Dealing with the problem, as it manifests itself and not as it is presumed to be or people would like it to be, requires first and foremost assessment of the need, not assessment only of what can be done with what resources are available. Armed with this a further assessment must be made of what satisfaction will require, which can then lead to deciding what can be afforded, or what will have to be left out. But that decision cannot be taken by, and should not be left to the Governor of HOLLOWAY, or the Director General of the Prison Service, although both should be called upon to give their advice. How well HOLLOWAY will be able to meet the demands of its present and future population depends on decisions that can only be taken by Ministers, because they require and depend on a complete reappraisal of resource provision. I hope that this report will help to explain the reason why, and indicate some of the considerations on which decisions should be based.

All that should be enshrined in a detailed action plan for HOLLOWAY, which I hope will be produced, well before the Inspectorate returns in two years time.

Sir David Ramsbotham **March 2001**

HM Chief Inspector of Prisons

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INTRODUCTION

Short inspections have been developed to ensure that the Inspectorate visit and check establishments between full inspections. They are carried out by a small team, last two or three days and are usually unannounced. Clearly they cannot serve functions of full inspections but we believe that they are important in highlighting issues of concern or praiseworthy areas relating to the treatment of prisoners. They are not intended to cover every aspect of the prison.

We carried out an unannounced short inspection of Holloway from the 11 to 15 December 2000. The inspection's main purpose was to review progress on recommendations made after the last inspection in 1997. The team also monitored the treatment of prisoners using the model of the healthy prison described in Chapter Seven of 'Suicide is Everyone's Concern' published by HM Inspectorate of Prisons in 1999. During their visit they met prisoners and staff and had discussions with the Governor and the Chairman of the Board of Visitors. They discussed their conclusions with the Governor, Operational Manager and members of the Senior Management team before they left.

FACT PAGE

Task of establishment:

Local prison

Brief history:

Rebuilt during the 1970's and 80's – serves a multi-purpose function, which includes lifers.

The prisoner population:

Mixture of convicted and unconvicted adults and young prisoners.

Area organisation:

Directorate of Women's Prisons

Number held:

487 average

Cost per prisoner per annum:

£40,543

Certified Normal Accommodation:

517

Operational capacity:

Normally 532 (during rewiring 492)

Last full inspection:

December 1997

Last short unannounced inspection:

June 1996

Description of Residential units:

Approximately 50/50 split between single cells and multi-occupancy dormitories.

CHAPTER ONE

THE PRISON

History

1.01 HMP Holloway was first built in 1849, completed in 1851 and opened in October 1852 with three wings for males and one for females. Towards the end of the 19th Century it became a remand prison and in 1903/04 became an all female prison. The idea to replace the old Victorian radial style prison was first conceived in 1968: the intention was for a 'hybrid' between prison and hospital with a therapeutic regime; however ideas changed about the type of regime suitable for women prisoners. The new prison opened in 1977 although buildings were not complete until the mid eighties. The present roll of Holloway, which has an operational capacity of 532 prisoners, and a certified normal accommodation indicator of 517, is to hold convicted and unconvicted prisoners remanded by the courts in the south east of England.

The prisoner population

1.02 On the first day of the inspection 507 prisoners were unlocked. The following statistics are based on population figures provided on 11 December. On this date 519 prisoners were unlocked; after discharges and escorts to court etc, 467 prisoners remained in the prison during the day. Of these, 10% were young prisoners (aged between 16 and 20) with the largest proportion of prisoners aged between 30-39 years. 45 percent of prisoners had been sentenced and 55 percent were on remand or unsentenced. Drug related offences were the most common (31%) and 22% were in custody for burglary or theft. Thirty-five percent of the population were from ethnic minority backgrounds; 17 were black Caribbean. Thirty-four percent were from London and the majority of the remainder were from the Home Counties and other counties bordering London; 24% were of no fixed abode. Details of the population by age, status, main offence, ethnic origin and home area can be found at Appendix II.

CHAPTER TWO

PROGRESS SINCE THE 1997 REPORT

Introduction

2.01 In order to examine the progress that had been achieved following our last inspection in December 1997, we have used the recommendations from that report as a framework for our examination of the establishment.

2.02 We have commented where we have found significant improvements and where we believe little or no progress has been made and work remains to be done. We have also highlighted additional information relating to work being undertaken and reported on new good practice examples. During this inspection we concentrated on aspects that directly affected the treatment and conditions for prisoners and therefore not all the recommendations from the last inspection were examined. The numbers in brackets at the end of each recommendation identify the paragraph of text in the last report.

To the Secretary of State

Foreign Nationals

2.03 *Better systems should be introduced to predict the release dates of foreign nationals due for deportation and make speedy arrangements with the Immigration Service to effect their departure. (2.6)*

Achieved.

To the Director General

Security

2.04 *Security arrangements for female prisoners across the Prison Service should be reviewed in accordance with recommendations in the thematic review 'Women in Prison'. (3.32)*

This issue is ongoing. **We repeat the recommendation.**

Health Care

2.05 *The care of mentally disordered inpatients should be under the direction of a fully trained psychiatrist. (3.228)*

One of the former Senior Medical Officers working at Holloway had completed psychiatric training but had not been recently in NHS practice. **The HIMP should aim to provide psychiatric input that is integrated with local psychiatric services.**

Psychological Services

2.06 *The Psychology Department at Holloway should be recognised as a centre of excellence, sufficiently resourced, to provide a research and development function for the female estate. (3.156)*

Not achieved. We therefore repeat the recommendation and we refer also to the further recommendation in paragraph 2.148 of this report.

Tackling Offending Behaviour

2.07 *There should be a national needs analysis conducted into the offending behaviour needs of women prisoners and, properly resourced, targeted provision. (3.35)*

Not achieved. We therefore repeat the recommendation. A wide ranging needs analysis for the women's estate remains outstanding.

Drug Strategy and Mandatory Drug Testing

2.08 *The computer programme notifying the requirement for Mandatory Drug Testing should be reviewed to take account of prisoner discharge dates. (3.134)*

Not achieved. There were still difficulties with the information technology provided to manage the Mandatory Drug Testing element of the Drug Strategy. The names of prisoners who had been discharged as well as those close to their discharge date continued to show on the system that provided the list for random testing.

Performance Planning and Review Systems (PPRS)

The development of a strategy for the management of difficult to manage female prisoners should be one of the first priorities for the Director of Female Prisons. (3.35)

Not inspected.

Senior Officers and Principal Officers should be providing more guidance and support to junior staff. (3.41)

Not inspected.

The Business Management Unit at Headquarters should visit Holloway and discuss with appropriate personnel selection staff and line managers, the career management of staff who are persistently absent on sick leave. (3.42)

Not inspected.

To the Operational Manager

Bail and Legal Aid

2.09 *The Bail information Officer post should be filled; work of the department should be fully analysed and sufficient resources made available to provide a full Bail Information service for all prisoners held in Holloway Prison not just those committed from the London courts' area. (3.108)*

There were four staff working in the Bail and Legal Aid office. Two of these staff had been Bail Information trained. Unfortunately there were regular redeployments from this office and this meant that staff could only provide a full Bail Information service for prisoners committed by the 42 London courts most local to the establishment. If this unit were fully staffed up, they felt they could cover the 92 courts in Holloway's catchment area. **We urge that this is made possible.**

Health Care Management

2.10 *The Area Medical Adviser should support the governor and managing medical officer in securing the services of competent personnel, and in dispensing with the services of those whose performance is unsatisfactory. (3.11)*

The area medical adviser posts were no longer operational. The problems in securing competent staff and dispensing with the services of those whose performance was unsatisfactory remained unsolved. **The prison Health Task Force should support the Governor and the Health Care Manager to achieve this recommendation.**

To the Governor

Employment

2.11 *Unit managers should be made accountable for prisoners not attending activities. (3.181)*

Not achieved. There were several features which mitigated against full accountability by unit managers.

2.12 Firstly, a recent change of management structure had resulted in Principal Officer Unit Managers being withdrawn into central services and other similar roles. Their unit management roles were being carried out by Senior Officers. Apart from giving a lower supervisory grading to these posts the move had also introduced less accountability, as no Senior Officer had overall responsibility. Their line manager had become a junior governor grade who was too overloaded to give full attention to many of the day to day activities in the units.

2.13 Secondly, the system of allocating prisoners to activities, particularly education, was not always helpful to prisoners or staff. Attendance at education was on a 'first come, first served' basis. In reality this sometimes meant that prisoners would leave the unit to attend classes but found that they were all full and had to return to the wing. This was beyond the responsibility of the Senior Officer.

2.14 Finally, there did not appear to be any structure for monitoring the attendance of prisoners at activities and the possible accountability of staff or unit managers for non-attendance. **The recommendation is repeated.**

2.15 *The software should be improved. (3.183)*

Not inspected

Regime Monitoring

2.16 *There should be a specific agenda item for Regime Monitoring at management meetings. (3.187)*

Partly achieved. We were told that regime monitoring was an agenda item at the monthly Senior Management Team meeting and at the monthly Regimes meeting. We were, therefore, surprised to discover apparently serious anomalies in the recording of association hours on a regular basis which had not been queried by managers in the Activities group or at senior management level. **Regime monitoring figures should be reviewed to make them more realistic and checked thoroughly to ensure their accuracy.**

Additional information

2.17 Given the anomalies surrounding the use of IT in regime monitoring we were also very surprised to discover poor use of the LIDS system. In every other prison we have inspected, this system, whilst far from perfect, has been a most useful management tool to provide information on the immediate location of a prisoner, i.e. wing, landing and cell number and, usually, a record over many months of changes of location. The importance of knowing which cell a prisoner is in has clear importance but the custody history may also be important evidence in later claims, allegations, investigations and so on.

2.18 At Holloway we found that the LIDS system contained the unit but not the cell or dormitory number. Hence all prisoners on, say, D2 were recorded as being in cell 001. Apart from being nonsensical, this was inaccurate and unhelpful. We were assured that this had always been the case at Holloway but did not find this a convincing explanation for its continuation. **The LIDS system should be used properly and accurately.**

Education

2.19 *There was a need to develop the curriculum for the proposed young prisoner unit (3.188)*

Achieved. A new unit for juveniles had recently been established on D 0. The education department had appointed a full time member of staff to take responsibility for the work of the new unit. The post-holder was involved with all aspects of

individual guidance and programme planning for juveniles. This important initiative had been resourced (i.e. paid for) out of existing budgets (i.e. no new money to support this important initiative).

2.20 *Consideration should be given to the appointment of additional assistant therapists/teachers in the day centre. (3.188)*

Even though the number of instructional officers in the day centre had been reduced (from two to one) a teacher had been appointed to work in this unit and was offering high quality support in this important area of work. Considerable progress had been made since the previous inspection (and see below in paragraph 2.25).

2.21 *Hairdressing or beauty therapy courses should be considered. (3.189)*

Not achieved. The recommendation is repeated.

2.22 *There should be better liaison with some middle managers. (3.190)*

The Education Manager had little contact with the senior/middle managers in the establishment other than regular informal contact with the prison Governor and occasional contact with the Head of Inmate Activities. **The recommendation is repeated.**

2.23 *Educational needs analysis should be undertaken. (3.191)*

The education department had devised a detailed programme/set of arrangements for the induction and needs assessment of new arrivals but they were not working well. Each Wednesday morning was designated for this important activity. Teachers and assessment co-ordinators were available to interview and test new arrivals at this time but much of their time was wasted because of low-attendance levels. **Attendance levels at the weekly induction and needs assessment of new arrivals should be improved to take full advantage of the services on offer.**

2.24 *Consideration should be given to adjusting the daily routines to make attendance at evening classes more attractive. (3.191)*

Attendance at evening dasses was low and was a matter of concern. Numbers attending classes were dictated by the ratio of officers to women (1:10) when moving prisoners from the wings to the education block. With two officers on duty, the maximum number of students allowed to attend was 20 (even though there were 40 places available). **We therefore repeat the recommendation.**

2.25 *Education in the medical units should be provided. (3.191)*

Considerable progress had been made since the last inspection. The education department was currently offering 16 sessions per week in the health centre (with the support of improved regime funding). Much of this work was provided by teacher/therapists (drama, dance) and was of a very high standard.

2.26 *There should be a programme of computer replacement, a photocopier should be provided and the Department should have access to the LIDS system. (3.192)*

Tremendous progress had been made. High quality ICT was available in the education department. Over £100,000 had been spent recently on the provision of computer hardware/software in the education department with the support of improved regime funding.

2.27 *Vocational training classes were not represented within the Induction process; consideration should be given to delivering these courses within the education system. (3.192)*

Limited progress had been made. Vocational training courses did not come under the responsibility of the education manager. New arrivals, at the time of the induction, were informed of the range of vocational courses on offer. If they expressed an interest in vocational training classes they completed an application form and were interviewed by specialist teaching staff at the end of the induction programme. **Consideration should be given to delivering vocational courses within the education system.**

2.28 *Additional staff for the library should be considered. (3.193)*

An increase in staff for the library had been achieved through enhanced regime funding.

2.29 *The accommodation for both education and library should be redecorated. (3.194)*

The library and education departments were in good decorative order.

2.30 *The carpet in the library should be replaced. (3.194)*

Achieved.

Anti-Bullying Strategy

2.31 *Supervision should be improved in the bath and showers areas of Reception and in the clean side holding room. (3.127)*

Not achieved. We were told that current staffing levels made no allowance for the additional supervision required in these crucial areas of Reception. Staff in this area acknowledged that the showers presented a particularly serious potential risk in view of the capacity for up to four prisoners to be in that area at one time. In practice, significant numbers of prisoners at reception declined the use of showers and baths. **We repeat the recommendation.**

2.32 *Staff training in the Anti-Bullying Strategy should be a priority. (3.128)*

Not achieved. We found that for the larger part of the past year the Anti-bullying strategy had been afforded low priority across the majority of the prison. The notable exception was in D0 (Juvenile) wing to which we have made separate reference below. Elsewhere we detected a lack of clarity of ownership of bullying issues by line management. Discussion with senior and middle managers revealed an absence of an anti-bulling policy to underpin the strategy. We found only one minuted meeting of the Anti-bullying Committee from the past year and this meeting, dated 7 November 2000, had neither Governor grade attendance nor apology. We were told on 12 December that the meeting scheduled for the next day was postponed because the Inspection Team had occupied the Boardroom. Discussion with a wide range of staff revealed their awareness of the damaging potential of bullying and its possible links to self-harm incidents but, apart from staff in the Juvenile Unit, all too many

officers expressed a disturbing sense of powerlessness in the face of this phenomenon. There was a significant need for training and ongoing support of staff and **the recommendation is therefore repeated.**

2.33 There was clear evidence that bullying issues received considerable attention in 1998. The Psychology Department was active in conducting a snapshot survey of the whole prisoner population on 7 June of that year. The subsequent analysis and report provided a significant insight into women prisoners' experiences of bullying and attitudes to the behaviour. This led to the introduction of the practical anti-bullying document known as 'Bulldoc' in October 1998 but reference to the minutes of the Anti-bullying committee minutes of 7 November 2000 suggested that, two years on, there was a lack of clarity about its use. Equally there appeared to be an absence of ideas about addressing the needs of victims of bullying. Staff on the adult residential units expressed cynicism about the 'Bulldoc' system and we found indications that many staff did not raise the documentation in relevant cases. We considered that this was further evidence of a negative drift away from a well-constructed system, largely in the wake of policy neglect in the past year. The basis of a sound policy existed and **the Anti-bullying Committee must meet regularly, be chaired by a Senior Manager and have a multidisciplinary membership with a view to producing an anti-bullying policy document** to underpin this crucial work.

2.34 The 'Bulldoc' system was being used to good effect in the Juvenile Unit. We found a level of confidence in the system among staff in D0 and they told us that the Juvenile team "made the scheme work because there was no alternative" – given the standards required in the care of Juveniles and the limits on transfer options. Amongst Juvenile trainees we found a high level of awareness of the Juvenile Unit approach to bullying and saw an impressive bullying survey of Holloway Young Offenders dated 1 November 2000. We were told that this latest information was used to further enhance the anti-bullying strategy of the Unit. **We recommend that the successful implementation of 'Bulldoc' in D0 should inform a more widespread anti-bullying action plan for the whole establishment.**

Bail and Legal Aid

2.35 *Lockable sealed display cabinets should be made available in strategic areas around the establishment for Bail and Legal Aid information. (3.103)*

Not achieved. We repeat the recommendation.

2.36 *The Personnel Department should inform Legal Aid of staff movements, in and out, to ensure information is kept up-to-date. (3.105)*

The list of foreign language speakers referred to by this recommendation should be kept up to date but not by the Legal Aid office. **This job should be carried out by the Foreign Nationals Liaison Officer.**

Buildings and maintenance

Not inspected.

Catering

2.37 *All employees should be examined by the doctor before taking up work in the kitchens (3.95)*

Achieved.

2.38 *Cleaning standards in the kitchen should be improved (3.97)*

Achieved.

2.39 *The delays between cooking food and serving it to prisoners on their units should be reduced. (3.97)*

It could still take up to thirty minutes for the food to get from the kitchen to the units. Food was generally cooked just before leaving the kitchen but on occasion items might be put onto trolleys early if there were only a few staff in the kitchen. Delays would also occur once trolleys reached the units before food was served. **We repeat the recommendation.**

2.40 *There should be better quality control in the kitchen. (3.98)*

Achieved. Production control records were kept to report time food was cooked. Temperature and visual checks were made and food tested by the Duty Governor and a health care worker (medical officer or nurse) on occasion.

2.41 *There should be better liaison between the kitchen and residential unit. (3.100)*

Partially achieved. Liaison between the units and the kitchen had appeared to have improved. Friction was still occurring when numbers of meals were wrong but the kitchen staff felt that this was a landing based problem sometimes due to the turnover of prisoners.

2.42 *A food committee should be introduced (3.100)*

Not achieved. We repeat the recommendation. There was no Food Committee. Food surveys had taken place and the Catering Principal Officer regularly informally liased with prisoners. There were no **food comments books** – these **should be introduced.**

2.43 *Basic training supervision at serveries, timely serving of meals, checks of meals and portions and continuity of a trained prisoner workforce should be reviewed. (3.102)*

Training records were kept for all prisoners working in the kitchen. The Catering Principal Officer recognised that the training of servery workers was not consistent and needed to be improved. He had plans to train staff, preferably designated Cleaning Officers, so that they would train prisoners. We observed prisoners who were not properly attired for servery work, some without hats, gloves or whites. **All servery workers should be properly attired and have health and hygiene training before being allowed to work on the serveries.**

Drug Strategy and Mandatory Drug Testing

2.44 *Information Technology to maintain a comprehensive database to facilitate the management and administration of Mandatory Drug Testing should be provided. (3.134)*

There were still difficulties with the Information Technology provided to manage the Mandatory Drug Testing element of the Drug Strategy. The names of prisoners who had been discharged as well as those close to their discharge date continued to show on the system that provided the list for random testing.

2.45 The database to collate and produce relevant statistics did not function accurately and was unreliable. This meant that information was still collated manually, which was time consuming and not an efficient use of resources.

2.46 Testing targets were being met although there were some problems with meeting weekend targets. Difficulties in receiving accurate and timely information from health care staff in relation to whether positive results were consistent with medication contributed to those facing adjudication being remanded and delayed the final outcome.

2.47 Supplementary quantitative information such as refusals to provide a sample, abandoned tests, tests awaiting confirmation and independent analysis, results sent on to other establishments when women were transferred and results received after women have been discharged should be collated and analysed to inform the work of the MDT Team and wider discussions both within Holloway and the Women's Estate. **The MDT information technology systems and the procedures for working together amongst all departments involved in the MDT process should be reviewed in order to maximise efficiency.**

Detoxification Unit

2.48 *Reports should be made available to the Senior Medical Officer. (3.219)*

Achieved. The Health Care Manager was responsible for overseeing the Detoxification Unit (Detox) which also had a dedicated Senior Medical Officer.

2.49 *The recruitment and retention of staff should be reviewed. (3.220)*

See paragraph 2.50 below.

2.50 *The Programme Manager was not involved in the selection and recruitment of staff for the unit and had no line management responsibility; this should be considered. (3.137)*

There were difficulties with ensuring that those who staffed the Detox Unit wished to work with substance users and had been trained for this role. The current staff team was made up of nurses and officers plus external facilitators for some of the group sessions. Consideration should be given to employing specialist workers from other disciplines where necessary to maintain delivery of an appropriate service. **The Detox programme manager who was a clinical nurse specialist from Brent, Kensington, Chelsea and Westminster NHS Trust, should be involved in the selection and training of all staff working on the unit in order to ensure standards of care are adhered to.**

2.51 The Detox Unit had recently been expanded to 40 beds. The physical environment was dilapidated and dingy. There was no treatment room available for nurses to carry out the necessary basic primary care.

2.52 Forty five percent of new receptions to Holloway underwent detoxification: 65% of whom were on remand, 20% were young women (under 21 years) and a significant number were pregnant. The duration of the basic methadone detoxification regime was in line with the 1999 Department of Health Guidelines on Clinical Management for Drug Misuse and Dependence and could be extended according to clinical need. It was recognised that the current detoxification regime was not sufficient to meet the needs of all women presenting. Additional symptomatic relief was provided to help overcome this.

2.53 A low-key supportive group work programme was offered alongside the chemical detoxification. A CARAT drug worker accompanied by a CARAT peer support worker also visited the Unit daily to provide information and encourage the women to access the Post Detox Programme.

2.54 Maintenance or longer-term slow reduction programmes were available for some prisoners including pregnant women, remanded women and those on short sentences who were prescribed methadone in the community and women whose

health needs so indicated. Provision was also made for those who had only found out they were pregnant through the detox admission process and needed time to consider whether they wished to continue with the pregnancy or not.

2.55 Referrals were made to the Women's Health Advisor for support and screening for communicable diseases and immunisation. However demand outstripped the service and the potential to offer immunisation for Hepatitis B on the Detox Unit was being considered. Around 72-75% of women undergoing detoxification were injecting drug users. The number of crack cocaine users who may be sharing smoking equipment was unknown. A recent public health survey also showed an alarming increase in sexually transmitted diseases in young women therefore **a review of the communicable diseases and health promotion interventions should be included in the planned needs analysis.**

Developments since the last inspection

2.56 We did not carry out a full inspection of the Drug Strategy however a number of changes had taken place since our previous inspection. These included the commencement of the Counselling, Assessment, Referral and Advice (CARAT) service, the closure of A5 Unit residential treatment programme, and the development of the Post Detoxification programme in its stead. Cranstoun Drug Services provided the CARAT and Post Detox services. The Team consisted of a Manager and six workers. **As both the CARAT work and Post Detox Unit require ongoing monitoring and evaluation, administrative support for the team should be provided.**

2.57 No local needs analysis had been carried out prior to making these changes therefore we were unable to ascertain whether resources were being targeted most effectively. There were plans to collate information from MDT, Voluntary Drug Testing and the Detoxification Unit in order to inform the development of the Voluntary Testing Programme. The manager of the Detoxification Unit hoped to begin a period of reception testing of all women, which would also provide additional information in relation to non-opiate users, prescribed benzodiazepine use by 'non-drug users' and pregnancy. Analysis of the data would highlight areas of unmet need. Within appropriate parameters it should allow monitoring of Foreign Nationals, young

women, juveniles and minority ethnic women to ascertain whether they were able to access services within Holloway and if not, why not. **A thorough needs analysis including an assessment of the needs of pregnant women on C4, those on the Mother and Baby Unit and both remanded and sentenced young women and the juveniles should be a priority in order to underpin a review of the Drug Strategy.**

2.58 In our survey 48% of the respondents indicated that they had used drugs at some time, 14% said that their drug use was still a problem to them. Three of these women said they had received help for their problem in the form of Detox, Post Detox or CARATs.

2.59 The written Drug Strategy document was unsatisfactory. The harm minimisation element was directed towards staff health and safety procedures. This document should detail all initiatives taking place with protocols for working together with clear performance indicators and outcome targets for individual services and for the establishment as a whole. The action plan for development of the strategy should be time-bounded and indicate specific areas of responsibility. **It is essential that alongside audit procedures, quality assurance mechanisms for each service are also included.**

2.60 A new drug strategy co-ordinator had recently been appointed in order to provide some strategic oversight and management of the strategy. The interventions taking place were not formally integrated and communication relied on the goodwill of the individuals involved. **A regular meeting of service providers should be held to support working together and aid mutual understanding of different roles and tasks.** 'Shared care' thinking and co-working would further best practice and aid in ensuring appropriate referrals to different treatment interventions available in Holloway. While it has been stated that there is no clear evidence that a history of abuse makes women more likely to re-offend[1], women may use drugs as self medication in order to deal with the complicated feelings arising from abuse. Such issues must be taken into consideration when developing care plans with the individual woman and in the development of the Drug Strategy as a whole.

[1] Criminogenic Needs of Women Prisoners: a Retrospective Study, D A Clark and J Howdell-Windell,

2.61 We continued to be concerned that some prescribing practices were still at odds with the overall treatment policies and procedures. Women completing the detoxification programme and/or the Post Detox programme were likely to have their medication increased once on ordinary location. A respondent to our survey commented: "Doctor is too willing to prescribe medication. A lot of the girls are dependent on sleeping pills. They are probably just as drugged up as they were on streets. People abuse health care and medication because it's free here."

2.62 We understand there are plans to introduce standardised treatment charts for medication in order to overcome this problem. The Drugs and Therapeutic Committee with support from local Camden and Islington Health Authority were also developing a Drug Formulary as a guide to prescribing for doctors initiating treatment within Holloway

2.63 A sleep strategy had been instigated on the Detox Unit where women could be provided with hot chocolate through the night and a half dose of their sleep medication. The overall response to this strategy had been positive and it was hoped to continue it on the Post Detox unit and then extend it to general location. Supportive interventions such as this are preferable to increasing medication levels.

2.64 As indicated in the Detox statistics, a significant number of women entering Holloway were taking either prescribed and/or illegal drugs or had an alcohol problem. Thirty one percent of our survey respondents said they had had a drug or alcohol problem at reception and 38% said they had a health problem. It is well established that a history of problematic substance use commonly features alongside other health issues as well as self-harm, suicide attempts, panic attacks and seizures. **It is essential that the Drug Strategy begins in reception. A review of the interventions taking place at this first stage is needed.** The detoxification programme manager and the CARAT manager should be involved in this process.

2.65 The Post Detox Programme had been extended to three weeks and moved to a 23-bed unit. At the time of our visit the Unit was being redecorated. The programme included acupuncture, dance movement and dramatherapy, health education groups,

initial relapse prevention work and information about accessing treatment and support. The main focus of the Unit was to provide each woman with full CARAT assessment and a care plan. Post Detox monitoring indicated that approximately 20 women had been on the Unit more than once in the first six-month period. Factors affecting these women should be researched in order to inform future service developments.

2.66 It was crucial that women completing Post Detox should have access to the Voluntary Testing Unit (VTU) in order to build on the work already undertaken. There were problems with access as non-drug-using women were also resident on the Unit. This affected the throughput and availability of spaces. The five Peer Supporters who had completed the Post Detox Programme and undergone training, provided by Cranstoun Drug Services, resided on the VTU and attended the Detox and Post Detox Units daily. There were also plans to begin a relapse prevention group on the VTU.

2.67 Some group work services were available for those women and young women with substance problems who did not access detoxification or who completed it and went straight to ordinary location bypassing Post Detox. There was a crack cocaine group facilitated by a specialist CARAT worker from the Blenheim Project. A Throughcare Group providing help for those women only in Holloway for a few days ran as required and there were also plans to offer a harm minimisation group.

2.68 Young women and juveniles had access to the Detox Unit and the 18-21 year olds to the Post Detox Unit. It was essential that each of these services had clear policies and procedures for meeting the particular needs of these young women and children. The sentenced young women on D0 underwent a separate CARAT Induction and were offered a monthly group facilitated by a CARAT worker.

2.69 There were still insufficient services for those with alcohol problems as opposed to poly drug users. This is a national issue but a local alcohol strategy should be developed. 24 percent of our survey said they had an alcohol problem and of these 50 percent had received help through Detox and Alcoholics Anonymous.

2.70 ADFAM continued to work closely with the establishment and a Family Link Worker operating from the Visitors Centre had been employed to help develop work with families.

2.71 Both staff and prisoners were smoking throughout Holloway and there appeared to be little adherence to No Smoking signs. Access to tobacco at reception should be provided as nicotine withdrawal only exacerbates withdrawal from other substances and contributes to raised anxiety levels and subsequent 'difficult behaviour'. The withholding of tobacco as a means of behaviour modification or punishment for some prisoners should be stopped and alternative strategies developed.

2.72 While the shortage of staff and the lack of appropriately trained staff affected the delivery of services, two responses to our survey question "What was positive about Holloway for you?"

"*One-to-one counselling, drug rehab, education.*"

"*Getting myself drug free, getting housed on release, living a drug free, crime free life and not coming back again.*"

showed the value of the work already taking place and highlighted the importance of developing an effective local and national Drug Strategy that took into account the particular needs of women.

Equal Opportunities and Race Relations

2.73 *A training package for all RRLOs should be delivered as soon as possible. (3.68)*

The wing Race Relations Liaison Officer system was no longer in operation at the time of this inspection. The establishment's RRLO had been appropriately trained and had in addition completed the Training for Trainers course so that she could deliver local training to staff. The RRLO was a Senior Officer at the time of the inspection and she was clearly keen to improve the service to prisoners. She was concerned that racial incidents were under reported and was having yellow post boxes installed in every unit so that prisoners could contact her directly and raise complaints about racial incidents. It was felt that staff also under reported incidents and that there was a lack of understanding of the definition of a racial incident. There was a need for staff training and **we urge that local training takes place for all staff.**

2.74 Holloway was in the fortunate position of having relatively large numbers of staff from minority ethnic groups but these were predominantly in the lower grades. The prison had actually exceeded its initial RESPOND target by 16 Officers. Whilst four Senior Officers (three temporarily promoted) and the Senior Medical Officers were from minority ethnic groups, **we noticed a general lack of managerial grades from ethnic minorities** across the establishment **and urge that this is addressed.** Rec included in Ch5, so if any change delete from there too.

2.75 *Efforts should be made to recruit more female Governor grades. (3.71)*
Just before the inspection there were a good number of female operational managers. Unfortunately the establishment had just lost its female Deputy Governor (on promotion) and three more junior operational managers were due to leave the establishment in December 2000 and January 2001. **We repeat the recommendation.**

2.76 *The Harassment at Work national policy should be made available to all staff and published widely, and policy on the display of such material should be developed and published. (3.71 and 3.72)*
Harassment at Work training had been restarted in September 2000. Since then, 31 staff had completed the training. A local training pack had been developed for managers and 47 managers of Senior Officer grade and above had been trained. The Heads of Personnel and Psychology had created a local training pack because the national pack was felt to be inappropriate for the needs of Holloway.

Fire precautions
Not inspected.

Health Care
2.77 Results from our questionnaire to prisoners at Holloway showed a very high level of dissatisfaction with the health care provided. Of those who had experience of the service and who provided information, 68% thought the service 'bad' or 'very bad'. Rather fewer of the young prisoners (53%) than the older women (70%) were so dissatisfied, perhaps reflecting our frequent finding that young prisoners expect and

feel they deserve a low standard of care. Prisoners gave some unexpected explanations as to why they thought the service was so bad: over-prescribing of medication was a common complaint coupled with failure to examine before prescribing. Other complaints were about long waiting times and unprofessional attitudes during interviews by both doctors and nurses. Some of these problems had been highlighted during the audit of the service by MEDACS earlier in 2000.

2.78 *There should be an audit of the needs of vulnerable prisoners in the whole prison to help determine whether placement in the Health Care Centre is the best possible arrangement to protect them and best use of limited and expensive Health Care time. (3.197)*

Achieved. A needs assessment had been completed by prison and health authority. We were pleased to hear that the mental health needs of the prisoners were being 'scoped' by senior medical and nursing from the Camden and Islington NHS Trust. A health improvement plan (HIMP) was available in draft. Vulnerable women and those recovering after detoxification are now housed in a residential block instead of the Health Care Centre.

Staffing

2.79 *A full patients' needs-based establishment review with independent skill help should be held (3.199)*

Achieved. The needs assessment had been completed and the draft HIMP attempted to equate staffing to need.

2.80 *The role of nurses and discipline officers should be set out in job descriptions. (3.199)*

Achieved. All staff both nursing and discipline had new job descriptions.

2.81 *The urgent need for additional registered nurses should be reviewed. (3.199)*

Not achieved. There remained an urgent need for more mental health nurses – see below. **The recommendation is therefore repeated.**

2.82 *To increase the amount of time spent in direct contact with patients, nurses' administrative duties should be reviewed (3.200)*

Achieved in part – by an increase in administrative and secretarial services.

2.83 *Overtime levels should be reviewed and reduced to safe levels for the health and safety of staff and patients to ensure that the professional competence of staff is not compromised. (3.201)*

Not yet achieved. The recent staff reprofiling exercise had led to a new attendance plan that should reduce overtime. However at the time of our visit there were 8 vacancies and two staff were on long term sick leave and nursing overtime was costing the prison £40,000 per month. The new establishment has an overall allowance of 25% built in which was good practice, but the new shifts had no handover time built in and the handover we heard was very perfunctory and quick. **The recommendation is therefore repeated.**

2.84 *There should be a named nurse scheme, continuity of care and shift handover communication should be improved. (3.201)*

Achieved. Named link nurses for Primary Care had been established, and each patient in C1 had a named nurse and named officer.

2.85 *The Senior Ward Sister should be responsible for all the staff including discipline officers. (3.201)*

Achieved. All staff were managed by the Health Care Manager regardless of their discipline.

2.86 *Nurses should have security training and be able to enter and leave patients' rooms. (3.201)*

Not achieved but was under consideration.

2.87 *There should be a strategy for nursing development. Arrangements should be made to ensure the development of nursing practice and options should be explored. (3.202)*

Not yet achieved. The training strategy was being developed but at present there was no targeted strategy for the development of nursing practice.

2.88 *A practice development nurse should be appointed. (3.202)*
Not yet in post.

2.89 *Training targets should reflect those that operate in the NHS. (3.203)*
Being implemented but not yet achieved. Professional development plans were in place, a consultant was working with the staff helping them to construct their personal portfolios, in line with the model adopted by the Whittington Hospital.

2.90 *Training needs should be included in annual appraisals and should be met. (3.203)*
Being implemented but **not yet achieved.** Training needs analysis was completed in October 2000 but needs had not yet been met.

<u>Needs assessment, budget setting and the purchasing of Health Care</u>
2.91 *A needs assessment exercise should be undertaken urgently and conducted in the light of advice from those with expertise in this process. (3.206)*
Achieved. An appraisal of health needs was completed in January 2000.

2.92 *The implementation of health care standards should be audited. (3.207)*
Achieved. Audit by MEDACS completed 2000.

2.93 *There should be greater involvement of all grades of staff in assessing and commenting on the quality of service for patients and staff development. (3.207)*
Not yet achieved and developing only slowly. Leadership had been divided and lacking direction. The new health care manager had made arrangements to link with the local community Trusts programme for the development of evidence based practice and clinical governance.

2.94 *The next business plan should have an integrated approach*. (*3.207)*
Achieved.

2.95 *The need for secretarial and clerical support should be reviewed. (3.204)*
Completed. There was at the time of our visit one administrative assistant, three administrative officers, one typist/secretary.

Primary care

2.96 *Primary care should be given by or under the direction of fully qualified and trained general practitioners. (3.209)*
Only partly achieved. The strategy for the development of primary care set out in the draft HIMP showed one possible way of improving the range and quality of primary care in Holloway. There were no nurse led clinics and not all prisoners had prompt access to specialist care. **We repeat our previous recommendations (3.246, 3.247) relating to problems in access to specialist care, i.e. there should be an audit to determine the causes of cancellation of NHS appointments and to suggest courses of action to reduce these calculations and there should be discussions with local NHS Health Authorities and trusts to see how these delays can be reduced.**

2.97 We were very concerned to have drawn to our attention an example of the probable over-prescription of psychoactive drugs that, as we have said above was one complaint made to us by prisoners. At one primary care surgery for girls from D0 there were 15 patients. Thirteen were prescribed psychoactive drugs. We do not examine the individual clinical practice of staff but this seemed to us an unusually high rate of prescription. **Protocols for the prescription of psychoactive drugs should be established and adherence to the protocols monitored. Deviations from the protocols must be justified by the prescribing doctor.**

Inpatient care

2.98 Rather than review the individual recommendations made at our last inspection relating to health care management, inpatient and mental health care we undertook a new appraisal of these services at Holloway.

Health Care Management

2.99 A health care manager had recently been appointed and commenced employment the week prior to our inspection. She was responsible for all staff in the health care service whether discipline, nursing or medical. ***This appointment is an example of good practice and should greatly assist in better management of the service.*** A Health Board had been set up but we were unable to establish its exact role in the new management structure and we had some concerns lest it lead to a dilution of the single management focus provided by the new management arrangements described above.

2.100 The Governor had commissioned two reports, one on the training needs to deliver effective health care and another which audited activities in health care. Both were published in October 2000. **The recommendations of both these documents should be considered carefully by the health care manager and, where appropriate, incorporated into the HIMP with an agreed timescale for implementation, review and evaluation.**

Medical staffing

2.101 We found the medical staffing of the health care service at Holloway very confusing and a cause for great concern. So far as we could determine there was a Principal Medical Officer (formerly an area medical adviser), a Senior Medical Officer, an acting Senior Medical Officer, a former Senior Medical Officer with psychiatric qualifications looking after mentally ill inpatients and three Medical Officers. One Medical Officer was on sick leave, was subject to a disciplinary inquiry and was unlikely to return. A locum filled his place. The arrangements did not appear to us to be a medical staffing structure based on the needs of patients. At least in part it seemed to reflect the need to find work for senior staff displaced during recent reorganizations nationally. At the very least the multiplicity of senior staff seemed likely to result in confusion and varying priorities. **We were very pleased to see that the HIMP contained sensible proposals for medical staffing based on the needs assessment. These should be supported.**

Nursing staffing

2.102 Nursing staff were delegated to work in three areas of health care, inpatient unit, primary care with reception and the detoxification unit. The total complement of nurses was 46 trained staff and four health care assistants. There were seven RMNs, one acting G grade, three F grades and three E grades. Eight nurses were on permanent night duty and provided cover of four per night.

2.103 At the time of our inspection there were eight vacancies and two members of staff on long-term sick leave. This resulted in severe staffing problems compounded by the inability to obtain appropriate agency nurses. Nursing overtime had been running at a cost to the prison of approximately £40, 000 per month.

2.104 **Whilst there are no regulations about overtime, excessive overtime can lead to unsafe practice and put patients at risk. We were assured that the new centralised off duty would decrease the need for excessive overtime but the shortfall in nurses must be addressed urgently.**

2.105 **There are national and regional initiatives to establish nurse banks and the health care manager should make contact with the NHSE London Regional Office.**

2.106 **Because of the extent and seriousness of the problems regarding nursing at HMP Holloway, consideration should be given to setting up a local nursing task force. The membership should reflect the clinical skills required in the delivery of prison health care to women and their children.**

Nursing policies and practice

2.107 We saw no evidence of policies and procedures, the lack of which can lead to unsafe practice. Nor was there any evidence of clinical supervision. The health care standards require that both these be in place. **Nursing policies and procedures should be written and implemented with input from specialist nurses. Clinical supervision should be established for all nursing staff.**

Inpatient services

2.108 The inpatient unit at the time of our inspection had been reduced to 27 beds. These comprised six for physically ill women and the remainder was for women with mental health problems. At the time of the inspection there were 25 patients. We reviewed the notes available with a view to identifying the optimal placement based on clinical need of these patients.

NHS secure psychiatric care	59%
Notes too poor to assess	18%
Notes missing	37%
Properly located in HCC	23%

2.109 In short there were at least 15 inpatients in the Health Care Centre who were so ill that they should have been in an NHS facility as their health needs were far beyond the capacity of the staff on the ward. **We repeat our previous recommendation (3.236). The seriously inappropriate placement of so many seriously mentally ill women should be drawn to the attention of the mental health lead at the NHS London regional office. The quality and availability of medical notes should be audited and improved.**

2.110 The number of nurses employed on the inpatient unit was grossly inadequate. On the days of the inspection there was only one trained nurse with two nursing assistants on duty to care for these very disturbed patients, a level of nurse staffing completely inappropriate to the patients' needs. We were deeply disturbed by the very low quality of care for the group of patients we observed. This is not a reflection on the individual staff who coped as best they could in difficult circumstances but the level of nursing provided for this group of patients was totally unacceptable. **If this level of staffing had occurred in a Nursing Home the inspecting Health Authority would have served it with notice to close beds.**

2.111 Any qualified nurse working in this situation is in breach of the UKCC Code of Conduct "as a registered nurse, midwife or health visitor you are personally accountable for your practice and in the exercise of your professional accountability, must:

i) act in such a manner as to promote and safeguard the interests and well-being of patients and clients;

ii) ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, conditions or safety of patients and clients".

2.112 **The nursing staffing of the inpatient unit must be reviewed urgently and increased to provide an environment, which affords a level of therapeutic activity which meets the patients' needs.**

2.113 None of the 14 discipline officers working in health care were health care trained and again struggled with shortages of staff in situations for which they had had little or no preparation. We were told that staff took time off sick because of the pressures on the unit. The Prison Service is currently developing an NVQ in health care but it will not be available until late 2001. **A training programme should be provided for officers working on the inpatient unit. Links with the Health Authority and therefore access to the Education and Training Consortia should be used to ensure that the programme is established within an educational awarding framework.** The Consortia is already providing a programme of education for RGN to complete RMN training.

Care planning and multidisciplinary working

2.114 To try and make sense of what was happening on the ward the staff had devised multidisciplinary records and had started to have joint meetings. However, the care plans that we saw were very poorly filled in and some had been left blank. The content of the narrative was poor and there was no attempt to evaluate the care that had been given. We were pleased to hear about the development of care planning and multidisciplinary working but new ventures require the commitment of all staff and support through training and development. **A training programme should be implemented to give staff the required skills and understanding to complete care plans.**

2.115 **The nursing establishment, levels of nursing and health care officers as well as skill mix required urgent management action. In addition to the 'scoping' exercise, discussions should take place with the Trust to provide**

supervised mental health practice and a mentoring scheme for the nurses working on the inpatient unit.

2.116 **The task force should also be approached to provide on-going support to the Health Care Manager by identifying examples of good practice and providing mentoring for senior nurses on how to develop good working practices.**

Support for health care staff

2.117 ***A support group had been implemented for all staff working in health care and was facilitated by a visiting psychiatrist on a monthly basis. This was good practice.*** Unfortunately because of staff shortages it was not always possible for staff to attend.

Reception

2.118 The MEDACS Audit in October 2000 reported serious problems relating to the attitude of nurses to women being received in the reception. We found the health reception area cramped with three nurses and a doctor working in three small rooms. Privacy was a problem and conversations could at times be overheard. The reception area was clean and well equipped.

2.119 We spent three hours one evening observing the health screening of prisoners and saw none of the hostility to prisoners reported by MEDACS. The health assessments were well done and problems were identified such as a woman very bruised allegedly following an assault from her husband. Most women had serious problems and over 50% were abusing drugs and needed detoxification facilities, many others were showing signs of mental illness and one was suffering from the effects of CS gas. The nurses guided the locum doctor through all the different procedures. There were disagreements with prisoners about the need to supply drugs but histories were carefully checked and only emergency medication was given until the prisoner's GP could be contacted. All staff behaved in a professional manner, the only complaints related to the lack of hot tea and the quality of the meal given. **We were however disappointed that the women were not given the opportunity to make a telephone call if they did not have the money to buy a phone card.**

Pregnancy and childbirth

2.120 The management of pregnancy and childbirth at HMP Holloway was through a Service Level Agreement with the NHS. The local midwifery service provided three visiting midwives who attended the prison three times weekly. There were also three midwives working at HMP Holloway but employed on generic duties following the purchasing of NHS services.

2.121 In the past a scanner had been purchased but it was no longer being used. Pregnant prisoners had to attend the NHS hospital for scans; 25-30% of appointments were regularly cancelled because of problems in providing escorts. **The provision of maternity services should be reviewed to ensure that women at HMP Holloway are not being disadvantaged in their pre and postnatal care.**

Mother and Baby Unit (MBU)

2.122 At the time of the inspection there were 16 mothers and babies. One baby was on the child protection register.

2.123 *Arrangements should be made for the nursery nurses to have supervision. (3.222)*

The provision for nursery nurses was contracted through the Reliance Agency and the two nursery nurses working in the crèche had only recently commenced. The previous two nursery nurses had resigned because of a pay dispute. Supervision was provided by the Reliance Agency on a monthly basis. Given that these two nurses had only recently started working in the prison, **supervision should be more frequent than monthly for an agreed period of time, such as three months, and then it should be reviewed. The health visitor should meet twice weekly with nursery nurses to discuss any issues concerning the babies' development.**

2.124 *Child Protection Guidelines were completed and the Area Child Protection Committee (ACPC) should endorse the guidelines and ensure their comprehensiveness. (3.224)*

We were shown a copy of the guidelines as they related to the MBU. In line with current Prison Service guidance these were being updated to take account of the rest

of the prison. A Child Protection Committee with representatives from across the prison has been set up and had met twice. The Governor grade who had chaired the committee and had acted as Co-ordinator left at the end of December 2000.
The Governor must appoint a Child Protection Co-Ordinator as soon as possible. The new guidelines were due to be agreed in January 2001 by the prison and were then due to be ratified by Islington ACPC.

2.125 *All new staff should be required to read the Child Protection Guidance on the first day in the MBU. (3.225)*
Not only should new staff be required to read the guidelines but they should attend child protection training and receive ongoing support.

2.126 *Staff on detached duty inexperienced in the care of mothers and babies should not be allocated to the MBU. (3.225)*
There were four dedicated officers in the MBU and in addition officers were sent from central detail as required. Where possible the same officers were allocated.
Unfortunately two of the staff dedicated to duties in the MBU were shortly due to leave. **Until replacement staff have been appointed and trained, we recommend that all other staff detailed to the MBU must have training in child protection and child care.**

2.127 During the inspection we observed very poor, if not dangerous, child care practice. A mother was 'prop feeding' her baby. This is not only bad practice because of the lack of bonding between mother and baby but has also been implicated as a possible cause of Sudden Infant Death Syndrome. Prison officers also complained that they felt powerless to correct poor practice. **Although the Inspection Team recognises that the purpose of the mother and baby unit was different from those in the community, we recommend that time spent in the MBU should be used constructively to promote good parenting and childcare.**

2.128 *The Whittington Hospital Social Services should have responsibility for the MBU at Holloway to ensure continuity of care. (3.226)*
Due to financial constraints, Social Services no longer attended the Admissions Board and were available to provide information by telephone only. **This arrangement**

should be reviewed and the Governor should discuss adequate provision with the Director of Islington Social Services to ensure continuity of care.

2.129 *The medical care provided for babies should be reviewed by the Senior Medical Officer. (3.227)*

Achieved. General practice medicine was available in the usual way. In addition, a paediatrician attended fortnightly and the health visitor weekly.

Dental services

Not inspected.

Pharmacy

2.130 Although many of the recommendations from the previous report had not been acted upon until the pharmacist started to have control over the department, it appeared that the pharmacy department now recognised their deficiencies and are working hard to correct them.

2.131 *Air conditioning should be installed in the pharmacy. (3.251)*

Achieved.

2.132 *Stocks held in the trolleys should be reduced to a minimum; when a doctor prescribes medication for a patient the prescription should be dispensed by the pharmacy. (3.253)*

This was beginning to be implemented following the arrival of the pharmacist.

2.133 *Professional checks should be made prior to supply. (3.253)*

On the last inspection it was a concern that the pharmacist was not seeing all the prescription charts. The new pharmacist was working towards this recommendation.

We repeat the recommendation.

2.134 *The computerised PMR (Patient Medication Records) should be completed for the pharmacist to undertake his or her professional duties. (3.254)*

This will not be achieved until all prescription charts are processed through the pharmacy. **We repeat the recommendation.**

2.135 *A system should be in place so that the pharmacist sees all patients' Prescription and Administration Record Cards if any changes to them have occurred. (3.254)*

This will not be achieved until all prescription charts are processed through the pharmacy. **We repeat the recommendation.**

2.136 *A system should be in place so that the pharmacist sees all patients' Prescription and Administration Record Cards if any changes to them have occurred. (3.256)*

This will be achievable when all transactions are put through the pharmacy. **We repeat the recommendation.**

2.137 *The treatment room should be provided with a sluice. (3.257)*

It was reported that this had been done.

2.138 *Methadone should be dispensed by the pharmacy on a named patient basis. (3.258)*

This was not being done. A Bristol pump that leaked and could not measure accurately quantities less than 5ml was still in use by nurses despite concerns raised on the previous inspection. It was decided that it should be removed and the pharmacy either dispense on a patient named basis (the preferred option) or supply proper glass stamped conical measures with suitable training provided by the pharmacy staff. **We repeat this recommendation.**

2.139 *Dispensing to members of staff should not take place. (3.259)*

This recommendation had been complied with.

2.140 *An audit of prescribing tranquillisers and hypnotics should be undertaken and protocols for their use developed in the light of the audit findings. (3.218)*

This had been done.

Health and Safety

Not inspected.

Life for Prisoners

2.141 *All staff should be trained to work with adolescents. (3.74)*

See section on sentenced children and young offenders in Chapter 3.

2.142 *Custody planning should be arranged for unconvicted prisoners. (3.76)*

Not achieved. No custody planning was undertaken for unconvicted prisoners. We were told that shortages of staff trained in Sentence Planning Competencies and lack of consistent staffing of the Remand Unit (caused by regular cross-deployment) prevented progress in this area. **The recommendation is therefore repeated.**

2.143 *The transfer of unconvicted prisoners should be kept to a minimum. (3.78)*

This problem had been caused by large numbers of overcrowding drafts at the time of the previous inspection and this was not such a problem during this inspection.

2.144 *The local Race Relations Management Team notice which included the names and locations of Foreign Nationals Liaison officers should be distributed throughout the establishment. (3.83)*

Photoboards showing the local Race Relations Management Team members were on each unit and in every activity area. **They were in need of updating.** Lists of Foreign Nationals Liaison Officers were on units.

2.145 *Structured time should be built into the work schedule of the Foreign Nationals Liaison Officers to carry out their work. (3.84)*

Not achieved. We were told that Foreign Nationals Liaison Officers from wings had not been able to attend foreign nationals meetings held by the establishment Foreign National Liaison Officer. However, packs had been issued to all wing Foreign National Liaison Officers so they could provide information to prisoners. Foreign nationals made up 30% of the prison population. Whilst we felt that the Foreign National Liaison Officer was doing good work, and we were pleased to find out that foreign national groups were being run by the Probation Department, we felt that **the prison should consider forming a multidisciplinary Foreign Nationals Committee or at least include foreign nationals as a standing item on a related committee, for example the Race Relations Management Team meeting.**

2.146 *A system should be in place to inform Immigration Nationality Department of the discharge dates of any detainee in good time for them to deal with any deportation issues by that date. Upon completion of sentence, detainees should be transferred to an Immigration Detention Centre. (3.85)*

Achieved. The speed of deportation at the end of sentences had improved as the Immigration Service had dealt with a backlog of cases. The prison was linking properly with the Immigration Service.

2.147 *Psychology staffing levels should be reviewed to ensure that statutory lifer work was not affected. (3.93)*

Achieved. At the time of the inspection there were 15 Life Sentence prisoners in the establishment and there was sufficient Psychology resource to meet the Lifer Plan requirements.

2.148 We had a joint meeting with the Head of Psychology and the new Principal Area Psychologist who was making her initial visit to the prison at the time of the inspection. We were impressed by the ready availability of reliable data on Programmes, Anti-bullying, Staff Bullying, Life Sentence Prisoners and Young Offenders – all of which was contained in the Psychology Unit's computerised database. Observations from other departments indicated that the Psychology team was held in high regard throughout the prison and there was a positive attitude from the Head of Unit towards active liaison with a wide range of other staff. *We consider that the 'Guide to the Psychology Unit' produced in January 2000 and issued to all other departments was an example of good practice which encouraged a culture of care and understanding in the treatment of prisoners.*

2.149 In the face of the very positive influence of this unit, we were disturbed to learn of proposals to reduce the complement of Psychologists at Holloway by non-replacement of a vacant post. **We recommend urgent re-consideration of this proposal in the interests of continued positive influence on the regime. Furthermore, this recommendation is vigorously underlined in light of the original recommendation in the 1997 report to the Director General regarding**

the importance of the Psychology Department as a resource to the women's estate.

Management and Communications

Not inspected.

Personnel Management and Staff Training

Meeting with Staff Group

2.150 We met with a cross-section of five officers representing those who had day to day care of prisoners in the capacity of personal and residential unit officers. Their underlying level of concern for prisoners' well-being impressed us but staff issues dominated the exchanges. There was a sense in which staff felt isolated from management. They were especially worried about the removal of Principal Officers from their active line management. They felt that this placed burdens on Senior Officers which in turn cascaded on to already hard-pressed officers – who then felt that they had nobody to turn to for support. The officers acknowledged that the inspection was taking place at a time when new routines had just been introduced. However, they were at pains to point out that much of their frustration stemmed from seeing prisoners' needs which they were unable to meet through inadequate staffing levels and what they perceived as a depleted management support system.

A strategy to deal with staff bullying should be developed. (3.14)

Not inspected.

Line managers should inform the Personnel Department when a member of staff begins a period of absence, and when she/he returns to duty. (3.14)

Not inspected.

The training received by each Operational Support Grade since his/her appointment should be reviewed and appropriate training provided with delay: in future all newly appointed Operational Support Grades should take part in a structured Induction programme. (3.16)

Not inspected.

Staff training needs analysis should be carried out. (3.18)

Not inspected.

The Head of Personnel should adopt a strong proactive co-ordinating role to training to ensure that it is appropriate to and consistent with the business aims and strategies of the prison. (3.18)

Not inspected.

Performance Planning and Review System (PPRS)

Not inspected.

Prison shop

2.151 *Checks should be carried out by staff familiar with the nature of stocktaking. (3.110)*

Achieved. Weekly stock checks were carried out by the canteen (shop) staff and quarterly stock checks were carried out by staff from the Procurement Office.

2.152 *The security arrangements for the shop must be improved immediately. (3.113)*

Not achieved. There was still no place for staff valuables. Separate shop keys were on shop staff key sets. A logging out system was in place for these keys. Loose tobacco was still available but only to those with canteen keys. **We repeat the recommendation.**

2.153 *Goods should be placed in clear plastic bags which are properly heat sealed. (3.114)*

Not achieved. This suggested system was not in place. **We repeat the recommendation.**

2.154 *The arrangement where Governors authorise the issue of goods from the shop for encouragement or reward should be reviewed. (3.115)*

A book records individual prisoner or units (e.g. C1) that goods were going to and who authorised this expenditure from the general purpose fund.

Segregation Unit

2.155 *The Segregation Unit conditions, particularly the temperature should be improved. (3.121)*

A temporary Segregation Unit was in use at the time of our inspection.

Suicide Awareness

2.156 We were pleased to learn that there was a direct phone line to the Samaritans. We were also pleased to see that there were two care suites, one in health care and one based on level 3. The 'befrienders of Holloway' (Listeners' scheme) had contributed to the drafting of the protocol for the use of these rooms. In addition there was a gated cell for constant observation of an identified prisoner requiring more support and a ligature free cell available in health care. **The taps in the ligature-free cell and the gated cell should be flush with the wall. The splash-backs behind the taps should be removed as they could be pulled off the wall and used as an instrument causing injury.**

2.157 We were pleased to learn that a psychologist saw every woman who had an open F2052SH within 24-48 hours. A programme of three to four ongoing sessions were offered or other counselling interventions.

2.158 During our inspection there were 52 open F2057SHs. That equated to 10% of the prison population. The number was emailed to each department daily. All open F2052SH's were discussed at the Governor's morning briefing. **The needs of these individual women must have put pressure on all the available resources and where necessary there should be a reallocation of staff. The number of open of F2052SH's should be reviewed weekly and trends notified to the Governor for discussion with the visiting psychiatrist.**

2.159 The quality and recording of the documents was not of a reasonable standard. Many reviews had not taken place within 72 hours. The level of completed training for prison officers was 23-25% of all staff. Given the high level of self-harm this was not adequate. **A concerted effort must be made for more staff to attend the training. The training programme must include completion of the documentation to improve the quality of entries.**

2.160 *The Self Harm register and F2052SH should be initialled daily by the duty Governor. (3.139)*

Achieved.

2.161 *Refresher training for all staff should be arranged as a priority. (3.140)*

Achieved.

2.162 *A direct telephone line to the Samaritans should be provided. (3.142)*

Achieved.

The Establishment

2.163 *A member of the Board of Visitors should <u>always</u> be told whenever any prisoner is located in a special cell or a protected room. (2.06)*

Achieved.

2.164 *Holloway should be considered as a national training resource for staff who are to work in the female estate; this should be considered by Headquarters. (2.06)*

Not achieved. We repeat the recommendation.

Throughcare

<u>Reception</u>

2.165 *The proposed redevelopment of the reception area should commence as soon as possible. (3.144)*

Achieved. The new layout of the reception area was much improved, allowing improved supervision of prisoners.

2.166 *The provision of ventilation within the area should be improved. (3.144)*

Partially achieved. There was a ventilation system but we were told it was not working efficiently. The system was linked to the kitchen area, from where it had to be switched on. There was some misunderstanding from the kitchen staff, however, about the link and whether the system should be switched on. **We repeat the recommendation.**

2.167 *Staff at Holloway and the contractors should develop a strategy to prevent delays occurring in the evenings. (3.145)*

Partially achieved. There had possibly been some improvement in recent months but late arrivals were a regular occurrence, for example arrivals were still occurring at 8.20pm despite a 7pm local time limit. Quarterly meetings with Securicor had not resulted in any strategy being decided upon. **We repeat the recommendation.**

2.168 *No evening visits had been paid to the establishment by the contract monitors; contract monitors should pay frequent and regular evening visits. (3.146)*

Not achieved. Contract monitors did not pay frequent and regular evening visits to reception. Court lay visitors, however, were regular visitors at reception. **We repeat the recommendation.**

2.169 *Meal provisions for those receptions arriving after the evening mealtime should be improved. (3.147)*

Achieved. A food trolley was available at reception with salads, fruit and biscuits. Otherwise microwave meals were stocked in the freezer in reception. Bread was issued to prisoners when available.

2.170 *Staff should provide adequate supervision in reception. (3.148)*

Achieved. Supervision was provided by reception staff, including the Reception SO, and nursing staff, after search and property checks by wing locators prior to location on D3. Two holding rooms were allocated in the Reception main office for vulnerable prisoners, prisoners on F2052SH and convicted sentenced juveniles.

2.171 *All new receptions should be seen by the Medical officer on arrival. (3.149)*

All new receptions were seen on arrival by the Medical Officer. Major delays, however, did occur, for example women arriving at 12.35pm were not being seen until 6.30pm. All change of status prisoners of over four years (i.e. the old long term inmate classification LTI) were seen by the Medical Officer. Any women received into the establishment with injuries were seen by the doctor, as was any woman who made a request to see the doctor.

Allocation and Transfer

2.172 *New job descriptions, covering the complete areas of work in the Throughcare Department should be issued to staff. (3.161)*

Achieved. New job descriptions had been agreed and issued to staff in allocations/throughcare covering the work of that department. However, staff were still required to do considerable additional work, for example being cross-deployed to Level 5 at weekends.

2.173 *The Governors order should be enforced and all transfers from the establishment should be notified to the Throughcare Department. (3.163)*

Not achieved. The Governor's Order had not been enforced. Some women were being transferred without the knowledge of the Throughcare department, for example 141 medical transfers, Governor arranged transfers, and others. **We repeat the recommendation.**

2.174 *A review of the numbers being held should be carried out. A single manager should be given the authority to place prisoners on hold. (3.164)*

Partially achieved. People in all departments were allowed to put prisoners 'on hold'. 60 women at any one time could be on hold. The list was reviewed quarterly to ensure it did not go unchecked. Some women were put on the bottom of the transfer list to delay their transfer.

Child protection

2.175 *Training should be provided for all uniform staff working in the Mother and Baby Unit to enable them to develop an awareness and understanding of issues pertinent to child care and protection. (3.170)*

Not achieved. See paragraph 2.125. **We repeat the recommendation.**

2.176 *The extended continuation of the service provided by the Whittington hospital should be reviewed through liaison with Islington Social Services. (3.171)*

Not inspected but paragraph 2.127 refers.

Incentives and Earned Privileges Scheme

2.177 *The incentives and earned privileges scheme documentation should be quality checked by governors. (3.175)*

We were told that the Head of Residence checked a sample of the Incentives and Earned Privileges (IEP) forms very occasionally and that residential Governor 5s checked them occasionally. The forms we inspected had not been signed to show that these checks had taken place. **We recommend that those who check IEP forms sign to show this.**

2.178 *The compact which prisoners signed to be located on A5 drugs free unit should be rephrased to encourage prisoners to feel a sense of commitment to the principles it embraced. (3.175)*

A5 was being redeveloped as a Voluntary Testing Unit at the time of the inspection so compact arrangements were being reviewed.

2.179 *The residential governors should sample changes every month. Adequate records of the sampling processes should be kept. (3.177)*

We were told that changes in IEP levels were compiled by the residential governor grades but we saw no evidence that this had happened recently. There were two new Governor 5s in post and **this sampling procedure should be better evidenced.**

Sentence planning

2.180 Sentence planning was organised via a dedicated team under the title Prisoner Management. This was a busy department under the leadership of a specialist Principal Officer. Whilst the schedules for adult sentence planning reviews were organised by this unit, the specialist prisoner management staff did not attend these meetings which were often poorly attended with many being comprised of only the prisoner and her personal officer.

2.181 Prisoner management staff were responsible for maintaining files but, at the time of the inspection, no new sentence planning files had been raised for five weeks as a result of a shortage of administration staff elsewhere. We considered this to be a major failure of the system and **a review of the administrative support**

requirements of sentence planning should be undertaken to ensure that Prison and Probation Service Standards are met.

Probation Department

2.182 We found an atmosphere of enthusiasm and commitment in the department. Levels of liaison with the psychology unit were creative and there was good co-operation in programme development and delivery. The Senior Probation Officer (SPO) told us that the level of contact from the Inner London Probation Service, via an Assistant Chief Probation Officer, was regular and supportive. The fact that this external professional support came from a Probation Service Senior Manager with a functional responsibility for prison work was seen as an additional benefit. At the time of the inspection the probation department was carrying two and half Probation Officer vacancies and this clearly had a major impact on those staff present.

2.183 We were told that at the start of 2000 the team comprised one SPO and nine probation officers. In February of that year the probation officer complement went down to eight. Throughout the ensuing period various vacancies have been unfilled for significant periods. We were disturbed to be told of further proposals to reduce the department to an SPO and only seven probation officers from 1 April 2001. **We recommend that proposals to further reduce the complement of probation officers be urgently reviewed in acknowledgement of the contribution that the Probation Department makes, with others, in identifying risk and meeting the needs of prisoners thereby safeguarding the public.**

2.184 There was no Throughcare Committee. We were told that this was disbanded upon the departure of the previous SPO and on further enquiry we learned that this had not been picked up by a senior manager due to oversight. **We recommend that a Throughcare Committee be appointed immediately, to be chaired by a senior manager to co-ordinate throughcare policy in all areas of the establishment in accordance with Prison Service Standards.**

2.185 We noted that in addition to the above, there was no Resettlement Committee or sub-group and given the wide range of needs presented by the population **we**

considered that a resettlement sub-group should operate under the auspices of the Throughcare Committee, once the latter is established.

Visiting Arrangements

2.186 *The quality of the closed circuit TV system in the visiting room should be improved. (3.119)*

Not achieved. The CCTV system had not been changed. There were, however, plans to improve CCTV equipment and move the monitoring staff out of the Visits Room and into a separate office soon after the inspection. **We repeat the recommendation.**

2.187 We did not fully inspect the Visits Area but did visit both the Visitors Centre and the Social and Legal Visits room. We make the following comments:- the historic booking line problems had been reduced but could be further improved. The two computers in place were not being used due to a lack of available trained staff. **The visits booking computers should be utilised properly**.

2.188 The procedures around Schedule One Offenders and Child Protection were not in place and **this needs to be urgently addressed.**

2.189 The Visits areas were grubby and the carpet very stained. **Flooring in the Visits areas needs to be replaced and levels of cleanliness throughout improved.**

2.190 The prisoner waiting room outside the Visits Room was littered with cigarette ends and full of smoke. **This room should be made a non-smoking area.**

2.191 The creche was not staffed by the crèche worker during every social visits session. Bearing in mind the large number of children visiting the establishment, **it is vital that this person is in place for every social visits session.**

2.192 ***The Visitors Centre, opened since the last inspection, was an excellent resource and one of the best we have seen, and is commended.***

Works Service Department

The intention to reduce the Head of Works Services from Governor IV to Governor V should be reviewed. (3.58)

Not inspected.

CHAPTER THREE

ADDITIONAL AREAS INSPECTED

Care of Young Prisoners and Juveniles

3.01 A number of significant changes in the Youth Justice System, notably the introduction of Detention and Training Orders under the newly created Youth Justice Board and to child protection protocols, led us to inspect these arrangements in more detail than is usual in an unannounced follow up inspection such as this one. This inspection is outlined below.

Sentenced Children and Young Offenders

3.02 At the time of the last inspection, there were no special arrangements for sentenced children and young women under the age of 21. This had already been recognised as a major deficiency and there were outline plans to accommodate them in a separate unit. We thought it would therefore be advisable if we fully inspected the new arrangements for the young women and children held at Holloway.

3.03 By the time of this inspection, D0 wing had been established for almost two years, underpinned by funding that, initially at least, had been ring-fenced and a dedicated (in every sense of the word) staff group. Indeed, there was now uncertainty over its continued future at Holloway. This was partly because, quite reasonably, questions were being raised as to whether this was an appropriate function for a central London prison and partly because there were plans that all those under 18 should be relocated to Bullwood Hall by the end of March 2001.

3.04 D0 had a capacity for 40, and for most of the days of this inspection there was a population of 33, of whom nine were under 18 and serving Detention and Training Orders (DTOs). The staff consisted of a Principal Officer, two Senior Officers and 14 Officers (with 12 currently in post). Attached to the wing, and very much part of the team, was a psychologist, a teacher, a Probation Officer and a health visitor seconded from the local NHS trust as health adviser. This was the last wing at Holloway to be managed by a Principal Officer, a post to be deleted on her imminent departure. This

was clearly a matter of considerable concern, because a lot of the development, along with the stability over the previous 12 months had depended upon the Principal Officer.

3.05 Accommodation was in a combination of single cells and three four bed rooms. Activity space on the wing was very limited, especially for a regime, which was seeking to be largely self-contained. There was a small activity room and an even more cramped classroom, which could not hold more than four if they were to work effectively.

3.06 Holloway was holding about 10% of the 80 girls serving the Detention and Training Order in England and Wales. This inspection was one of the first of female establishments holding those under 18. Its progress will now be reviewed following the sequence of the essential features of the healthy prison. As those under 18, i.e. those who were still children, shared most activities with those under 21, this report will use the generic term 'young women' to cover the whole age group.

3.07 The apparent absence of coherent strategies and policies within Holloway as a whole to identify and support the vulnerable was a serious problem for the staff of D0 in working with their age group. These problems were compounded by what appeared to be an absence of leadership from Prison Service Headquarters. Inspectors formed a strong impression that the work of the wing was owned neither by the Women's Policy Group nor the Young Offender Group. Confusing messages from staff of the Youth Justice Board did not help either, who continued to make as many DTO placements as ever at Holloway and who were said to disclaim any knowledge of the stated Prison Service policy that the establishment was no longer to serve this function.

3.08 The actual needs of, and associated risks for, those under and over 18 on the wing differed very little, although as children, provision for the younger group should comply with the standards of the Youth Justice Board, those of PSO 4950, and child protection requirements.

3.09 It was a tribute to the staff team that, on their own initiative, they had developed a regime that appeared generally to achieve this and that the standards of care for those over 18 were as high as those of the children.

3.10 When any newly sentenced under 21 arrived at Holloway, Reception staff called a staff member from DO Wing who then undertook much of the procedures, including completing, in the case of those under 18, the prescribed vulnerability assessment. The new arrival was then quickly moved to the wing. Although there were no formally laid down first night procedures, the fact that one of the unit's own Officers was on duty all night meant that there was a continuity of care and monitoring.

3.11 At the time of this inspection, there was an average of six F2052SH (self harm monitoring) documents open. Two were opened on one evening when inspectors were present, in part as a result of the turbulence created by the sudden cancellation of association because wing staff had to be deployed elsewhere in the prison.

3.12 The challenge was the greater because the wing was still recovering from a death on the unit in June 2000, obviously highly traumatic for everybody and the staff team had clearly worked very hard to deal with their own emotions as well as restore the equilibrium of the unit.

3.13 Inspectors were impressed to see that vulnerability did not just depend on the F2052SH procedures, and that there were regular special case conferences when there were concerns, which the young woman to whom these related normally attended. There was also a daily meeting of the whole staff team at which issues, events and particular concerns were discussed. In all these the specialists made strong contributions, although a significant absence was any formally designated representative from Holloway's Health Care Department. This was a serious lack, particular in the light of the fact that reviews of the recent death had indicated that a failure by the medical staff to communicate information to the wing might have been a contributory factor.

3.14 Inspectors spoke with a number of girls and young women individually and girls in groups. It was clear from that this that almost all normally felt safe and would turn to one of the staff if or when they did not. This did not alter the fact that self-harm was very prominent in many of their thoughts, both in the sense of the possibility of engaging in it and its risks. They felt that the staff were very tough on bullying, and that it was not always fair that staff put someone on a bullying document. Staff themselves felt that Holloway's laid down procedures within which they had to work were rather out of date and reactive. They had attempted to customise them for work with this age group, but were looking to secure funding from outside sources to allow for a video and a more proactive preventive approach.

3.15 In the weeks preceding this inspection, a team from the University of North London had completed an environmental audit of the wing, in which issues of safety and emotional support (for both staff and residents) had featured. Inspectors were pleased to see that their much more detailed surveys had confirmed their own impressions.

3.16 It was a serious deficiency in Holloway as a whole, but in particular on DO wing, that the child protection procedures required by Annex B to PSO 4950 issued in February 2000 were still not in place. The only advice that wing staff had was three years old, predated the opening of the new unit on the wing and related only to the very different circumstances of the Mother and Baby Unit. Inspectors were told that a draft new procedure should be available by the end of January 2001. In the meantime it was very unsatisfactory that staff had no guidance on the subject, particularly when there were, as was quite frequently happening, disclosures of abuse that may have happened prior to arrival at Holloway.

3.17 Staff were concerned, quite correctly, to restrict the contact young women had with older prisoners and protect them from abuse and bullying. There were limits to how much could be made of the wider opportunities in Holloway, particularly in education and PE. However, sensible precautions were taken such as all changing for Gym with showering afterwards taking place on the wing. Officers from the wing supervised all group movements along the common corridor areas.

3.18 To summarise, **we recommend:**

A representative of the Health Care Department, with appropriate deputising arrangements, should be formally nominated, to liase closely with DO staff and to attend team meetings and case conferences.

DO Wing should be supported by the establishment as a whole in developing more proactive anti-bullying arrangements.

As a matter of urgency the child protection procedures required by PSO 4950 should be prepared and issued in consultation with Islington Area Child Protection Committee.

3.19 It will already be evident that inspectors found a concerned and caring environment on DO wing with staff very knowledgeable about every individual. Officers, with each normally responsible for three children or young women, took their Personal Officer role very seriously as was evidenced in the very detailed reports and records in training and sentence plans.

3.20 The Incentives and Earned Privileges (IEP) was an important feature of life on the wing, with a lot of thought put into movements upwards or downwards, with commendations, encouragement and warnings being fully discussed with the individual. A developing problem however was that the increasingly frequent cancellation of association because of the need to supply staff to other wings was eroding the differentials between incentive levels.

3.21 Staff were frustrated that what they considered as imaginative developments of the regime had been countermanded from high, ironically on health and safety grounds even though the consequence was to expose the residents to more danger. This was, however, apparently acceptable as it was a risk for which the Prison Service could not be held liable. Thus, for some months a punch bag, with appropriate protective gloves, had been installed in an empty cell. This had proved very successful in teaching alternative responses to outbursts of anger, aggression or gestures of self-harm. This had recently had to be removed, as it was not permissible

to use it without it being supervised by a qualified PEI, which was clearly impracticable.

3.22 Likewise, staff had been told that they could not provide a ball when there was exercise outside, the result being games of the potentially much more violent British Bulldog. The restricted physical space on DO inevitably made it at times claustrophobic and we felt that the wing staff were entirely correct to be concerned to harness the natural adolescent energy of this age group in appropriate ways.

3.23 With very few exceptions, the residents had long histories of substance abuse and self-neglect. It was accordingly heartening to see the efforts that staff were putting into encouraging non-dependant lifestyles in the relatively short stays on the wing. This ranged from staff encouraging a pride in personal appearance to wide ranging discussions on lifestyles and healthy living led by the attached health visitor, in which no topic was barred.

3.24 Here again the poor liaison with medical staff was a major concern, because wing staff were striving to convince girls that there were alternatives to psychotropic drugs and sleeping medication (wing staff were finding that hot chocolate, administered in a caring and supportive way could be an effective alternative). Medical staff, however, continued to prescribe these drugs, often in response to threats of self-harm. Had they entered into discussion with wing staff, an acceptable alternative therapeutic strategy might have evolved which left the young woman safe but at the same time began to wean her away from a lifetime's dependency on medication. Inspectors observed a group of 16 (i.e. 50% of the wing population) leave for the weekly clinic. 13 returned with medication having been prescribed for them.

3.25 The conditions in which meals had to be served were unacceptable. There was no purpose built servery, so that staff served food from canisters placed on standard dining tables. This meant that not only was the presentation of food very unattractive, but that having already lost much heat after the long journey from the kitchen, it was very lukewarm by the time that it reached the plate. Unsurprisingly, the wastage was considerable and the complaints were considerable.

3.26 To sum up**, we recommend the following:**

Urgent steps should be taken to increase opportunities for physical activity on DO Wing, and in particular the punch bag should be reinstated and the use of a ball permitted in the outside activity area.

There should be consultation between medical and wing staff with a view to a joint strategy being agreed about the prescription of medication.

Significant improvements in the arrangements for serving food were needed, particularly in the light of the fact that a number of the young women were likely to have suffered eating disorders.

3.27 The detailed training and sentence plans set out clear objective, targets and programmes for each young woman. Three Officers had been specially trained in the arrangements required for the Detention and Training Order, and the quality of their work as well as that of their liaison with Youth Offender Teams (YOTs) were as good as inspectors have found in any establishment, male or female.

3.28 Initial and subsequent review conferences were all held at the required intervals and chaired by the YOT representative or the wing's Principal Officer. For the over 18's the somewhat different prescribed procedures were followed and these reviews were chaired by the wing's Senior Officers. All conference were attended by specialists as required, and invariably by the wing's teacher who provided good liaison with the rest of Holloway's Education Department, capitalising on the considerable opportunities there were for responding to individual needs.

3.29 There was a range of group activities, in addition to that on lifestyles referred to earlier, covering substance misuse, offending behaviour, victim awareness, anger management and assertiveness training. Every day's activity was different, and few young women were doing the same thing. Thus on the morning when inspectors carried out a census, 18 of the 33 residents were on the wing, nine in a CARATS (substance misuse) Group, one attending a case conference, one being inducted for

education, one on bed rest, three acting, in rotation, as cleaners. Only two were unemployed and this as a result of cancellation of classes. Of the 13 off the wing, seven were at classes, four in the Gym, two in the Activities Centre attending a resettlement project run by 'Women in Prison', one at Art Therapy and one attending a specialist health clinic. Had it been term time, one would have been attending outside college.

3.30 As well as being concerned to find legitimate outlets for adolescent energy, staff were keen to develop recreation activity. At the time of the inspection, a very innovative photographic project in which six young women had participated (and modelled), funded by the CAST charity, had produced some dramatic results. The scope for future projects of this kind was clearly considerable.

3.31 Resettlement issues featured prominently in review and case conferences as well as in the life of the wing generally. With an increasing number of short sentences, the anxieties in relation to returning to unchanged circumstances in the community were very considerable and was a theme of many of the discussions between staff and young women. Staff worried about the over dependency of young women on them as they approached discharge, and were clearly very anxious during this inspection about the ability of a very vulnerable and depressed young woman to cope when she left the wing four days after the inspection.

3.32 Accommodation on discharge was a major problem, and staff spent much time liasing with YOT workers about this. The support of the 'Women in Prison' project to the wing was considerable. For example, during the inspection, a young woman from East Anglia, who wished to break her troubled links in this area, going out for an interview with an Islington housing association. Her Personal Officer accompanied her to this as support.

3.33 Holloway's achievement in establishing the quality of care found on DO Wing during this inspection had been considerable. However, the regime was fragile. There were a number of signs that the wing's special status was being eroded, with the withdrawal of the Principal Officer post and the frequent requirement that its staff relieve on other wings. A new Young Offenders' Management Group chaired by the

Governor Grade, newly in post, responsible had been set up and inspectors were pleased that a number of the issues, which concerned them, were already on the agenda for future meetings. **It is important that this group has the support of the wider establishment and that the uncertainty over the future of DO Wing be resolved as soon as possible.**

Unsentenced Young Prisoners and Juveniles

3.34 The contrast between the care given to those sentenced and those remanded or as yet unsentenced could not have been greater. At any one time there were a similar number in this situation as those sentenced who were located on DO Wing – that is between 30 and 40. There were no special arrangements for those under 21, let alone children under 18; so far as living conditions were concerned, they shared in the same lottery that any other unsentenced woman experienced. The only exception was that the Children's Society Remand Review Initiative was contacted on the arrival of a girl under 18, but the role of their staff ceased once it had become clear that a bail alternative was not going to be achieved. The plight of the under 21 group threw into relief the overall unacceptability of conditions for unsentenced women as a whole who were, after all, 55% of Holloway's population.

3.35 Ironically, perhaps nearly 50% of those sentenced located on DO had spent longer periods in Holloway in an unsentenced status. A number spoke to inspectors about the bullying and, in several cases, of the criminal contamination they had experienced during these very uncertain periods. It was small wonder that on arrival on DO wing, once sentenced, they spoke of their resentment at now being treated as 'children' and some rather gloried in the criminal sophistication that they had acquired during their remand period. Staff, on the other hand, spoke of the challenge they had to break through the veneer of coping mechanisms that the young women had necessarily developed as a mechanism for survival.

3.36 Almost without exception, staff throughout Holloway thought that the treatment of those unsentenced and under 21 was wrong. One Officer described it as grotesque. The sentenced young women on DO put it rather more colourfully, describing some of the criminal behaviour they had been inducted into whilst awaiting their trials, one adding that if the state had actually intended to give them a criminal

education, it could not have tried harder. Many had at that time been in custody and away from their homes or communities for the first time. Inspectors spoke to a number of those currently unsentenced and found them, on the whole, unable to be as graphic about their experiences as had been the veterans of DO Wing. A number were still obviously traumatised.

3.37 The circumstances of the unsentenced under 21 age group are perhaps most effectively illustrated by the case histories of the three children under 18 who were remanded to Holloway at the time of this inspection. Taking account of the fact that there was little difference in the needs, vulnerability and immaturity between those under and over 18 on DO Wing, this trio probably represent a fairly accurate cross section of the young unsentenced population as a whole.

3.38 Case 1. A 17 year old who had been on D3, the induction wing for over six months. She was relatively content and settled. She had persuaded staff to let her remain on this wing where the normal stay was a week or less because she had proved her worth as a wing cleaner. She worked with a group of four other older women who she said had 'adopted' her and looked after her and protected her. Although she had been attending college outside studying for GNVQs, she had decided not to attend education at Holloway because this would have meant leaving D3 and having much less time out of cell.

3.39 Case 2. A Dutch national, who had been in Holloway for two months, arriving just after her seventeenth birthday. This was her first visit to Britain, and she had got as far as the Eurostar terminal when she had been arrested for carrying a kilo or more of heroin for her 39-year-old former boyfriend. Her English was poor and she was in a very distressed state when an inspector spoke to her and clearly needed to talk. She had had five changes of wing during her time and was now in a room with three other older women where she was very unhappy because she said she was constantly being bullied.

3.40 She had had two consular visits, which were of some help, particularly because her English was so poor. She had had one visit from her father, which had

left her very miserable because her father was ill. She could not phone home because she could not afford the phone cards. She was very frightened because she did not know what was going to happen to her or when her trial would be and just hoped she would see her father again soon.

3.41 Case 3 A girl of Somali origin, now 17, who had arrived at Holloway when still 16 just over two months previously. She had had four changes of wing and was now held on B4, which apart from her, consisted entirely of convicted, mainly much older women serving sentences of up to nine years. Although she had been attending college outside, and had asked to be allowed to go to Education, this had not yet happened. She shared a room with two others, one of whom was frightening her a lot. She badly wanted to move somewhere safer. Whilst talking to the Inspector she asked to speak to an Officer (who did not know her, as she was relieving from another wing) to report that the previous night this woman had started convulsing and the room was full of smells which made the girl sick and dizzy. The Officer's view that this was the result of crack cocaine. She had asked staff three times to speak to a Samaritan or Listener, but this had never happened. She wanted to go to services on Fridays and also meet with the Imam. The wing listing however described her as being of no religion.

3.42 Apart from Case 3, where the Inspector was able to corroborate most of the information in a discussion with the YOT worker, it was impossible to confirm the statements as recorded above because there were no records on the wing covering their period at the establishment.

3.43 It appeared that there had been no attempt at Holloway to make arrangements for unsentenced children that complied with Youth Justice Board standards in that:

- There were no post court reports and none of the other prescribed documentation, or certainly not in a way that was accessible to wing staff.
- There was no evidence that the required vulnerability assessments were being carried out at the time of reception.
- There was no apparent ongoing liaison between prison staff and YOT workers to agree a programme of activity whilst on remand.

- There appeared to be no effort to provide opportunities for purposeful activity comparable to that available to this age group when sentenced.

3.44 Even more seriously, two of the three children described were being accommodated in conditions so unsafe as to breach the basic requirements of child protection. The alarming thing was that none of the staff on duty at the time inspectors met with them seemed to be aware of this, either because they were staff relieving from other wings or the child had been on the wing for such a brief period.

3.45 It was truly ironic that once sentenced, girls and young women received such good care at Holloway, but that until this point their particular needs appeared to be so neglected that none of the conditions of a healthy prison could be met. Inspectors asked why it was not possible to hold at least the most vulnerable and youngest of the unsentenced on DO. They were informed that it was contrary to Prison Service policy to mix the unsentenced and sentenced of these age groups. This response was not convincing because it already happens in certain male establishments and in any event Holloway was already holding the girl described in case three in the much more corrupting setting of an adult convicted wing.

3.46 The situation of unsentenced children in Holloway could become even more exposed when and if those sentenced and under 18 are sent to Bullwood Hall. Whatever solution is adopted, **we recommend urgent improvements to the care of the unsentenced under 21 age group which:**

- **are based on continuing vulnerability assessments linked to effective child protection arrangements;**
- **provide for continuity of care and relationships for the period on remand, underpinned by a Personal Officer Scheme;**
- **offer a quality of regime comparable to that available to those sentenced;**
- **have effective links with Youth Offending Teams and other community agencies.**

3.47 In addition **we recommend that the newly established Juvenile Operational Management Group should have its remit extended to include the care of the**

unsentenced. Particular care must be also be taken that the transfer of those under 18 to Bullwood Hall does not leave the unsentenced of this age group as exposed as seen during the inspection.

Short Stay Unit – D2

3.48 This Unit had recently changed its role to become a 'short stay unit' for women who were temporarily feeling unable to cope on ordinary location or were in need of additional support. Places on the unit were to be allocated according to need following an assessment process. The aim of the unit was to help them return to ordinary location as soon as possible. This would be achieved through a care plan involving targets agreed with the individual woman, groupwork and support from staff. The maximum length of stay was to be six weeks.

3.49 At the time of our visit the role of the unit was still aspirational with a number of areas that needed clarification. These included outcomes for those women who were not ready to return to ordinary location at the end of the six-week period and how the role of the unit fitted with other units in the establishment. There was a need to provide training and support for staff working on the unit and awareness training for staff who worked on units that would receive those completing the six weeks.

Housing needs - accommodation on release

3.50 Eight of the 49 women (including young women) who responded to our prisoner survey said that housing issues were an immediate concern to them on arrival in Holloway. Thirty one percent (15) did not know where they would live on their release from prison; 49% (24) had been living in their own or rented accommodation prior to custody; but only 20% (10) said they would be going to their own or rented housing on release. Twenty nine percent (14) of the women had lived with their parents or family prior to custody, and 22% (11) said they would live there on release. One of our respondents had been sleeping rough and four said they slept in "various places".

3.51 Although eight women had had help with their housing needs while at Holloway, the majority (45%, 22) said they needed help with their housing needs for

release. Of the remainder, 31% (15) said they did not need help and four of the women (8%) said that release was too far away to think about housing needs.

3.52 There were two Housing Officers and a number of external agencies that worked from the Activities Centre dealing with women's housing needs. There was a lack of co-ordination and some women were not getting a service while others had several different agencies working on their behalf. Neither of these situations was satisfactory.

3.53 The Housing Officers were not being allocated sufficient hours to carry out their tasks and also lacked the necessary equipment to do the work efficiently. A computer should be provided in order to facilitate the use of accommodation databases and aid the development of referral and tracking systems. A dedicated fax line would streamline and speed up the process.

3.54 Access to suitable accommodation is an essential element of the resettlement process as in the case of those making bail applications and those seeking early release on Home Detention Curfew. **The various departments within Holloway and the external agencies need brokerage and co-ordination to avoid the current waste of resources and to maximise the likelihood of finding accommodation for those in need.**

Counselling, Psychotherapy and Forensic Arts Therapies

3.55 ***Holloway provided a number of excellent interventions for women with different emotional needs and those on several specialist units.***

3.56 The Bourne Trust offered a counselling service to women on remand and had recently set up The First Night in Custody Project, which provided an initial reception intervention for women who were in custody for the first time. This included contact with family and friends, referral to other services within the prison and emotional support.

3.57 An external psychotherapist provided access to a longer-term intervention for those for whom it was appropriate.

3.58 The Psychology Unit employed a full-time counselling psychologist and used four post-graduate trainee counselling psychologists to offer a crisis intervention counselling service within 72 hours to those women who were identified through the F2052SH procedures as being at the risk of self harm or suicide. An evaluation of this service is planned.

3.59 Bereavement counselling was available through the Chaplaincy and through the Psychology Unit who also offered a bereavement support group.

3.60 State Registered Art Therapists, Dramatherapists and Dance Movement Therapists ran groups in Health Care, the Detoxification and Post-Detoxification Units, the Short Stay Unit and the Young Offenders Unit.

3.61 These services dealt with many of the issues that affect women in prison, often those experiences underlying their substance use, self-harming, suicide attempts and challenging behaviour. They were **important therapeutic initiatives and should be evaluated to inform future practice, especially in light of recent research by Royal Free and University College Medical School highlighting the effectiveness of counselling in the short-term as opposed to General Practitioner care.**

CHAPTER FOUR

TESTS OF A HEALTHY PRISON & CONCLUSION

4.01 As we have stated in previous inspection reports on the work of the establishment Holloway is a complex prison, in some ways more complex than any other in the country. It is asked to accommodate every type of female prisoner including 16 year old remands, sentenced young offenders, remanded adults, sentenced adults, short sentenced prisoners, lifers, mothers and their babies and those with psychiatric illnesses who really should not be in prison at all. Furthermore the design of the prison, particularly the provision of dormitory cells, is unhelpful in trying to manage this disparate population.

4.02 The problems of managing Holloway prison are not new and progress in resolving them is slow. A recurring problem is the recruitment and retention of staff of all grades to give consistency of approach and sufficient numbers on duty to provide a reasonable regime for prisoners. At the time of this inspection, for example, over a third of the senior officers were temporarily promoted exposing a vulnerability at that management level but also leaving unfilled posts at office level. In consequence activities such as association were being cancelled frequently because of staff shortages. Inexperienced staff were left in charge of units in which prisoners were locked up. We met one such officer who was only four weeks out of training and another with 18 months service who was on duty, without a break for 9 hours. These examples are used to illustrate some of the difficulties facing the Governor in trying to provide positive outcomes for women prisoners in decent and humane conditions in what should be the centrepiece of the female estate of the Prison Service.

4.03 As is often the case in providing long term solutions to longstanding problems we found that considerable time and energy had been put into plans for the future. On an even larger scale we were impressed with plans for the health care provision for women prisoners. We noted many good initiatives involving multidisciplinary work and local community organisations.

4.04 We include in our inspection reports an appraisal of an establishment's performance against the model of a healthy prison as described in our 1998 thematic review "Suicide is Everyone's Concern". In an unannounced inspection such as this we do not necessarily inspect every area of the prison. However, from our discussions with women prisoners, young offenders and staff, Board of Visitors and from our own observations, we are confident of the following conclusions.

Four Tests of a Healthy Prison

Test 1 – All prisoners are safe

- Women prisoners and young offenders generally felt safe at Holloway. Responses to our questionnaire revealed that 49% never or rarely felt unsafe. Only 3 reported that they often felt unsafe.

- However, 14% of respondents said that they had been assaulted by other prisoners whilst 6% (N=3) said that someone other than another prisoner had assaulted them.

- We were seriously concerned about staffing levels in the Health Care Centre and thought that the levels on C1, where psychiatrically ill women were held, were most unsafe.

- A new system of escorting women to activities had been introduced three weeks before the inspection, mainly we were told to reduce opportunities for bullying. From what we observed opportunities were greatly enhanced by the new system which led to large groups of women waiting for long periods of time with minimal supervision and increasing frustration. We were told that the system would improve as people became used to it. We were not convinced and thought that the "free flow" system used previously should be reintroduced, perhaps with a few extra staff to supervise.

- The anti-bullying scheme had been neglected and had no strategic direction. It should be relaunched and given a new impetus.

- **There was no risk assessment procedure when allocating women to shared cells and dormitories. In particular where under 18 year olds were sharing with adults no consideration had been given to child protection issues.** In the light of the deaths of Christopher Edwards at Chelmsford and of Saheed Mubarek at Feltham the continuing absence of effective risk assessment procedures for initial cell allocation in local prisons is a matter of the utmost concern.

- The regular cancellation of association led to unpredictability for women to be able to arrange telephone calls to families and friends. It also led to frustration amongst women which, had serious implications, particularly in shared cells and dormitories.

- We were very pleased to note that a counselling psychologist interviewed all women who had an F2052SH opened.

Test 2 – All prisoners are treated with respect

- There were many examples of good relationships between staff and women prisoners/young offenders.

- Communal areas of the prison and its grounds were dirty. It was clear that regular cleaning was not taking place in these areas.

- Low levels of association meant that personal hygiene opportunities for women were greatly reduced. Some women reported to us that it was possible to have only one bath a week. Discussions with staff and our own observations confirmed this. 47% of questionnaire respondents said that they had association between 0 and two times a week.

- The prisoner questionnaire revealed a poor regard for the health care service. 49% of respondents felt that it was bad or very bad. Complaints centred on attitudes of nurses and doctors and medication practices. These are described in greater detail in the body of the report.

- There were many examples of women who were mentally ill and who really should have been in psychiatric hospitals rather than in prison.

- It was inappropriate to remove tobacco from women who were clearly psychiatrically ill as punishment following adjudication for being abusive to staff.

Test 3 – Prisoners are fully and purposefully occupied and are expected to improve themselves

- The quality of education provision was good but prisoners were not receiving the full benefit. The delivery of the programme was poor because of cancellations and time lost in escorting prisoners from wings to the education centre. We estimated that approximately 40% of education provision was being lost mainly because of the prison's inefficiency.

- The physical education facilities and programme were excellent.

- The psychology department was providing good quality courses for women prisoners but we were concerned to learn that at least one psychologist post was to be lost, particularly as we had previously reported a reduction in 1998.

- The library was an excellent facility described by our inspectors as one of the best they had seen.

- There were anomalies in the regime monitoring system which amounted to thousands of hours each week. Equally worryingly was the fact that managers had not noticed these until pointed out to them by inspectors. We wondered what use this managerial information had been put to.

Test 4 – Prisoners can strengthen links with their families and prepare themselves for release

- We were surprised to find that social visits were allowed only in the afternoons. However, other features of visits were good, particularly the visitors centre near

the gate which was outstanding. All day family visits which included the use of the library and swimming pool were also good.

- We have already described how access to telephones was limited and unpredictable thus making this avenue of maintaining family links unreliable and frustrating. There were also telephones without hoods which reduced levels of privacy and confidentiality.

- Temporary licence had been used for a variety of reasons including attendance at college, Outward Bound courses, educational purposes and hospital appointments.

- There was little available for the life sentenced prisoners in helping them prepare for the next stage of their sentence and preparation for eventual release. Managers were aware of this and were considering the options.

Conclusion

4.05 Much management time and effort had been given to improving the health care service which was desperately needed. However, such diversion of management resources had led to less attention being given to other important aspects of life for women prisoners such as the residential units and education.

4.06 There was a need for managers to ensure that basic outcomes for women prisoners were at least provided consistently whilst maintaining and improving purposeful activity.

4.07 In all areas there were many conscientious staff who were trying their best often in difficult circumstances.

4.08 Despite the difficult design of the prison there were, generally, good facilities notably the Physical Education department, the Education department, the Library and the Visitors Centre which was the best we have seen.

4.09 However, as the inspection progressed we became increasingly uncomfortable and concerned about outcomes for women prisoners in several important areas. Those that were most pressing included:

- **Unsafe staffing levels in the Health Care Centre, in particular, on C1.**
- **Poor levels of association and the associated problems of access to showers, baths, evening activities and telephones.**
- **The mixing of young remand prisoners with adults and the irrational (although legal) separation after sentence.**
- **The time-wasting and inefficient system for escorting women prisoners to education and other activities.**
- **The management model which had removed Principal officers from residential units where leadership and support was desperately needed and the distancing of functional heads from policy-making meetings.**
- **The unfortunate timing of the transfers of four female managers who were all leaving key posts around about the same time and none were being replaced by other female managers.**

All these issues must be addressed urgently.

CHAPTER FIVE

SUMMARY OF RECOMMENDATIONS

To the Secretary of State

5.01 Urgent improvements should be made to the care of unsentenced young women who are under 18 years of age. These should include:

- separation from adult prisoners
- continuing vulnerability assessments that are linked to effective child protection arrangements
- continuity of care and relationships for the period of remand, underpinned by a Personal Officer Scheme
- a quality of regime comparable to that available at Holloway to sentenced children
- effective links with Youth Offending Teams and other relevant community agencies. (3.46)

To the Director General

5.02 The seriously inappropriate placement of so many seriously mentally ill women should be drawn to the attention of the mental health lead at the NHS London regional office. (2.109)

5.03 Effective cell allocation procedures should be introduced in all Prison Service establishments without delay. (4.04)

5.04 Security arrangements for female prisoners across the Prison Service should be reviewed in accordance with recommendations in the thematic review 'Women in Prison'. (2.04)

5.05 Contract monitors should pay frequent and regular evening visits. (2.168)

5.06 HIMP should aim to provide psychiatric input that is integrated with local psychiatric services. (2.05)

5.07 The Psychology Department at Holloway should be recognised as a centre of excellence, sufficiently resourced, to provide a research and development function for the female estate. (2.06)

5.08 There should be a national needs analysis conducted into the offending behaviour needs of women prisoners and, properly resourced, targeted provision. (2.07)

5.09 The computer programme notifying the requirement for Mandatory Drug Testing should be reviewed to take account of prisoner discharge dates. (2.08)

To the Operational Manager for Women's Prisons

5.10 More female Governor grades should be recruited for Holloway. (2.75)

5.11 The nursing staffing of the inpatient unit must be reviewed urgently and increased to provide an environment, which affords a level of therapeutic activity which meets the patients' needs. (2.112)

5.12 Holloway should be considered as a national training resource for staff who are to work in the female estate; this should be considered by Headquarters. (2.164)

5.13 Urgent re-consideration of the proposal to reduce the complement of psychologists is needed in the interests of continued positive influence on the regime. Furthermore, this recommendation is vigorously underlined in light of the original recommendation in the 1997 report to the Director General regarding the importance of the Psychology Department as a resource to the women's estate. (2.149)

5.14 The work of the department should be fully analysed and sufficient resources made available to provide a full Bail Information service for all prisoners held in Holloway Prison not just those committed from the London courts' area. (2.09)

5.15 The prison Health Task Force should support the Governor and Health Care Manager in securing the services of competent personnel, and in dispensing with the services of those whose performance is unsatisfactory. (2.10)

To the Governor

Urgent Action

5.16 Immediate steps should be taken:

- to address unsafe staffing levels in CI
- to provide an efficient system for women prisoners to get to education and other activities
- to provide more effective leadership and support for residential units
- to recruit female governor grades to replace those who have transferred out of Holloway. (4.09)

Employment

5.17 Unit managers should be made accountable for prisoners not attending activities. (2.14)

Regime Monitoring

5.18 Regime monitoring figures should be reviewed to make them more realistic and checked thoroughly to ensure their accuracy. (2.16)

5.19 The LIDS system should be used properly and accurately. (2.18)

Education

5.20 Hairdressing or beauty therapy courses should be considered (2.21)

5.21 There should be better liaison with some middle managers. (2.22)

5.22 Attendance levels at the weekly induction and needs assessment of new arrivals should be improved to take full advantage of the services on offer. (2.23)

5.23 Consideration should be given to adjusting the daily routines to make attendance at evening classes more attractive. (2.24)

5.24 Consideration should be given to delivering vocational courses within the education system. (2.27)

Anti-Bullying Strategy

5.25 Supervision should be improved in the bath and showers areas of Reception and in the clean side holding room. (2.31)

5.26 Staff training in the Anti-Bullying Strategy should be a priority. (2.32)

5.27 The Anti-bullying Committee must meet regularly, be chaired by a Senior Manager, have a multidisciplinary membership and ensure the effective implementation of the Anti-bullying Policy. (2.33)

5.28 The successful implementation of 'Bulldoc' in D0 should inform a more widespread anti-bullying action plan for the whole establishment. (2.34)

Bail and Legal Aid

5.29 Lockable sealed display cabinets should be made available in strategic areas around the establishment for Bail and Legal Aid information. (2.35)

5.30 The Personnel Department should inform the Foreign Nationals Liaison Officer of staff movements, in and out, to enable the FNLO to keep an up to date list of foreign language speakers for use by the Legal Aid department. (2.36)

Catering

5.31 There should be better quality control in the kitchen. (2.39)

5.32 A food committee should be introduced. (2.42)

5.33 Food comments books should be introduced. (2.42)

5.34 All servery workers should be properly attired and have health and hygiene training before being allowed to work on the serveries. (2.43)

Drug Strategy and Mandatory Drug Testing

5.35 A thorough needs analysis including an assessment of the needs of pregnant women on C4, those on the Mother and Baby Unit and both remanded and sentenced young women and the juveniles should be a priority in order to underpin a review of the Drug Strategy. (2.57)

5.36 The MDT information technology systems and the procedures for working together amongst all departments involved in the MDT process should be reviewed in order to maximise efficiency. (2.47)

5.37 The Detox programme manager, who was a clinical nurse specialist from Brent, Kensington, Chelsea and Westminster NHS Trust, should be involved in the selection and training of all staff working on the unit in order to ensure standards of care are adhered to. (2.50)

5.38 A review of the communicable diseases and health promotion interventions should be included in the planned needs analysis. (2.55)

5.39 Administrative support should be provided to the Cranstoun Drug Services team to assist with ongoing monitoring and evaluation of the CARAT work and the Post Detox Unit. (2.56)

5.40 It is essential that alongside audit procedures, quality assurance mechanisms for each service are also included in the Drug Strategy. (2.59)

5.41 A regular meeting of service providers should be held to support working together and aid mutual understanding of different roles and tasks. (2.60)

5.42 It is essential that the Drug Strategy begins in reception. A review of the interventions taking place at this first stage is needed. (2.64)

Equal Opportunities and Race Relations

5.43 Local race relations training should take place for all staff. (2.73)

5.44 The lack of managerial grades from ethnic minorities across the establishment should be addressed. (2.74)

Health Care

Staffing

5.45 Additional registered nurses should be recruited. (2.81)

5.46 Overtime levels should be reviewed and reduced to safe levels for the health and safety of staff and patients to ensure that the professional competence of staff is not compromised. (2.83)

5.47 We repeat our previous recommendations (3.246, 3.247) relating to problems in access to specialist care: 3.246 – that there should be an audit to determine the causes of cancellation of NHS appointments and to suggest courses of action to reduce these calculations; and 3.247: there should be discussions with local NHS Health Authorities and trusts to see how these delays can be reduced. (2.96)

5.48 Protocols for the prescription of psychoactive drugs should be established and adherence to the protocols monitored. Deviations from the protocols must be justified by the prescribing doctor. (2.97)

Primary care

5.49 The recommendations of the reports on training needs to deliver effective health care and on the audited activities of health care should be considered carefully by the health care manager and, where appropriate, incorporated into the HIMP with an agreed timescale for implementation, review and evaluation. (2.100)

Nursing staffing

5.50 There are national and regional initiatives to establish nurse banks and the health care manager should make contact with the NHSE London Regional Office. (2.105)

5.51 Because of the extent and seriousness of the problems regarding nursing at HMP Holloway, consideration should be given to setting up a local nursing task force. The membership should reflect the clinical skills required in the delivery of prison health care to women and their children. (2.106)

Nursing policies and practice

5.52 Nursing policies and procedures should be written and implemented with input from specialist nurses. Clinical supervision should be established for all nursing staff. (2.107)

Inpatient services

5.53 The quality and availability of medical notes should be audited and improved. (2.109)

5.54 A training programme should be provided for officers working on the inpatient unit. Links with the Health Authority and therefore access to the Education and Training Consortia should be used to ensure that the programme is established within an educational awarding framework. (2.113)

Care planning and multidisciplinary working

5.55 A training programme should be implemented to give staff the required skills and understanding to complete care plans. (2.114)

5.56 The nursing establishment, levels of nursing and health care officers as well as skill mix requires urgent management action. In addition to the 'scoping' exercise, discussions should take place with the Trust to provide supervised mental health practice and a mentoring scheme for the nurses working on the inpatient unit. (2.115)

5.57 The task force should also be approached to provide on-going support to the Health Care Manager by identifying examples of good practice and providing mentoring for senior nurses on how to develop good working practices. (2.116)

Pregnancy and childbirth

5.58 The provision of maternity services should be reviewed to ensure that women at HMP Holloway are not being disadvantaged in their pre and postnatal care. (2.121)

Mother and Baby Unit (MBU)

5.59 Supervision for the nursery nurses should be more frequent than monthly for an agreed period of time, such as three months, and then reviewed. The health visitor should meet twice weekly with nursery nurses to discuss any issues concerning the babies' development. (2.123)

5.60 The Governor must appoint a Child Protection Co-ordinator. (2.124)

5.61 Not only should new staff be required to read the guidelines on their first day in the MBU but they should attend child protection training and receive ongoing support. (2.125)

5.62 Until replacement staff have been appointed and trained, all other staff detailed to the MBU must have training in child protection and child care. (2.126)

5.63 Time spent in the MBU should be used constructively to promote good parenting and child care. (2.127)

5.64 The Governor should discuss more adequate provision with the Director of Islington Social Services to ensure continuity of care for the women and children in the MBU. (2.128)

Pharmacy

5.65 Professional checks should be made prior to supply. (2.133)

5.66 The computerised PMR (Patient Medication Records) should be completed for the pharmacist to undertake his or her professional duties. (2.134)

5.67 A system should be in place so that the pharmacist sees all patients' Prescription and Administration Record Cards if any changes to them have occurred. (2.135)

5.68 A system should be in place so that the pharmacist sees all patients' Prescription and Administration Record Cards if any changes to them have occurred. (2.136)

5.69 Methadone should be dispensed by the pharmacy on a patient named basis (the preferred option) or proper glass stamped conical measures should be supplied with suitable training provided by the pharmacy staff. (2.138)

Life for Prisoners

5.70 The Personnel Department should inform the Foreign Nationals Liaison Officer of staff movements, in and out, to enable the FNLO to keep an up to date list of foreign language speakers for use by the Legal Aid department. (2.36)

5.71 Custody planning should be arranged for unconvicted prisoners. (2.142)

5.72 The local Race Relations Management Team notices, with names and locations of Foreign Nationals Liaison Officers, distributed throughout the establishment, should be updated. (2.144)

5.73 The prison should consider forming a multidisciplinary Foreign Nationals Committee or at least include foreign nationals as a standing item on a related committee, for example the Race Relations Management Team meeting. (2.145)

Prison shop

5.74 The security arrangements for the shop must be improved immediately. (2.152)

5.75 Goods should be placed in clear plastic bags which are properly heat sealed. (2.153)

Suicide Awareness

5.76 The taps in the ligature-free cell and the gated cell should be flush with the wall. The splash-backs behind the taps should be removed as they could be pulled off the wall and used as an instrument causing injury. (2.156)

5.77 The needs of the high numbers of women on F2052SHs must have put pressure on all the available resources and where necessary there should be a reallocation of staff. (2.158)

5.78 The number of open of F2052SH's should be reviewed weekly and trends notified to the Governor for discussion with the visiting psychiatrist. (2.158)

5.79 A concerted effort must be made for more staff to attend the suicide awareness training. (2.159)

5.80 The suicide awareness training programme must include completion of the documentation to improve the quality of entries in F2052SHs. (2.159)

Reception

5.81 The provision of ventilation within the area should be improved. (2.166)

5.82 Staff at Holloway and the contractors should develop a strategy to prevent delays occurring in the evenings. (2.167)

5.83 The Governors order should be enforced and all transfers from the establishment should be notified to the Throughcare Department. (2.173)

Incentives and Earned Privileges Scheme

5.84 Governor grades who check IEP forms should sign them to show they have done so. (2.177)

5.85 The sampling procedure by governors of changes of IEP levels should be better evidenced. (2.179)

Sentence planning

5.86 A review of the administrative support requirements of sentence planning should be undertaken to ensure that Prison and Probation Service Standards are met. (2.181)

Probation Department

5.87 Proposals to further reduce the complement of probation officers should be urgently reviewed in acknowledgement of the contribution that the Probation Department makes, with others, in identifying risk and meeting the needs of prisoners thereby safeguarding the public. (2.183)

5.88 A Throughcare Committee should be appointed immediately, to be chaired by a senior manager to co-ordinate throughcare policy in all areas of the establishment in accordance with Prison Service Standards. (2.184)

5.89 A resettlement sub-group should operate under the auspices of the Throughcare Committee, once the latter is established. (2.185)

Visiting Arrangements

5.90 The quality of the closed circuit TV system in the visiting room should be improved. (2.186)

5.91 The visits booking computers should be utilised properly. (2.187)

5.92 The procedures around Schedule One Offenders and Child Protection should be urgently addressed. (2.188)

5.93 Flooring in the Visits areas needs to be replaced and levels of cleanliness throughout improved. (2.189)

5.94 The prisoners' waiting room outside the Visits Room should be made a non-smoking area. (2.190)

5.95 It is vital that the crèche worker is in place for every social visits session. (2.191)

Care of young prisoners and juveniles

5.96 A representative of the Health Care Department, with appropriate deputising arrangements, should be formally nominated, to liase closely with DO staff and to attend team meetings and case conferences. (3.18)

5.97 DO Wing should be supported by the establishment as a whole in developing more proactive anti-bullying arrangements. (3.18)

5.98 As a matter of urgency the child protection procedures required by PSO 4950 should be prepared and issued in consultation with Islington Area Child Protection Committee. (3.18)

5.99 Urgent steps should be taken to increase opportunities for physical activity on DO Wing, and in particular the punch bag should be reinstated and the use of a ball permitted in the outside activity area. (3.26)

5.100 There should be consultation between medical and wing staff with a view to a joint strategy being agreed about the prescription of medication. (3.26)

5.101 Significant improvements in the arrangements for serving food were needed on DO, particularly in the light of the fact that a number of the young women were likely to have suffered eating disorders. (3.26)

EXAMPLES OF GOOD PRACTICE

5.102 The appointment of a health care manager responsible for all staff in the health care service whether discipline, nursing or medical should greatly assist in better management of the service. (2.99)

5.103 A support group had been implemented for all staff working in Health Care and was facilitated by a visiting psychiatrist on a monthly basis. (2.117)

5.104 The 'Guide to the Psychology Unit' produced in January 2000 and issued to all other departments was an example of good practice which encouraged a culture of care and understanding in the treatment of prisoners. (2.148)

5.105 The Visitors Centre, opened since the last inspection, was an excellent resource and one of the best we have seen and is commended. (2.192)

5.106 Holloway provided a number of excellent interventions for women with different emotional needs and those on several specialist units. (3.55)