REPORT ON

AN UNANNOUNCED INSPECTION

OF

HM PRISON WANDSWORTH

20 – 24 JANUARY 2003

BY

HM CHIEF INSPECTOR OF PRISONS

INTRODUCTION

Wandsworth is now the largest prison in England and Wales. It was last inspected two years ago. This unannounced inspection showed a prison that, in spite of maintaining improvements in culture, healthcare and safety, was failing to meet basic standards of decency and activity for most of its 1460 prisoners. Essentially, the prison was trapped between the twin pressures of overcrowding and understaffing, exacerbated by inefficient deployment of staff.

We were assured that plans were in hand to improve matters, with more staff, new work patterns for staff, and more work opportunities for prisoners; and we recognise the commitment of the Governor and senior managers to drive through improvements. However, as in all inspections, we report what we find and what prisoners experience; and their experience, at the time of the inspection, was among the most impoverished we have seen, in any prison.

Wandsworth held 200 more prisoners than at the time of the last inspection. More of them were therefore held two together in cells meant for one. Most of them spent the great majority of their time in those cells. Time out of cell was minimal and had significantly deteriorated since our last inspection. 53% of prisoners told us that they had never had association while at Wandsworth, compared to 8% at the time of the last inspection, and an average of 1% in local prisons generally. Only 14% of prisoners had six hours or more out of cell, against a local prison average of 37%.

Management had attempted to ameliorate these problems by unlocking prisoners for short periods to access showers and telephones, but in practice this was patchy and unpredictable. Given a shortage of telephones, prisoners had great difficulty in practice in using them in the time available. Only 12% of prisoners told us that they could shower more than five times a week (compared to a local prison average of 65%).

Average regime monitoring figures, supplied to managers, disguised the impoverishment of the regime for the majority of prisoners who were unemployed. In

practice, many prisoners told us that they spent 23 hours a day in cell; without even the benefit of in-cell television, which could not be provided on most wings, since the size of the prison meant that it would have required its own electricity sub-station.

At the time of the inspection, most prisoners were without any purposeful activity. During the inspection, we found around 1,000 prisoners were on the wings, 800 of them locked in their cells. The few workshop places available were under-used, and opportunities to acquire accredited skills were limited. Improvements to the quantity and quality of available work were planned, imminent and much-needed.

Resettlement was also underdeveloped. There were a number of good initiatives, mainly provided by voluntary agencies, but they were not co-ordinated or related to assessed need. As there was no effective applications system, sentence planning process or personal officer scheme, the majority of prisoners, who were rarely unlocked, had insufficient opportunity to access such opportunities as there were.

It is to the credit of committed staff and managers that, in spite of this overall gloomy picture, pockets of good practice identified at the last inspection had largely been retained. Wandsworth was largely a safe prison, with active work to reduce suicide and self-harm. The care and separation (previously segregation) unit continued to be well ordered, but recording systems needed improvement. Healthcare continued to improve, though there was an urgent need for permanent doctors. Support for foreign national prisoners was among the best we have seen in the prison estate. There was active attention to race relations: though the prison's own monitoring had revealed the very troubling statistic that 73% of those on the lowest, basic regime level were black or minority ethnic prisoners (who represented only 45% of the prison population). This was under review, and we recommend urgent action to identify the causes.

We do not underestimate the commitment of managers, and many staff, to drive forward improvements at Wandsworth. But neither they, nor the Prison Service, should underestimate the scale of the task they face. We therefore plan to reinspect, within a year, to see whether the hoped-for improvements have materialised.

Wandsworth, as we found it, stands witness to the damaging effects of simply cramming more people into prisons that do not have the capacity or resources to do more than contain them: unable to offer fundamental conditions of decency, let alone carry out effective work to reduce reoffending. We commend the efforts of those within the prison, including its committed Board of Visitors, to bring this to the attention of the Prison Service and the public. With them, we strongly recommend that the prison's operational capacity should be reduced unless and until a decent and purposeful regime can be provided for prisoners.

Anne Owers **April 2003**

HM Chief Inspector of Prisons

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FACT PAGE

Task of the establishment

A London category B local with training prison for vulnerable prisoners.

Brief history

The prison was built in 1851. Since 1989, a new reception area has opened and the total refurbishment of four of the main prison wings has been completed. A and B Wings re-opened in autumn 1998. The remainder of the wings have had in-cell sanitation fitted. The refurbished health care centre opened June 1997; the refurbished social visits in October 1998; the new gymnasium in October 1999. The new kitchen and workshops are due to be opened in 2003. The refurbishment of reception, the health care centre and E Wing will be carried out in 2003/2004 under the auspices of the Safer Custody Project.

Area organisation

London Area

Number held

Unlocked: 20/01/03 = 1417; 21/01/03 = 1416; 22/01/03 = 1430; 23/01/03 = 1439; 24/01/03 = 1459

Cost per place per annum

£23,359

Cost per prisoner place per annum

£18,131

Certified normal accommodation

1163

Operational capacity

1461

Last full inspection

October 1994

Last short unannounced inspection

20-23 November 2000

Description of residential units

A Wing	Sentenced workers
B Wing	Voluntary testing unit – sentenced workers
C Wing	Unconvicted, first night & induction
D Wing	Sentenced - unemployed
E Wing	Detoxing prisoners (following initial detoxification in Kearney & pre-release)
E1	Care & separation unit
G H & K	Vulnerable prisoners unit – mainly sentenced long-term sex offenders
Health care centre	Psychiatric & physical care
Kearney Ward	Detoxification unit

CHAPTER ONE

HEALTHY PRISON SUMMARY

Introduction

1.01 All inspection reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern,* published in 1999. The criteria are:

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

1.02 HMP Wandsworth held 200 more prisoners than it had during our last inspection in November 2000. However, as no new accommodation had been provided, more prisoners were sharing what were meant to be single cells. The establishment had also experienced difficulty in the recruitment and retention of staff. At the time of this inspection, therefore, there were more prisoners and fewer staff than there had been at our last inspection. Many middle managers, including most of those on residential units, were substituting to a higher grade while attempts to recruit permanent managers were ongoing. At the same time, existing staff profiles did not deploy staff in a way that matched the requirements of the regime.

1.03 Plans were in place to refurbish both E Wing and the health care centre. The stated intention was to decant existing prisoners into, and thereby further overcrowd, other wings. The current overcrowded conditions and staffing problems made it impossible to provide a decent environment for prisoners and this was likely to deteriorate further with increased overcrowding during refurbishment.

1.04 The work of senior and principal officers had been re-profiled and new shift patterns had been introduced the day before our inspection. A similar exercise for prison officers was due to take place in April, which senior managers believed would resolve many of the current problems.

Safety

1.05 There was no indication, either in what we saw or were told, that Wandsworth was an unsafe prison. Of those prisoners surveyed during this inspection, 64% said that they had never felt unsafe. However, there were several elements of the regime where policy and practice were insufficiently rigorous to ensure the continued safety of prisoners.

1.06 The anti-bullying policy was comprehensive and included the appointment of designated anti-bullying officers on the wings. Despite this, very few prisoners had been identified as bullies and placed on the scheme in the last year. Officers on the wings did not appear fully to understand the policy. This suggested that the policy may not have been fully adopted by wing staff and that some bullying may have gone unidentified or unchallenged.

1.07 Prisoners were received in a temporary reception area that was wholly unfit for the purpose. The small amount of space made private conversations or the proper segregation of processed and unprocessed prisoners difficult. In particular, the cell-sharing risk assessment, which required prisoners to answer quite personal questions, was carried out in public. In such circumstances, prisoners were unlikely to answer truthfully and risk factors may have been missed. Despite the shortcomings of the environment, the atmosphere was relaxed and staff treated prisoners reasonably.

1.08 First night and induction procedures were inadequate. We found little evidence of any first night support in wing history sheets or conversations with prisoners; indeed prisoners were advised to ask their cell-mates for necessary information. Risk assessments for cell sharing were rarely completed, in spite of the fact that we had urged this in 1999. The induction programme was basic and inadequate, with an inappropriate level of responsibility placed upon prisoner orderlies

1.09 A reception board had been introduced recently with the intention that basic information and needs would be dealt with here and the Initial Classification and Allocation form (ICA1) completed. However, this process was only in place for convicted prisoners and many of these did not attend. This meant that a substantial proportion of prisoners were not receiving even this basic service.

1.10 The segregation unit, known as the care and separation unit, was calm and controlled. The interaction between prisoners and staff was limited but polite and respectful. Prisoners serving a punishment of cellular confinement were placed in cells where the bed was a concrete plinth, and the table and chair were also formed concrete. This was an unacceptable environment in which to expect anyone to live.

1.11 Recording systems for the use of force, prisoners in segregation and the use of special, unfurnished cells were not always followed: forms were sometimes opened but not completed and, in particular, the reasons for the use of a special cell were not always recorded. While the systems were not apparently being abused, this failure to document events properly in such a sensitive area did not allow this to be evidenced.

1.12 The rate of adjudications was fairly low for the size of the population and hearings were conducted thoroughly and respectfully. Punishments given were consistent and not excessive.

1.13 The incentives and earned privileges (IEP) scheme was poorly designed and implemented, offering little incentive for prisoners to progress. Given the lack of in-cell electricity on most wings, televisions could not be used to reward good behaviour. Prisoners on the basic regime received very few privileges, although any loss of privileges had less of an impact in the not uncommon event that they shared a cell with a prisoner on the standard regime. Although the rules of the prison were widely published and well understood, prisoners could be awarded a negative IEP report for breaking minor, but unpublished, rules. Clearly this was open to abuse.

1.14 The suicide and self-harm strategy was good and an active multi-disciplinary team, including prisoners, met regularly. However, the case files for prisoners at risk

of self-harm (F2052SHs) showed that reviews did not always take place on time, or indeed at all, and that some of the agreed care plans were inappropriate or impractical.

1.15 With prisoners spending very little time out-of-cell and the consequent lack of interaction, staff did not know prisoners as individuals. As a result, there was no application of the concept of dynamic security and only minimal intelligence was gained from prisoners.

Respect

1.16 The respect shown to prisoners by staff varied widely: some staff were abrupt, used volume as a means of making their orders known and were barely civil; others were polite, caring and put themselves out to try to meet prisoners' needs. The majority were somewhere in between.

1.17 The environment, including cells and common areas, was acceptably clean and in reasonable decorative order, particularly for a prison holding so many people. In-cell toilets were mostly unscreened, despite our recommendation following the last inspection. This was wholly unacceptable in those single cells shared by two people. Although screens were in production at another prison, repeated delays meant that none had been received at Wandsworth. The establishment would not be able to provide in-cell electricity (and therefore in-cell television) on most wings, because its size meant that it would require a separate electricity sub-station to do so.

1.18 There were good recreational facilities on the wings although showering facilities were variable. The water in the showers, particularly those on D Wing, was often tepid or cold. Prisoners' use of any of these facilities was severely restricted by the lack of association time.

1.19 Association was rarely available in the evenings. 53% of prisoners in our survey stated that they never received association, compared to 8% in 2001 and an average of 1% in local prisons. Time out-of-cell was similarly limited: on average 37% of prisoners in local prisons tell us that they have six hours or more out of cell, but only 14% did at Wandsworth; and 41% claimed to be out for less than an hour a day.

1.20 In recognition of the fact that prisoners were able to spend only a little time out-of-cell and that consequently it was difficult to have a shower or make a telephone call, a 'social and domestic' arrangement had been introduced recently. By this, prisoners without activity were unlocked for between 20 and 40 minutes during the day as and when staffing levels allowed. The timing and frequency of these sessions were unpredictable, varying across wings and even for different prisoners on the same wing. Equally, there was rarely enough time for prisoners both to take a shower and make a telephone call, especially given the very long queues for the few telephones. Records kept by the wings showed that prisoners had been given the opportunity for a shower and a telephone call, even though this was not possible in practice. These records also showed that many prisoners received only one such opportunity a week. In our survey, only 12% of prisoners said that they had had the opportunity to have a shower more than five times in the average week and 64% said that they had difficulty accessing a telephone. This compares to a local prison average of 65% receiving a shower five times a week and 37% having difficulty accessing a telephone. Management relied on average figures to monitor access to both showers and telephones but these were distorted by prisoners who had secured employment and consequently had far greater access to all services and facilities. Prisoners without employment, who spent most of the time locked in their cells, had very little opportunity to access anything at all.

1.21 The applications system, which was the subject of a recommendation in 2000, was barely functioning. Rather than being recorded, applications were simply handed to staff and the system was not managed or monitored. Prisoners rarely received a reply to their applications and had no faith in the system. Instead, they tended to use the newly-introduced complaints procedure or to apply to the Board of Visitors.

1.22 The complaints system was well administered, although replies were not always focussed, helpful or respectful. Complaints were only tracked for one month, after which they were effectively lost. Managers told inspectors that this problem had been rectified during the week of the inspection.

1.23 The food was of reasonable quality and quantity, which was a laudable achievement given the conditions in the temporary kitchen. The serveries were clean

and well managed, although the timing of meals was inappropriate, with, for example, the serving of lunch beginning at 11.30am.

1.24 An active race relations committee met regularly and monitored trends. A recent increase in the number of racial complaints indicated that there was some level of prisoner confidence in the system and the complaints themselves were generally investigated thoroughly. The committee had noted and reviewed the high number of black and minority ethnic prisoners on the basic regime, but they still constituted 73% of those on the basic regime at the time of this inspection. The committee intended to wait until the revised incentives and earned privileges scheme had been implemented to see whether this resolved the issue. However, the sheer numbers involved indicated that there may have been underlying racist issues that merited separate and immediate attention.

1.25 There was good support for foreign national prisoners and deportees. Four prisoner orderlies were trained to give advice and, where necessary, to contact immigration agencies to resolve issues. The Detention Advisory Service also visited the prison and helped to resolve individual problems. However, this support did not extend to the wings, where foreign national prisoners experienced difficulties in gaining their entitlements to telephone calls and airmail letters.

1.26 Prisoners in the health care centre were provided with appropriate clinical treatment and staff dealt with them with care and respect. In-patients received reasonable time out-of-cell and had access to facilities. The health care centre staff were developing links with the local primary care trust and were in contact with community services in relation to prisoners with mental health or detoxification problems. Prisoners reported communication problems with doctors, who were mainly locums, and frequently felt more confused after a consultation than before one. In conjunction with the primary care trust, plans to appoint replacement doctors were being pursued actively.

Purposeful activity

1.27 Although new workshops had been built and were almost ready to take prisoners, the lack of activity for most of the population was a cause for grave

concern. Most prisoners were without activity. A check made during the inspection revealed that, of the 1430 prisoners, approximately 1000 were on the wings, 800 of them locked in their cells.

1.28 Given the limited number of staff available, it had proved impossible to run a week-long induction course and this had now been reduced to a single day. This was cancelled frequently and, even when it did run, was not available to all new receptions. In theory, new receptions were located on C Wing; in practice, they were located on whichever wing had spaces available. Only those on C Wing received induction.

1.29 At our previous inspection, we criticised the system of allocation to activity. This remained poor. It was not based on any assessment of individual need, although those prisoners who had attended a reception board were able to indicate what activity they would prefer. Activity places were allocated primarily to prisoners located on A or B Wings, leaving those on other wings at a disadvantage.

1.30 Those activity places that were available were not used to their maximum effect. When inspectors checked, for example, only 169 of the 293 workshop places were occupied. At the same time, slippage in the times of moving prisoners to activity contributed to an unacceptably short working day.

1.31 The relevance of available activities to the probable needs of prisoners varied: from the brush shop, where no employable skills were gained, through to highly marketable computer skills. There were limited opportunities to gain accredited skills or qualifications. We were pleased to see that more, and more relevant, workshops were planned, together with a new working week, which would again depend upon the success of the new profiles.

1.32 The education curriculum was adequate. The target for acquisition of basic skills at entry level and levels 1 and 2 was set at 412. While little progress towards these targets had been made earlier in the year, the last four months had seen an increase in the number of prisoners achieving basic skills qualifications.

1.33 As the better paid jobs were mainly the unskilled ones, particularly wing cleaners, prisoners had no incentive to pursue either education or offending behaviour programmes.

1.34 Although the library was well-stocked, prisoners had limited access to it. A check made on 22 January revealed that A Wing prisoners had not been able to visit the library at all that month. Similarly, the physical education department provided an active and varied programme but only a minority of prisoners attended frequently; the majority did not attend at all. In our survey, 58% of prisoners said that they did not attend the gym in an average week.

1.35 The chapel services were well attended. There was usually a waiting list of prisoners who wanted to attend but for whom there was no space, and the chaplain was looking at ways to accommodate them. It is likely that this waiting list would be reduced if more opportunities were available for activity throughout the week.

Resettlement

1.36 Despite the large number of remand and sentenced prisoners being released into the community, resettlement was not a core activity and various resettlement and re-integration initiatives, mainly provided by voluntary agencies, were not co-ordinated or driven by assessed need. Over half of those about to be released told us that they had nowhere to live on release.

1.37 There was no effective bail information service, despite the fact that a probation service officer had been appointed to run one. Legal services officers were trained and well-resourced but were often re-deployed to meet more pressing staffing needs. They were unable to deal with all requests from prisoners and still less able to take a pro-active role in seeking out those who might have benefited from their services.

1.38 There was no personal officer system. Some officers attempted to address prisoners' needs while on landing duties but the level of contact was far too limited to have any real impact.

1.39 There was no sentence planning for the majority of prisoners beyond completion of the initial assessment (ICA1). 737 sentence plans remained outstanding. For prisoners on the vulnerable prisoners unit, who were serving medium to long-term sentences, there was nominal sentence planning. While the sentence planning forms (automatic conditional release and discretionary conditional release) were kept, reviews were not up to date, targets were largely irrelevant and no attention was paid to the targets between the review dates. Effectively, therefore, there were no means, either formal or informal, by which staff could get to know prisoners, identify their offending behaviour needs or provide programmes/services to meet those needs.

1.40 The accredited offending behaviour programmes – the Sex Offender Treatment Programme (SOTP) and the Enhanced Thinking Skills (ETS) – were well-administered and both had received a 100% implementation quality rating. With no sentence planning and therefore no mechanism by which to identify needs, prisoners gained access to the programmes by self-referral. Although the psychology unit tried to persuade sex offenders to attend the SOTP, the take-up was minimal. The target for completions of the SOTP was 32, which could not possibly meet the real needs of a population of over 300 vulnerable prisoners, most of whom were sex offenders. In these circumstances, the status of the vulnerable prisoners unit as a training unit was questionable.

1.41 Several voluntary agencies provided support for prisoners about to be released into the community but could only help those prisoners who accessed them. For those prisoners who spent their time locked up, and without a reliable application system, such access was very difficult. As a result, prisoners who did make contact were those with the most access to work and other regime activities and therefore potentially were not the most needy. At the same time, these prisoners tended to make use of all of the agencies, which meant that sometimes efforts were duplicated. A community services forum, introduced by the prison to share information on the respective services and avoid overlap, had ceased to operate.

1.42 Prisoners' contact with their families was restricted by short visiting times and numerous mistakes or delays. As many as 40 complaints a week were being received from visitors about booking mistakes and the treatment that they had received. By

contrast, the visitors' centre provided a good service, including some innovative group-work with families and pre-release preparation. Visitors generally reported that they were also treated well by staff once they had accessed the visits room.

1.43 A good range of services was provided within the drugs strategy, including an excellent detoxification programme and a 12-step RAPt programme for prisoners in both the vulnerable prisoners unit and the main prison. The CARATs team were largely tied into assessment and were unable to provide any throughcare or treatment, and the voluntary testing unit was not operating significantly differently from any other wing. The various services available were not linked together in a way that provided maximum benefit for prisoners.

Conclusion

1.44 Wandsworth was overcrowded, inadequately staffed and unable to provide a decent or active regime for most of its prisoners. The mechanisms for assessing individual needs, particularly a personal officer scheme and sentence planning, were not in place. The available activities, programmes and various support agencies were insufficient to meet the needs of the population. Equally, they were accessed by a minority of prisoners, while the majority received little attention, support or time out-of-cell.

1.45 Managers and many of the staff were keen to provide a better service to prisoners and a great deal of hope was invested in the re-profiling of the work of staff as a means to achieve this.

Main recommendations

1.46 **The operational capacity of Wandsworth should be reduced to allow for the refurbishment of E Wing and the health care centre, and there should be a further reduction in numbers unless and until a decent regime can be provided for prisoners.**

1.47 **A comprehensive and supportive first night procedure that meets the needs and ensures the well-being of newly-arrived prisoners should be established. This should be available to all prisoners across the establishment.**

1.48 **An induction programme should be provided for all prisoners and should identify their immediate needs as well as providing them with comprehensive information about the prison and their entitlements.**

1.49 **All prisoners should be provided with predictable and more frequent association periods, and with access to, and reasonable time to use a shower and a telephone every day.**

1.50 **There should be more activity places, they should be fully utilised and the timetable for activities should be adhered to.**

1.51 **The application system should be replaced with a one that is reliable, managed and auditable.**

1.52 **The situation whereby 73% of prisoners on the basic regime are black should be looked into in order to identify and remedy any underlying problems.**

1.53 **A personal officer system should be introduced on all wings.**

1.54 **Resettlement provision should be extended to provide for all prisoners, including those on remand, in accordance with Prison Service Order 2300.**

1.55 **Sentence plans should be completed for prisoners sentenced to more than 12 months and should determine allocation to activities and programmes.**

1.56 **The role of the vulnerable prisoners unit should be reviewed and, if it remains at Wandsworth, it should be underpinned by a strategy and appropriately resourced.**

CHAPTER TWO

ARRIVAL IN CUSTODY

Courts and transfers

Expected outcomes

The expected outcomes for courts and transfers procedures are:

Safety: Prisoners travel in safe conditions to and from court and between establishments

Safety: Prisoners are safe in crown court cells and other holding areas

Respect: Prisoners are held in decent conditions in escort vehicles and at court

Respect: Prisoners are provided with opportunities for refreshment, toilet and washing facilities at reasonable time intervals

Respect: The individual needs of prisoners during escort and while at court are given proper attention

2.01 Wandsworth regularly took overcrowding drafts from other establishments and vice versa. In these cases, Population Management Unit simply contacted the prison to tell them the numbers and the prison(s) involved. Although reception officially closed at 7pm, in reality prisoners continued to be received until 8pm or later. We were told that many of the prisoners arriving had been discharged to court from Brixton prison that morning. However, either because Brixton was full or because it did not accept prisoners after 5pm, they were brought to Wandsworth in the evening.

2.02 The transfer clerk dealt with prisoners' onward movements to establishments suitable for their categorisation. She also dealt efficiently with the regular 'one off' movement of individual prisoners to a neighbouring establishment, usually Brixton, Pentonville, Belmarsh or Wormwood Scrubs. These latter moves were first agreed and confirmed by fax between the transfer clerk and a member of the receiving

prison's observation, categorisation and allocation department. If necessary, a prisoner could be moved between establishments in a taxi with an officer escort.

Reception, first night and induction

Expected outcomes

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

Safety: Everything reasonable is done to help prisoners feel safe on their reception into prison; prisoners' needs are identified, including physical and mental healthcare, in order that they may be cared for and supported by competent trained staff

Respect: The way in which entry procedures are conducted and the approach of competent staff preserves the personal identity of prisoners, respects their privacy and dignity and is responsive to their individual needs

Respect: Prisoners are made aware of prison routines, how to access available services and cope with imprisonment

Purposeful activity: Prisoners are constructively occupied during their first days in prison, preferably as part of a comprehensive induction programme

Resettlement and reducing re-offending: Prisoners' welfare needs are identified and appropriate help offered to deal with them

Reception

2.03 Wandsworth dealt with a high number of prisoner movements, discharging and receiving some 60 to 70 prisoners every morning and evening.

2.04 While the usual reception area was being refurbished, a temporary arrangement had been set up on the floor above. The refurbishment had begun in October 2002 and was expected to be complete during February 2003. In the meantime, the temporary reception was accessed at the side of the building via a staircase of 20 steps. This meant that it was not possible to accept any prisoners with walking difficulties.

2.05 A dedicated team of one senior officer and seven officers staffed the reception. They had an established routine that allowed them to cope quickly with the large number of prisoner movements.

2.06 Reception officers went to the residential wings at 7am each day to collect those prisoners who were due for court appearances. Prisoners due for discharge had to wait until these movements to court had been completed and were usually discharged at about 10am.

2.07 Escort staff brought the paperwork and belongings of arriving prisoners into reception, where staff quickly checked them before the prisoners were escorted from the vehicles. Reception staff told us that documentation such as pre- or post-sentencing reports was often missing. We were also told that half of the new prisoners were from courts other than those from which Wandsworth was, in theory, allocated its population.

2.08 The paperwork showed that it was not uncommon for prisoners to have been dealt with at court by late morning but not to arrive at the prison until after 5pm. We saw, for example, one group of prisoners who had completed their court appearances at lunchtime but were only arriving at Wandsworth at 6pm. Clearly, prisoners were being kept in court holding cells for considerable lengths of time before being moved to the prison.

2.09 As had been noted during our inspection of 1999, there was often a bottleneck of vehicles in the reception yard, with many arriving together in the late afternoon or early evening. As a result, many prisoners had to wait in the vehicles before being moved into reception. We were aware that senior managers had communicated their dissatisfaction with this situation to both the Population Management Unit and Prisoner Escort Services but apparently to no avail.

2.10 With no holding room available, both prisoners and escort staff queued at the top of the reception staircase while each prisoner was called into the reception office. This small, cramped room was usually staffed by a senior officer, two or three officers and a nurse.

2.11 The senior officer called prisoners into the office by their surname only. Staff were not introduced to the prisoner and did not wear name badges. The prisoner was asked to confirm his personal details and whether he understood what had happened at court that day. If he was new to custody or if the necessary form was not included in his paperwork, the cell-sharing risk assessment was also completed. Although staff were aware of issues such as self-harm and looked for evidence of any pre-convictions of a sexual nature, the completion of this assessment appeared to be little more than a 'tick-box' formality. Equally, the questioning about any convictions of a sexual, racial or homophobic offence and any drug or alcohol problem did not take place in private. As many as five other people could be in the immediate vicinity of the office and escort staff and prisoners were also clustered outside within earshot. Not surprisingly, we did not hear any prisoner admit to such offences or problems. No attempt was made to find out whether the prisoner had any immediate welfare issues or problems.

2.12 While we appreciate that officers were dealing with large numbers of prisoners, there was little engagement with the prisoner and only minimal conversation. Officers confirmed that the holding warrant and necessary documentation was complete but the quality and quantity of individual contact with the prisoner was poor. The whole process, including the risk assessment, took about two to three minutes.

2.13 We did observe prisoners being asked whether this was their first time in custody, although only 28% of respondents to our survey, compared to a local prison average of 47%, said that this had happened to them. Even if they were in prison for the first time, they were not offered anything different from more experienced prisoners. There was no private interview with an officer to offer any reassurance or answer any questions and no first night information was provided either verbally or otherwise.

2.14 All prisoners were offered either a smoker's or non-smoker's pack worth £2.50, which was repaid at 50 pence per week. They were also offered a £2 telephone

card, which was paid for in full immediately if the prisoner had enough money on him.

2.15 Following this short interview, the prisoner was moved to a holding room, which had a table and fixed benches along the walls and was located immediately to one side of the office. It had no information for prisoners and there was nothing there, such as a television or reading material, to help them pass the time while waiting to be searched.

2.16 Prisoners were called into a large search area where they were strip-searched appropriately. This area was a temporary arrangement and the screening allowed only minimal privacy and dignity.

2.17 Following the search, an orderly provided prison-issue clothing to convicted prisoners; remanded prisoners could wear their own. Another set of clothes would be provided on the wing. There was no shortage of prison-issue clothing.

2.18 Prisoners' belongings were stored either in the property room, which was inadequate for the amount of possessions stored there, or an additional storeroom. Property was controlled by volume and a convicted prisoner was given 28 days to pass any excess to visitors. The possessions of prisoners serving more than 12 months were sent to the Prison Service stores at Branson.

2.19 Property held in the storeroom was easily accessible. Property handed or posted in was quickly noted on the prisoner's property card before the prisoner was called to the reception area to collect it. Records showed that this was generally completed within 48 hours.

2.20 Although we were told that newly-arriving prisoners were issued with a toiletry pack, many of those we met on the wings told us that this had not been the case either at reception or on their arrival on the wing.

2.21 Once searched, prisoners were moved into a separate area with four holding rooms. Again, each of these had fixed benches but no display of information and

nothing with which to pass the time. These rooms were not locked and prisoners were able move about freely, talking to other prisoners, using the telephone or toilet and obtaining refreshments. A nurse saw each prisoner and those new to custody were given a full health screening by a doctor in the reception area.

2.22 The atmosphere was generally relaxed and friendly despite the often large number of men milling about. The prisoners appeared to appreciate this small freedom of movement and we did not witness any unpleasantness between prisoners or between prisoners and staff.

2.23 It was not unknown for prisoners who had been searched to find their way back into the initial reception area to talk to others in the first holding room. If this happened, they were returned to the post-search holding rooms by staff. Although the design of the area did not ensure a good flow of prisoner movement between the various reception procedures, officers were aware of the possibility of intimidation and bullying and controlled the areas as best they could.

2.24 There was no showering facility available. If they had chosen to buy one, prisoners used the £2 telephone card provided in the reception office. Unlike in some other establishments, they were not offered a telephone call at the prison's expense.

2.25 Each prisoner was given a pillowcase containing a towel, two sheets, cutlery and a mug prior to his movement to the main prison.

2.26 There did not appear to be any smoke-free areas within reception and both prisoners and staff smoked wherever they wished. This was unhealthy and did not take the preferences of non-smokers into account.

2.27 A number of orderlies worked in reception from early morning until it closed. Two worked specifically in the reception kitchen and one was a trained listener. The orderlies' main role was cleaning and providing refreshments. A good selection of ready-prepared meals was available. There did not appear to be any expectation that they would undertake any peer support work and we did not see them interacting with prisoners in any meaningful way. Given that there was no first night information (see

below) or any opportunity to speak at length with an officer, the fact that the orderlies were not expected to use their knowledge and experience to support prisoners in reception was disappointing. Prisoners could spend some time in the area waiting to be moved onto a wing, which would have provided an ideal opportunity for such contact.

2.28 Vulnerable prisoners were the first to be moved from the escort vehicles. They were placed in a locked holding room that was in the same area as the four holding rooms used by all the other prisoners. As the first room in the area, all prisoners passed by it and could see the vulnerable prisoners inside through a window in the door.

2.29 During our inspection of 1999, the room in which vulnerable prisoners were held was marked with a red dot and 'VP' written in large letters. While such 'advertising' was no longer used, it was still obvious to everyone that they were being segregated from the rest and it would not have been difficult to guess why.

2.30 During this inspection, there was always an officer present in the property records office, which was directly opposite the vulnerable prisoner holding room. We did not hear anyone making abusive comments to the vulnerable prisoners but were told by prisoners in the establishment that this was not uncommon.

2.31 We felt that the location of the holding room and the ease with which vulnerable prisoners could be identified left them open to abuse. Such treatment was unnecessary and unprofessional. We also heard a few reception staff refer to vulnerable prisoners as 'nonces'.

Conclusion

2.32 Reception staff worked to an established routine that allowed them to process large numbers of prisoners both into and out of the establishment. Unfortunately, such processes did not allow for any quality of contact between officers and individual prisoners. The temporary reception area had inadequate facilities and was not designed for its current use. Officers were aware of the shortfalls and maintained

control and safety. The language used by some staff to refer to sex offenders was unacceptable.

Recommendations

2.33 **Prisoners who have completed their court appearance should be transferred into prison custody as quickly as possible rather than being held in court holding cells.**

2.34 **The new reception area should be of an appropriate design to offer the necessary facilities and to allow a good flow of prisoner movement.**

2.35 **Officers should introduce themselves to prisoners and should address prisoners by their title and surname.**

2.36 **Each prisoner should be interviewed in private in an area that cannot be overlooked by other staff and prisoners.**

2.37 **Appropriate information, in a variety of media and an appropriate range of languages, should be made available in all reception holding rooms.**

2.38 **First night information and support should be developed and made available in reception.**

2.39 **Prisoners should be provided with the means to pass the time while waiting in the holding rooms.**

2.40 **All prisoners should be offered a telephone call at the prison's expense.**

2.41 **Prisoners entitled to receive toiletries should be given these in reception.**

2.42 **No smoking areas should be provided.**

2.43 **Vulnerable prisoners should be held in a safe, private area.**

2.44 **The knowledge of the orderlies should be put to wider use by providing the opportunity for them to engage with incoming prisoners.**

2.45 **Staff waiting in reception should use appropriate forms of address regarding vulnerable prisoners.**

First night

2.46 In theory, all new arrivals to Wandsworth were accommodated on C Wing for a first night and an induction programme. In reality, some prisoners went directly to health care or the vulnerable prisoners unit and others were often located on other wings because of an apparent inability to move those prisoners who had finished induction off C Wing.

2.47 We were told that the senior officer on evening duty would allocate an officer to 'first night in custody' duties. Wandsworth had produced its own first night risk assessment form, which this officer was expected to complete. They also completed the final section of the cell-sharing risk assessment that had been started in reception.

2.48 The inspection report of 2000 had commended the introduction of a dedicated first night in custody officer. It was disappointing, therefore, to find that this dedicated role no longer existed.

2.49 While we were unable to observe any work specifically with those spending their first night in custody, a high proportion of prisoners across all wings told us that that they had received little information to prepare them for their first night or day. Only 13% of respondents to our survey said that they had been given either written or spoken information about what would happen on their first night or day, compared to a local prison average of 33%.

2.50 We met six prisoners waiting in a holding room on C Wing to be allocated to a cell. As there were no seats in the room, the prisoners were standing or perching on hot pipes. There was no information on display and nothing had been provided to help them pass the time. Five of these prisoners had arrived at the prison the day

before and had been accommodated on various other wings overnight. Two of these men had been transferred in from other establishments, one had arrived from court but was not new to prison and two were experiencing prison for the first time. The sixth prisoner had been relocated to C Wing after spending several days in health care.

2.51 None of these prisoners had received any specific first night information and none had been able to have a shower. Some had not been given any toiletries and some had not had breakfast. One man new to custody told us that the cell in which he had spent his first night had no toilet paper and he had therefore had to use his hand. This situation was clearly unacceptable.

2.52 In our survey, 50% of respondents said that they had felt confident about what would happen to them on their first night and day, compared to a local prison average of 57%. Of these, 90% said that this was because they had been in prison before; 58% had been in Wandsworth itself. Only 4% said that their confidence stemmed from speaking with a staff member. Over a third (37%) were experiencing imprisonment for the first time.

2.53 Following our inspection in 1999, we recommended that special observations be carried out for all new receptions and that risk assessments should be carried out prior to any shared cell allocation. During the current inspection, we looked at 20 wing files chosen at random from C Wing: only two contained a full and complete cell-sharing risk assessment signed by the locating officer and only seven contained the establishment's own first night risk assessment form. The wing history sheets contained no evidence of staff offering first night support to prisoners. In fact, many had only limited comment and we were surprised to find that a significant number had no entries at all.

2.54 Wandsworth had produced a leaflet guide to the first night. This did not appear to offer much constructive support and was not available in other languages or media forms. This leaflet identified that the first night 'will be your most difficult…. Whether or not this is your first time in prison, this is a very stressful situation'. It went on to advise that 'the night staff are available for emergencies only' and at one

point stated that 'chances are, once you are in your cell and the door is locked, you will not see anyone until the next morning'.

2.55 The leaflet offered only very basic information to prisoners: the time of the morning 'unlock' procedures; the time that the induction programme would start (9am); what to do in an emergency (use the cell bell) and what to do if feeling depressed or suicidal (use the emergency bell). There was little in the way of encouragement or comfort for prisoners and no suggestion that staff were available or willing to help with immediate problems. There was no mention of any formal first night support and, by contrast, the leaflet ended with the words: 'Your cellmate can be your best reassurance. He may have been here for a few days, has done the induction and 'knows the score'. And since he is in the same situation as you, he can answer many of your questions and help you get settled in'. We felt this to be irresponsible and placed the onus for support on the prisoner rather than members of staff.

Conclusion

2.56 The establishment did not offer an effective or supportive first night system. Although apparently an officer was allocated to first night duties, we found little evidence of any first night support in wing history sheets or in our conversations with prisoners.

Recommendations

2.57 **An appropriate first night in custody officer job description should be developed. Dedicated officers should be supported through specific training about the needs of new prisoners.**

2.58 **A more appropriate and prisoner-friendly first night information leaflet should be developed.**

2.59 **First night cell sharing risk assessments should be completed in all cases.**

2.60 **Accurate first night records should be kept in wing files.**

2.61 **If they have not made a telephone call in reception, all prisoners should be allowed the use of a telephone on arrival on the wing.**

2.62 **Staff should ensure that all prisoners receive a toiletry pack and that breakfast is made available the morning following their arrival.**

2.63 **The holding room on the induction wing should contain seating and a selection of appropriate information in a range of languages.**

Induction

2.64 The induction programme took place in a specified room on C Wing. Whether or not this ran daily as planned depended on staffing levels. During our inspection, it was taking place for the first time in seven days.

2.65 According to our survey, 41% of respondents had attended the induction programme. This compares to 67% during our inspection in 2000 and the local prison average of 57%.

2.66 The induction programme itself was supposed to run over three days, with day one covering the rules and regulations, day two covering induction to the gym and day three covering drugs. However, we were told that the gym induction did not always take place on the second day and drugs had not been covered for some weeks. In reality, the programme appeared to last just one day.

2.67 The programme was only available to prisoners on C Wing, even though there were other newly-arrived prisoners accommodated on different wings. A separate programme for vulnerable prisoners was supposed to run weekly but we were told that only three of these had taken place since 12 December 2002. Prisoners in health care, we were told, were given verbal information by staff. A booklet was available giving information about the prison.

2.68 We attended part of an induction session on the first day of our inspection. The programme was led by an induction officer who was able to keep control and used humour effectively. He said that normally he would use an overhead projector

but that this was broken. The prisoners sat in rows. Two induction orderlies sat at the back of the group but were not involved in delivering the programme, which seemed a wasted opportunity to use their knowledge and experience of the prison in some form of peer support.

2.69 Following our inspection in 1999, we commented on the fact that a second officer was present but appeared to contribute little to the programme. This situation was unchanged and it was unclear what purpose the second officer's presence served.

2.70 The session we attended was the first day of the programme, covering basic information and focussing mainly on rules and regulations. With no overhead projector, the induction officer talked through the slides he would have shown. A range of information was given, including landing rules, the incentives and earned privileges scheme, routines, procedures and activity, mealtimes, visits, complaints procedures, access to health care, race relations and anti-bullying.

2.71 While there was some opportunity for prisoners to ask questions, the emphasis appeared to be on giving information. There was no use of video or other media and no presentations were made by representatives from other parts of the prison, such as the Board of Visitors, the probation team or the suicide prevention team. The listeners told us that although they were welcome to attend the group, they had no regular session.

2.72 There did not appear to be any information given that could be forwarded to family and friends, such as details of the assisted prison visits scheme, visits or the name of an officer to contact with any queries. Equally, no information was given about various benefits, such as housing benefit.

2.73 The prisoners were given an evaluation form at the end of the session. This asked for their name and, although it stated that providing such information was optional, we felt that prisoners would be more inclined to make useful criticism if all the forms were completely anonymous.

2.74 At the end of the day, each prisoner was asked to sign a rules and regulations and an anti-bullying compact, both of which had been prepared and were collected by the induction orderlies. We were told that these were not read through with an officer. Very few compacts were found in wing history files and of those that were, many were unsigned by a member of staff.

2.75 Each night, the two induction orderlies employed on C Wing were given a list of new arrivals and had to compile a list of those eligible for induction. They had been given a 41-page induction orderly training guide that detailed their duties. This book advised orderlies that 'detail is everything' and that their job was 'to talk to all prisoners from the time they arrive on the wing until they have finished the entire induction course'. One of their duties was 'tracking', which required them to 'walk the landing' to determine who had arrived and who had moved.

2.76 The orderlies' other duties included: producing paperwork for each prisoner; producing paperwork for staff; preparing a relocation list each night; dispensing toiletry packs; documenting special diets; preparing compacts for signing; informing the library when book stocks were low; and tracking those who must appear at court. They were asked to keep a copy of every form and to hand all daily induction forms to the wing principal officer at the end of each month. This officer would then compile the information to produce graphs, which were then returned to the orderlies.

2.77 The training book also advised orderlies that it would be 'a good idea for you [the orderly] to review the graphs and statistics as they will help make you more aware of the trends involved in the induction process. Remember, the more information you have….the better qualified you are to do your job…you must be aware of every rule, regulation, facility and question posed by new arrivals….get answers so you can better serve the needs of the individual officers and the prison….that is your job'.

2.78 These duties appeared to cover the work that induction staff should have been doing. Effectively, staff were displacing their responsibilities on to prisoners.

2.79 A daily reception board was held for convicted prisoners only. We were disappointed to find that no such board existed for remanded prisoners to discuss their situation and custody plan. The board itself was held in the legal services office, which was inappropriate as the legal services officer was in the room, raising the issue of confidentiality.

2.80 The reception board consisted of two officers. Each prisoner was asked to confirm his personal details and legal status, and questioned about his literacy skills. The prisoner was informed of his categorisation and this was explained if he did not understand. Work was offered in the kitchen, gym or stores and the prisoner was given a facilities list. Some were given information about services available in the education department.

2.81 The officers concerned operated to the best of their ability but the quality of information given and gained was basic and limited. There was no discussion of the prisoner's offence or of any previous convictions to determine whether the provisions of Prison Service Order 4400 should be enacted or whether Schedule One offender procedures or racially-motivated issues applied. One prisoner did volunteer that his offence was harassment-related but this had not been solicited by the interviewing officers.

2.82 None of the prisoners were advised about the possibility of appealing against their conviction or sentence. There was little discussion of home circumstances, the situation of a partner or children, drug or alcohol misuse, and prisoners were not asked about their mental or physical well-being. There was no needs assessment or attempt to identify any skills that the prisoner might have.

2.83 Only six of the 20 prisoners due to attend the reception board on the day we observed turned up. This meant that officers had to 'chase up' the missing men, which led to those new arrivals due at the next board being delayed.

2.84 Prisoners could only make purchases from the shop on one specific day of the week, regardless of when they had arrived in custody. This left some newly-arrived

prisoners without access for a week or more, which could lead to borrowing or lending and, therefore, increased the possibility of bullying and intimidation.

Conclusion

2.85 The induction programme was basic and inadequate. Responsibility for a large proportion of the induction process was placed with the prisoner orderlies. It did not reach all eligible prisoners and was not presented creatively or in a way that would engage or reassure them. Reception boards did not involve all prisoners and did not elicit all necessary information.

Recommendations

2.86 **The induction programme should be more creative and engaging, using different forms of presentation such as video, slides and discussion, and including talks from representatives of other areas of the establishment.**

2.87 **Induction officers should be detailed to the work and should receive training to help them engage better with prisoners.**

2.88 **Compacts should be explained by an officer and should be signed and counter-signed in their presence.**

2.89 **Induction orderlies should be used to provide active peer support and information during induction and should not be used to carry out the duties of staff.**

2.90 **A reception board should be provided for remanded prisoners.**

2.91 **The reception board should be held in an appropriate area to ensure confidentiality, and should provide staff with all necessary information.**

2.92 **There should be more flexibility for newly-arrived prisoners to be able to buy items from the shop.**

Legal services

Expected outcomes

The expected outcomes for legal rights procedures are:

Safety: Prisoners are safe from repercussions or recrimination in making any application, request or complaint

Respect: Prisoners are told their rights of access to due process in relation to bail, legal aid, legal representation and appeals and can exercise those rights while in prison

Respect: Unconvicted prisoners are treated as innocent, unsentenced as not having a custodial sentence, and both are given the same opportunities and activities as convicted or sentenced prisoners

Purposeful activity: The regime provides reasonable opportunity to seek release on bail and prepare for trial

Resettlement: The regime provides reasonable opportunity to preserve accommodation and employment and to pursue legitimate business and social interests

2.93 Although the keen and committed legal services officers offered a very good legal service, prisoners' access to it was poor. Following our inspection in 1999, we highlighted the fact that there were four legal services officers, so it was disappointing to find that there were now only two.

2.94 The two officers were both fully trained. Their office contained all the necessary equipment, such as a fax and answering machine, as well as solicitor directories and Law Society information. Unfortunately, the same office was used by the reception board each morning (see induction above).

2.95 A full legal support service was offered to convicted and sentenced prisoners but the officers were not trained in, and did not deal with, bail requests for remanded prisoners, although they would help a prisoner to complete the appropriate forms. The officers also provided information for repatriation reports requested by Prison Service Headquarters.

2.96 Each application was recorded, as was every appeal and each stage of the appeal. A member of the discipline staff also kept a record of the various stages of the appeals procedure, which provided a back-up check.

2.97 Various publications about legal matters and state benefits were freely available. Prisoners had access to 23 Community Legal Service booklets covering a wide range of areas, including financial, immigration and race, disabilities, human rights and employment. These were not available in languages other than English, although the legal services officer believed that translated versions would be available from the publishers on request. Information about the Criminal Cases Review Commission and the Prisons and Probation Ombudsman was also available.

2.98 The legal services officers did not see all prisoners automatically but responded to applications. They were often detailed to work elsewhere in the establishment, which meant that legal services were not always available daily and further limited the time given to this important work. The situation was even more difficult when one of the officers was off duty for any reason.

2.99 Both officers were aware of the Language Line service but did not have the necessary equipment to use it appropriately. Colleagues or prisoners were used to help when translations were needed, as was the case during our inspection in 1999.

2.100 Although the induction manual mentioned the availability of legal services, awareness among prisoners appeared to be limited. Equally, prisoners were not routinely advised by the reception board about the possibility of an appeal against their conviction and/or sentence.

2.101 The library held an appropriate range of legal reference books as well as a number of Prison Service Orders and Prison Service Instructions. It also held the prisoners' information book in 19 languages.

2.102 Following our inspection in 1999, we stated that 'every opportunity to prevent unnecessary imprisonment should be taken and all new remanded prisoners should be seen'. As part of this, we recommended setting up a 'full and effective bail

information service as a matter of priority'. Again, during our inspection in 2000, we noted that bail information was given 'low priority' and that it was inappropriate that not all eligible prisoners were seen. We suggested that the establishment should consider involving the probation service and repeated the recommendation from 1999. Given this background, we were appalled to find the situation little changed. In fact, the legal services officers were no longer providing the limited service that had existed during earlier inspections. Remanded prisoners did not have the opportunity to be given information at a reception board and were not seen automatically by anyone regarding their legal status.

2.103 If anything, bail information appeared to be given an even lower priority than that identified in 1999 and 2000. There was no record of how many potential candidates there were for the service, although our survey indicated that remanded prisoners made up 13% of the population. This was an important issue for a large number of prisoners and the absence of managerial intervention to improve this situation was a cause of serious concern.

2.104 A dedicated bail information officer seconded from the probation service was in post. However, a bail information scheme was not yet operational, although, with the officer's training now complete, it was anticipated that it would be in the near future. A dedicated office on the induction wing was nearing completion.

2.105 The two video link rooms, accessible to a large number of courts in England and Wales, were well used by the establishment. The facility for legal visits by video link was also available. This was used by solicitors and, in some cases, by the probation service. All bookings were made via the video link department in the prison.

Conclusion

2.106 The establishment was not giving legal services and bail information high priority, with the result that prisoners were not receiving the information and support to which they were entitled.

Recommendations

2.107 **Legal services officers should be detailed to their work during each core week day and should not be used elsewhere in the establishment.**

2.108 **The number of legal services officers should be increased.**

2.109 **Legal services officers should be included on reception boards.**

2.110 **The necessary equipment to use Language Line should be made available.**

2.111 **The information and literature in the legal services office should be made available in a range of appropriate languages.**

2.112 **A full and effective bail information scheme should be made available.**

CHAPTER THREE

RESIDENTIAL UNITS

Expected outcomes

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

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

Accommodation and facilities

3.01 Wandsworth prison's residential accommodation was divided into the main prison and the vulnerable prisoners unit (VPU). The main prison, built in 1851, consisted of five four-storey wings set in a radial pattern meeting at the centre. The VPU, built in 1861 very close to the main prison, consisted of three four-storey wings with their own centre. At the time of the last inspection, the certified normal accommodation was 1162, the operational capacity was 1371 and the prison held 1230 people. At the time of this inspection, the certified normal accommodation was 1134, the operational capacity was 1461 and the prison held 1454 prisoners, making it the largest of the 137 prisons in England and Wales.

3.02 The accommodation was used as follows:

Wing	Purpose	Operational capacity	Number of cells
A	Sentenced employed	235	157

B	Sentenced employed	249	152
C	Unconvicted	248	132
D	Sentenced unemployed	194	148
E	Sentenced unemployed	167	117
E1	Care and separation unit	2	(18)
G	VPU training places	109	81
H	VPU training places	116	89
K	VPU training places	88	64
K1	RAPt drug treatment	18	16
HCC	Health care	35	29
Total		**1461**	**989**

3.03 Sixty-eight per cent of the prisoners were in shared accommodation. The level of over-crowding had placed particular pressure on facilities and services such as showers, water boilers, telephones and television rooms, which had not been increased in line with the additional number of prisoners.

3.04 All wings had serveries on the first or second landing. Prisoners were unlocked to collect their meals, which they took back to their cells immediately. All wings had a television room for prisoners to use during association, although these were too small for the number of prisoners who might want to use them. All wings also had table tennis or pool tables for prisoners to use during association.

3.05 Not enough hot water for prisoners' drinks was available on any of the wings. The reason was threefold: inadequate boilers; the fact that flasks were issued, which increased demand; and the limited time prisoners had to collect hot water. Some wings had no boilers, which led to the unacceptable practice of providing prisoners with water that had been boiled in the kitchen and brought to the wing.

3.06 Some wings, including A, B and the vulnerable prisoners unit, had in-cell television for which prisoners paid £1 a week. Although appropriate cabling had been installed, the electricity supply was insufficient to allow televisions to be used on other wings. Prisoners on these wings could request a battery-operated television but

these were of poorer quality, and the prisoners had to buy the necessary batteries, although the prison subsidised the price and had issued them free for occasions such as the World Cup. All the same, this provision for prisoners who spent the most time in their cells was clearly inadequate.

3.07 All cells were fitted with in-cell sanitation. Following our inspection in 1999, we had recommended that proper screening should be provided where prisoners share cells. This had not been achieved and was becoming ever more important given the increased restriction on prisoners' time out-of-cell to use screened communal facilities. Prison managers had clearly tried to address this problem but any improvement was being hindered by the lack of progress of the national project to install screens. Some wing residential managers allowed prisoners an additional bed sheet to use as a temporary screen and we felt that this was a decent and respectful response to the problem.

3.08 In general, the residential accommodation was in a reasonable decorative condition with adequate lighting and heating. While we found the internal areas to be clean, there was an on-going problem with litter being thrown from cells into the external yards. Wing cleaners were allocated to this job daily, although many areas were difficult to access and the situation remained unsatisfactory. All cells contained the required appropriate furniture, although prisoners in shared cells found it difficult to find enough space for their belongings. This particularly affected long-term prisoners. In the main, the policy on the display of offensive material appeared be adhered to.

3.09 We were concerned that the results of our survey showed that only 30% of prisoners reported having cell bells answered within five minutes. All cells were fitted with emergency call bells. Partly because they had limited time out of their cells in which to see staff and resolve problems, some prisoners occasionally used these bells in non-emergency situations. This served to further undermine the system.

3.10 All wings had notice boards, although the range of information available varied widely. Prisoners on 'social and domestic' time could not leave their own landing and therefore had restricted access to some notices. Some wing managers

used to display the day's routine to allow prisoners to plan their time but this had proved impractical because staffing problems meant that daily routines could not be confirmed in advance.

Conclusion

3.11 All the residential facilities were under extreme pressure from a combination of overcrowding and short periods out of cell when prisoners were able to make use of them. The better accommodation and in-cell television had been allocated to employed prisoners, who were also due to benefit from the installation of a wing fitness suite. We were concerned about the level of disadvantage on those wings holding the large number of unemployed and remanded prisoners, whose accommodation conditions and access to facilities fell well below an acceptable level in many cases. The absence of in-cell television on most wings added to this pressure.

Recommendations

3.12 **Prisoners should have access to hot water for drinks at meal times and during association periods.**

3.13 **Where two prisoners share a cell, proper privacy screening for the toilet should be in place.**

Clothing and possessions

3.14 Convicted prisoners were issued with prison clothing in the reception area. This included prison-issue underwear and socks that had been worn by many people before them. Those prisoners we asked said that they would prefer to provide and wear their own underwear.

3.15 Remanded prisoners could wear their own clothes, although prison-issue clothing was available if necessary. They were allowed three pairs of trousers, three tops, three jumpers, two pairs of shoes and seven sets of underwear and socks. A suit could also be held for them in the property room. All this clothing had to be handed in on a visit.

3.16 Prison clothing was changed weekly on the wings, with wing laundry orderlies employed for this purpose. Remanded prisoners could exchange dirty clothes for clean ones during a visit. This did not appear to cause any problems, although a number of prisoners told us that they washed their clothes in the sinks in their cells and dried them on the hot pipes.

3.17 While the laundries on some wings were restricted to prison-issue clothing only, remanded prisoners on some others were able to use them to wash their own clothes. It was unfair that this arrangement did not apply to all remanded prisoners.

3.18 Property could be posted or handed in on a visit and a clear facilities list was available. Following a visit, prisoners were given some items, such as books or cassette tapes, on their return to their cells. Remaining property was entered onto the prisoner's property card at reception before the prisoner was called to collect it. This procedure was carried out quickly.

Conclusion

3.19 Clothing appeared to be generally clean and in reasonable condition.

Recommendations

3.20 **All prisoners should be able to wear their own socks and underwear.**

3.21 **All prisoners should have equal access to adequate laundry facilities.**

Hygiene

3.22 The overall standard of cell and wing cleanliness was adequate.

3.23 Some cells were not particularly well cleaned. This was most noticeable in some of the cells on the second landing of the induction wing, where large patches of toothpaste, which is used to stick pictures to walls, were much in evidence. We had anecdotal evidence that some prisoners in these cells had not been provided with toilet paper on arrival.

3.24 Prisoners had adequate supplies of their own toiletries in their cells and we were told that further items were freely available on the wings. Washing powder was available for prisoners to buy for their own use.

3.25 While all wings had communal showers recessed on each landing, on only some of the wings, such as A and B, were they hot enough and sufficient in number. There were only 12 working shower heads for 313 prisoners on the vulnerable prisoners unit and the showers on D Wing frequently ran cold or, depending on demand elsewhere, ran dry. The establishment had recognised the problem and funding for an improved system for D Wing had been approved.

3.26 According to our survey, 9% of respondents never had access to a shower, 56% had access once or twice a week, 17% between three and five times and 12% more than five times. This compares to the local prison average of 65% for prisoners accessing showers more than five times a week.

3.27 While prisoners could not shower on arrival in the temporary reception, the prisoner manual stated that they would be able to shower at the end of the first day of the induction programme. There was, however, no guarantee that the induction programme would be running on the day following an individual prisoner's arrival.

3.28 Records showed that prisoners located on smaller units, such as care and separation or health care, had better, often daily, access to showers and other facilities, such as telephones, simply because of the low numbers involved and the availability of staff.

3.29 The action plan stated that a reprofiling exercise had been completed and the planned new work patterns should provide a more consistent regime, including access to showers. We were told that these were due to be introduced in a matter of weeks.

3.30 There were no baths on the wings but some were available in health care if required.

3.31 One sheet, pillowcase and towel were changed each week, which we felt was insufficient. Equally, prisoners should have access to more than one towel. There did not appear to be any system in place for washing blankets.

3.32 There was a shortage of pillows within the establishment and not every prisoner had one. There did not appear to be any shortage of mattresses and those we saw were generally in reasonable order, although some needed to be replaced.

3.33 The cleaning equipment was colour-coded for use in the appropriate areas.

3.34 There were two health and safety issues: pigeons were sometimes found in the main prison, and it was quite common practice for waste, including waste food, to be stored under the centre grill in the main prison prior to disposal.

Conclusion

3.35 This very large and busy establishment was generally cleaned to an acceptable standard. Prisoners' access to showering facilities was unacceptable.

Recommendations

3.36 **Bed linen should be completely changed each week.**

3.37 **Cells on the induction wing should be cleaned adequately between occupants and toilet paper should be provided automatically.**

3.38 **There should be enough working hot showers to allow daily access by all prisoners.**

3.39 **The establishment should ensure that newly-arrived prisoners are provided with enough toiletries.**

3.40 **Blankets should be laundered on a regular basis.**

3.41 **Enough pillows should be made available to meet prisoner need.**

3.42 **Pigeons should be prevented from entering the prison buildings.**

3.43 **The storing of food under the centre grill in the main prison should cease.**

CHAPTER FOUR

DUTY OF CARE

Anti-bullying

Expected outcomes

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

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

4.01 A comprehensive and up-to-date anti-bullying strategy was in place, managed by a multi-disciplinary committee that met monthly. Wings had designated anti-bullying prison officers whose role was supposedly to advise both staff and prisoners. Each wing had a folder containing the strategy, guidance on completing the forms and a running record of the number of reported incidents for the year. Wing managers clearly had a grasp of the strategy and were able to produce these folders immediately. The same could not be said of the prison officers: some claimed not to know about the strategy, despite there being anti-bullying notices on the wings; others, while being able to demonstrate a rudimentary knowledge of the strategy, held the view that it was more effective to move identified bullies onto another wing with an informal warning about their behaviour.

4.02 There had been very few reported bullying incidents in 2002, with three each in A and B Wings, four in D Wing, 19 in the vulnerable prisoners unit and none in either C or E Wing.

4.03 At the time of our inspection, there was one identified bully located on one of the vulnerable prisoner wings. The documentation had been completed properly and the prisoner had been moved to another vulnerable prisoner wing. When we spoke to him, he readily admitted to threatening his cellmate and fully understood why he had been placed on the anti-bullying strategy.

4.04 Prisoners appeared to get along with each other and good relationships existed between them. Their view was that bullying did take place and that either the prisoners themselves or prison officers dealt with it informally. A prison survey had not been undertaken to determine the extent, cause or location of bullying. The prevailing staff culture was militaristic, with officers addressing each other by their title or 'sir'. This made prisoners wary of staff and therefore did not encourage them to share any anxieties they may have had.

Conclusion

4.05 An anti-bullying policy was in place supported by good documentation. Not all staff were properly aware of how to deal with bullies and it was likely that informal action was sometimes taken. There were concerns over the existing staff culture, which made it unlikely that prisoners would feel confident to tell them about bullying incidents. The very low numbers of reported bullying incidents did nothing to allay these concerns and there was a real need to give this strategy a much higher profile.

Recommendations

4.06 **Staff should be trained in bullying awareness and how to complete anti-bullying documentation.**

4.07 **A prisoner survey should be conducted to determine the extent of bullying, its causes and where it takes place.**

Preventing self-harm and suicide

Expected outcomes

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

Safety: Prisoners are held in an environment in which all reasonable steps are taken to protect prisoners from self-harm and suicide and honouring the prison's duty of care to every prisoner

Safety: Significant information about individual prisoners at risk of self-harm or suicide is communicated effectively by those who hold it to those who need it and integrated into the support plan

Respect: Prisoners know where to find help and access it in times of crisis or need

Respect: Raising and maintaining prisoners' self esteem, especially in times of transition or change, should be inherent in the prison's culture, management, regimes and activity

Respect: The treatment of those at risk of self-harm or suicide shall always maintain confidentiality, preserve or enhance the dignity of the prisoner and shall not itself be dehumanising

Purposeful activity: Those prisoners at risk of self-harm or suicide are encouraged to participate in appropriate purposeful activities including specific programmes for their needs in this respect

4.08 The establishment had a comprehensive suicide prevention policy and strategy document that clearly laid down the various procedures to be followed.

4.09 A suicide awareness and prevention management team (SAPMT) met monthly chaired by the deputy Governor. This team contained an extremely broad range of multi-disciplinary staff from across the prison, including the listeners, the Samaritans co-ordinator, the anti-bullying co-ordinator, members of the counselling, assessment, referral, advice and throughcare (CARAT) team and a representative of the escort service provider.

4.10 The role of safer custody officer was taken by a senior manager who had close links with, and acted on information from, the safer custody group. He was a

knowledgeable and able manager who had contributed much to the development of the establishment's policies and practices in this area.

4.11 We viewed the minutes from the SAPMT meetings in October, November and December 2002. These showed that the team was committed to furthering the support of prisoners in the establishment. It was noticeable, however, that at none of these meetings had there been a report from the SAPMT representative from the main prison. Clearly, staff working in the main prison had not had an opportunity to discuss any progress or concerns about suicide and self-harm issues with their SAPMT representative. Given that the main prison contained the largest proportion of the population, this was a cause for concern.

4.12 Every month, the team reviewed a list of all incidents of self-harm and attempted suicides during the previous month. This included when and where the incident took place and whether the prisoner concerned was already on a self-harm watch.

4.13 There was no record of the numbers of prisoners seen by the listeners in the previous month, their locations or timescales involved. There were no quality assurance checks of self-harm books.

4.14 There were 49 prisoners on suicide and self-harm monitoring (F2052SH) at the time of this inspection. Staff were generally vigilant and comments in the F2052SH booklets were mainly of good quality and in some cases excellent. It was not clear, however, why some prisoners were still kept on a 'watch' when the comment in their booklets appeared to be favourable.

4.15 Reviews were not always completed at the required times and there were occasions when the necessary forms were not filled in. Equally, some reviews had taken place without a member of the management team, such as a psychologist, probation officer or chaplain, being involved. While a manager signed the booklets every day, no action was taken if the reviews had not been undertaken or documentation was incomplete.

4.16 The care plans that were agreed for prisoners maintained on a F2052SH were not always appropriate. For example, one care plan recommended 'personal officer input' despite the fact that no effective personal officer scheme existed. Another prisoner was advised to take 'tranquillity tea bags'. While these might be effective, access to a good personal officer or more time out of his cell would probably have been of more direct benefit.

4.17 Many wing staff on duty during the core day knew the location of the office ligature shears and first aid box. This was not the case with night staff, who were not certain where the ligature shears were kept and appeared to have only a limited grasp of emergency procedures. The management team were aware that improvements were needed and a meeting had been held 10 days before our inspection to discuss how these could be implemented.

4.18 Many prisoners were referred to the external Wandsworth Counselling Service, which offered access to eight counsellors. At the time of the inspection, 17 prisoners were involved in counselling and 67 were on the waiting list. The average waiting time to see a counsellor was six months, which would be prohibitive for those on remand or serving short sentences.

4.19 All referrals were passed via the psychology department, although they were not clinically responsible for the service. Each referral was recorded. We were not clear about what the service was offering or what intervention techniques were used. This was equally unclear to the establishment, which had recently met with the providers to develop an agreed protocol.

4.20 Prisoners in need of a constant watch were moved to a 'gated cell' in health care where, if necessary, a nurse would sit directly opposite the open door. This room was dirty with various stains on the walls. Although we understood that it was soon to be out of use, we did not feel that, in its current state, it was a respectful room to place a prisoner in need of such support.

4.21 The establishment had access to an in-reach team, a pilot scheme offering the services of a team leader, two community psychiatric nurses and two nursing staff

employed by the prison. This team worked specifically with prisoners with 'severe and enduring' mental health problems. Prisoners were assessed and, if appropriate, supported in the establishment. The team produced reports for the transfer of prisoners and liaised with care workers in the community to provide information for the development of a care in the community package. Staff had been trained by the Samaritans and it was felt that this had increased staff knowledge and awareness. This training was planned to continue.

4.22 There were 19 listeners in post, with more awaiting assessment and training. The listeners told us that they were very well supported by the Samaritans and met with them on a weekly basis. No photographs of the listeners were displayed in the main prison, although there were plans to introduce these. Listeners told us that staff generally supported them, although a small majority of officers appeared to be obstructive. Recently, listeners in the main prison had been issued with a pass that enabled them to visit all the wings without being accompanied by an officer. They had access to private cells on B and E Wings, although these were very basic and unattractive. New care suites were due to be available in the very near future.

4.23 The number of listeners on the vulnerable prisoners unit was appropriate. Listeners here had access to a large, reasonably comfortable care room and two further rooms were being developed. Two listeners attended every time a prisoner on the unit requested this service. This was done to safeguard both listener and prisoner against any false allegations.

4.24 A mobile telephone that could only connect to the Samaritans was available on each wing and could be given to a prisoner to use in his cell. The free-phone Samaritans number was also displayed on notice boards around the establishment.

4.25 We spoke to a number of prisoners currently on a F2052SH booklet. Many complained about the simple lack of contact with staff. They felt that their situation could be improved if 'someone' would talk and listen to them and perhaps offer some assistance. We were told that a number of staff were responsive and compassionate to prisoners but equally that there were a few who prisoners would not approach.

Conclusion

4.26 A great deal of training and hard work had brought about much improvement since our inspection in 1999 and there was a committed suicide prevention management team. The ongoing changes had not been communicated adequately to all staff in order to ensure that the systems were followed thoroughly. The development of a personal officer scheme and an effective first night system would make an important contribution to encouraging all staff to work together to provide a caring environment in which prisoners can share their troubles and ask for support and help.

Recommendations

4.27 **Each wing should have an allocated suicide prevention liaison officer who can act as a bridge between wing staff and the suicide awareness and prevention management team.**

4.28 **Self-harm documents should be completed properly, monitored effectively and reviewed regularly.**

4.29 **The counselling service should be evaluated to establish whether it is meeting the needs of both prisoners and the establishment.**

Good practice

4.30 *The pass to allow listeners to move through the prison to undertake their work was good practice.*

Race relations

Expected outcomes

The expected outcomes for race relations are:

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

4.31 Over the past three years, the prison had benefited from a part-time race relations principal officer. At the time of this inspection, a temporary full-time principal officer was in post pending a selection process. The two deputy race relations officer posts were not filled.

4.32 The race relations committee was chaired by the deputy Governor and met monthly. Nine of the 12 standing members had received the Prison Service race relations training and the remaining three were awaiting course places. The prison had amended its training programme to substitute diversity training for the previous course and some 150 of the total number of over 600 staff had attended one of these courses in the previous two years.

4.33 The race relations post was going to form part of a wider diversity team working together under a diversity manager. The prison had a high proportion of black staff at operational support grade, officer and senior officer level. The dedicated work of the outgoing race relations liaison officer (RRLO) had focussed on ensuring

that prisoners' grievances were reported and investigated appropriately. Their work was well publicised around the prison and complaints were running at about 20 a month. While this low number of complaints was a concern, prisoners' improved confidence in the complaints system was a positive sign. The race relations incidents were well investigated. The reports, which indicated a fair and respectful approach to all parties, were analysed by the type of incident, location and identities of both parties.

4.34 The prison's population included the following ethnic groups:

Ethnic group	**Number of men**
Asian Indian	6
Pakistani	14
Bangladeshi	2
Other	21
Black African	75
Caribbean	381
Other	16
Mixed White and black Caribbean	8
White and black African	5
White and Asian	11
Chinese	2
White British	710
Irish	31
Other	15
Other	146
Total	1443

4.35 There was a good race relations regime monitoring system that highlighted any locations or activities with disproportionate numbers of any group. However, there did not appear to have been any information provided on resettlement and some other significant areas. The race relations management team had previously identified

a tendency for a disproportionate number of black and minority ethnic prisoners to be on to the basic regime. Although this had been reviewed and amended it had re-emerged at the time of this inspection that 73% of those were black or minority ethnic prisoners. The psychology department had conducted a survey of 79% of prisoners and staff in the summer of 2002 and this was being used by the race relations management team to plan future targets.

4.36 Our survey indicated that 14% of respondents claimed to have experienced racial abuse from staff, with the highest proportion of these from the remand wing. Only 2% of prisoners reported racial abuse from other prisoners. Those who said that they were dissatisfied with aspects of the prison conditions or regime did not usually relate their experiences to their ethnic origins.

4.37 The RRLO worked with the foreign national liaison officer and both were known by name by most staff and many prisoners.

Conclusion

4.38 Race relations issues were taken seriously at Wandsworth. The race relations management team was working well to address any problems that emerged and the prison-wide survey was a positive step. There was an absence of positive racial messages on the residential wings and events to celebrate the racial diversity of the population were limited to the work of the chaplaincy and education department. Surveys revealed a very high percentage of black and minority ethnic prisoners on the same regime. However, the work of both the race relations liaison officer and the foreign national officer appeared to be having a real impact on the experiences of this very diverse community that was living in generally adverse conditions.

Recommendations

4.39 **The race relations monitoring returns should be completed consistently and accurately for all areas of activity.**

4.40 **Race relations training should be provided for all staff.**

4.41 **Positive messages and events celebrating the racial diversity of the community should be organised by the race relations management team.**

Foreign nationals

4.42 There were 350 foreign national prisoners, 19 of whom were detained solely under Immigration Act powers. Despite the work of the staff in the prison, six men had been detained for at least six months, two of whom had been held under Immigration Act powers for two and half years because of a series of appeals.

4.43 The foreign national population profile was remarkable both for its size and its diversity of culture and languages. The work of the foreign national officer, which we commended in our last inspection report, had continued in the further development of policy and practice.

4.44 Wandsworth benefited from a part-time probation officer dedicated to working as the foreign national officer. The establishment also paid for a representative of the Detention Advice Service to work at the prison on one day a week. While previously a lot of investment had been put into the training of foreign national wing officers, staff changes and shortages had undermined the impact of this initiative. However, the foreign national orderly jobs, which had been established and were taken by four very well-informed multi-lingual prisoners, had proved a success.

4.45 The foreign nationals committee chaired by the Deputy Governor included many staff disciplines and the foreign national orderlies. The committee's objective was to develop policy, ensure its implementation and provide a sustainable service to foreign national prisoners.

4.46 This team of staff and prisoners supported between 12 and 14 meetings each month for prisoners, including:

- weekly meetings in the main prison and the vulnerable prisoners unit
- fortnightly Irish and travellers meetings
- monthly meetings for Spanish and Portuguese speakers

- a monthly immigration workshop

4.47 We observed the foreign national orderlies at work. The level of support, advocacy and accurate detailed information that they were able to offer fellow prisoners surpassed that offered by staff at many other prisons. This work, together with their fluency in a wide range of languages, was an invaluable resource.

4.48 The foreign national team had produced a wide-ranging up-to-date policy and resource pack that was widely distributed and readily available for prisoners to borrow for reference purposes. Easy guides to the policies for foreign national prisoners and the use of the Language Line translation services had also been produced and were visible in all residential areas.

4.49 The policy, which covered access to telephone calls in lieu of visits and the exchange of prison-issue letters for airmail letters, was distributed widely on all wings. Despite this, however, the experience of individual prisoners varied, as did the implementation of the policy between staff and wings, and some prisoners reported applications not being dealt with or extreme delays in receiving telephone calls. The policy also covered visits, discharge grants, foreign currency on reception, the conduct of self-harm reviews and early release entitlements.

4.50 Wandsworth had information leaflets about the foreign national policy translated into 25 different languages and reception information in 13 different languages. In addition, a survey of all foreign national prisoners had been conducted annually for the last few years and results had been used to inform the plans for the following year's work.

Conclusion

4.51 The work of the foreign national officer had rightly been recognised by the Butler Trust Committee and the level of policy development and the structure of the foreign national team was commendable. The detailed casework and advocacy with the immigration detainees was of a very high standard. The lack of wing foreign national officers, however, had impacted negatively on the delivery of services to this large population. This work will need to be integrated into the routines of the

residential wings to ensure that all foreign national prisoners benefit and that the work continues when the current committed participants move on.

Recommendations

4.52 **All foreign national prisoners should receive the telephone calls and airmail letters provided for in the prison policy.**

4.53 **Those subject solely to immigration warrants should not be held at Wandsworth for lengthy periods.**

Good practice

4.54 *The constitution of the foreign national committee, with its partnership between prisoners, staff from all levels of management and external agencies, was an example of good practice.*

Substance use

Expected outcomes

The expected outcomes for substance use are:

Safety: All prisoners are as safe as possible from exposure to and the effects of substance use whilst in custody

Respect: Prisoners with substance related needs are identified at reception and throughout their time in custody

Purposeful activity: All prisoners receive effective drug and alcohol education interventions to meet their needs

Resettlement and reducing offending: Prisoners, according to their individually assessed needs, are provided with the necessary support and treatment both in prison and after release to maintain healthy lifestyles and avoid the harmful effects of drug use

4.55 While describing the major initiatives within the prison and including some policy statements, the current drug strategy failed to address development and lacked action planning. Relevant prison managers were aware that this needed to be rectified

and this provided an appropriate opportunity to review the individual services within the prison and the framework within which they operated.

4.56 All prisoners new to Wandsworth were assessed for potential substance use problems at reception. The prison had protocols for dealing with all standard forms of drug use, including poly-drug use and alcohol. This included a protocol for the use, where appropriate, of methadone as a medical detoxification agent. The prison was also providing maintenance prescribing of methadone for those on remand, those serving short sentences or those for whom it was clinically appropriate. This was in line with best practice and in accordance with Prison Service Order 3550, which sets out the standards for 'Clinical Services for Substance Misusers'.

4.57 We were also pleased to find that a community-based, specialist consultant was attending the prison to support and supervise the treatment of prisoners with substance use-related problems. This was a progressive step and one that similar prisons should follow. Further initiatives included the employment of a dual diagnosis nurse and a close working relationship with the safer custody group. Plans to develop E Wing as a safer custody unit linked directly to the Kearney Unit, which dealt with those with acute needs, were likely to further strengthen the support given to those with chronic substance use problems.

4.58 We spoke to a number of prisoners on the Kearney Unit, which had 16 specialised drug detoxification beds. Both these prisoners and those in the main prison who were undergoing detoxification felt that their treatment was sympathetic and that they were given adequate support.

4.59 Wandsworth had a scheme where a substance misuse throughcare co-ordinator interviewed all prisoners applying to the drug services and referred them on as appropriate. This post had been established originally in response to the number of agencies operating in the prison and issues of duplication, and because prisoners were applying to all the services indiscriminately. However, given that a counselling, assessment, referral, advice and throughcare (CARAT) service had been developed, that role could now be taken by this team.

4.60 The CARAT team was provided by Cranstoun, an independent sector provider. The funding was for nine posts, although recruitment and retention problems meant that the team was rarely operating at full strength. It was struggling to achieve its key performance target of 1560 initial assessments in the year 2002/2003. There were questions as to how appropriate this target was, since concentrating on initial assessments left little time to provide group-work opportunities or support for resettlement.

4.61 The main non-medical treatment available for those with substance use problems was the 12-step programme provided by RAPt, another independent sector provider. The main RAPt programme, based on K1, was run discretely from the rest of the prison. The programme had three phases: pre-admission, which lasted up to two months; primary, which could take up to 16 prisoners and incorporated the most intensive part of the programme; and aftercare. At the time of our inspection, there was a significant number of vacancies on the primary phase as not enough effort had been put into marketing the programme to the rest of the prison, which had led to fewer referrals.

4.62 RAPt were also offering a similar programme to those prisoners based on the vulnerable prisoners unit. This was still very much in its infancy and it was unclear whether there were any significant differences between the two groups.

4.63 The prison's voluntary testing unit was based on B Wing where, in theory, all prisoners should have been signed up to compacts. In reality, however, the redeployment of testing staff and the pressures of overcrowding meant that the prison was nowhere near its recommended target of testing all those on compacts 1.5 times a month. The redeployment of staff was also affecting the prison's mandatory drug testing scheme. While the target of randomly testing 5% of the population each month was likely to be met, little of the required targeted testing was being achieved. Although a significant number of uniformed officers were funded by specific and ring-fenced money, vacancies and their consistent redeployment to other tasks meant that they were clearly not delivering the expected service.

4.64 Concern was expressed throughout the prison that drugs were becoming more available than they had been for some time. To some extent, this was supported by the increase in positive returns from random drug tests over previous years. A number of factors were contributing to this increased availability, not least the growing number of prisoners with a history of chronic drug use. Despite this, at the time of this inspection, the closed circuit television cameras were not in use in the visits room, the passive drug dogs had not been used to screen visitors for some months and searching targets were not being met. This was a concern, given that, while security measures by themselves do not prevent all drugs being brought into a prison, they do play a significant role in reducing availability. We were told that such measures were due to be reinstated during the month following our inspection.

Conclusion

4.65 Wandsworth had been very pro-active in developing a framework of services for substance users and had pioneered a number of initiatives over the years. However, it was clear that a thorough review of its strategy was now needed to ensure that it was still relevant and that services were delivering the required outcomes. In particular, there was a need to look at whether it was making efficient use of the significant resources it had been given and whether it was addressing the targets identified in the revised national drug strategy.

Recommendations

4.66 **In liaison with the area drug co-ordinator, the prison's substance misuse policy group should conduct a full review of existing services and their structural links to ensure that they are still appropriate and meet the needs of the prison's population.**

4.67 **In developing the new drug strategy for the prison, the roles of the substance misuse policy group and the CARAT team should be reviewed. Consideration should be given to merging the two and ensuring that all those that require it get access to relevant services rather than going through a two-stage assessment procedure.**

4.68 **The role and service specification of the CARAT team should be reviewed and targets should be developed that are relevant to the needs of the prison's population.**

4.69 **The substance misuse throughcare co-ordinator should review the way in which the RAPt programme is promoted in the prison and whether the assessment and referral systems could be improved.**

4.70 **The RAPt programme for vulnerable prisoners should be monitored carefully to ensure that it is providing an effective and relevant intervention.**

4.71 **The area drug co-ordinator and the substance misuse policy group should review the way in which the specifically-funded drugs officers are deployed to determine whether they could be used more efficiently. Particular consideration should be given to breaking them down into smaller teams with specific and separate tasks, as is the norm in most other establishments.**

Maintaining contact with family and friends

Expected outcomes

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

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

Visits

4.72 Visits took place seven days a week, morning and afternoon, except on Sunday when they were in the afternoon only. Monday afternoons were dedicated to family visits, which were child focussed and involved a small number of families who were allowed to interact on a far more informal level than during domestic visits. There were two sessions of visits in the mornings, afternoons and at weekends. Visits were usually booked up quickly. Evening visits could have taken the pressure off existing visiting times but staffing difficulties made it impossible to provide these.

4.73 Prisoners received their statutory entitlements to visits, although for some this was fairly minimal. Convicted prisoners on the basic regime could receive only one half-hour visit per fortnight, while those on the standard regime only benefited from an extra 15 minutes. These times were often further reduced by delays in starting visits and getting prisoners to the visits room. In our survey, 55% of respondents claimed that they did not arrive for their visit on time and only 32% said that they and their family or friends were treated 'well' or 'very well' by visits staff, compared to a local prison average of 42%. While some of this dissatisfaction could be resolved by better systems and responding to complaints more effectively, it was clear that the prison's current population was too great for the existing visit resources.

4.74 We noted a large number of complaints from visitors, mainly about being able to get through to the visit booking line and mistakes being made in allocated visit times. Many visitors were clearly unaware that the prison had recently extended the times when the booking line was staffed and we were surprised that the line itself did not have a queuing system or a message informing callers of the new booking times. We were equally surprised that the prison had not set up a system to allow visitors to book their next visit while still at the prison.

4.75 The prison's excellent visitors' centre was run as an independent charitable association. All domestic visitors were expected to report here before their visit and were offered a wide range of services as well as support and advice about the routine on entering the prison. The visitors' centre was represented on relevant committees within the prison and provided support for visitors attending the 'family visit' session on Monday afternoons.

4.76 Building work was taking place in the centre to prepare it to pilot a Learndirect scheme offering visitors tuition in basic skills. This appeared to be an imaginative scheme and, if successful, was an initiative that could be offered in visitors' centres elsewhere. On average, 350 children attended the centre each week. There was a supervised play centre in the building as well as one in the visit room, although the latter was run separately, staffed by volunteers, and was not open during all visit sessions.

4.77 The visits room itself was somewhat shabby and its collection of loose chairs and tables both gave it a makeshift feeling and made it difficult to supervise. Vulnerable prisoners had their visits in the same room and, although they were restricted to a particular area to ensure their safety, they were treated the same as any other prisoner. The closed visit facility was poorly sited, with visitors in complete view of the rest of the room. It also needed decorating and proper ventilation on the prisoners' side. Visitors could purchase a range of drinks and snacks for themselves and the prisoners from a staffed refreshment bar.

4.78 The chaplaincy was responsible for running the prison visitors scheme, including the recruitment, training and support of volunteers. The chaplaincy was also involved in arranging 'special' visits at times such as following a bereavement. On these occasions, the visit would normally take place in the chaplaincy premises rather than in the main visits room.

4.79 We were told that prison officers were generally helpful and treated visitors politely and respectfully. However, we were concerned that some of the operational support grade staff did not have the same skills or training and appeared to treat visitors in an offhand way. The high level of visitors and the pressure this placed on staff made it imperative that all staff were trained to deal with the public.

Conclusion

4.80 Overall, both prisoners and visitors had a poor experience of visits apart from the excellent visitors' centre. The visits facility, which was highlighted as inadequate following our last inspection, was now being used to service 16% more prisoners. Given the importance of contact with family and friends in the rehabilitation of

prisoners, it was disappointing that our recommendation in 1999 that visits should start on time still had not been addressed satisfactorily.

Recommendations

4.81 **Management should review both the time given for visits and the delays in getting prisoners and their families to the visits room. This should be undertaken with the aim of supporting and maintaining family and community links.**

4.82 **The prison should investigate the possibility of allowing visitors to book visits while at the prison and of using more modern technology to make booking over the telephone easier.**

4.83 **Management and visitors' centre staff should meet to consider the future of the play scheme in the visits room with the aim of having it open on a consistent basis.**

4.84 **Management should ensure that all staff working in the visits area receive training in issues related to prisoners' families and the visits environment.**

Post and telephones

4.85 All new prisoners were given a letter on arrival at reception and then one for every subsequent week. Foreign nationals were allowed to exchange standard letters for airmail versions, although we were concerned that this facility was not widely understood by all eligible prisoners or readily available from all wing staff. Stamps and letters could also be bought from the prison canteen. There did not appear to be any systematic or undue delays either in sending or receiving letters.

4.86 The three telephones available on most wings were inadequate for the number of prisoners wanting to use them, particularly given the short amount of time they normally had to access them. In our survey, lack of access was the main complaint about the telephones, with 64% of respondents saying that they found it difficult compared to the local prison average of 37%. We were told that the prison would

shortly be moving to a PIN telephone system and that a significant number of extra telephones would be fitted at the same time.

4.87 Many prisoners complained to us that they were often only able to get to a telephone once or twice a week. The situation was compounded for those prisoners with working family or friends because access to telephones in the evenings and at weekends was particularly difficult and on some wings non-existent. The prison was trying to address the problem with 'social and domestic' time but this also only took place during the day and was not available in the evenings. This allowed prisoners out of their cells for short periods of time when prisoners could choose between various activities such as making telephone calls, taking a shower or cleaning. However, with no pre-booking system for the telephones and the unpredictability of when 'social and domestic' time would happen, prisoners clearly still had insufficient time to make calls.

Conclusion

4.88 The telephone is often the main channel through which prisoners can maintain relationships and the current restrictions reflected the general problem of lack of time out-of-cell. Access to telephones was particularly difficult for unemployed and remanded prisoners. However, the limited availability of telephones for all prisoners and the inconsistent provision of airmail letters to foreign prisoners were unacceptable.

Recommendations

4.89 **Prisoners' access to telephones should be equitable and fair across the establishment.**

4.90 **Telephones should be fitted with effective acoustic hoods for privacy.**

4.91 **The exchange of visiting orders or standard letters for airmail letters for foreign national prisoners should be readily available to eligible prisoners.**

Applications, requests and complaints

4.92 Each landing had a fabric holder containing the various types of application forms and all those prisoners to whom we spoke knew where to find them, although we found that the full range of forms was rarely available. Prisoners could help themselves to forms whenever they were unlocked and handed them in to the landing officer in the mornings. The landing officer was then responsible for dealing with all applications.

4.93 We spoke to many prisoners across all the wings about the applications system and their unanimous response was that they had no confidence in it. Applications got lost, were not responded to for weeks and prisoners were often told to reapply. Applications were not recorded and there was no tracking or any management intervention. As a result, the system was open to abuse by staff. Senior managers were aware of the problem and had plans to introduce new procedures.

4.94 The complaints system, on the other hand, was well administered. Prisoners could post their forms in one of the secured boxes available on all the wings. These were opened only twice each week by two members of the administration department and the forms were properly logged before being sent to the relevant department for a response. All forms were tracked, with reminders sent out when replies had not been received within the required timescale. Unfortunately, this tracking was limited to a month and we found many that were months old and unlikely ever to receive a reply.

4.95 The standard of replies to prisoners varied: those written by governor-grade senior managers were respectful, courteous and gave a reasoned answer; those answered by other grades, of which there were many, were not focussed on the complaint, dismissive, sometimes critical of another department without the form having been passed on to be dealt with properly and often written to the prisoner in the third person.

4.96 Applications to the Board of Visitors were well administered. These were logged by the clerk and a reply was sent to the prisoner concerned confirming receipt and giving a time when a member of the Board of Visitors would see them. This was usually within one week of receiving an application.

Conclusion

4.97 The applications system was ineffective, not sufficiently managed and open to abuse by prison officers. The complaints system was well administered, although some of the replies were dismissive and disrespectful, and some prisoners did not receive one at all. The applications system for the Board of Visitors worked well.

Recommendations

4.98 **Adequate supplies of forms should be available at all times.**

4.99 **Complaint boxes should be emptied every day.**

4.100 **Complaint forms should be tracked until the prisoner has received a reply.**

4.101 **Replies to complaint forms should be respectful and answer the questions asked.**

4.102 **A senior manager should sample replies to complaint forms regularly to check that prisoners receive respectful and thorough replies.**

CHAPTER FIVE

HEALTH CARE

Expected outcomes

Inspectors will make judgements about health care against the following outcomes:

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

5.01 The quality of health care provision at Wandsworth had improved since the previous unannounced inspection in November 2000. Most of the recommendations

had been achieved or there was evidence of good progress towards doing so. The appointment 15 months ago of an I Grade registered nurse as head of health care speeded up the process. There was greater clarity of team roles, although further development of job specifications, team communication and structure was needed.

5.02 There was evidence of robust joint working with Wandsworth Primary Care Trust, which had been supported by the Trust's appointment of a project manager who visited the prison regularly. The partnership board, which included both the Governor and the chief executive of the Trust, met monthly. Proposals were being developed to include a prisoner on the board. The prison was rated amber under the traffic light system.

5.03 Wandsworth was a site for several of the national pilots: clinical supervision, hepatitis B, mental health in-reach and suicide awareness. With the exception of clinical supervision, all had become firmly established.

5.04 The major capital works programme within the prison had implications for health care, as the in-patient unit, detoxification unit and day care centre were due to be relocated on H, D and F Wing respectively during the rebuild.

Environment

5.05 In the main prison, A and B Wings shared a primary health care treatment room, while C, D and E Wings each had their own, as did the separate vulnerable prisoners unit. The care and separation unit on E Wing had a cell that could be used for examining prisoners and, if required, these prisoners were seen in the treatment room shared by A and B Wings.

5.06 Although the wings overall were in need of some redecoration, all the treatment rooms were clean and tidy with enough privacy to ensure patient confidentiality. They varied in size but even the small, cramped rooms were well equipped with plenty of lockable storage and filing cabinets. All had good lighting and most had access to fresh air. All contained an examination couch, drug refrigerator, hand-washing facilities and emergency equipment that was checked daily. Health promotion literature and health care centre information were readily

available, accurate and visible on all wings. All areas had a very impressive and up-to-date copy of the health care protocols with which staff were well acquainted.

5.07 The prison officer who managed primary care was based in a separate office on B Wing where she was assisted by a health care officer. This office was next door to that of the substance misuse and dual diagnosis nurses, which encouraged good communication.

5.08 The hospital wing was in a separate two-storey building adjacent to and accessed through E Wing. This consisted of: Addison Unit, a psychiatric/general ward made up of eight single cells, three double cells, a seclusion cell and a gated cell; Jones Unit, a seven-bed isolation ward; and Kearney Unit, a 15-bed in-patient detoxification unit. The doors of all cells had been adapted to allow access to wheelchair users.

5.09 Following our last inspection, we recommended that the seclusion cell be withdrawn from use immediately. We found that it was still in use, albeit only rarely. It was dark and dingy with damp mould areas clearly visible in one corner. As such, it remained unacceptable and wholly unsuitable for in-patient use.

5.10 A ward on the upper floor had been converted for use as a day care centre. This was large, bright and well decorated with a small integral kitchen area.

5.11 The dental surgery, situated in the hospital wing, had been refurbished recently to a very high standard. It had been re-equipped with a new dental chair, several lockable instrument and storage cupboards, a new autoclave and plenty of work surfaces.

5.12 The hospital wing also contained a functional, clean and tidy x-ray facility that we understood was due to be upgraded.

5.13 Appropriate clinical areas were available for the visiting chiropodist and optician.

Records

5.14 Our examination of inmate medical records showed that record keeping was accurate and notes were filed in date order. Nurse treatment records were also filed here. Random checks of the controlled drug registers revealed that entries were legible and accurate. Dental records were kept in a lockable filing cabinet in the dental surgery.

Staffing

5.15 We could not establish the exact number of filled or vacant posts as a full staff list was not available at the time of this inspection. We were told that there were 44 health care staff and that the main staff shortages were in the in-patient facility, although we understood that a re-profiling of the prison was in progress and this number was subject to review. Bank nurses were used regularly and some continuity was achieved through the use of the same nurses on a regular basis.

5.16 The head of health care was an I Grade registered nurse with previous experience in the prison service. He was also a registered psychiatric nurse and held a first degree in education. As head of health care and director of nursing services, he was directly accountable to the Governor and was a member of the senior management team.

5.17 A prison officer who was also a registered nurse managed primary health care, which comprised 14 general registered nurses and one registered psychiatric nurse. An optician, a chiropodist and a physiotherapist visited regularly, while the prison employed a pharmacist and two pharmacy technicians.

5.18 General medical care was provided by one prison doctor (the senior medical officer, who was undergoing general practitioner training as required by the recommendations of the Doctors' Working Party) and four other general practitioners. Of these four general practitioners, one worked full-time in the prison and three were independent practitioners employed on a sessional basis. One of the independent practitioners worked mainly in the vulnerable prisoners unit. All four provided out-of-hours cover. Four joint general practitioner posts had recently been established

between the prison and Wandsworth Primary Care trust and it was hoped that the new contracts would be in place within the next few months.

5.19 The in-patient Addison Unit was managed by a H Grade registered psychiatric nurse and had one F Grade and two E Grade registered psychiatric nurses, one E Grade enrolled psychiatric nurse, one senior health care officer and three health care officers.

5.20 There were two psychiatrists, one employed by the prison and the other, who was the medical director of the local Springfield Hospital psychiatric unit, a sessional visiting consultant. There was no out-of-hours psychiatric cover. A new consultant psychiatrist (0.6 whole time equivalent) and a staff grade associate specialist were due to come into post in February 2003 to replace some of the existing services and to provide clinical input to the prison in-reach team.

5.21 The prison in-reach team, which was jointly managed by the prison and Springfield Hospital, had 1 H Grade and four G Grade community psychiatric nurses.

5.22 The day care centre was staffed by two registered psychiatric nurses, one of whom was also a general nurse.

5.23 The detoxification unit, Kearney Unit, had a unit manager, six E Grade and two F Grade nurses. A consultant psychiatrist specialising in addictive behaviour visited daily during the working week.

5.24 Visiting specialists included a consultant in genito-urinary medicine and two health advisors from Kings College Hospital

5.25 Administrative support was provided by an administrative officer, an administrative assistant and a typist.

Delivery of care

5.26 Health care was organised into discrete teams, each with its own leader. The team leaders met monthly with the head of health care and weekly clinical meetings were held with representatives from all areas.

5.27 The level and management of long-term staff sickness had been the subject of an internal review by the head of health care, who instigated an overtime ban on those personnel who had been off sick within the previous three weeks. This had reduced staff sickness levels and, therefore, had improved overall patient care.

5.28 Health care services included primary care, mental health, dental care, chiropody and genito-urinary medicine. Out-patient care was provided by Kings College Hospital, St George's Tooting and, for psychiatry, Springfield Hospital.

5.29 All new prisoners were given a leaflet on health care containing all the necessary and appropriate information. They were screened on arrival by one of the nurses in the barely adequate temporary reception area and were seen by a general practitioner within 24 hours.

5.30 Nurse-led primary care triage (assessment) clinics were run on the wings every day except Sunday. Prisoners requesting medical attention had to fill in a medical application form and place it in designated wing boxes. Any necessary treatments were prescribed and undertaken by the nurses within the agreed group protocols before prisoners returned to their cells. If required, an appointment would be made for the prisoner to see a doctor, usually within 48 hours. The general practitioners attended daily except Sunday when there was an 'on call' system in place.

5.31 Nurses could also refer inmates to other health professionals such as the chiropodist or optician. There was a 'special sick' policy and prisoners feeling unwell outside normal clinic times could see a triage nurse at any time if necessary. There was a nurse on duty 24 hours a day who was able to triage, treat or refer prisoners to the medical officer at any time, including during the night if required. They were also responsible for identifying those prisoners who would be attending court or other

external areas the following day and preparing any necessary medications or treatments for them.

5.32 Prisoners reported that the majority of staff were generally respectful and caring. However, there were complaints that some of the medical officers could be indifferent and occasionally appeared rather abrupt. Some prisoners did not always understand what the doctors were telling them and often felt confused following a consultation.

5.33 Nurse-led clinics, such as for chronic obstructive pulmonary disease, asthma and diabetes, were provided by specialist nursing staff from local NHS hospitals. These specialist nurses were training prison nurses to take over these clinics in the future. A chronic disease register was in place and a hepatitis B screening and vaccination programme was undertaken by external specialist nurses.

5.34 Hepatitis C and HIV testing were part of the service provided by a visiting genito-urinary medicine consultant from Kings College Hospital, who was assisted by two health care advisors. They provided confidential consultation and treatment for prisoners, who could self-refer if necessary. Most prisoners considered this to be an excellent service, although some chose to undertake other activity instead of attending the clinic.

5.35 Specialist out-patient appointments were available at either St George's or Kings College Hospital and the waiting period for an appointment was not unreasonable. The relationship with these hospitals was very good. We were concerned about how often out-patient appointments were cancelled through lack of escorts due to staffing shortages in the prison. In December, for example, almost 36% of out-patient appointments were cancelled for this reason.

5.36 A good pathology service was provided by St George's Hospital, with a 24 to 48-hour turnaround in results.

5.37 The chiropodist and optician attended regularly and both had a small waiting list. A visiting physiotherapist attended as and when necessary. The dentist,

supported by a dental nurse, provided six sessions: two each on Monday, Tuesday and Friday. At the time of this inspection, some 150 prisoners were waiting to be seen, representing an eight-week waiting list.

5.38 The pharmacist had a background in community pharmacy and had been in post only three months at the time of this inspection. She was assisted by two pharmacy technicians who had worked at the prison for some time. Current practice was for the nursing staff to dispense treatments on the wings and the technicians would check and maintain the drugs cupboards.

5.39 An in-possession policy was in place. The pharmacist had made contact with the primary care trust pharmacy advisor to develop further policies and protocols and had recently started work on updating the formulary. There was also a newly-reconstituted drug and therapeutics committee whose membership was under review. A new pharmacy computer system, installed in December 2002, should improve stock control and management, although systematic medicines management would be difficult in the absence of a corresponding primary care information management system.

5.40 The prison in-reach team set up the previous year was jointly managed by the prison and the local NHS trust. The five registered psychiatric nurses provided a community mental health team service to the prisoners and were also available to give guidance on mental health and related issues to prison staff. From February, the team would be increased by the addition of a consultant psychiatrist and an associate specialist. This service was greatly appreciated by prisoners, who were able to identify with the nurses and benefit from ongoing therapy.

5.41 The day care centre was open daily from Monday to Friday. Prisoners from the wings were able to use this area for recreational and educational purposes and it provided an alternative to being locked up. However, the two nurses were used as escorts to collect and deliver prisoners from and to their cells, which reduced the amount of time available for therapeutic activity. A needs assessment had indicated the need for significant additions to the delivery of care in the day care centre,

including more psychosocial input and additional assistance from the education department.

5.42 The Addison Unit provided the in-patient facility for up to 15 patients and we were glad to see that it was not on the certified normal accommodation. The average number of in-patients was 13. One of the general practitioners usually did a daily ward round and any patients assessed as needing secure NHS in-patient care were referred to Springfield Hospital. At the time of this inspection, only one patient had been waiting three months for transfer.

5.43 The unit's equipment for prisoners with disabilities, such as hoists and bathing facilities, was relatively new and effective. One such prisoner was in the unit during this inspection.

5.44 Time out-of-cell was limited because of the staffing shortages and most prisoners had periods out of their cells on most days including, on occasion, during the evening. This was appreciated by prisoners, who were aware that this level of association did not occur in other parts of the prison. We were concerned to hear of the proposal to move the three health care officers to ordinary location in the near future. We also understood that they might be replaced by different members of staff on a daily basis. If this happens, it could be detrimental to continuity of care and could leave staff and prisoners in a vulnerable position.

5.45 Prisoners with psychiatric problems received care from two prison psychiatrists and a visiting psychiatrist from Springfield Hospital. There were expectations that the care programme approach would be initiated for prisoners with severe and enduring mental illness once the new consultant psychiatrist was in post. This would ensure continuity of care for those prisoners who were on the care programme approach before entering prison as well as ensuring appropriate follow-up on discharge.

5.46 Discharge planning was in place for all prisoners and, wherever possible, ongoing treatment was organised prior to release either with a prisoner's own GP or his local hospital.

5.47 The detoxification unit, Kearney Unit, dealt mainly with opiate users, although an increasing number of poly-drug users were being treated and many were quite unwell on admission. There was a rapid turnover of patients in the unit. The average length of stay was three to five days, after which prisoners would be moved to normal location and followed up by the detoxification nurse. The consultant attended each weekday and did a daily ward round. The general practitioners were available for prisoners on request only and did not visit the unit routinely to provide primary care.

5.48 Some of the nurses had been trained in auricular acupuncture, which was a popular and therapeutic treatment.

5.49 There were some difficulties in arranging appointments with specialists at the local hospital for prisoners with deep vein thromboses. There were plans to purchase a Doppler scanner for use on the unit to reduce the need for external visits and discussions were in hand to fast track prisoners to the local anti-coagulant clinic.

5.50 As in the Addison Unit, time out-of-cell for prisoners on Kearney Unit was restricted by staff shortages, although efforts were being made to improve the situation. Some prisoners were out of their cells for up to 27 hours a week.

5.51 There were two patients in the so-called 'isolation unit' (Jones Unit). These men were undergoing tests and were being held there primarily as a precaution as they had been in contact with a prisoner who had recently been diagnosed with tuberculosis.

5.52 The importance of clinical governance was acknowledged. We were told that there was a clinical governance programme under development and that the head of health care worked closely with the local health economy to co-ordinate its implementation. The majority of staff felt supported in their continuing professional development programmes. Many were attending professional courses that would enhance the level of care given to prisoners and the advice given to other prison staff.

5.53 A resuscitation training programme was in place to train staff in basic life support and the treatment of anaphylactic shock. There were established links with St

George's Hospital's resuscitation officer and it was hoped to access training places there.

5.54 Clinical supervision remained an aspiration as it had become difficult to establish links with a local trust that could assist. All health care staff should be able to demonstrate that they have access to support and professional supervision either within the establishment or through local NHS providers. Training for potential supervisors was proving very expensive, although places for trainee supervisors had been identified at Kings College. The head of health care was actively pursuing funding for this, which would provide health care staff with a proper support framework and, in turn, improve patient care.

5.55 In common with many other prisons, Wandsworth lacked a comprehensive and modern information technology system that could link into the local primary care trust. It was impossible to audit clinical care or medicines management effectively with the current technology as only the most basic of data could be collected. We understood that training on the new computer system had started recently.

Conclusion

5.56 Health care was delivered in a safe clinical environment and in a respectful and caring way. There was clear evidence of sustained good practice, although this could be jeopardised if the proposed changes in medical staffing take place. Staff shortages were still a problem. It was clear that, through good joint working with the local health economy, the new head of health care had been instrumental in bringing about a significant improvement in the standard of care delivered. However, while recognising the complexity and scale of health care provision, there was still a need to co-ordinate the delivery of services to improve efficiency and quality of care.

Recommendations

5.57 **Urgent consideration should be given to introducing primary care compatible information systems to support clinical audit, chronic disease management and medicines management.**

5.58 **In consultation with the dentist, the dental waiting list should be reviewed. Extra clinical sessions should be offered to reduce the waiting list to a more acceptable level.**

5.59 **The Governor, the head of health care and the chief executive of Wandsworth Primary Care Trust should continue to work together to ensure that the medical staffing profile complies with the recommendations of the Doctors' Working Party.**

5.60 **The seclusion cell is unfit for its purpose and should be taken out of use immediately until appropriate refurbishment has taken place.**

5.61 **Consideration should be given to enabling the pharmacist to be available for over-the-counter consultations. The pharmacist should continue to work with Primary Care Trust staff to develop policies and protocols.**

5.62 **Changes to the day care regime should be based on the needs assessment within a clear planning framework.**

5.63 **The proposal to remove three permanent members of discipline staff from the in-patient mental health unit should be reconsidered urgently as this could seriously jeopardise the level of care and supervision provided to patients.**

5.64 **Clinical supervision for nurses is a statutory requirement and the head of health care should work with the Primary Care Trust to ensure its introduction as a matter of urgency.**

CHAPTER SIX

ACTIVITIES

Employment

Expected outcomes

The expected outcomes for prisoner employment are:

Safety: Prisoners work in a safe, suitable environment

Respect: The range, type and availability of work activity meets the needs of the prison population and prisoners are treated fairly in all aspects of their work, its allocation and pay

Purposeful activity: Prisoners are engaged in well-organised employment; work programmes are integrated fully with residential units and other departments

Resettlement and reducing re-offending: Prisoners are occupied in realistic work that prepares them for employment on release and helps to reduce re-offending

6.01 Two years ago, we recommended that a proper system for the allocation of work should be introduced and this was recorded as achieved in the prison's own action plan. However, the level of control and management of work was at the heart of the poor use of scarce employment places during this inspection. The labour control officer was unaware of the number of work places available to prisoners. This was found to be a theoretical maximum of 665, of which 293 were in workshops, 110 were in education and 262 were in cleaning or orderly jobs. If all these places were full-time, 785 prisoners were left unemployed. However, on one afternoon of this inspection, only some 500 of these placements were occupied, leaving 950 unemployed prisoners. An audit of prisoners on wings during a different afternoon found 1000, of whom approximately 200 were recorded as being engaged in work, leaving up to 800 unemployed. We therefore concluded that the unemployment figure at the prison was between 800 and 950 people or between 55% and 65% of the population. This was supported by the results of our survey, in which 64% of respondents said that they had never had a job at Wandsworth.

6.02 Work was allocated to prisoners in response to their requests by written application or to information from reception boards, although only newly-sentenced prisoners attended such boards. The absence of sentence planning prevented the multi-disciplinary assessment of the prisoners' needs being used to inform decisions.

6.03 Allocation of work was based primarily either on where a prisoner was located, with those on A and B Wings given priority, or on whether a wing officer or work supervisor had made a specific request. Work continuity was undermined by prisoners choosing to leave work with no notice in favour of better paid jobs or by officers giving wing jobs to prisoners without the permission of the labour control office. On one afternoon, one third of jobs were unoccupied due to predictable prisoner absences, such as attendance at court, allocation to courses, sickness or release from custody. There was inadequate use of the system of overcalling prisoners to workshops to cover for those who would predictably fail to attend.

6.04 The pay structure for prisoners ranged from £5 to £12 per week, although we heard reports of higher pay for wing cleaners. The pay structure acted as a disincentive for prisoners to attend courses or education to support their personal development and rehabilitation. A full review of the pay structure was planned.

Conclusion

6.05 Allocation to activity by the labour control office was not based on the assessed needs of the prisoners but on information from applications or reception boards. There was inequality in access to activities depending on a prisoner's location and many other factors acted to undermine the efficiency of labour allocation. There were insufficient work and activity places and those that existed were not well managed and were undermined by the pay structure.

Recommendations

6.06 **Access to activity places should be allocated fairly across the prison and in accordance with prisoners' assessed needs.**

6.07 **The planned reviews of the pay structure should take the importance of rehabilitation activities into account.**

Workshops and training

6.08 There were five main workshops and the kitchen and the laundry provided two other major employment areas. Most of the workshops had restrictions on the number of prisoners they could accommodate due to staff sickness or workshops moving location.

6.09 The prison had experienced a history of inadequate space to run workshops, although a new workshop complex had been built and was two-thirds occupied at the time of this inspection. The appointment of new workshop supervisors and instructors was well advanced and staff had been selected for the planned increase in the number and range of placements. It was also proposed that the system for employing prisoners would be reorganised around a four-day week and taking into account the additional workshops. The numbers of placements at the time of this inspection and the proposed number were:

Current workshop/ employment	**Current maximum number of places**	**Actual number**	**Proposed work places**	**Prisoners on roll with four-day week**
Brush shop	42	33	45	54
Textiles	42	20	45	54
Contract services	30	25	60	72
Tailors	12	12	45	54
Data entry	30	30	50	50
Laundry	70	60	64	80
Kitchen	40	40	40	48
Proposed workshops			**Proposed work places**	**Prisoners on roll with four-day week**
Industrial cleaning			24	24
Plumbing			24	24
Painting and decorating			16	16
Total	**266**	**220**	**413**	**476**

6.10 A wide range of work skills was required, the majority of which were unlikely to improve the future employment prospects of prisoners. Contract services involved low level assembly skills and the brush workshop required limited use of tools and working with others. In our survey, 83% of respondents who had some form of employment said that they were not gaining any skills or experience that would help them to find a job on release. By contrast, those employed on the computer database or in the tailoring or embroidery workshops were being trained in skills that could very possibly be relevant to future employment.

6.11 The fact that prisoners were not given information about employment during an induction programme meant that many were at a disadvantage when it came to making requests for work. Almost certainly, it was those prisoners who had been in Wandsworth before who would be most likely to negotiate a favourable work placement.

6.12 There was no integration of basic skills within the employment workshops and there were limited opportunities to gain qualifications. There was no evidence that work placements had been identified for those with physical or other disabilities, although all the new workshops were accessible to wheelchair users. There was one internal verifier of national vocational qualifications (NVQs), although most qualifications seemed to be planned rather than available at the time of the inspection. Planned NVQs included: information technology; food handling and hygiene; painting and decorating; plumbing; industrial cleaning; and clothing manufacturing. The qualifications available at the time of the inspection were manual handling, clothing manufacturing and information technology. Workshop instructors were not involved in the sentence planning process.

Conclusion

6.13 The range of tasks in the workshops, such as brush-making and packing had limited relevance to rehabilitation and future employment. There was limited skills training and opportunities to certify skills had not been maximised. With the new workshops and instructor recruitment programme, greater involvement of education, availability of qualifications and the new working week, it was hoped that workshops would have a more positive impact on prisoners' lives in the future.

Recommendations

6.14 **Employment in the workshops must include involvement in basic skills work or work skills qualifications.**

6.15 **Future workshops should be developed to enhance prisoners' employment opportunities on release.**

6.16 **The workshop staff should contribute to sentence planning and other statutory reports on prisoners.**

6.17 **Workshops must accommodate those with limited English, limited mobility and those with learning difficulties or other impairments.**

Education

Expected outcomes

The expected outcomes for education are:

Safety: Prisoners receive education and work skills training in a safe, suitable environment in which they are enabled to participate fully

Respect: Prisoners are offered opportunities in education and work skills training that meet their identified needs and different levels of ability, and promote and respect personal responsibility; education is facilitated and valued by the establishment and reflects a sensitivity to equality of opportunities issues

Purposeful activity: Prisoners have the opportunity to engage in a range of education and work skills training that provides constructive and meaningful activity and potential for self-expression

Resettlement and reducing re-offending: Prisoners are involved in education and work skills training specifically to enhance their employment opportunities

6.18 The education department was located below one of the residential wings. The rather dark vaulted area had been adapted to provided classrooms and office space. There were also classrooms on the vulnerable prisoners unit and in the health care centre. Classrooms were equipped with a blackboard, wooden tables and chairs. There were 12 computers in the computer classroom, although the hardware and

software was out of date and the room was badly designed. The funding to update these had been identified and, when this had been done, it was planned to provide CLAIT Plus and the European Computer Driving Licence.

6.19 Office accommodation for teachers was inadequate, with limited access to computers and no access to the internet or an external telephone line to assist in preparing classes.

6.20 Education services were provided by Amersham and Wycombe College as part of a five year contract that was due to be re-tendered in the next two years.

6.21 The department reported that it provided approximately 270 full-time or part-time education places each day. A further 135 prisoners were reported to be supported in their distance learning studies in their cells. Most of this distance learning, which was supported by one dedicated teacher, was at GCSE level or above. It was greatly to the credit of the department that it had supported so many students in obtaining external funding to enrol on and pursue these courses.

6.22 The department offered basic level courses in social skills, literacy and numeracy, as well as CLAIT, art, English as a second language, African studies and drama. The small amount of drama was geared towards productions supported by outside educational bodies.

6.23 Although the education department aimed to provide induction assessments for all new prisoners, only about half of those eligible had been given one in the three months prior to this inspection.

6.24 Classes were scheduled to run for two hours in the morning and afternoon, although the sessions were frequently cut short because of regime restrictions.

6.25 Very few basic skills qualifications had been achieved before September 2002, when this work had been prioritised by the contract manager. The prison's target of 170 passes for literacy, numeracy and social skills was likely to be met by the end of the contract year and increased for the next period. There were no key skills

workshops in other departments, although the distance learning teacher did support students in other activity places.

6.26 The education department had been experiencing problems with its course database, which made it difficult to review attendance lists. However, there was also a discrepancy between the number of activity places reported at the labour control office and the number observed during the inspection week. In addition, on one afternoon the labour control officer reported 110 education places of which only 68 were used. It was extremely difficult to reconcile the activity place and attendance figures offered from managers and staff working in different parts of the activity function and to match this with actual places for prisoners. Our survey indicated that 70% of prisoners had not received education or training during their time at Wandsworth, although 77% of prisoners rated the education department highly.

6.27 Prisoners accessed education through an application or following the induction assessment. However, with no form of sentence planning, education could not be planned as part of a co-ordinated rehabilitation plan. The education department prepared reports for parole or life-sentenced prisoners, although many of the requests for these were received from the prisoners themselves rather than the throughcare department.

Conclusion

6.28 The curriculum appeared to be adequate and a range of non-vocational courses had been maintained or introduced where funds allowed. We welcomed the recent significant focus on basic skills and the plan to introduce these to other activity areas was clearly appropriate. There seemed to be merit as the education services were being developed in reviewing the elements that were full and part-time in order to ensure that students' needs were met while maximising access to this valuable resource.

Recommendations

6.29 **The furniture, teaching aids and technical support in the education department should be reviewed to provide an appropriate learning environment.**

6.30 **Office accommodation, computer and telephone access for teachers should be improved to allow better use of the extended preparation time in the middle of the day.**

6.31 **The computer room should be redesigned, refitted and provided with appropriate equipment and software teaching aids.**

6.32 **The number of prisoners attending classes full-time and part-time should be recorded and the results used to improve targeting of under-represented populations.**

6.33 **Key skills workshops should be introduced in both the workshops and the physical education department.**

6.34 **Access to education should be based on need. Places should be allocated fairly and maximised for all prisoners, while taking into consideration the need for some full-time courses.**

6.35 **The education department should be integrated into the sentence planning and labour allocation process.**

Library

6.36 The library, which was located at the heart of the main prison in E Wing with a trolley service provided for the vulnerable prisoners unit, was large, clean and obviously well cared for. The books were neatly racked and the atmosphere was not dissimilar to that in any local community library. There were some 22,000 books in stock and a very good range of literature in languages other than English was provided for minority ethnic groups. The librarian, who had been in post for only five weeks, acknowledged the need for the library to reflect and represent the multi-cultural nature of the prison's population. The required stock of legal books and a complete set of up-to-date prison service orders were prominently displayed.

6.37 The librarian's key problem was getting prisoners into the library. Although each wing had its designated day and time to attend, these were not always adhered to.

While this problem was not uncommon in all wings from time to time, at the time of this inspection it seemed to be centred particularly on A and B Wings. On 21 January, for example, no prisoner from A Wing had been able to visit the library at all that month and only 92 of those from B Wing had been given this opportunity. This was clearly unacceptable. Staff appeared to be unwilling to allow prisoners their right to use the library.

6.38 The librarian encouraged and provided other activities in the library, including a debating society, regular visits from a writer in residence and events relating to the history of black people.

Conclusion

6.39 The library had a good range of books, a pleasant atmosphere and provided a stimulating range of activities available for those who were allowed to attend. However, prisoners were not being allowed their statutory right to attend the library.

Recommendation

6.40 **All prisoners should have the opportunity to attend the library once a week.**

Physical education

Expected outcomes

The expected outcomes for physical education are:

Safety: Prisoners are safe during physical education activities

Respect: The range, type and availability of physical education activities meet the needs of the prison population; prisoners are treated fairly in all aspects of physical education

Respect: Physical education is part of the provision of a healthy lifestyle in promoting personal health, fitness and co-operative and team skills

Purposeful activity: Prisoners are engaged in suitable physical education programmes that are fully integrated with other purposeful activities

6.41 At the time of this inspection, the physical education team was made up of six officers and one senior officer, which was exactly half of what it should be when fully staffed. By the end of the previous month, each member of staff was owed an average of 60 hours of time off in lieu. There was a very limited redeployment of physical education staff to other discipline duties and further members of staff who were suitable to qualify as physical education officers had been identified.

6.42 With one sports hall and two gymnasiums, the department planned to offer a balance between courses leading to qualification and recreational activity. There was no outside sports area. Changing areas were in good condition, clean, adequate in size and had sufficient showers and toilets. Funds had been allocated to provide a fitness suite for A Wing, which will act as a pilot for other residential units.

6.43 The prison had basketball and volleyball teams. Fifteen prisoners were undertaking the Community Sports Leadership Award for two hours each morning, with the intention that all those who achieved it would go on to further courses, possibly including GCSE modules. The department also provided specific sessions for remedial work, induction, those on the RAPt drug programme and those on the vulnerable prisoners unit. A system had been devised to ensure equitable access to the gym across the prison. However, a review of prisoners attending the gym in the previous 16 days showed that priority was being given to vulnerable prisoners and those wings where the prisoners were most likely to be employed and on higher landings. The planned provision of a fitness suite on A Wing, where prisoners had some of the best access to the gym, reinforced the impression that there was an established differential in activity between these prisoners and those who were remanded or unemployed. It was equally clear that some prisoners were not being given any opportunity to attend the physical education department. This was supported by the results of our survey, in which 58% of respondents said that they had not attended and 29% said that they attended only once a week.

6.44 In the 16 days prior to our inspection, an average of 153 prisoners spent an average total of 175 hours in the gym each day. There was no evidence that the physical education department was involved with any other areas of the prison to provide healthy living, smoking cessation or stress management support.

Conclusion

6.45 The facilities were adequate given the small number of staff, although an outside area would make a significant improvement. There was unequal access to the department. The very valuable database of prisoner attendance in the gym that was available in the information technology workshop could be used to manage prisoners' access in the future.

Recommendations

6.46 **Prisoners' access to physical education should be fair and equitable, and should be recorded and monitored.**

6.47 **The balance between courses and recreational activities in the physical education department should be reviewed.**

6.48 **The physical education department should work with other areas of the prison to support healthy living, basic skills and drug treatment programmes.**

Faith and religious activity

Expected outcomes

The expected outcomes for faith and religious activity are:

Safety: Prisoners can safely take part in spiritual activities

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

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

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

6.49 The large chaplaincy team was made up of full-time and sessional ministers, individual volunteers and community groups. There were three full-time Christian chaplains, with a number of others who provided services as required. The Imam's 12-hour per week contract was due to become a full-time post in the very near future. Visiting ministers from three local evangelical churches celebrated services on a

regular basis as well as providing bible study classes, and the Alpha course was run by an external group about three times a year. There was also a comprehensive list of ministers from minority denominations who attended on request. A small number of accredited chaplaincy volunteers worked with individual prisoners and the chaplaincy team also managed the 15 volunteers from the prison visitors scheme.

6.50 The prison had a wide range of facilities for services: a central chapel used for Church of England services and other activities for up to 120 people; a mosque that could accommodate up to 110 people; a non-conformist chapel with a baptism pool; a separate Catholic chapel that was full to its capacity of 150 prisoners every Sunday; and a small synagogue. A room in the health care centre was also used for Sunday services. All these facilities reflected the high demand put on the chaplaincy for services across a wide range of denominations. Five Christian services were held on Sundays with a total attendance of some 320. The Muslim prayers held on Fridays and the classes held on Thursday afternoons were also well attended.

6.51 An informative leaflet explaining the range of facilities and services was available to prisoners in reception.

6.52 The chaplains were actively involved in the pastoral care of individual prisoners, including those at risk of self-harm or recently bereaved. They made daily visits to the care and separation unit and the health care centre. The team shared all pastoral duties and, when he became full-time, the Imam would be included on the rota to conduct reception interviews.

6.53 Although the diverse range of services related directly to prisoners' needs, the size of the central chapel meant the up to 30 prisoners each week were unable to attend the main Church of England service. This problem had been identified during a previous inspection. A number of prisoners indicated that they were not always unlocked to attend services.

6.54 The Imam was content with the certification and availability of the halal diet for Muslim prisoners. The practice of providing the facility for shared prayer, meals and celebration for Eid had stopped recently.

Conclusion

6.55 We were impressed with the range of facilities available and particularly with the imminent inclusion of a full-time Imam on the chaplaincy team. We were also encouraged by the team's shared approach to statutory tasks and pastoral care across the full-time and part-time ministers and volunteers.

Recommendations

6.56 **Appropriate action should be taken to ensure that all prisoners wishing to attend religious services can do so.**

6.57 **Consideration should be given to supporting communal celebrations of religious festivals.**

Good practice

6.58 *The inclusion of a full-time Imam in statutory and pastoral work was an example of good practice.*

Time out-of-cell

Expected outcomes

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

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

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

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

6.59 The daily timing of wing routines and other activities depended entirely on staffing levels.

6.60 Those prisoners who worked on the wing were unlocked each day to do their job, during which time they also had access to facilities such as the showers and

telephones. Unemployed prisoners, on the other hand, spent most of the day locked up.

6.61 The local prison average for prisoners spending more than six hours out of their cells on a weekday is 37%. The results of our survey showed that only 14% of respondents had this opportunity (8% said six to eight hours and 6% said over eight hours). Forty-one per cent said that they spent less than one hour a day out of their cells.

6.62 The local prison average for prisoners spending more than four hours out of their cells at a weekend is 40%. This compares to just 14% of respondents to our survey (3% saying four to six hours, 8% saying six to eight hours and 3% saying more than eight hours). Of the remainder, 7% said two to four hours, 27% said one to two hours, 5% didn't know and the vast majority, 47%, said less than an hour.

6.63 Management were aware that access to showers, telephones and cell cleaning was limited. In an effort to improve the situation, 'social and domestic' periods had been introduced when landing officers unlocked usually a quarter of a landing at a time so that prisoners could access these facilities. While records kept on each landing showed the number of prisoners unlocked for this purpose, the limited amount of time prisoners were given meant that they had to choose between queuing to use a telephone and taking a shower. As a result, we found that the prison's record showing that, on average, each person had the opportunity to shower 4.4 times a week did not match the actual experience of a significant number of prisoners.

6.64 Patterns of unlock varied between wings, between landings and between officers on duty. Some officers told us that prisoners would only be unlocked when there was a set amount of staff, while one officer said that although he should only have the wing cleaners unlocked, he also unlocked those prisoners who he did not expect to be 'any trouble'. While this was beneficial for those prisoners lucky enough to be unlocked, it meant that there was no equality of opportunity for those who were not. Many prisoners clearly did not know when they would be able to shower or use the telephones.

6.65 Following our inspections in both 1999 and 2000, we recommended that the prison increase the number of opportunities for prisoners to be unlocked, to shower and to use the telephones. We were, therefore, disturbed to find the situation little changed.

6.66 Association times were infrequent and unpredictable. We were told that the senior officer on duty decided when association would take place and how many prisoners would benefit. However, there were rarely enough members of staff on duty to allow association to take place. Many prisoners were unaware of their entitlement to association or when it was supposed to take place on the wing. Some prisoners had not had association for several months.

6.67 The recorded, but not observed, pattern of association for the week beginning 5 January, as shown below, indicated when evening association took place but did not reveal the length of the association periods

Wing	Population	Numbers on association
A	229-237	Nil
B	249	Tues-85 Wed-91 Thurs-60
C	222-249	Nil basic/standard Mon-30 Wed-25 Fri-40 Enhanced only
D	183-190	Wed-77 Thurs-68
E	163-175	Nil
VPU	313	Mon-160 Wed-95 Fri-180

6.68 Prisoners did not receive enough association, there was insufficient access to association in the evening to telephone home, it was unpredictable and there was no equality of access across the prison.

6.69 Those few association periods that we did observe were relaxed and friendly. Prisoners had access to a range of activities and games, such as table tennis, pool, table football, dominoes, chess and cards.

6.70 All wings were offered daily exercise except in bad weather. There was no provision of waterproof clothing or footwear and exercise was cancelled automatically in wet weather.

6.71 Prisoners moving to an exercise yard from their wing were required to walk around, not across, the centre grill in the main prison. The same rule applied to prisoners moving from B Wing to A Wing for medication when, although the wings were directly adjoined, prisoners had to walk clockwise in single file around the centre grill on the way out and anti-clockwise on the way back. This practice, which we were told was a way of keeping order and was also a 'Wandsworth tradition', had already been highlighted as inappropriate following a previous inspection.

6.72 We joined some prisoners in one of the exercise yards. They walked in an anti-clockwise direction, there was nowhere for them to sit down, no toilets and no outdoor games equipment.

Conclusion

6.73 Following previous inspections, we have expressed grave concern at the lack of time out-of-cell, the limited access to showers, cell cleaning and telephones, and the serious lack of association. As such, it was indefensible to find that so little had changed and indeed in some areas had become worse. The prison expected that the introduction of new work profiles detailed in the action plan would have an impact across all these areas. It aimed to provide regular association and daily access to telephones and showers for every prisoner.

Recommendations

6.74 **An alternative out-of-cell provision should be provided when bad weather leads to external exercise being cancelled for three days in a row.**

6.75 **Seating and access to toilet facilities should be made available in the exercise yards.**

CHAPTER SEVEN

GOOD ORDER

Expected outcomes

The expected outcomes for good order are:

Safety: Prisoners' safety is protected by clear rules necessary for the maintenance of good order and discipline and enforced by the properly exercised authority of prison staff

Respect: Prisoners understand the rules of the establishment and are treated fairly; they are able to appeal against decisions

Respect: Segregation, the use of force and application of category and status are used for their proper purposes and not as punishments

Respect: Every opportunity is taken to encourage good behaviour even when enforcing boundaries of control

Purposeful activity: Good order is supported through activities for prisoners which are challenging and well-organised

Rules of the establishment and security

7.01 Many of the rules of the prison were clearly available to prisoners at Wandsworth. Those prisoners who were able to attend the induction programme, which was not always offered, were advised of the basic rules and there were many notices on display around the prison indicating the routines of the prison and what was expected of prisoners. Each wing also had a set of three coloured folders: one containing important information; one with information that would be useful to prisoners; and one with information described as 'nice to know'. Unfortunately, given the limited amount of time they spent out of their cells, prisoners were not able to make as much use of this information as they should.

7.02 Instructions about how prisoners should behave when leaving the wing were displayed on the gates at the end of each wing. These included taking hands out of pockets, being properly dressed and only walking in one direction. The style, tone

and content of these notices reflected a lingering and traditional element of the Wandsworth culture.

7.03 A review of warnings given to prisoners under the incentives and earned privileges scheme indicated that many of the rules that they were considered to be breaking were not ones that had been included on notices on the wings or during the induction process. Some of these infringements were for minor offences, including talking to someone on a landing above, using a flask to get hot water from a boiler and a general one of 'disrespect'. Prisoners frequently complained to us about the petty nature of the rules at Wandsworth and the fact that many of the staff insisted on applying them regardless of individual circumstances.

7.04 Although security matters were taken seriously at Wandsworth, the focus was on procedural and physical rather than dynamic security. As a result, the basic principles of dynamic security were not in place. As prisoners spent so much time in their cells, they had little contact with staff, few of whom felt it necessary or important to pay prisoners any personal attention. At the same time, prisoners were engaged in very little constructive activity. Considerable changes in staff attitudes and prison routines would be required if dynamic security were to be a real factor in the life of the prison.

Conclusion

7.05 While prisoners were provided with information about the rules of the prison, many of those they infringed were not ones that had been made clear to them in the available documentation. The basics of dynamic security were not in place at Wandsworth.

Recommendations

7.06 **Prison rules should be clear and consistently applied.**

7.07 **The basic principles of dynamic security should be in place.**

Night routines

7.08 A principal officer was in charge of the prison at night and the staff comprised night patrols, prison officers and nurses. Staff on duty on the wings had night orders to guide them in the event of any emergency and they could all produce these when asked. The orders advised them to get help before entering a cell, which they all said they would do whatever the situation, and each staff member was properly equipped with ligature scissors, first aid equipment and keys to the fire hoses and inundation points. Despite this, not all staff could demonstrate that they knew how to use the equipment and in one case we had to point out that ligature scissors were part of the pack an officer was wearing on his person. Similarly, not many of the staff could produce inundation point keys or knew how to use them.

7.09 All staff knew where prisoners subject to F2052SH (self-harm booklets) were located and were aware of the need to check on them regularly and record this in a supervision log. No-one to whom we spoke had had any training in carrying out night duties.

7.10 The nurses on duty in the hospital had been briefed on the prisoners for whom they were responsible. They spoke confidently about individuals and their likely needs during the night. There was also a nurse on duty in the prison whose task was to administer medication to prisoners on the main wings if necessary.

Conclusion

7.11 While the staff on duty were properly equipped for their duties, many did not know where equipment was located or how to use it. The prisoners in the hospital were well cared for.

Recommendation

7.12 **Staff should be trained regularly for working night duty. This training should include the location and use of all potentially relevant equipment.**

Discipline

7.13 During 2002, there were on average five new reports each day that prisoners had breached rules and therefore faced adjudication. Given the size of the prison, this

was a low number, although it may partly reflect the amount of time that prisoners spent in their cells. Prisoners were placed on report for a range of offences, the vast majority of which appeared appropriate. There was no indication that prisoners in any part of the prison were subject to excessive levels of adjudication.

7.14 The punishments awarded by Governors were generally consistent and not excessive, although they had not been subject to a formal standardisation procedure. The majority resulted in reductions in pay and restrictions on the use of the canteen. Cellular confinement was not used excessively.

7.15 Adjudications were thorough and detailed, and checks were made to ensure that prisoners understood the process. The prisoner involved had been allowed time to prepare his case and to receive legal advice if he wished it. The process was clear, open and fair, and adjudications were conducted in a relaxed atmosphere with no sense that prisoners could expect any form of repercussion afterwards. All prisoners were given the opportunity to state their case and they were listened to by the adjudicating officer who ensured that he or she heard all the appropriate evidence. Findings of guilt were based on the evidence presented at the adjudication.

Conclusion

7.16 Adjudications were conducted in a thorough and detailed way, and prisoners were given a fair hearing. Punishments awarded were consistent and not excessive.

Use of force

7.17 On average in 2002, control and restraint techniques were used 25 times a month, which was a high figure given the amount of time prisoners spent in their cells.

7.18 Standard documentation was provided for each occasion when force was used, although the frequent lack of detail in this made it difficult to confirm that force had been used legitimately as a last resort. Among the comments found were:

"He placed his hand on the door and I feared for my safety"

"Following an alleged fight …."

"He threw his dinner in the air in his cell"

7.19 The documentation was equally unhelpful in determining whether or at what point the violent behaviour was defused. Although a check list included space for indicating whether or not the violence had been defused during the use of force, the reports themselves frequently failed to state whether or when this had occurred.

7.20 There were no clear patterns in terms of staff or locations that would indicate that force was being used inappropriately or excessively by certain individuals.

7.21 The records indicated that there had been no use of mechanical restraints either in 2002 or in the first month of 2003. This was impressive and underlined the ability of staff to interact well with difficult prisoners.

7.22 The special cell had been used 36 times in 2002, although the reason why was unclear in 16 of these. The documentation did not always give details of what behaviour had resulted in a prisoner being moved to the special cell. Neither was this information included in the separate log book held on the unit. However, authority for such locations had been given by a member of staff at the appropriate level on all occasions and it was clear that a Governor had been present during most removals and locations into the special cell.

Conclusion

7.23 Control and restraint techniques were used by staff more frequently than we would have expected if their use was purely legitimate and as a last resort. The documentation completed following the use of force was not always sufficiently detailed. This was similarly the problem with the documentation regarding the use of the special cell, which did not always indicate why it had been necessary to locate a prisoner there. Mechanical restraints were not used during 2002.

Recommendation

7.24 **There should be an internal review of the quality of documentation produced following the use of force and the location of prisoners in special cells.**

Segregation unit

7.25 The segregation unit, which was located on E Wing, consisted of 18 ordinary cells, two special cells and one cell converted to hold prisoners undertaking dirty protests. A further cell was used for strip-searching prisoners when they arrived in the unit. The segregation unit had been renamed the care and separation unit and most staff throughout the prison referred to it in this way.

7.26 The unit was well decorated and all areas were acceptably clean. Equally, the overall standard of cell cleanliness was satisfactory, although some parts of the fabric around the pipe work at ground level required additional cleaning.

7.27 On the first day of this inspection, 12 prisoners were held in the unit. It was staffed by a senior officer and five officers in the morning, a senior officer and four officers in the afternoon and two officers in the evening.

7.28 All prisoners were strip searched on arrival in the unit, which seemed excessive, particularly for those prisoners who were awaiting adjudication for less serious charges and who presented no threat to staff, other prisoners or the general security and running of the unit. We were told that all prisoners were provided with a comprehensive booklet outlining the rules of the unit. However, it was clear from the prisoners to whom we spoke, and the senior officer who had difficulty in locating the booklet, that this was not always handed out.

7.29 Authority for locating prisoners in the unit was always given by the duty or another available Governor, although this was not always made clear in the documentation. This was particularly the case for prisoners who were taken to the unit under restraint and held there on Rule 53 pending adjudication. While we were satisfied that prisoners were not being located in the unit inappropriately, the documentation needed to show clearly that such locations had been authorised at the appropriate level.

7.30 All prisoners to whom we spoke knew why they were being held in the unit, although some of them disputed the reasons or claimed that they were not sufficiently detailed.

7.31 The Governor, the duty or other available Governor, the chaplain and the medical officer made daily visits to the unit. Members of the Board of Visitors also made frequent visits to the prisoners. All these gave prisoners the opportunity to raise any issues that concerned them.

7.32 In general, there was good interaction between staff and prisoners, albeit not very much of it. Prisoners were let out of their cells only to shower, use the telephones and exercise. These were not always offered to prisoners on a daily basis.

7.33 The records monitoring prisoners' behaviour were very poor quality. On one day when 12 prisoners were held in the unit, local records were available for only seven of them and these gave no clear indication of the monitoring of prisoners' physical, mental or emotional well-being. Staff were well aware of the issues facing prisoners but were clearly not committing this knowledge to any kind of historical record.

7.34 Case reviews of prisoners in the unit were not being held. The details of the last recorded case review, held in October 2002, were kept in a small notebook in the senior officer's drawer. The details in this were clearly inadequate.,

7.35 Not enough activity was provided for prisoners in the care and separation unit: they had no access to even menial work that they could do in their cells; they had no access to the gymnasium; and education provision was very limited. Prisoners did have access to a stock of books that was changed about every two weeks. They were usually allowed to use the telephones if they had telephone cards, although not in the evenings when the unit was effectively on patrol state. Visits were taken in the normal visits area and we heard no complaints about this. We were told initially that prisoners had daily access to showers and exercise but this was clearly not always the case and prisoners normally had access to showers every other day. An hour's exercise was usually offered each day, although this could be cancelled for some prisoners if the adjudication process extended into the afternoon.

7.36 Of greatest concern were the so-called concrete cells where the standard of accommodation was entirely unacceptable. Rather than moveable furniture, these

cells had a plinth for a mattress, a concrete post sticking out of the floor for a seat and a semi-circular extension of the cell wall for a table. We were told that these cells were used mainly for those prisoners given cellular confinement at adjudication.

Conclusion

7.37 The care and separation unit provided a calm and controlled environment in which prisoners exhibiting difficult behaviour could be managed. Routines were applied rigidly with little flexibility, resulting in some prisoners missing out on basic entitlements to such facilities as exercise and showers. Some of the documentation in the unit lacked detail, which could allow for abuse. However, we were satisfied that staff working in the unit did not take advantage of this and that prisoners in the unit were not subject to any form of physical abuse.

Recommendations

7.38 **Cells with concrete furniture should be re-furbished and should not be used for holding prisoners in the interim.**

7.39 **All prisoners held in the care and separation unit should have comprehensive daily records completed by staff detailing their physical, emotional and mental well-being.**

7.40 **Regular monthly case reviews should be held on prisoners in the care and separation unit.**

7.41 **Prisoners in the care and separation unit should have daily access to showers and exercise.**

7.42 **Clear, written authority from the duty or other Governor should always be given when prisoners are held in the care and separation unit.**

Treatment of vulnerable prisoners

7.43 The vulnerable prisoners unit, which was a separate block of three wings, accommodated 313 remanded and sentenced prisoners who were segregated at their own request. It was designated a training prison for sentenced prisoners.

7.44 This unit was isolated from the rest of the prison and prisoners were allocated work in specified workshops. Movements to shared facilities such as the gym were organised to ensure that the two communities of prisoners did not meet. We found no examples of any difficulties in securing the vulnerable prisoners' safety.

7.45 Problems with interviewing prisoners in private in the reception area had led to some prisoners being allocated to the unit against their wishes. These men had been seen and reallocated by the wing Governor. Sentenced prisoners who were transferred in were not seen specifically to discuss their separation as it was assumed that this had been dealt with at the sending establishment.

7.46 The facilities on the unit were poor but equal to those in the main prison. The atmosphere on the unit was calm and ordered. There were only 12 showers for the whole population and staff shortages meant that prisoners had little association time. Relationships between prisoners and staff were generally civil.

7.47 Prisoners in the unit had more sessions in the gym than the main prison and 159 work placements in the prison laundry, data entry and tailors workshop. This was planned to increase to 184 by offering a painting and decorating course. The education department offered 30 classroom places in the unit, which were generally fully subscribed. The Sex Offender Treatment Programme was also run, including the rolling, extended and core programme, although, with only 31 completions in the previous year, this was unlikely to be meeting the needs of the population. On one afternoon of the inspection, 153 prisoners, about half the total population on the unit, were found to be unemployed on their wing.

7.48 Staff were allocated to the unit rather than volunteering and a number of new officers in their probation period were on the unit when we inspected. There was little or no preparation or training of staff on the unit and no working methods or wing management strategies had been built in to challenge the prisoners' behaviour. The possibility of the conditioning of particularly inexperienced staff was recognised by wing managers. The unit had no specific management strategy or working practices to fulfil the role of a training prison for sex offenders, some of whom had been on the unit for over five years. It suffered from the same restricted regime as the main

prison, had no personal officer scheme and sentence planning was non-existent or superficial. Most parole reports were completed late and staff made little use of history sheets.

7.49 Although there were some activities where prisoners from the vulnerable prisoners unit mixed with other prisoners, such as the foreign national orderlies' meetings, these were the exception.

Conclusion

7.50 The problems that existed in the infrastructure of the prison as a whole equally affected the vulnerable prisoners unit. It was possible for staff on the unit to work with prisoners without any knowledge of their offence, risk factors or the targets they were required to progress. The lack of awareness of the nature of the population and limited opportunities to intervene to challenge inappropriate behaviour seriously restricted the chances to reduce the risk of reoffending. The environment and opportunity to have time out-of-cell for association or constructive activity was more restricted than we would normally expect for long-term prisoners in a training prison.

Recommendations

7.51 **Selection criteria should be set for staff working with sex offenders and they should receive relevant training and support.**

7.52 **The vulnerable prisoners unit should introduce a multi-disciplinary risk reduction policy to inform all aspects of work with sex offenders.**

7.53 **Enough suitable activity places should be provided for prisoners in the vulnerable prisoners unit.**

7.54 **There should be an assessment of prisoner need for the Sex Offender Treatment Programme and enough places should be provided.**

Incentives and earned privileges scheme

7.55 The considerable inadequacies of the incentives and earned privileges scheme had been recognised and a review had been undertaken, with the result that the scheme was in a state of transition at the time of this inspection. Clear proposals for change were in place and a pilot scheme of a comprehensive new system was about to be undertaken.

7.56 The current scheme was not understood well by staff or prisoners. A significant reason for this was that each wing was operating the system differently and there was a lack of easily available information as to how it should work. Prisoners were, however, being reviewed on a monthly basis, although this consisted of an examination of any warnings or positive comments and was generally conducted by a senior officer alone. Slips containing positive or negative comments about prisoners were held in the wing office, with copies having been given to the prisoners concerned. Two negative reports in a month would mean that a prisoner was demoted one level of the scheme, while two positive reports in a month led to promotion by one level. The appeal system in place was entirely inadequate: in some wings, it simply involved the prisoner writing to the senior officer on the back of his copy of the negative report form and the senior officer would then choose independently whether or not to accept the prisoner's account.

7.57 This system was clearly open to abuse: it would be easy for a member of staff to give a prisoner two warnings in a short space of time, thus changing his regime level from standard to basic, without having to justify his decision and without a process by which his decision would be scrutinised or examined.

7.58 The fundamental flaws in the system as it was operating at the time of this inspection included:

- The system was not managed or monitored centrally.
- There was no meaningful differentiation between regime levels: access to the prison shop, sometimes to a television and a 15-minute difference in terms of visits was all that separated the basic from the standard regime.

- Warnings were not open to scrutiny (one prisoner was given a warning for ringing his cell bell because he had not been given a shower or telephone call for five days. The member of staff concerned concluded that his account of events was probably true but that this was still no reason to ring his cell bell).
- Monthly reviews did not involve prisoners and were fundamentally an administrative exercise conducted by the senior officer.
- The appeals procedure was not clear or followed through uniformly on all wings and did not always involve the prisoners concerned.
- Historical records were not kept: copies of warnings or positive reports given to prisoners were only held for a month before being destroyed.
- The reasons for which warnings could be given were inadequate (on the back of the warning form, staff were told that it was perfectly acceptable to give a prisoner a behavioural warning for 'making repeated requests').

7.59 A cause of great concern was the fact that 73% of those prisoners on the basic regime at the time of our inspection were from minority ethnic backgrounds. The reasons for this required urgent management investigation.

Conclusion

7.60 At the time of this inspection, Wandsworth had recognised that its incentives and earned privileges scheme was not operating effectively. A review of the system had taken place and proposals were being put in place that would result in a much improved system. We were concerned that 73% of those prisoners on the basic regime were from a black or minority ethnic background.

Recommendations

7.61 **The new incentives and earned privileges scheme should be introduced and should be in place throughout the prison by the end of March 2003.**

7.62 **A programme of intervention should be introduced to help prisoners on basic regime to progress.**

Categorisation

Expected outcomes

The expected outcomes for categorisation are:

Safety: Prisoners are held in accommodation which is appropriate for their own and others' safety

Respect: Prisoners are located in an establishment that is as close to home as possible and able to meet their identified needs

Respect: Criteria for determining security categorisation and allocation procedures are clear, open and fair, and rules governing transfer arrangements are fairly and consistently applied without discrimination

Purposeful activity: Security conditions do not unnecessarily restrict prisoners' access to purposeful activity

7.63 The initial categorisation and allocation form was completed for most prisoners during the reception board. Some prisoners chose not to, or were unable to, attend this board and therefore missed the opportunity to become involved in discussions about their security category and likely allocation. Following the board and based on the prisoner's security category, a clerk allocated him to an appropriate prison and notified him of the result. If the prisoner disagreed with his allocation, he could submit an application for reconsideration and name his preferred prison. His appeal would be considered either on compassionate grounds, such as if a close relative was sick, or on vocational/educational grounds where the prisoner identified courses he wanted to complete. The allocation would be changed if the grounds were valid and the prisoner's behavioural record was acceptable to the receiving prison. As wing staff did not normally play any part in this process, appeals received by the clerk were often inappropriate.

7.64 Some prisoners, particularly those who had been repatriated from other countries, wanted to be allocated to their home areas, which, in some instances, were

hundreds of miles from London. The same process of presenting compelling reasons was followed, although it was far more difficult to place a prisoner out of the local area and this frequently involved accepting another prisoner in return. More often than not, this process was overtaken by other events and the prisoner remained in Wandsworth until formal complaints, including solicitors' letters, refocused attention on his request.

7.65 Prisoners who had been categorised as 'C' often had to join long waiting lists to be transferred to their allocated prison, while those assessed as suitable for open conditions moved on very quickly.

7.66 Once categorised, a prisoner's dates for potential re-categorisation were entered onto a computer programme that automatically prompted re-categorisation procedures. The file would be passed to the security department for comment before being considered by a principal officer and a Governor. Only when the decision had been made by the Governor would the prisoner be informed that he had been considered for re-categorisation.

Conclusion

7.67 While the categorisation and allocation process was conducted efficiently, prisoners had little opportunity to become involved. Prisoners awaiting allocation to a category C prison frequently spent a long time in Wandsworth and those who wanted an out-of-area allocation often had to resort to formal complaints. Prisoners were not involved in the re-categorisation procedure.

Recommendations

7.68 **Protocols should be developed to allow the transfer of prisoners, particularly those who had been repatriated, to their home area.**

7.69 **Wing staff should screen appeals against allocation and should discuss the appeal with the prisoner before forwarding it for consideration.**

7.70 **Prisoners should be involved in discussions regarding their potential re-categorisation.**

CHAPTER EIGHT

RESETTLEMENT

Expected outcomes

The expected outcomes for resettlement are:

Safety: Prisoners are able to trust staff to deal with details of their offending and personal circumstances responsibly

Respect: Sentence planning, offending behaviour and substance use programmes and re-integration planning are effective and meet prisoners' assessed needs

Respect: The approach of all staff encourages responsible behaviour and supports prisoners working on their offending, substance use and other problems and preparing for release

Purposeful activity: Access and allocation to purposeful activity is linked to prisoners' assessed needs and their planned targets

Resettlement and reducing re-offending: Prisoners address their offending behaviour and related problems and prepare for release while in custody

8.01 There was a designated head of resettlement, although the post-holder had changed several times and the current incumbent had been in post for some three months. There was no resettlement strategy but a resettlement protocol was available in draft form. In July 2002, the throughcare committee had been replaced by a resettlement policy committee with revised terms of reference. Although this committee was scheduled to meet on a quarterly basis, the last and only meeting had taken place in July 2002. This meeting had reviewed the work being carried out by the various voluntary agencies. It acknowledged that few prisoners were able to benefit from this and that development of the work was thwarted by the lack of prison officers to link and support the work of the voluntary agencies.

8.02 Prisoners' re-integration needs were met exclusively by voluntary agencies: the St Giles Trust provided advice and practical assistance with housing issues; the New Bridge Trust visited once a week and gave advice on employment; and the Benefits Agency came in once a week to give advice. A Dependency to Work project, run in conjunction with the health care in-reach team, provided support and advice on housing and employment for those with mental health and dependency problems. The St Giles Trust, in conjunction with the Prison Reform Trust, operated a prisoner passport system where prisoners were given a booklet in which they, or the voluntary worker, could note achievements and contacts made so that they always had a record of the work completed even if they moved prisons.

8.03 Prisoners who wanted to make contact with these agencies had to do so by application. However, as the application system did not function effectively, access was very difficult and the consequence was that those prisoners who had a job and therefore moved around the prison were most likely to be able to access the services. Prisoners without work who remained locked in their cells and who arguably had the greatest need for support, were unlikely to be able to make contact and gain assistance.

8.04 The work of the agencies was not centrally managed or co-ordinated, which meant that their work overlapped and they were likely to be dealing with the same prisoners without realising it. A community sector forum, where the agencies could share information on their work and achieve some level of self-regulation, had been established but the last meeting had been in January 2002.

8.05 While most of the voluntary agencies operated on a visiting basis, the St Giles Trust employed two workers who were situated in the prison full-time. Although their formal remit was to help remand and short-term prisoners with housing issues, the overwhelming need for help from all groups of prisoners was such that they routinely exceeded this brief. They offered what support and advice they could to any prisoner who accessed them and were able, in some instances, to refer prisoners on to their community day centre where they could complete a programme in basic skills and curriculum vitae writing. They employed and trained orderlies to provide basic advice to other prisoners and to refer them to the full-time workers where necessary.

These orderlies, together with the foreign national orderlies, were able to study for a national vocational qualification in advice and guidance up to level 4. Although only one orderly was in post at the time of this inspection, he took up to 30 applications a week and made himself available to prisoners on an informal basis, thereby avoiding the frustrations of the ineffective applications system. Despite the broadening of the remit and the employment of prisoner orderlies, the St Giles Trust estimated that they were seeing only about 10% of those with relevant needs.

Sentence planning

8.06 No sentence planning took place for prisoners in the main prison. The initial classification and allocation form (ICA1) was completed but, whatever their sentence or length of stay in Wandsworth, no further sentence planning documentation was completed. At the time of this inspection, there were 737 prisoners for whom sentence plans should have been prepared. Individual needs were not identified and no personal targets were set. There was, therefore, no means of allocating prisoners to appropriate activities, work, courses or programmes that may have helped to meet their offending behaviour needs and reduce their risk to the public on release. Access to such activities was achieved by self-referral and was largely unrelated to need.

8.07 Some limited sentence planning did take place on the vulnerable prisoners unit, where medium and long-sentenced prisoners were allocated to serve their sentences. Prisoners were identified as serving less than four years, where automatic conditional release documentation was appropriate, or over four years, where discretionary conditional release plans were used. Review dates were set and appropriate forms were generated, which, depending on whether the prisoner was a sex offender, were passed to either wing or probation staff for completion. While the clerks administering the system admitted that they had a backlog of uncompleted forms, they were unable to determine which or how many forms had not been completed. Where sentence plans were done and targets set, they did not form the basis of any further action but were filed away until the next review date. In practice, prisoners' activities were not determined by identified need.

Key workers (personal officers)

8.08 There was no personal officer scheme, or any alternative scheme, in place. Most prisoners spent so little time out of their cells that it was impossible for wing staff to get to know them. Although some officers attempted to deal with prisoners' written applications and help them with their immediate needs, this was on an ad hoc basis and was not widespread.

Conclusion

8.09 There was no active management or co-ordination of the resettlement initiatives, all of which were provided by voluntary agencies. There was no personal officer scheme and no effective sentence planning, which meant that prisoners' needs were not identified or met in any structured way. Access to services was through the ineffective application system with the result that few prisoners received assistance with their resettlement needs.

Recommendations

8.10 **The resettlement committee should meet regularly on a scheduled basis and should direct and co-ordinate all the resettlement work undertaken within the establishment.**

8.11 **Allocation to activities, including offending behaviour programmes, should be based on assessed needs.**

Offending behaviour programmes

8.12 The establishment was running the core, extended, rolling and occasionally the adapted Sex Offender Treatment Programme (SOTP), with a target of 32 completions per year. The Enhanced Thinking Skills programme (ETS) was also run for prisoners both in the main prison and on the vulnerable prisoners unit, with a target of 96 completions per year.

8.13 Both programmes, which were managed by the psychology unit, were well administered and both had received a 100% implementation quality rating. Few prison officers were involved in tutoring the programmes and the establishment found it difficult to attract more. There appeared to be little understanding of the programmes within the main body of the staff, and tutors often experienced a lack of

co-operation or even hostility in getting prisoners unlocked to attend. Awareness training had been scheduled but was frequently cancelled due to staff shortages.

8.14 Rather than being allocated to a programme on the basis of identified need, prisoners applied if they were interested in doing one. The psychology unit held induction groups on the vulnerable prisoners unit to persuade sex offenders to attend the SOTP. This was followed up with a second session if volunteers were not forthcoming. In the absence of sentence planning, however, both the SOTP and ETS programmes relied on voluntary attendance that was not necessarily related to need. If the needs of some 300 sex offenders in the vulnerable prisoners unit had been assessed, it was unlikely that they would have been met by the SOTP provision.

Conclusion

8.15 The offending behaviour programmes were being run to a high standard but were not integrated into, or generally understood by, the rest of the establishment. Allocation to a programme was not based on identified need and the provision of SOTP was insufficient to meet the predicted needs of the large number of sex offenders.

Recommendations

8.16 **Offending behaviour programme awareness training should take place to increase understanding and encourage prison officers to participate in the delivery of the programmes.**

8.17 **A prisoner needs assessment should be undertaken and the provision of programmes amended accordingly to meet the needs of the population.**

CHAPTER NINE

SERVICES

Catering

Expected outcomes

The expected outcomes for catering are:

Safety: Prisoners' food is prepared and served safely in accordance with Environmental Health regulations and religious requirements

Respect: Prisoners receive a fair portion of healthy, balanced, nutritious and varied meals to meet their physical, gender, health, religious, ethnic and medical needs

Respect: Prisoners have a choice and are encouraged to eat healthily to help them create and maintain healthy lifestyles

9.01 The kitchen was managed by a principal officer and two senior officers and employed seven civilian caterers. Up to 36 prisoners were also employed in the kitchen, although this number fluctuated due to the rapid turnover of prisoners who were suitable for this work.

9.02 The kitchen had been based in 'temporary' accommodation for some years and its physical condition was poor and deteriorating. New premises were close to completion at the time of our inspection and we were told that they were hoping to move in at the end of the following month. Equally, a lot of the equipment had reached the end of its useful life and this was making the task of delivering such a large number of meals extremely difficult. Given the imminent move, the prison was understandably reluctant to invest in the existing kitchen. All the same, its state was far from satisfactory.

9.03 Servery areas were basic in terms of equipment but all were clean and well managed by the wing staff. The temperature of the food was checked at the point of service and all the servery workers were properly clothed and adhered to health and hygiene rules. Except for prisoners in health care, everyone ate in their cells, which

was particularly distasteful when two prisoners were sharing a cell with an unscreened toilet.

9.04 Despite poor conditions and broken equipment, the prison was operating a multi-choice, pre-order system with four or five options for the lunch and evening meals. Breakfast was pre-packed and handed out in the evenings along with a small snack to be eaten later at night. New prisoners were usually allocated a vegetarian option on their first night and were able to make their own choices the following day.

9.05 The food we saw was well prepared and presented and included vegetarian, vegan and healthy eating options. The Muslim diet was well thought-out and a number of meals were aimed specifically at black and minority ethnic prisoners. Fruit was available at every meal. As the food comments books were no longer used, any prisoner wanting to raise a catering-related issue was expected to use the standard complaints system.

9.06 We received very few complaints about the food and most prisoners to whom we spoke were relatively happy with it. However, this was not reflected in the results of our survey, in which only 12% of respondents said that the food was good, compared to a local prison average of 20%. This could be explained to some extent by the unpopularity of the pre-packed breakfast and the recent introduction of a sandwich meal on Sunday evenings.

Conclusion

9.07 We were impressed with the standard of meals being provided by the catering department, particularly given the poor state of the kitchen and catering equipment. Providing meals for such a large and diverse population was a challenge and it was hoped that the new kitchen would allow staff to improve further their ability to ensure that prisoners received meals that met their needs.

Recommendations

9.08 **The new kitchen should be completed as soon as possible and this should be treated as a priority.**

9.09 **Prisoners should not have to eat their meals next to an unscreened toilet and urgent action should take place to remedy this situation.**

9.10 **The catering department should survey prisoners to determine why there was such a negative attitude to the food and to look at ways of remedying this.**

Prison shop

Expected outcomes

The expected outcomes for the prison shop are:

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

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

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

9.11 The prison canteen, or shop, was run by the prison through a team of eight staff managed by a senior officer. It operated throughout the week and prisoners on each wing had a designated day when their goods were delivered. All new prisoners were offered a smoker's or non-smoker's reception pack but then had to wait until their wing's canteen day before purchasing more items.

9.12 Canteen staff made a point of attending prisoner consultation meetings to get feedback on their service and any suggestions for new items of stock. They also had face-to-face contact with prisoners while delivering goods and were confident that they would quickly become aware of any problems or issues relating to the canteen.

9.13 Each week, prisoners were given an order form listing all the items currently on sale. A print-out detailing what money they had to spend was also attached. Goods were delivered to cells in a transparent, sealed bag so that prisoners could check the items before opening it. We were told that this system was extremely time-consuming and that the prison was considering reverting to the previous system where groups of prisoners were escorted to the shop to buy items directly over the counter.

9.14 There was a reasonable range of items on sale, including some that were aimed specifically at prisoners from black and minority ethnic communities. As the canteen was not privatised, the prison was also able to keep prices low. Essential items, such as the batteries that prisoners relied on for in-cell entertainment, were subsidised. As the stores were in the prison, any mistakes could be remedied immediately and we received few complaints about the canteen.

Conclusion

9.15 The prison shop offered prisoners a decent service that was responsive to their needs and provided a good variety of choice at reasonable prices.

CHAPTER TEN

RECOMMENDATIONS AND GOOD PRACTICE

The following is a listing of recommendations included in this report. The reference numbers at the end of each recommendation refer to the paragraph location in the main report.

To the Director General

Main recommendations

10.01 The operational capacity of Wandsworth should be reduced to allow for the refurbishment of E Wing and the health care centre, and consideration should be given to a further reduction in numbers until a decent regime can be provided for prisoners. (1.46)

Reception

10.02 Prisoners who have completed their court appearance should be transferred into prison custody as quickly as possible rather than being held in court holding cells. (2.33)

To the Governor

Main recommendations

10.03 A comprehensive and supportive first night procedure that meets the needs and ensures the well-being of newly-arriving prisoners should be established. This should be available to all prisoners across the establishment. (1.47)

10.04 An induction programme should be provided for all prisoners and should identify their immediate needs as well as providing them with comprehensive information about the prison and their entitlements. (1.48)

10.05 All prisoners should be provided with predictable and more frequent association periods, and with access to, and reasonable time to use a shower and a telephone every day. (1.49)

10.06 There should be more activity places, they should be fully utilised and the timetable for activities should be adhered to. (1.50)

10.07 The application system should be replaced with a one that is reliable, managed and auditable. (1.51)

10.08 The situation whereby 73% of prisoners on the basic regime are black should be looked into in order to identify and remedy any underlying problems. (1.52)

10.09 A personal officer system should be introduced on all wings. (1.53)

10.10 Resettlement provision should be extended to provide for all prisoners, including those on remand, in accordance with Prison Service Order 2300. (1.54)

10.11 Sentence plans should be completed for prisoners sentenced to more than twelve months and should determine allocation to activities and programmes. (1.55)

10.12 The role of the vulnerable prisoners unit should be reviewed and, if it remains at Wandsworth, should be underpinned by a strategy and appropriately resourced. (1.56)

Reception

10.13 The new reception area should be of an appropriate design to offer the necessary facilities and to allow a good flow of prisoner movement. (2.34)

10.14 Officers should introduce themselves to prisoners and should address prisoners by their title and surname. (2.35)

10.15 Each prisoner should be interviewed in private in an area that cannot be overlooked by other staff and prisoners. (2.36)

10.16 Appropriate information, in a variety of media and an appropriate range of languages, should be made available in all reception holding rooms. (2.37)

10.17 First night information and support should be developed and made available in reception. (2.38)

10.18 Prisoners should be provided with the means to pass the time while waiting in the holding rooms. (2.39)

10.19 All prisoners should be offered a telephone call at the prison's expense. (2.40)

10.20 Prisoners entitled to receive toiletries should be given these in reception. (2.41)

10.21 No smoking areas should be provided. (2.42)

10.22 Vulnerable prisoners should be held in a safe, private area. (2.43)

10.23 The knowledge of the orderlies should be put to wider use by providing the opportunity for them to engage with incoming prisoners. (2.44)

10.24 Staff waiting in reception should use appropriate forms of address regarding vulnerable prisoners. (2.45)

First night

10.25 An appropriate first night in custody officer job description should be developed. Dedicated officers should be supported through specific training about the needs of new prisoners. (2.57)

10.26 A more appropriate and prisoner-friendly first night information leaflet should be developed. (2.58)

10.27 First night cell sharing risk assessments should be completed in all cases. (2.59)

10.28 Accurate first night records should be kept in wing files. (2.60)

10.29 If they have not made a telephone call in reception, all prisoners should be allowed the use of a telephone on arrival on the wing. (2.61)

10.30 Staff should ensure that all prisoners receive a toiletry pack and that breakfast is made available the morning following their arrival. (2.62)

10.31 The holding room on the induction wing should contain seating and a selection of appropriate information in a range of languages. (2.63)

Induction

10.32 The induction programme should be more creative and engaging, using different forms of presentation such as video, slides and discussion, and including talks from representatives of other areas of the establishment. (2.86)

10.33 Induction officers should be detailed to the work and should receive training to help them empathise better with prisoners. (2.87)

10.34 Compacts should be explained by an officer and should be signed and counter-signed in their presence. (2.88)

10.35 Induction orderlies should be used to provide active peer support and information during induction and should not be used to carry out the duties of staff. (2.89)

10.36 A reception board should be provided for remanded prisoners. (2.90)

10.37 The reception board should be held in an appropriate area to ensure confidentiality, and should provide staff with all necessary information. (2.91)

10.38 There should be more flexibility for newly-arrived prisoners to be able to buy items from the shop. (2.92)

Legal services

10.39 Legal services officers should be detailed to their work during each core week day and should not be used elsewhere in the establishment. (2.107)

10.40 The numbers of legal services officers should be increased. (2.108)

10.41 Legal services officers should be included on reception boards. (2.109)

10.42 The necessary equipment to use Language Line should be made available. (2.110)

10.43 The information and literature in the legal services office should be made available in a range of appropriate languages. (2.111)

10.44 A full and effective bail information scheme should be made available. (2.112)

Accommodation and facilities

10.45 Prisoners should have access to hot water for drinks at meal times and during association periods. (3.12)

10.46 Where two prisoners share a cell, proper privacy screening for the toilet should be in place. (3.13)

Clothing and possessions

10.47 All prisoners should be able to wear their own socks and underwear. (3.20)

10.48 All prisoners should have equal access to adequate laundry facilities. (3.21)

Hygiene

10.49 Bed linen should be completely changed each week. (3.36)

10.50 Cells on the induction wing should be cleaned adequately between occupants and toilet paper should be provided automatically. (3.37)

10.51 There should be enough working hot showers for all prisoners. (3.38)

10.52 The establishment should ensure that newly-arrived prisoners are provided with enough toiletries. (3.39)

10.53 Blankets should be laundered on a regular basis. (3.40)

10.54 Enough pillows should be made available to meet prisoner need. (3.41)

10.55 Pigeons should be prevented from entering the prison buildings. (3.42)

10.56 The storing of food under the centre grill in the main prison should cease. (3.43)

Anti-bullying

10.57 Staff should be trained in bullying awareness and how to complete anti-bullying documentation. (4.06)

10.58 A prisoner survey should be conducted to determine the extent of bullying, its causes and where it takes place. (4.07)

Preventing self-harm and suicide

10.59 Each wing should have an allocated suicide prevention liaison officer who can act as a 'bridge' between wing staff and the suicide awareness and prevention management team. (4.27)

10.60 Self-harm documents should be completed properly, monitored effectively and reviewed regularly. (4.28)

10.61 The counselling service should be evaluated to establish whether it is meeting the needs of both prisoners and the establishment. (4.29)

Race relations

10.62 The race relations monitoring returns should be completed consistently and accurately for all areas covered by the current system. (4.39)

10.63 Race relations training should be provided for all staff. (4.40)

10.64 Positive messages and events celebrating the racial diversity of the community should be organised by the race relations management team. (4.41)

Foreign nationals

10.65 All foreign national prisoners should receive the telephone calls and airmail letters provided for in the prison policy. (4.52)

10.66 Those subject solely to immigration warrants should not be held at Wandsworth for lengthy periods. (4.53)

Substance use

10.67 In liaison with the area drug co-ordinator, the prison's substance misuse policy group should conduct a full review of existing services and their structural links to ensure that they are still appropriate and meet the needs of the prison's population. (4.66)

10.68 In developing the new drug strategy for the prison, the roles of the substance misuse policy group and the CARAT team should be reviewed. Consideration should be given to merging the two and ensuring that all those that require it get access to relevant services rather than going through a two-stage assessment procedure. (4.67)

10.69 The role and service specification of the CARAT team should be reviewed and targets should be developed that are relevant to the needs of the prison's population. (4.68)

10.70 The substance misuse throughcare co-ordinator should review the way in which the RAPt programme is promoted in the prison and whether the assessment and referral systems could be improved. (4.69)

10.71 The RAPt programme for vulnerable prisoners should be monitored carefully to ensure that it is providing an effective and relevant intervention. (4.70)

10.72 The area drug co-ordinator and the substance misuse policy group should review the way in which the specifically-funded drugs officers are deployed to determine whether they could be used more efficiently. Particular consideration should be given to breaking them down into smaller teams with specific and separate tasks, as is the norm in most other establishments. (4.71)

Visits

10.73 Management should review both the time given for visits and the delays in getting prisoners and their families to the visits room. This should be undertaken with the aim of supporting and maintaining family and community links. (4.81)

10.74 The prison should investigate the possibility of allowing visitors to book visits while at the prison and of using more modern technology to make booking over the telephone easier. (4.82)

10.75 Management and visitors' centre staff should meet to consider the future of the play scheme in the visits room with the aim of having it open on a consistent basis. (4.83)

10.76 Management should ensure that all staff receive training in issues related to prisoners' families and in working in the visits environment. (4.84)

Post and telephones

10.77 Prisoners' access to telephones should be equitable and fair across the establishment. (4.89)

10.78 Telephones should be fitted with effective acoustic hoods for privacy. (4.90)

10.79 The exchange of visiting orders or standard letters for airmail letters for foreign national prisoners should be readily available to eligible prisoners. (4.91)

Applications, requests and complaints

10.80 Adequate supplies of all the various applications forms should be available at all times. (4.98)

10.81 Complaint boxes should be emptied every day. (4.99)

10.82 Complaint forms should be tracked until the prisoner has received a reply. (4.100)

10.83 Replies to complaint forms should be respectful and answer the questions asked. (4.101)

10.84 A senior manager should sample replies to complaint forms regularly to check that prisoners receive respectful and thorough replies. (4.102)

Health care

10.85 Urgent consideration should be given to introducing primary care compatible information systems to support clinical audit, chronic disease management and medicines management. (5.57)

10.86 In consultation with the dentist, the dental waiting list should be reviewed. Extra clinical sessions should be offered to reduce the waiting list to a more acceptable level. (5.58)

10.87 The Governor, the head of health care and the chief executive of Wandsworth primary care trust should continue to work together to ensure that the medical staffing profile complies with the recommendations of the Doctors' Working Party. (5.59)

10.88 The seclusion cell is unfit for its purpose and should be taken out of use immediately until appropriate refurbishment has taken place. (5.60)

10.89 Consideration should be given to enabling the pharmacist to be available for over-the-counter consultations. The pharmacist should continue to work with primary care trust staff to develop policies and protocols. (5.61)

10.90 Changes to the day care regime should be based on the needs assessment within a clear planning framework. (5.62)

10.91 The proposal to remove three permanent members of discipline staff from the in-patient mental health unit should be reconsidered urgently as this could seriously jeopardise the level of care and supervision provided to patients. (5.63)

10.92 Clinical supervision for nurses is a statutory requirement and the head of health care should work with the primary care trust to ensure its introduction as a matter of urgency. (5.64)

Employment

10.93 Access to activity places should be allocated fairly across the prison and in accordance with prisoners' assessed needs. (6.06)

10.94 The planned reviews of the pay structure should take the importance of rehabilitation activities into account. (6.07)

Workshops and training

10.95 Employment in the workshops must include involvement in basic skills work or work skills qualifications. (6.14)

10.96 Future workshops should be developed to enhance prisoners' employment opportunities on release. (6.15)

10.97 The workshop staff should contribute to sentence planning and other statutory reports on prisoners. (6.16)

10.98 Workshops must accommodate those with limited English, limited mobility and those with learning difficulties or other impairments. (6.17)

Education

10.99 The furniture, teaching aids and technical support in the education department should be reviewed to provide an appropriate learning environment. (6.29)

10.100 Office accommodation, computer and telephone access for teachers should be improved to allow better use of the extended preparation time in the middle of the day. (6.30)

10.101 The computer room should be redesigned, refitted and provided with appropriate equipment and software teaching aids. (6.31)

10.102 The number of prisoners attending classes full-time and part-time should be recorded and the results used to improve targeting of under-represented populations. (6.32)

10.103 Key skills workshops should be introduced in both the workshops and the physical education department. (6.33)

10.104 Access to education should be based on need. Places should be allocated fairly and maximised for all prisoners, while taking into consideration the need for some full-time courses. (6.34)

10.105 The education department should be integrated into the sentence planning and labour allocation process. (6.35)

Library

10.106 All prisoners should have the opportunity to attend the library once a week. (6.40)

Physical education

10.107 Prisoners' access to physical education should be fair and equitable, and should be recorded and monitored. (6.46)

10.108 The balance between courses and recreational activities in the physical education department should be reviewed. (6.47)

10.109 The physical education department should work with other areas of the prison to support healthy living, basic skills and drug treatment programmes. (6.48)

Faith and religious activity

10.110 Appropriate action should be taken to ensure that all prisoners wishing to attend religious services can do so. (6.56)

10.111 Consideration should be given to supporting communal celebrations of religious festivals. (6.57)

Time out-of-cell

10.112 An alternative out-of-cell provision should be provided when bad weather leads to external exercise being cancelled for three days in a row. (6.74)

10.113 Seating and access to toilet facilities should be made available in the exercise yards. (6.75)

Rules of the establishment and security

10.114 Prison rules should be clear and consistently applied. (7.06)

10.115 The basic principles of dynamic security should be in place. (7.07)

Night routines

10.116 Staff should be trained regularly for working night duty. This training should include the location and use of all potentially relevant equipment. (7.12)

Use of force

10.117 There should be an internal review of the quality of documentation produced following the use of force and the location of prisoners in special cells. (7.24)

Segregation unit

10.118 Cells with concrete furniture should be re-furbished and should not be used for holding prisoners in the interim. (7.38)

10.119 All prisoners held in the care and separation unit should have comprehensive daily records completed by staff detailing their physical, emotional and mental well-being. (7.39)

10.120 Regular monthly case reviews should be held on prisoners in the care and separation unit. (7.40)

10.121 Prisoners in the care and separation unit should have daily access to showers and exercise. (7.41)

10.122 Clear, written authority from the duty or other Governor should always be given when prisoners are held in the care and separation unit. (7.42)

Treatment of vulnerable prisoners

10.123 Selection criteria should be set for staff working with sex offenders and they should receive relevant training and support. (7.51)

10.124 The vulnerable prisoners unit should introduce a multi-disciplinary risk reduction policy to inform all aspects of work with sex offenders. (7.52)

10.125 Enough suitable activity places should be provided for prisoners in the vulnerable prisoners unit. (7.53)

10.126 There should be an assessment of prisoner need for the Sex Offender Treatment Programme and enough places should be provided. (7.54)

Incentives and earned privileges scheme

10.127 The new incentives and earned privileges scheme should be introduced and should be in place throughout the prison by the end of March 2003. (7.61)

10.128 A programme of intervention should be introduced to help prisoners on basic regime to progress. (7.62)

Categorisation

10.129 Protocols should be developed to allow the transfer of prisoners, particularly those who had been repatriated, to their home area. (7.68)

10.130 Wing staff should screen appeals against allocation and should discuss the appeal with the prisoner before forwarding it for consideration. (7.69)

10.131 Prisoners should be involved in discussions regarding their potential re-categorisation. (7.70)

Resettlement

10.132 The resettlement committee should meet regularly on a scheduled basis and should direct and co-ordinate all the resettlement work undertaken within the establishment. (8.10)

10.133 Allocation to activities, including offending behaviour programmes, should be based on assessed needs. (8.11)

Offending behaviour programmes

10.134 Offending behaviour programme awareness training should take place to increase understanding and encourage prison officers to participate in the delivery of the programmes. (8.16)

10.135 A prisoner needs assessment should be undertaken and the provision of programmes amended accordingly to meet the needs of the population. (8.17)

Catering

10.136 The new kitchen should be completed as soon as possible and this should be treated as a priority. (9.08)

10.137 Prisoners should not have to eat their meals next to an unscreened toilet and urgent action should take place to remedy this situation. (9.09)

10.138 The catering department should survey prisoners to determine why there was such a negative attitude to the food and to look at ways of remedying this. (9.10)

EXAMPLES OF GOOD PRACTICE

Preventing self-harm and suicide

10.139 *The pass to allow listeners to move through the prison to undertake their work was good practice.* (4.30)

Foreign nationals

10.140 *The constitution of the foreign national committee, with its partnership between prisoners, staff from all levels of management and external agencies, was an example of good practice.* (4.54)

Faith and religious activity

10.141 *The inclusion of a full-time Imam in statutory and pastoral work was an example of good practice*. (6.58)