



REPORT ON

AN UNANNOUNCED INSPECTION

OF

HM PRISON WORMWOOD SCRUBS

10 – 19 DECEMBER 2001

BY

HM CHIEF INSPECTOR OF PRISONS

INTRODUCTION

We last inspected Wormwood Scrubs in February 2000. This was two years after the presentation of a dossier of allegations against staff which led to over a hundred officers being investigated, 27 suspended and three eventually convicted of violence against prisoners; and a year after the second of two damning Inspectorate reports. The 2000 report painted a more hopeful picture: of an establishment which was developing management and staffing structures capable of providing a decent, safe and purposeful environment for prisoners.

This report follows an unannounced inspection, carried out over a 10-day period in December 2001. As promised in February 2000, we wanted to see whether the green shoots we identified then had blossomed. Because of continuing allegations and public concern, we devoted considerable time and resources to the inspection, so that we could carry out a detailed assessment of the conditions and treatment of prisoners at that particular time. As well as our usual prisoner survey, we also carried out structured interviews with staff at all levels.

Six months before our inspection, a new Governor had arrived and was in the process of developing his medium-term plans for the prison. He was working with a virtually new senior management team and was very aware of the scale of the task he faced.

The good news for the prison is that during an intensive inspection, carried out with no forewarning, we found no evidence, at the time of our inspection, of a culture of brutality by officers towards prisoners. Indeed, in the segregation unit, the area which had previously caused greatest concern, we found evidence of good and carefully supervised practice. That is not to say that individual incidents of staff-prisoner assault or violence could not take place in the prison. But it is to say that we found both management and staff alert to this possibility, and systems in place designed to prevent and detect it. We also found, amongst both staff and managers, those who wanted to build on this base to drive the prison forward.

However, the bad news is that most of the green shoots of February 2000 had failed to blossom. The Home Secretary, two years ago, told Parliament that Wormwood Scrubs must be restored to its proper status as an effective and healthy prison. This report clearly shows that this had not yet happened. On all four of our key tests – safety, respect, purposeful activity and resettlement – Wormwood Scrubs was less healthy, or at best no healthier, than it had been 22 months earlier. As in 2000, our inspectors found themselves once again being provided with promises, plans and hopes, rather than achievements and outcomes.

Safety

Prisoners' safety is critically dependent upon the first few days in prison (when the risk of self-harm is greatest) and on a prison's ability to tackle bullying. Wormwood Scrubs may have instituted systems which made prisoners safer from staff; but it had no effective systems to make them safe from one another, or themselves. Though permanent reception staff were committed and well-meaning, they were assisted by untrained staff, and first night and induction procedures were inadequate to ensure that prisoners, especially first-time and foreign national prisoners, were properly supported and informed. The prison's anti-bullying strategy was also ineffective. In only two cases we examined had bullies been properly dealt with; in some cases, identified bullies were given jobs as cleaners, allowing them free access to others.

Our survey of prisoners told the same story. Allegations of assaults by staff remained at the same low level as 2000; but allegations of assaults by other prisoners had nearly trebled, from 5% to 14%. Claims of verbal abuse by prisoners on prisoners had also risen sharply, from 12% to 20%. Nearly one in three prisoners felt unsafe sometimes, often or most of the time. The prison's own statistics showed that 44% of recorded injuries were the result of self-harm, and a further 34% resulted from fights and assaults.

This is not to say that there were no efforts to improve self-harm and anti-bullying. Committees had been set up and research carried out, and there were good links to

drug teams. But these policies foundered at the operational end: with inappropriate allocation of prisoners, and staff who were reluctant to engage effectively with prisoners, and who were constantly being redeployed to locations and tasks they did not fully know.

Respect

We did not find any overt disrespect from staff to prisoners, and on some wings we record a relaxed atmosphere. But overall we found a distance, a reluctance to engage with prisoners. Systems that are fundamental to good running and relationships on the wings – personal officers, requests and complaints, incentives and earned privileges – were not working, or not working well. Race relations was undeveloped. Ironically, the best staff-prisoner relationships were on E wing, which was ‘rented out’ to Elmley prisoners and run by Rochester officers – in spite of the fact that prisoners and staff were strangers to one another and to the prison.

The prison’s healthcare centre had also deteriorated from the promising start in February 2000. There was still no clinical manager, the physical conditions of the in-patient wards was appalling, and regimes for patients, especially those undergoing detoxification, were highly unsatisfactory. Staff were trying to manage an impossible combination of patients, 39% of them with serious mental illness that required NHS care.

Purposeful activity

Purposeful activity had also declined. In February 2000, only 17% of prisoners told us that they were out of cell for less than four hours a day; by December 2001 this had risen to 44%. There were fewer opportunities for exercise and association. The prison had no means of accurately assessing what regime was being provided, and for whom, as its recording and reporting systems were inaccurate and incomplete. In spite of an enthusiastic education department, and an excellent PE department, many prisoners were not being delivered to classes and activities on time, or in some cases at all.

Resettlement

The prison still had no resettlement strategy (though there was some good work being carried out by NACRO and the CAB) and sentence planning was undermined by the continual redeployment of sentence management staff. More also needed to be done with lifers. Drug strategies were in their infancy and prisoners on the main wings had little help with detoxification.

This report therefore shows an establishment that during the last two years had stalled, or was sliding backwards, on all our key indicators. This raises important questions for the Prison Service, as well as the prison. The Prison Service has shown that it can rescue disastrously failing prisons: by changing the management, putting in resources and providing emergency support. But the really important task is to convert them into healthy and positive environments, and that had not yet been achieved at Wormwood Scrubs.

In spite of this, we found many examples at Scrubs in 2001, as in 2000, of initiatives that were designed to improve conditions for prisoners, and of people committed to providing a better regime and disappointed at the lack of substantial progress. Reception, visits, the developing atmosphere on A wing, offending behaviour programmes, work on self-harm and the changed environment of the segregation unit are all evidence of this. The new governor was developing a six-month strategy with clear targets designed to deliver change, and had imposed minimum staffing levels in the week of our arrival to seek to ensure a better regime for prisoners. There was a very active and committed Board of Visitors. It is all the more important, therefore, to identify why what we found in February 2000 had failed to develop, and what should now be done to ensure that Scrubs is not trapped in a permanent cycle of promising initiatives that fail to take root.

Two interrelated factors seem to us to be fundamental. The first is the absence of closure in relation to allegations of violence against prisoners. The situation at Scrubs was unprecedented, and continuing: prison officers remained under investigation and

suspended officers had returned to work. Yet there had been no independent and published inquiry. Staff, prisoners, governors, the Board of Visitors and the Prison Service were all involved. All were free to make their own assumptions and draw their own conclusions about what had happened, why and how. This situation was corrosive. It undermined prisoners' confidence and the morale of good staff, gave other staff a reason, or excuse, not to engage with prisoners, and took up a large amount of management time. It led prisoners to believe that they could only expect to get redress through solicitors, not through the prison management. It also infected staff-management relationships and undermined attempts to negotiate improved regimes.

Secondly, and partly as a result, the management of the prison was dysfunctional. Management at Wormwood Scrubs had to eradicate a deep and resistant negative culture. There was clearly still resistance, from some staff and middle managers, to change and progression in the prison; and what was described to us as an 'anti-management culture'. In such a culture, senior managers need support, experience and time if they are not to be worn down by trench warfare on major and minor issues. This had not been the case at Wormwood Scrubs. The departure of nearly all the previous Senior Management Team earlier in the year had undermined continuity and stability. Active management was further weakened by the delegation of management of the very large wings to Principal Officers, who in many cases distrusted the skills and experience of the relatively inexperienced junior governors they reported to.

These problems were compounded by the constant struggle to keep going a regime for which staffing levels had not been agreed, and in the face of staff sickness and suspensions. The prison had lacked the necessary support and direction from Prison Service Headquarters to drive through agreements on appropriate staffing levels. As a result, managers were involved in day to day negotiation about what could be provided and how staff might be redeployed to provide it. Our analysis showed that in two working days, 30% of senior officers and 25% of officers had been cross-deployed and were working in areas with which they were unfamiliar. What prisoners

could expect varied from day to day and from wing to wing; managers unfamiliar with a wing depended heavily on basic grade staff for information and sometimes decisions. The absence of accurate monitoring meant that there was no way for senior management to check, let alone influence, real outcomes.

These management problems were clearly a major barrier to the development of a new culture and positive outcomes. More worryingly, they also created gaps through which we feared that the old culture could re-emerge.

There are two messages that we would like this report to send. The first is to the Home Secretary and Prison Service. As this report shows, the failure to establish, publicly and independently, what took place at Scrubs during the 1990s has severely hampered attempts to change the culture and regime there, or to establish whether there were underlying systemic problems which may need addressing in this, and other, prisons. For that reason, many of those involved in Scrubs, from the Board of Visitors to the POA, have supported the call for a public inquiry. I would like to stress that this inspection, thorough though it was, is no substitute for that: it is a snapshot of the prison as we found it in December 2001. This Inspectorate does not of itself have the powers or the mandate to investigate past events.

However, even a public inquiry, though it might eventually bring closure, would not undo the damage that has already been caused by inconclusive, long drawn out inquiries. We are aware that the Prison Service is now proactively examining allegations. But this is too little and too late. We suggest that there is the need to develop and to use mechanisms for carrying out transparent and independent investigations to report quickly on serious allegations, or incidents, which go to the heart of the running of a prison. Prisons are closed environments and it is vital that an independent and external spotlight is directed on them when something appears to have gone seriously wrong. We would invite the Home Secretary to consider how this might be achieved under existing powers, what additional powers might be required, and, in parallel, how to ensure that any police inquiries are conducted quickly, effectively and with perceived independence.

The second message is a more immediate one, for the Prison Service and prison. We suggest that some fundamental and urgent steps are necessary to secure a lasting change in Wormwood Scrubs' culture and regimes. First, there must be agreement on the staffing levels needed to allow the prison to deliver agreed regimes, and an acceptance by staff associations of the need to work flexibly, and with proper professional standards, in order to provide a decent and positive environment for prisoners. Secondly, the Governor and his senior management team need to develop their vision for the prison over the immediate and medium term, share this with all staff and require a commitment to it. Thirdly, the senior management team should be strengthened, with a greater number of experienced governors. Finally, and crucially, over the next two years, the management team should give priority to training, supporting and involving Principal and Senior Officers so that they are able and willing to deliver and own the new vision.

Anne Owers
HM Chief Inspector of Prisons

April 2002

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HEALTHY PRISON SUMMARY

1 This summary of Wormwood Scrubs' performance is measured against the model of the healthy prison that focuses on safety, respect, constructive activities and resettlement of prisoners. We have also included an assessment of management and staff matters.

2 In our view the recommendations contained in this Healthy Prison Summary should be implemented within six months of the publication of this inspection report. There should be a public statement by the Director General of the Prison Service when he considers that they have been achieved.

Test 1 - Prisoners are held in safety

3 We neither saw, nor were we told of, any instances of staff brutality during the inspection. Intimidation by staff was not part of normal life for prisoners as we observed it although the quality of relationships between staff and prisoners varied significantly between the residential units. Given the conviction of some officers and the continuing police investigations, staff were more wary of intervening, even where necessary for the safety of prisoners.

4 Some prisoners' perception was that residential units were safe. That view was not shared by many other prisoners, who felt unsafe at particular times on the wing. Newly arrived prisoners were not risk-assessed before cell allocations. First Night procedures were almost non-existent and some new prisoners were routinely and inappropriately located on the Segregation Block, the Vulnerable Prisoners unit and the Max Glatt Centre. Many prisoners were not receiving Induction.

5 Our overall assessment was that life for prisoners on residential wings was clearly not safe. Indeed responses to our prisoner questionnaire reinforced our findings that prisoners felt less safe now than in February 2000. Bullying was not being systemically tackled and staff were ignoring security information and written

information in prisoners' history sheets. There was no link between the work of the anti-bullying committee and the group that met to discuss suicide and self-harm. Staff were not patrolling areas where prisoners were likely to intimidate other prisoners or visiting staff, such as nurses. Owing to extensive periods when prisoners were confined to their cells, they used cell bells in order to get staff attention for everyday problems. This made it impossible for staff to distinguish between such instances and cases of real emergency.

6 Most incidents of self-harm had taken place in the Health Care Centre, which had no resident Listener. Some new prisoners arriving at the prison had been put there without any subsequent induction. A night inspection showed that some staff on night duty on residential wings did not know where the self-harm response kits were or how to use them. Night staff did not know basic fire safety precautions or fire emergency procedures.

Recommendations

- **Proper First Night arrangements should be provided for all new prisoners.**
- **All prisoners should be properly inducted soon after arrival, irrespective of where they are located.**
- **Effective anti-bullying measures should be put into place.**
- **All staff should have current training in suicide prevention.**

Test 2 - Prisoners are treated with respect as individuals

7 We were pleased with several aspects of respect paid to prisoners on first reception. The area was kept very clean and the team of reception staff were dedicated and very professional. There was a healthy banter and Listeners were on hand to provide additional support. On the other hand some processes which help prisoners to settle down had declined, particularly as far as prisoners receiving important information was concerned.

8 There were many discrete groups of prisoners, each requiring differences in regime and services. Of all the groups, life-sentenced prisoners probably received the most consistent regime. There was no obvious recognition of the needs of the large group of remand and unsentenced prisoners. All regime activities were affected by central detailing arrangements, though Minimum Staffing Levels had been imposed in the week of the inspection to try to guarantee certain minimum regime requirements.

9 Single cells continued to be used for two prisoners. Sanitary arrangements in these circumstances were completely inadequate. Prisoners were still expected to eat meals in these cells.

10 Time out of cell was even less than prisoners had experienced in 2000 and most prisoners spent no more than four hours out of their cells each day. Opportunities for daily exercise had been reduced with many prisoners being offered time in the fresh air on only two days a week. Daily association was not available to most prisoners; many only had association twice a week. However, the introduction of a “domestic” hour each day allowed prisoners to spend time out of cell and to take showers.

11 Superficial relationships between staff and prisoners remained satisfactory and staff displayed an easy manner that was evident in the atmosphere on most residential wings. However, many staff seemed to adopt a position of benign supervision rather than actively engaging or informally conversing with prisoners.

12 There was no Personal Officer scheme, although landing officers performed some of these tasks. The extent to which staff engaged with prisoners varied across residential wings. The new staff shift system and central detailing did not provide the framework for establishing regular and frequent contact and relationships with prisoners. The Request and Complaint procedures were often not understood and many prisoners did not trust the system.

13 Senior managers had recognised the need to make specific provision for the many foreign nationals. Until that materialised, life for these prisoners was even more difficult than for those who understood English. There was limited evidence of the establishment having embraced the concept of equal opportunities, race relations and diversity. Prisoners were not unlocked on time to attend religious services. There were proper arrangements to enable prisoners of all faiths to see their ministers of religion.

14 Health care services had deteriorated since our last inspection. The physical condition of in-patient wards was appalling and patient regimes, including those for people undergoing detoxification, were highly unsatisfactory. Patients with mental health problems did not receive proper attention.

15 The prison continued to provide good standard meals for prisoners but the serving of meals on the wings was not properly managed. The service provided by the Prison Shop was generally good but the arrangements to deliver orders needed improvement. Prisoners transferred to other prisons at short notice often never received the goods they had paid for in advance.

Recommendations

- **The Prison Service should inform policy and expedite implementation of relevant services for unsentenced prisoners, using the findings and recommendations in the thematic review ‘Unjust deserts’.**
- **Prisoners should have more constructive time out of cell and all prisoners should be offered daily exercise and daily association.**
- **A Personal Officer Scheme should be introduced.**
- **There should be a clear definition of “Foreign National” and these prisoners should receive additional support as required for their particular situation.**

- **All staff should receive training in understanding race relations and diversity.**
- **Health care services and specific needs for mental health patients should be urgently improved and should be consistent with National Health Service standards.**

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

16 As with many large local prisons, Wormwood Scrubs could not provide opportunities for purposeful activity for many of its prisoners. Even when activities were available in theory, staffing difficulties meant that they were either cancelled or reduced because prisoners were not brought to them on time. There was no reliable system to record regime activities.

17 The education department continued to provide classes for prisoners who had poor literacy and numeracy skills. There was insufficient in the curriculum for higher education or creative work. Prisoners who were not on the main residential wings did not have equal access to education.

18 The workshops were properly run. There was no formal strategy for developing and introducing National Vocational Qualification and key skills but the work and effort that went into the available certificated training was excellent. The Physical Education department continued to provide a good range of activities.

Recommendations

- **There should be a reliable and accurate system to record regime activities, the number of prisoners participating in each activity and any cancelled sessions.**
- **The education curriculum should be enriched.**

- **Courses leading to the award of National Vocational Qualifications should be developed.**
- **All prisoners should have the opportunity to have Physical Education.**

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

19 There was a continuing commitment towards providing arrangements outside the prison that would make visitors to prisoners at Wormwood Scrubs feel welcome. However, the closed visits area needed refurbishment and the booked visits system was still not providing a satisfactory level of service for visitors.

20 There was no resettlement strategy in place. Some prisoners being released from Wormwood Scrubs were given useful help to enable them to cope with their return to society but there were insufficient pre-release resources for all such prisoners. Pre-release arrangements were not co-ordinated. Staffing levels and the continual redeployment of Sentence Management Unit staff affected the completion of sentence plans.

21 The accredited Enhanced Thinking Skills programme had only recently received a reasonable rating. We were pleased that unaccredited work was also being carried out. Without a needs analysis, it was difficult to assess whether the offending behaviour work reflected the current need. Security risk assessment and public protection rules, where mandatory, were being undertaken.

22 Drug strategies were still in their infancy. 'On suspicion' testing was not systematically being undertaken. Patients undergoing detoxification on the wings

received little help and support. Work on substance use was another activity affected by staffing problems and the scheme to train officers as CARAT¹ wing liaison officers had not materialised.

Recommendations

- **Resettlement policies should be developed and implemented in response to the identified needs of each category of prisoner held at Wormwood Scrubs.**
- **All prisoners being discharged should be offered individual help and advice beforehand.**
- **Sentence plans should be relevant and should be completed on time.**
- **Relevant recommendations on the treatment of life sentence prisoners contained in the joint thematic report ‘Lifers’ by the Prison and Probation Inspectorates should be introduced.**
- **The Drug Strategy Group should ensure that it meets its targets for supply reduction.**

Management

23 Recent wholesale changes to the prison’s senior management team meant that it was suffering from a lack of continuity and stability at senior management level. There was very little shared recognition of or consensus on important issues and, therefore, no corporate vision for the short and medium term. Poor information systems did not reflect true achievements and concealed unacceptably low levels of regime provision.

24 A powerful culture still existed in which uniformed staff were wary of senior managers. There was confusion as to who ran the residential wings. Management

¹ Counselling, Assessment, Referral, Advice and Throughcare services – part of the Prison Service drug strategy.

supervision was poor. Existing staff shift systems had meant that the regime had become unpredictable for prisoners. Staff made decisions for managers, creating disparities in regime provision and timing of activities across the wings.

Consequently, activities such as association were cancelled with little notice to prisoners. Much of the prison's time was spent in daily crisis. Managing staff deployment was wearing down both staff and managers, as was the need to work additional hours just to provide basic services.

25 Overall, staff training within the prison was poor. In part, this resulted from the current staffing situation. The prison was failing to meet its mandatory training and staff development targets. Some Prison Service nursing staff were being used and paid for as agency cover. Staff found it difficult to detach themselves from the history of the allegations and investigations and many were anxious about possible future allegations.

Recommendations

- **The Governor should communicate his vision and focus for the prison as soon as possible to the Senior Management Team and to junior managers.**
- **A staff deployment system should be introduced, with sufficient staff to ensure that prisoners receive a healthy regime.**
- **Information should be accurately recorded and reported, and used as the basis for decisions.**
- **Principal Officers and Senior Officers should receive management training and should be given clear guidance on what is expected of them as residential wing and specialist managers.**
- **Managers should rigorously control the timing of regime activities. No task should be dropped without permission from the duty governor.**

- **Managers should more vigorously challenge and change any aspect of an intransigent staff culture by making overt management checks.**

BACKGROUND

Context

1 This unannounced inspection of Wormwood Scrubs fulfils the commitment made at the time of the publication of the last inspection report by Sir David Ramsbotham, the former Chief Inspector of Prisons², to return within approximately one year. Whereas the 1999 inspection had highlighted serious weaknesses, the 2000 report recorded the beginnings of a movement towards the creation of a new and more robust management team with a clearer vision for the future of the establishment. This appeared to promise the foundations of an improved regime for, and better treatment of, prisoners.

2 The overall purpose of this inspection in December 2001 was to see to what extent that promise had been realised. The tests for a healthy prison we applied were those published in the Chief Inspector's Annual Report for 2001 and are the criteria by which we assess the treatment of, and conditions for, prisoners. As far as possible judgements are based on the actual outcomes for prisoners although due recognition has also been given where the establishment had clearly made good progress towards the speedy implementation of processes that would likely result in positive outcomes.

3 It had been over two years since the Home Secretary told Parliament that Wormwood Scrubs must be restored to its proper status as an effective and healthy prison.

4 Apart from inspecting areas of life for prisoners, we conducted an analysis of prisoners' perceptions, the results of which can be found in an annex to this report. The analysis has been constructed in such a way as to provide comparisons between what prisoners told us on this inspection and what they had said in February 2000. For the first time as part of an unannounced inspection, we also interviewed staff on

² See the preface to *Her Majesty's Inspectorate of Prisons. Report of an Unannounced Inspection of HMP Wormwood Scrubs, 7 to 17 February 2000*, Home Office, London, 2000

residential wings, including Health Care, to discover their views on what it had meant to be working in the aftermath of proven cases of staff brutality, continuing police investigations and adverse published inspection reports. Our researchers interviewed 39 staff, including six Principal Officers and five Senior Officers and our findings are summarised in another annex to this report.

Considerations

The Effects of Police Investigations

5 The impact of the long period of police investigations and the trial of officers some of which resulted in imprisonment had stigmatised Wormwood Scrubs. It was publicly identified as a prison whose managers were not in control of their staff. The events of the past few years had proved extremely difficult for many staff, who felt ashamed to be identified with the actions of a small group of their peers.

6 Most wanted to put the whole event behind them but, as the long shadow of a new set of police investigations continued, morale and confidence had again been undermined. One consequence of this was the distance that we observed between staff and prisoners, with staff reluctant to intervene to enforce proper standards of behaviour and control, or to work positively with prisoners. Feelings of “when will it all end” had permeated all ranks and were crippling progress. To some extent uniformed staff had moved closer together in an attempt to survive the constant public gaze. They were, at the same time, trying to carry through some changes as well as stave off others that were required of them.

Staffing Issues

7 Although previous reports had identified a powerful largely negative staff culture, the introduction in early 2000 of a new staff deployment system was seen to give fresh opportunities for good industrial relations. But this system had not been running for even a year when, in December 2000, Prison Service Management Consultancy Services presented for consideration proposals for another system.

These proposals called for a significant reduction in uniform staff and, in anticipation of its implementation, the numbers of Officers and Senior Officers had been reduced.

8 At the time of the inspection this was having direct consequences for managing the prison and for prisoners themselves:

- regime activities were often cancelled and evening association periods were severely curtailed each week
- the overall number of prisoners who could be housed at Wormwood Scrubs had to be reduced. With a decision that there were not enough staff for E Wing and the upper landings of D Wing, this reduced the maximum number of prisoners able to be held by about 300. To help with the overcrowding in all prisons, a small portion of E Wing was “rented out” to the Kent Area Manager, who employed detached duty staff from Rochester to supervise prisoners from HMP Elmley
- there was a serious backlog of additional hours that had been worked voluntarily by uniformed staff that needed to be paid back. In order that this could happen, staff training was affected and regime activities for prisoners cancelled
- there were continuing problems with staff on long-term sick leave as well as until recently, 27 officers suspended from duty. Some of these had been allowed to return to normal duty. Special re-entry programmes had been provided to help them adjust to returning to work. The shortage of staff meant that absences were hard to provide cover for.

9 After protracted negotiation with local union representatives, the new staff deployment systems were still without a date for introduction. Consequently, the Governor had decided to impose minimum staffing levels, whereby staff could be compelled to attend duty in order to ensure that certain essential components of the regime could take place. This action had only just started at the time of the inspection but it was beginning to provide some welcome continuity for prisoner regime activities.

Prisoner Population

10 The size of the prisoner population had risen over the previous 18 months from 639 to nearly 1,000 prisoners. This increase had created a new dimension to managing the establishment. Large local prisons often have different characteristics than small or medium-sized local prisons. The systems and services required to deal with large numbers of prisoners often undermine the individual attention that prisoners receive in smaller establishments. Communication links between senior managers and staff become stretched. Changes become more difficult to carry out and managers have to work very hard to ensure that there is effective communication between themselves and their staff and between different departments.

11 Wormwood Scrubs had an unusually high proportion of Foreign Nationals (439), comprising 44% of the total prisoner population. Many had been arrested at Heathrow Airport and transferred, via Uckfield Magistrates Court, to await trial or serve a sentence. Foreign Nationals, especially those who do not understand any English, require time and resources. Apart from the difficulties in communication, there is the need to provide a range of services to people from diverse cultural backgrounds.

Management

12 The Governor had been in post for six months, the Deputy Governor had been appointed two months earlier and many senior managers were new. The Governor had decided that Principal Officers should run residential wings. Senior managers each had responsibilities for several areas. A new manager for health care had been appointed. A published strategic plan had placed the creation of a healthy prison as an important priority. Wormwood Scrubs faced an audit of its performance against Prison Service standards within the next three months.

13 Staff cuts during the 2000-2001 financial year had already provided the savings demanded by Prison Service headquarters. The Governor was expected to find savings of £300,000 from his budget for the next financial year. No decisions had been taken about how to do this; managers and staff believed that any further cuts

would inevitably reduce regime services for prisoners. Staff regarded these cuts as a failure by Prison Service headquarters to assess the needs of Wormwood Scrubs at a time of change and to recognise the particular stress that staff were experiencing.

CHAPTER ONE

ARRIVAL IN CUSTODY

Reception

1.01 The importance of the safe introduction of prisoners into custody is properly summed up in the World Health Organisation statement: “Reception of a person into any type of prison can be a traumatic and frightening experience – even where a prisoner has simply been moved from another prison. The reception area and procedures should be organised in such a way as to minimise mental distress. Wherever possible, facilities should be provided to enable prisoners to make early contact with their families. Experience has indicated a particularly high risk of suicide in the first month that a prisoner spends in a new prison, with heightened risk during the first days. Reception staff should be trained to detect signs of mental illness and acute distress and to take appropriate action”.

1.02 When we returned to Wormwood Scrubs for this inspection, we found that many of the factors listed above had been considered in planning for an improved reception service. All the specialist Reception staff, the Principal Officer, Senior Officers and Officers worked hard, with staff from Securicor and other escorting companies, to provide a safe environment. Despite the pressures of having to process high numbers of prisoners, who were constantly arriving and leaving, staff were striving to provide a consistently good service. Their efforts were undermined by the need to use staff from other departments and residential units to supplement or replace reception staff whenever necessary, which proved to be often. Other staff understandably had little or no grasp of the importance of reception processes. In consequence, the treatment of prisoners passing through reception largely depended on which staff they met.

1.03 The effects of this discontinuity were evident to inspectors. Initiatives that we had identified in the previous inspection had either been weakened or fallen into disuse. For example, not all prisoners received the excellent briefing sheet, which explained in detail what prisoners should expect from the time of leaving court to arrival on their wings. Sixty-three per cent of respondents to our prisoner questionnaire had not received any written or spoken information. Further, where before the information had been in various languages, the briefing sheet was now available only in English. We found that senior staff, unaccustomed to working in reception and lacking knowledge of its systems and routines, were unable to use the computer systems.

1.04 We inspected many of the escorting cellular vans from different companies. Each compartment we saw was spotless and in good condition, regardless of the distance travelled. Vans used for court escorts had slippery seats, unlike the fabric seats used for longer journeys. Prisoners expressed concern about the lack of seat belts in these vehicles. We observed prisoners' progress from the vans and into reception, which continued to be a busy unit.

1.05 Our prisoner questionnaire showed that:

- 39% said that they were treated well or very well in reception
- 34% said neither well nor badly
- 14% said badly, and
- 8% said very badly.

1.06 Unlike the previous inspection, prisoners were no longer made to stand behind a yellow line. In general, there was a good atmosphere with prisoners and officers exchanging some banter while reception procedures were carried out. On one evening there had been 66 arrivals, of which 15 were new to imprisonment. There were often as many as 20 new prisoners arriving on an evening. We noted that prisoners were not always asked whether this was their first time in prison. This was reflected in the prisoner questionnaire, which showed that a third of respondents new to prison had not been asked this question.

1.07 Undoubtedly the group that suffered most from untrained reception staff were prisoners who understood or spoke little or no English. Many of them arrived at the prison direct from court and from Heathrow airport. We observed one such batch from Heathrow, who arrived, confused and frightened, shivering in short-sleeved shirts on a cold December evening. We were not confident that sufficient attempts were made to reassure and calm these men.

1.08 A Prison Reform Trust leaflet provided some information about prisons in 15 dialects or languages but this was not specific to Wormwood Scrubs nor was it relevant to arrival in prison. There were some excellent “Translation for Reception” questionnaires produced some while ago by the Race Relations Liaison Officer at Canterbury and available in 27 languages. On one night we observed, none of the staff working in reception knew where these questionnaires were. This did not happen when regular reception staff were on duty, when translations were readily available.

1.09 The language cassette tapes mentioned in our last report were no longer in evidence. We asked staff several times where these cassettes were. They found them eventually. Tapes were available in 42 languages and dialects. The next hurdle was locating the single cassette player. When it was found, it had no batteries or a battery cover and had clearly not been used for some time. The reason given was that the batteries were needed for the camera used in reception.

1.10 We were given numerous definitions of how, at Wormwood Scrubs, a prisoner was categorised on the computer as a Foreign National. We have found at many other prisons that a definition attributed to Foreign Nationals by the first receiving prison can often be misleading. Inaccurate recording at the outset will waste a great deal of time later. It will affect or delay an accurate assessment of the prisoner’s language and cultural needs at subsequent prisons.

1.11 Arrangements for handling and recording prisoners' personal property were good and storage procedures were explained. An impressive and vast area housed all the various suitcases, musical instruments and other possessions regularly accompanying prisoners arriving at Wormwood Scrubs.

1.12 In spite of heavy use, the entire reception area was clean. All the rubbish from prisoners passing through and food being eaten in the holding rooms was regularly and thoroughly cleaned up. The reception cleaners clearly took great pride in their work.

1.13 During our inspection, 39% of prisoners were in reception for more than three hours. The holding rooms varied as to how much information was available. Some contained posters in many languages, including information about anti-bullying policies, drug services, The Samaritans, the Listener scheme and race relations. Other rooms were not so well endowed and there was little to occupy prisoners during waiting times. No rooms had informative videos that prisoners could watch or magazines, newspapers or paperbacks to read. Many prisons find several organisations and people associated with their prison who are happy to provide this sort of material.

1.14 According to their category and status, prisoners were held in different holding rooms. Vulnerable prisoners were kept separate and new arrivals were separated from those returning from courts or transferring from other prisons. We saw tactful and careful procedures for prisoners who were alleged to have or had been involved in offences against children.

1.15 Although we were told that all new prisoners were offered a phonecard, in practice we found that this depended on who was on duty. Fifty-four percent of prisoners in our questionnaire survey said that they were given an opportunity to make a telephone call, compared with sixty-three per cent at the last inspection. Although showers were available in reception, they were not used often. Our recommendation

to provide modesty clothing had been implemented and towelling bathrobes were provided to prisoners after they had been strip-searched.

1.16 The arrangements for providing and serving meals in reception had considerably improved since the last inspection and late arrivals were offered meals freshly cooked in the reception microwave. Meal choices included vegetarian and Halal options. Prisoners serving food in reception had all received training in basic food handling.

1.17 We were pleased to find that Listeners were still on duty in reception and the two working there took great pride in their work and their Listener training. Their first language was Spanish and they spoke excellent English. We saw them putting many prisoners at ease, reassuring them about what was going to happen to them. They were easily identifiable by their Listener sweatshirts, which they wore with pride. They were approachable and had responsibility for handing out clothes as well serving meals in reception. They specifically watched for anyone looking frightened or vulnerable and often alerted officers or the health care staff. A separate Listeners' room was available if necessary. In spite of the excellent work of the Listeners, staff needed to be vigilant and there were ligature points in the holding rooms and shower areas.

Conclusions

1.18 We found that the team of reception-based officers working in reception were dedicated and very professional and took great pride in their work. Other officers who were equally committed but had not been reception-trained and did not often work in reception sometimes undermined this good work. Reception was considerably cleaner than at our previous inspection and meal arrangements had improved. Respect and consideration were evident in the continued presence of Listeners and the removal of unnecessary barriers to interaction with prisoners. On the other hand, there had been a diminished provision in the reception process. Staff were no longer regularly providing briefing sheets to help first-time prisoners through this difficult period. Hours spent in holding rooms were devoid of stimulation, men

new to prison were not being identified and offers of a telephone call had dropped considerably. Previous arrangements for prisoners without English had all but fallen into disuse.

Recommendations

- 1.19 The number of reception-based and reception-trained officers should be increased.**
- 1.20 The explanatory briefing sheet should be reinstated and provided in as many languages as necessary.**
- 1.21 Consideration should be given to installing and wearing seat belts in cellular vans.**
- 1.22 There should be proper arrangements to identify people who had not been in prison before.**
- 1.23 All staff working in reception should have race relations training.**
- 1.24 Almost all translated material should be easily accessible and all officers working in reception should know about and use them.**
- 1.25 Several working cassette players should be available in reception.**
- 1.26 There should be one set of definitions of a Foreign National and it should be used consistently across departments in Wormwood Scrubs and throughout the Prison Service.**
- 1.27 Information taken at reception should include a prisoner's first language and, where relevant, whether communication in English is possible.**

- 1.28 **Information should be displayed in all reception holding rooms in the languages identified most often as the first language of prisoners arriving at Wormwood Scrubs.**
- 1.29 **Consideration should be given to providing reading material in English and other languages in the holding rooms in reception. This could be supplemented with video information about reception and other prison procedures.**
- 1.30 **All newly-arrived prisoners should be automatically offered a phonecard. Arrangements for Foreign Nationals should be made to enable them to contact their families overseas soon after arrival in the prison.**
- 1.31 **Ligature points in the holding rooms and shower areas in reception should be assessed as soon as possible.**

First Night Arrangements

1.32 It is very important that new prisoners receive enough information about the details of prison life, and especially about their first 24 hours. This enables them to adjust to and cope with custody, and helps staff detect problems and provide the necessary support. We believe that, for many prisoners, resettlement begins at reception. Our inspection in March 1999 found inadequate arrangements for prisoners spending their first night in Wormwood Scrubs.

1.33 During the weeks of this inspection, a new First Night Officer (Induction Officer) system started. In this, the officer arrived in reception to greet newly-arrived prisoners, explained what would happen to them and where they would be located. We observed one session, in which the officer used a simple list of questions as a prompt. The interview was conducted in a quiet room; it was well paced, handled with sensitivity and allowed the opportunity for the prisoner to raise any concerns he had. This was also an opportunity to ensure that prisoners received a telephone card. It was proposed to issue an induction pack as part of the reception process; this would

begin shortly. Prisoners were given a notepad and pen. The initial assessment by the First Night Officer was ultimately attached to the prisoner's history sheet.

1.34 There was some duplication of questioning of the prisoner between the Reception officer and the First Night Officer. One prisoner had already been issued with a telephone card from a Reception officer. The principle of First Night Assessment was a good one but staff were not available to conduct this interview. On some evenings during the Inspection, they had been diverted to other tasks.

1.35 In addition to the First Night Assessment, a "First Night Cell Occupancy Risk Assessment" form had been introduced about three months previously. Reception and health care staff would complete these. The Orderly Officer would make a final decision on the best location for a prisoner. The use of these risk assessment forms was not widely known among staff on the wings and the forms themselves were filed in reception.

1.36 In February 2000, we found that prisoners had effectively been abandoned without being properly introduced to their surroundings and with little or no idea what was expected of them. There were plans, which had then only just been implemented, to hold all new receptions in specially designated induction cells for their first night. These plans were unsatisfactory. Not all prisoners had been located in these cells nor had they seen the new information booklet kept in their. Further, only one prisoner had been spoken to by officers on the wing before being locked up.

1.37 Nearly two years later, First Night procedures were non-existent or worse than last time. Some new prisoners were routinely and inappropriately located on the Segregation Unit, the Vulnerable Prisoner Unit and in the Max Glatt Centre. The last provided group psychotherapy to personality disordered prisoners. All these locations were unsuitable. The inherent dangers of isolating prisoners in segregation cells cannot be overstated.

1.38 We spoke to many prisoners after their first night in custody. Those placed in the Segregation Unit said that these cells were particularly bare and many had felt very frightened. Some commented that they had heard prisoners being brought down there under restraint which they found intimidating. Even prisoners who were used to prison felt frightened.

1.39 Foreign Nationals were particularly vulnerable. Most did not speak English. Possible experience or knowledge of incarceration in other countries may have made those first nights at Wormwood Scrubs terrifying. Night patrol staff on all wings were not routinely told, nor did any of them know, who the new prisoners were or where they were located.

1.40 Our prisoner questionnaire showed that 34% of prisoners did not feel safe on their first night in Wormwood Scrubs. The questionnaire also revealed that 44% did not know what was going to happen to them on their first day or night (compared to 32% of prisoners in 2000). Prisoners were asked: “Did you feel safe on your first night here?”. Their responses were:

Wormwood Scrubs 2001 (n=110)

Yes	58% (n=64)
No	34% (n=37)
Yes and No	1% (n=1)
Missing information	7% (n=8)

1.41 Of those claiming to feel safe and giving reasons for this (n=45) these were having been in prison before and knowing the routine (n=9), being locked up (n=6), having a good cellmate (n=5), staff being helpful (n=2), knowing people already (n=2), being on the Max Glatt unit (n=2). Other reasons were signs on the wall, cleanliness of the prison, the atmosphere on D wing, having a TV and being on the VP wing.

1.42 Of those claiming to feel unsafe and providing reasons (n=34), these were not knowing what to expect (n=6), Reception staff being unhelpful/frightening (n=4), first time in prison (n=4), heard stories/prison reputation (n=3), health problems (n=2), being worried about cellmate (n=2). Other reasons included: feeling unsafe, being in shock, being on detox, being beaten up, being black, being scared of other prisoners and spending several days on D wing (now on different wing).

1.43 Prisoners also spoke about the morning after their first night in prison. They had nothing to do and there was no reading material or any writing implements.

1.44 We met one prisoner who had not been in prison before. His first night in prison was spent on the Segregation Unit and he remained there over the weekend. During this time, he had been brought to B Wing for a 20-minute exercise period. He talked of additional problems – his telephone card had been stolen in Reception and he was told to sort this out once he was located on his residential wing. Wing staff had told him that reception staff should resolve the problem. In the interim, he had not been able to contact his family. Matters such as this should have been resolved that night or the following day. Such an example illustrates how the work of residential staff and Induction staff is central to the well-being of prisoners during their first few days in custody.

Conclusions

1.45 We are at a loss to know why the establishment had so clearly failed to make proper provision for prisoners, especially those new to prison, on their first night there. The new First Night Officer scheme had yet to get off the ground. Even in its infancy, there were signs that its future depended on whether there was sufficient commitment from staff and managers to make it work. In our estimation, not only were there no proper arrangements but the locations in which some prisoners were housed were positively dangerous. The proposed solution for induction cells had hardly materialised. Many staff continued in their failure to recognise, or to care about, the effect of imprisonment on many of these individuals.

Recommendations

1.46 **Immediate steps should be taken to provide proper First Night arrangements. These should include close management of the First Night Officer system through its initial implementation and the issue of a First Night Pack to all new prisoners.**

- 1.47 **Risk Assessment Forms should be attached to Personal History sheets and they should be held on the wing.**
- 1.48 **The use of inappropriate and possibly unsafe locations for first night prisoners should cease immediately.**
- 1.49 **In the interim, wing managers and their staff should make it their responsibility to speak to all prisoners arriving on the residential unit and to deal with any immediate problems raised by them.**
- 1.50 **Night staff on all residential units must know whether any prisoners were spending their first few nights in custody and in which cells they had been placed.**
- 1.51 **All prisoners should be provided with writing material and some reading material in English and other languages, to help them through their first night in custody.**

Induction

1.52 At the time of the last inspection, a two-stage Induction process was in place. Stage 1 on A Wing was for all prisoners entering the establishment. Stage 2, held on B Wing, lasted two days and catered for the needs of newly-sentenced prisoners. The Induction programme was generally sound. We suggested ways it could be improved so that all prisoners received induction, regardless of where they were located. We recommended more frequent delivery, so that any sessions missed by prisoners could be picked up later. There should be proper arrangements to ensure that prisoners without English could follow the programme. The process should involve other departments within the prison.

1.53 At the time of this inspection, B Wing had recently been designated as the Induction wing. There were six Induction Officers, who were responsible for conducting a first night assessment and delivering a one-day induction programme.

We were told that two officers each day were detailed for Induction and one for evening duty. Only two officers had received external training in Induction. The remainder had to learn from their colleagues over a short period.

1.54 Not all new receptions were immediately located on B Wing; many prisoners therefore would not receive any formal induction. This was undoubtedly so for lifers, who were assigned to D Wing. They had a 15-minute induction board in which they were introduced to some of the prison staff who would be working with them, including probation, psychology and education. Life-sentenced prisoners need a formalised induction. This enables them to start to come to terms with their sentence, understand the significance of a life sentence, understand wing routines and start the planning process.

1.55 There were agreed procedures in which new receptions located on A Wing attended B Wing for Induction. Compliance with this procedure could be described as erratic at best and non-existent at worst. We spoke to many such prisoners on A Wing who had not been to B Wing nor received any form of formal induction. They had been given very little information about daily routines or opportunities within the establishment. They received no general information to enable them to have a picture of what would happen to them during their time at Wormwood Scrubs. Many prisoners said that they gained most of their information from other prisoners or by asking an officer. One prisoner said “It’s not so bad if you’ve been in prison before, but first timers are lost, you get told nothing here”. Life-sentenced prisoners on A Wing said, “they assume that because you’ve been in prison a long time that you know everything there is to know, but all prisons are different; and we need certain things in writing so that we know what goes on”.

1.56 We found that it was only possible to start using B Wing for induction once discharges to court and other prisons had been concluded. By this time, many new prisoners were moved on to other wings. Prisoners not on B Wing for their first night were meant to find their way to the Induction wing during “free-flow”. Officers told

us that, in practice, by the time those going to education, work and legal visits had been unlocked, it was too late to find these new prisoners and direct them to B Wing.

1.57 The extent to which prisoners were not being inducted into the prison was evident in figures covering three months before this inspection. Between August and October 2001, there had been 946 new arrivals. Of these, only 27.3% had received the full one-day induction; 26.3% had received part induction (this excluded the personal risk assessment) and 39.8% had received no Induction at all. Our prisoner questionnaire reinforced these findings with 48% of respondents saying that they had received no Induction. We met one prisoner identified as being at risk of self-harm who had been in the prison ten days without being on the Induction programme.

1.58 We observed one morning session of the Induction programme at which only three prisoners were present. This session had not run every day throughout the Inspection. The session, delivered by an Officer, was done from a set of prepared slides reproduced on paper that covered a range of services available in the prison. A lot of information was given to prisoners in a short period and they had been issued with a notepad and pen. The session was delivered with confidence and patience and the Officer was prepared to take questions and to listen to prisoners.

1.59 One prisoner was finding it difficult to concentrate. Many new arrivals will find the first few days tiring and arduous, not least because of the stress of being in prison. They may have had a sleepless night or be suffering from withdrawal from substances. The Officer was not sure which staff from other departments would be attending the session but was expecting representatives from CARATs, Chaplaincy, Bail Information, Citizens Advice Bureau and Listeners. In that respect, our previous recommendation that all departments regularly attend induction sessions, was still not being met. There were handouts, which prisoners could take from the session. As part of the induction, prisoners were called up to complete an education assessment.

1.60 In the afternoon session of the Induction day, an Induction Officer saw participants individually. He shared an office with the Bail Information Officer. At

this meeting, an 'Induction and Needs Assessment' was completed. It was comprehensive and provided prisoners with an opportunity to raise concerns. Prisoners were also given an opportunity to make a telephone call if required. At the interview we observed, the officer was arranging a call for a Foreign National prisoner.

1.61 It was entirely inappropriate that the Induction Officer and Bail Information Officer should have to conduct simultaneous interviews with individual prisoners in the same small office (previously a cell). We also found that, because of training and other commitments, the Bail Information Officer could not see all prisoners who needed help and, mostly, urgent advice on getting bail.

1.62 Responding to the needs of prisoners who could not speak English was a problem and should not be underestimated. Some induction information had been translated in to other European languages. Induction information had been translated into sixteen languages with the help of the embassies in London and was soon to be made available to B wing. Encouragement had recently been given to the use of Language Line by the Foreign Nationals Governor, but it was still generally believed to be too expensive and its use had been very limited. Some staff had compiled a list of prisoners who would be available to assist as translators, although one wing manager expressed concern over the accuracy of the translation. There was also a list of staff who spoke another language. One manager described the prison as 'managing on a wing and prayer'.

1.63 The one-day Induction programme gave too little time in which to assess prisoners. Many would not have assimilated the information over such a short period, through shock, drug withdrawal or language problems. Prisoners may not immediately divulge problems during the individual risk assessment meeting. Following this period, some prisoners may be ready to move on from Induction and will be conversant with the prison routine. Although a prisoner may have been in prison before, there should not be an assumption that he will cope. The assessment process is essential to establishing the readiness of prisoners to move on to normal

location. Staff involved were concerned that Induction was not given the priority it required and would be one of the first tasks to be dropped to cover other duties.

Conclusions

1.64 Many prisoners were not receiving Induction. A one-day programme, which included some risk assessment, was not long enough to make judgements on whether prisoners were settling in. The promising start made to Induction during our last inspection had not been sustained. If anything, matters had slipped and staff were being moved to other duties, making any catching up exercise an impossible task. Participating departments were still not regularly attending Induction sessions and there was little or no provision for prisoners who did not speak English. This was yet another initiative that had failed to deliver.

Recommendations

- 1.65 **Staff should be trained to work as Induction Officers.**
- 1.66 **Life-sentenced prisoners should be given a formal induction course.**
- 1.67 **All prisoners should be properly inducted, irrespective of where they are located and soon after arrival.**
- 1.68 **The prison should consider giving the Bail Information Officers their own office.**
- 1.69 **Efforts should be made to ensure that Bail Information Officers see all potential candidates for bail.**
- 1.70 **We repeat the recommendation that more care should be taken during induction training to ensure that prisoners who do not speak English can understand what is going on.**

- 1.71 **Consideration should be given to extending Induction for at least two days during which time prisoners should be closely observed.**
- 1.72 **Induction staff should not be put to other duties.**
- 1.73 **The prison should seek the advice and assistance of the Safer Custody Group in developing a model for the Reception, First Night and Induction of prisoners.**

CHAPTER TWO

RESIDENTIAL UNITS

Introduction

2.01 There were five residential wings at Wormwood Scrubs. In this chapter, we treat them as one for the purposes of describing the accommodation, facilities and life on the wings. The Vulnerable Prisoner Unit on B Wing has its own section within this chapter, as does any provision special to life-sentenced prisoners. There is also a separate section on Foreign Nationals and Detainees. Induction on B Wing has been separately described in Chapter One.

2.02 Since our last inspection, there had been a change in the types of prisoner being held on most of the wings.

2.03 A Wing had previously held mainly remand prisoners but now contained convicted and sentenced prisoners. Its operational capacity was 279. On the first day of this inspection, it housed 272 prisoners, of whom 213 were sentenced and 43 were remand prisoners. It also held ten life-sentenced prisoners, one civil prisoner³ and five detainees. Of its current number of prisoners, 143 were Foreign Nationals. There was a rapid turnover of prisoners on A Wing of between 12 and 30 prisoners a day, being either transferred or discharged together with an equivalent number of new receptions.

2.04 B Wing had previously held sentenced prisoners and had recently been designated as the Induction wing. Although it could house a maximum of 173 places, this had been reduced to 169 at the time of the inspection. This was because the wing had four prisoners who were on the escape list and who had to be housed in single

³ A civil prisoner is someone imprisoned for a civil offence, such as the non-payment of fines

cells. The prisoner population on B Wing comprised 101 remands or trials, 27 convicted or sentenced and 33 detainees. Foreign Nationals made up 60% of this population.

2.05 C Wing had held Category C sentenced prisoners but now contained a mixture of sentenced, remand and lifer prisoners, and detainees. The maximum number that could be accommodated here was 262 and the wing was fully occupied during this inspection.

2.06 D Wing was being refurbished at the time of our last inspection but had reopened to hold first stage lifer prisoners. There were 165, of which 111 were mandatory, 8 were discretionary, 44 were Section 2 automatic and 2 were recalls.

2.07 E Wing had previously held the lifer population. Once this had moved to D Wing, E Wing had been closed because of insufficient staff. When HMP Downview became a women's prison, E Wing accommodated several of Downview's male prisoners during August and September 2001. At the time of this inspection, E Wing had 54 Category C sentenced prisoners, comprising 39 overspill prisoners from HMP Elmley and 15 prisoners from Wormwood Scrubs itself. The wing was staffed not by officers from Wormwood Scrubs, but by two teams of officers from HMP Rochester. It was expected that E Wing would offer temporary accommodation to prisoners from HMP Belmarsh, from February 2002. Any remaining prisoners on E Wing would be transferred to other establishments or absorbed into other wings at Wormwood Scrubs.

Cells

2.08 All wings had a mixture of single and double cells, the ratios of each type varying across the wings. A Wing and B Wing had mostly double cells, D Wing and E Wing had single cells and C Wing had 70 single and 96 double cells.

2.09 There were a few cells used for single occupancy on the first landing of A Wing; these were designated for life-sentenced prisoners. There were plans to move

the life-sentenced prisoners and use these single cells for prisoners with an assessed need or as part of the Incentives and Earned Privileges Scheme. Some single cells were being used as double cells by the simple addition of bunk beds. The ground floor of C Wing housed a wheelchair-bound prisoner and a prisoner on the 2s landing was deaf. Staff ensured that wing arrangements took account of the needs of these prisoners.

2.10 All cells had their own sanitation and television sets. Some double cells had *en suite* toilets, while others had a rudimentary arrangement for privacy using a shower curtain. The quality of cell furniture varied, but mostly consisted of a small storage cupboard for clothes and personal possessions, a small table and two chairs. The space for two prisoners required to eat in their cells was very restricted. D Wing had recently been refurbished and, at the time of inspection, only three landings were in use. All cells were equipped with wash basin, toilet, table, bed, chair, two lockers, a double electric socket and a television. Cells were personalised, there was sensible use of volumetric control and prisoners were allowed in-cell hobbies and handicrafts. Some prisoners on B Wing complained that their cells were cold.

2.11 There was scant information displayed on most wing notice boards and it was presented only in English. There was, for example, no information about the complaints procedure or about the Assisted Prison Visits Scheme. On B Wing, most of the landing notice boards were tidy and contained appropriate information but some thought should be given to which notices should take prominence. There was no written policy at Wormwood Scrubs covering the display of offensive materials. Consequently, there was the potential for prisoners and staff to exercise wide discretion. There was no policy on smoking in the prison or on the wing and staff were openly smoking on the landings.

Conclusions

2.12 Single cells continued to be used for two prisoners and sanitary arrangements in these circumstances were highly inadequate.

Recommendations

- 2.13 **Cells designed for one occupant should not be used as double cells.**
- 2.14 **Prisoners who share a cell should have toilet facilities that are fully screened.**
- 2.15 **There should be a clear policy on offensive displays, applied across the wings.**
- 2.16 **A smoking policy on residential wings for both prisoners and for staff should be drawn up and implemented.**

Hygiene

2.17 The overall standards of cell cleanness were adequate, although individual cell cleanness varied considerably and some cells had graffiti on their walls. Cleanness in communal areas also varied across the wings. On A Wing, cleaners kept the communal areas on the landings immaculate. On C Wing, communal areas could have been cleaner. Kitchen servery workers told us that after the meal had been served they were locked in cell. They then had to wait until they were unlocked, sometimes two hours later, in order to clean the servery. The top floor of E Wing was locked and unused. The rest of E Wing was not kept clean enough. Communal shower and toilet areas were littered with paper and empty toiletry bottles. The drinking fountain on the ground floor was filthy.

2.18 Prisoners on these wings could have daily showers during association times and the 'domestics' sessions. These periods were rarely cancelled and prisoners confirmed their availability. A Wing had between 8 and 16 showers on each landing and prisoners told us that there were rarely any queues for showers. We were told that the baths on A Wing were unusable. Consequently, they had not been cleaned for some time and were in an appalling state. Some prisoners would prefer to have the option of a bath.

2.19 On D Wing, each landing had six showers and six baths. The condition of shower and toilet recesses was not always good. In E Wing, the ceilings in these areas were flaking. Many prisoners told us the temperature of these showers was either too hot or too cold. Leaking pipes had resulted in a build up of mineral deposits over some of them.

2.20 Kit change took place at least once a week and prisoners' clothing generally appeared to be clean. There were particular problems for A Wing prisoners. Many items of their kit were in poor condition and had been modified by the prisoners. For example, some tracksuit bottoms had been crudely cut off below the knee. We were assured by managers that a supply of new kit was on order. Some A Wing prisoners felt that the quantity of kit was meagre. We were told by these prisoners that they were sometimes required to change their kit at the point of exchange, on the landing. This was to prevent them from collecting some kit, going back to their cells and then returning to collect more, thus accumulating more than their kit entitlement.

2.21 Bed linen in the cells we saw appeared clean and in a reasonable condition, although some mattresses were in need of replacement. Prisoners could change their sheets each week. Residential units had wing laundries and orderlies were employed to wash and dry prisoners' clothes. Prisoners on D Wing could wear their own clothes. On E Wing, the laundry could be used quickly and regularly because of the low number of prisoners. The equipment itself on all wings was in various states of disrepair. For example, on C Wing, two of its three washing machines were out of order and, until recently, one dryer had been inoperable.

2.22 The facilities list indicated that personal washing could be done in the wing laundry. We found this did not apply to remand prisoners. For those who had visitors, clothes could be handed out for exchange during the week but not at weekends. Remand prisoners who had no visits needed somewhere to wash their own clothes. Many purchased washing powder and hand-washed their clothes in their cells. This was an unsatisfactory and inequitable arrangement.

2.23 On reception, prisoners received a hygiene pack that contained basic items. Replacements could be obtained from cleaners on the wing who kept stocks in their cells. We commented on this in our last report. On A Wing, access to cleaning materials depended on the goodwill of individual officers. Delays were attributed to staff having insufficient time to deal with what were routine wing matters.

Conclusions

2.24 The standards of cleanliness in cells and in communal areas varied across the wings and within the wings. On some, prisoners had difficulty in getting cleaning materials. Most prisoners had daily showers and could change their clothes every week. The amount of prison clothing issued to prisoners was not necessarily seen by them as sufficient. Wing laundries were well used, although remand prisoners were excluded from this facility.

Recommendations

- 2.25 **The standards of cleanliness on all wings should be improved and cleaning schedules should be adhered to.**
- 2.26 **Consideration should be given to making the baths on A Wing functional again or otherwise taking them out.**
- 2.27 **The shower recesses on E Wing should be renovated. All wing shower units should be repaired as required and regularly maintained.**
- 2.28 **The amount of clothing issued to prisoners should be adequate for their use and should fit them properly.**
- 2.29 **Remand prisoners should be allowed to use the wing laundry.**
- 2.30 **Cleaning equipment should not be stored in wing cleaners' cells.**

2.31 **Prisoners should be encouraged to keep their cells clean and they should be regularly provided with cleaning materials.**

Time out of cell

2.32 The regularity and timing of wing routines and other wing activities depended almost entirely on Minimum Staffing Levels (MSLs). The new Governor had imposed MSLs in the week of our inspection, in order to ensure that certain minimum essential components of the regime could be delivered. (See also the chapter on Management). Without exception, there was no residential unit that provided prisoners with at least ten hours out of cell. Prisoners who were unemployed spent most of their time locked up. On days when there was no association, this amounted to 21 hours.

2.33 We examined one day on A Wing and found that 78 prisoners had gone to education or to work and 20 had attended a one-hour session at the gymnasium. There were 32 wing cleaners and orderlies. The remaining 160 prisoners were unemployed.

2.34 On B Wing, 76 prisoners were at education or work and 21 were away from the wing on visits. There were 30 wing cleaners and orderlies. The remaining 26 prisoners were unemployed.

2.35 There was no access to programmes, workshops or education for the Elmley prisoners on E Wing. Although we were told that the Wormwood Scrubs' prisoners had jobs, these were cleaner or orderly jobs. Time out of cell was less at weekends, as there was no evening association allowed on Saturday and Sunday. For prisoners on E Wing, this confined them to their cells for a period of 16 hours on these two nights.

2.36 The table below compares the prisoners' responses to the questions in our questionnaire for this inspection and the previous one on how much time they spend out of their cell.

Year	Weekday (On any one day)		Weekend (On any one day)	
	Up to 4 hours	4 to 8 hours	Up to 4 hours	4 to 8 hours
February 2000	17%	35%	35%	53%
December 2001	44%	26%	50%	24%

Conclusions

2.37 Most prisoners spent much of their day locked up in cell. Even those who had some purposeful activity still spent far too long in cell. Time out of cell was even less than prisoners experienced in February 2000.

Recommendations

2.38 **Prisoners should have the opportunity of spending at least ten hours out of cell each day on relevant constructive activity.**

Exercise

2.39 Generally, most prisoners received outdoor exercise every day unless the weather prohibited it. Any decisions to cancel exercise periods were authorised by a senior manager. Prisoners were not supplied with weatherproof clothing and shoes. B Wing prisoners received afternoon exercise for 45 minutes.

2.40 The exercise yard was an uninspiring tarmac area in which prisoners walked round and round or conversed with prisoners on exercise in the adjoining yard. It was no surprise therefore, that most prisoners chose to remain on the wing. On C Wing, there was no system in place to record any cancellations of exercise and association periods. E Wing prisoners who declined exercise were locked in their cells.

2.41 The table below compares the prisoners' responses to the question in our questionnaire on how many times a week they went out for exercise. Some prisoners in these replies may have been offered the chance for exercise but had declined it:

Year	Up to twice a week	3 to 5 times a week	6 or more times a week
February 2000	12%	3%	83%
December 2001	39%	22%	31%

Conclusions

2.42 There were regular exercise periods every day. No records were kept of cancelled sessions, so there was no way of telling how often this occurred. Although most prisoners said that cancellations were rare, the opportunities for daily exercise had diminished since the last inspection.

Recommendations

2.43 **Prisoners should be offered daily exercise in the fresh air and be supplied with weatherproof clothing and shoes for outdoor exercise in bad weather.**

Association

2.44 All wings were expected to provide prisoners with daily periods of association or other periods to enable them to have showers and make telephone calls. There was an hour designated for evening association on A Wing from 6.30 pm but little guarantee that it would take place at that time, if at all. Many prisoners we spoke to on A Wing had no idea whether there were prescribed times for association. They assumed that association took place when there were enough staff. Other prisoners on A Wing thought that they were entitled to association every other day, to enable the staff to unlock one half of the wing at a time. Even this rarely happened. On average, A Wing prisoners were unlocked for association twice each week. At the weekend, association times for all wings were limited to the hour between 2.00 pm and 3.00 pm, with no evening association.

2.45 The table below compares the prisoners' responses to the question in our questionnaire on how many times on average they had association each week (Monday to Sunday).

Year	Up to twice a week	3 to 5 times a week	6 or more times a week
February 2000	8%	11%	79%
December 2001	34%	22%	30%

2.46 Facilitating association on A Wing was impeded by the inordinate delays in the serving of the evening meal at 5.30 p.m. (See also the section on Catering). The system consisted of unlocking two landings at a time, then unlocking prisoners for legal visits, evening education or religious activity at 6.00 pm before unlocking the two remaining landings for their meals. This lengthy process meant that many A Wing prisoners often waited until 7.00 pm and beyond for their evening meals. Any evening association was considerably shortened as a result. There were plans to serve the evening meal at 4.30 pm to get round this problem but this option was equally unacceptable to us.

2.47 Across all wings, a daily “domestic” hour gave an opportunity for association, to use the telephone, cell cleaning and to shower. This ‘hour’ extended from around 09.45 am to 11.00 am and then from 2.00 pm to 4.15 pm. On all wings, the time was so arranged that one half of the wing was unlocked in the morning and the other half of the wing unlocked in the afternoon. The atmosphere on all wings during the domestic hour was relaxed. Staff generally seemed busy during these times, responding to prisoners’ requests and issuing application forms. There seemed little chance for them to engage with prisoners informally.

2.48 Linked with the ‘domestic’ hour was the introduction of a regular period of association between 6.15 pm and 8.00 pm, for each prisoner on alternate days. Times for this varied across wings, lasting for only an hour on A Wing, for example.

2.49 When staffing levels fell below minimum levels, as often happened, both the ‘domestic’ hour and evening association were cancelled. Prisoners saw this early failure as an indication that the new arrangements were unworkable and were not hopeful that they would see improvements in the short-term. Minimum Staffing

Levels had similar effects on whether prisoners' purchases from the prison shop could be delivered and whether prisoners ever made it to education or work. This was a disappointing reduction in provision, given our previous findings that daily routines were being followed scrupulously with no tasks being dropped due to perceived shortages of staff.

2.50 The Senior Officer's Daily Checklist recorded daily activities. For example, it provided the opportunity to record when exercise had been cancelled and the reasons for its cancellation. On B Wing, pages were missing from the file that contained these checklists and therefore it was not possible to establish how often this had occurred. On some wings, these checklists were not completed.

2.51 There were telephones on all wings for use by prisoners. Additional telephones had been installed on A Wing but there were still long queues to use them on the days following cancellation of domestic hours and association. A Wing had four telephone booths on the ground floor. Additional telephones at the north end of each landing were open and had no privacy hoods. Since this area was also adjacent to pool tables as well as the showers, it was almost impossible for prisoners to hear. This also applied to all wings except E Wing, which had telephone booths for all its telephones. Prisoner replies to our questionnaire revealed that 40% of them said that there were problems using the telephones on residential wings. Reasons for these were given as: not enough telephones (34%), not enough time to use them (25%), long queues (14%) and being in cell all day or having no association (11%).

2.52 The ground floor of E Wing was spacious and it was used as the wing recreation area. It contained association equipment and board games, consisting of two table football machines, two pool tables, table tennis equipment and a selection of board games, including dominoes. All the association equipment was well maintained. A table and chairs were provided for the use of board games, but there was no other seating.

2.53 Since the installation of in-cell television, there was no room set aside on A Wing for general association. Some recreational facilities such as pool tables and table football had been provided and prisoners said that the facilities were well used when they were given an opportunity to do so. On A Wing, most prisoners seemed to prefer simply to spend time together in conversation on their landings during association.

2.54 On B Wing, some pool tables required recovering. There were association rooms on the second and third landings of D Wing, which also had televisions.

2.55 There was adequate supervision by staff during periods of association and noise levels were reasonable. A Wing staff were approachable and prisoners took the opportunity to ask them about particular matters. We did not, though, see staff initiating conversations with prisoners, or making efforts to encourage those prisoners who chose not to participate in association. There were no records of prisoners' non-participation in out-of-cell activities. On C Wing, association periods were relaxed events and there was nothing to suggest that staff felt uneasy about being among a large group of prisoners.

Conclusions

2.56 There was significantly less association and time out of cell than during our last inspection. When evening association and the daytime 'domestic' periods did take place, they were relaxed affairs in which staff and prisoners integrated freely. There were particular problems on A Wing, where meal serving arrangements resulted in curtailing the precious time available for association. Prisoners on most wings had difficulty in holding telephone conversations, since few telephones had privacy hoods. Recreational facilities, with in-cell television, appeared sufficient to meet most prisoners' needs.

Recommendations

- 2.57 **Mealtimes and movements of prisoners should be co-ordinated and organised in such a way that it does not delay mealtimes or affect association periods.**
- 2.58 **Managers should ensure that prisoners reach off-wing activities on time and that wing domestic times and association should be provided every day.**
- 2.59 **Consideration should be given to providing a separate room on A Wing for prisoner association.**
- 2.60 **All wings should record daily activities and whether any had been cancelled, with reasons for this.**
- 2.61 **Recreational equipment should be in working order and repairs to pool tables should be carried out as soon as possible.**
- 2.62 **Additional seating should be provided on all wing association areas.**
- 2.63 **All wing telephones should be in booths or have privacy hoods fitted.**

Staff-Prisoner Relations

A Wing

2.64 Most prisoners described the attitude of staff on A Wing as helpful when approached. They went on to qualify this with an explanation that staff did what they could with what little time they had. "Staff try their best, but they really are short staffed on this wing. I feel sorry for them", one prisoner said. The understanding of

some prisoners meant that they were less likely to complain, as we were told, “There really is no point in complaining to staff; they don’t have the time to do anything about it anyway”.

2.65 A Wing was managed by a Principal Officer supervised by a Senior Manager; the latter who had been assigned there shortly before the inspection to assist with bringing in the new regime. A Senior Officer, working with nine Officers under the new Minimum Staffing Level, directed the daily routines. Before the introduction of MSL, staff had been accustomed to working with a Senior Officer and 11 or 12 Officers.

2.66 Many A Wing officers told us that the reduced staffing levels would have an adverse impact upon their ability to interact purposefully with prisoners. One officer said, “We want to engage more with prisoners and management say that they want to help and encourage us to do so, but they only pay lip-service to the idea. The reality is that they want the locks, bolts and bars done first and that leaves us with no time to do any meaningful work with prisoners”.

2.67 Staff were clearly unused to the levels of staffing and interaction with prisoners that MSLs would require. Some staff said that the new Minimum Staffing Levels would have an adverse impact upon safety on the wing, “putting officers’ lives in danger”, as one of them said. Some staff went so far as to say that there was a constant need for officers to operate in pairs, and that prisoners should be locked up during the day if they did not have any work. One officer spoke of coming to work “with a feeling of impending doom”.

2.68 Two officers, who had been suspended from duty for more than two years pending police investigations, had now returned to A Wing, having been found not guilty of charges made against them. We were told by staff that these officers had received no contact from the management at Wormwood Scrubs throughout the duration of their suspension, and had returned to work without a reintegration plan.

There was a great deal of empathy with these officers from others on this wing, and this situation was having a divisive effect on managers and staff.

2.69 These staff attitudes and fears needed management attention, if more positive wing relationships were to develop.

B Wing

2.70 Prisoner-staff relationships were described in various ways by prisoners on B Wing. There was no evidence that staff were assaulting prisoners but they said that some officers were verbal bullies – they were disrespectful and sarcastic to prisoners. Two officers were specifically mentioned as racist in their attitudes. Although prisoners were not saying there was overt racism, they did express some concerns. They believed that many staff saw all black prisoners as drug dealers and bullies. Some prisoners mentioned the body language of staff, others found the way that some officers impersonated their accents as offensive and disrespectful. It was said that too many officers brought their problems to work. Other prisoners in this group described officers in very positive terms. Some regretted having no personal time with officers.

2.71 There appeared to be a functional relationship between prisoners and the majority of staff, being neither warm nor hostile. The impression given from prisoners was that, overall. “Officers tended to leave you alone”. We observed staff busily dealing with the immediate routine requests from prisoners. Most of their interactions were short and to the point. These encounters offered staff the chance to engage with prisoners beyond the matter in hand but none of them took it.

2.72 The staffing complement for B Wing was 42 officers. We were told that there were only 35 officers, through the effects of light duties, maternity leave and, for four staff, long-term sickness. One Principal Officer and three Senior Officers managed the wing. This group included staffing for the Vulnerable Prisoner Unit located at one end of the wing.

2.73 Many B Wing staff told us that they did not support the central detailing of tasks. One manager said that this did not allow him to manage his own staff, since he would often be allocated staff from other areas. He described himself as more of a supervisor than a manager. We met a number of staff who said they were “only covering”. In these circumstances, there was little staff incentive to make a commitment to a wing when they were unlikely to be there regularly.

C Wing

2.74 Staff-prisoner relationships on C Wing were generally good. The prisoner group we spoke to said that, although some staff did not approach prisoners, they would deal with any queries and would not keep prisoners waiting long to resolve problems. This was confirmed in our conversations with other, individual prisoners. We observed staff on the wing. Some were static, taking up an observation point and not speaking to prisoners unless they were spoken to. Others, also on patrol, would talk to prisoners passing by or would go out of their way to engage with them. When meals were being served, the difference between these two groups of officers was clear. Prisoners felt free to make ‘small talk’ with some officers but would keep their distance from others.

2.75 The staffing arrangements were consistent with that of other wings and the impact of central detailing was equally the same. We did not find staff on C Wing dwelling on these difficulties and many of them just got on and did their work. They recognised the limitations on them of complying with Minimum Staffing Levels. Despite this, they were determined, as far as possible, to find ways that would enable prisoners to have more time out of cell. There was a refreshing openness about many staff on this wing that can be attributed to the commitment of the Principal Officer and most of his Senior Officers.

D Wing

2.76 There was a relaxed atmosphere on D Wing. Some prison officers called prisoners by their first name and some prisoners knew prison officers by their first name. It was evident by the way staff spoke to prisoners that good relationships

existed. Prisoners told us that they and staff generally got on well together. However, we found little to indicate that the prison officers were engaging with prisoners at the level expected when dealing with life sentence prisoners. On many occasions, we found prison officers in landing offices reading newspapers or chatting to other staff. There did not appear to be any supervision of staff. Prisoners complained that they were often locked up early and unlocked late and we found this to be true. We observed their being locked up at 4.30 pm instead of 5.00 pm. (See also the section on lifers).

2.77 The staffing complement for D Wing was one Principal Officer throughout the main day, with one Senior Officer and nine Prison Officers. The Senior Officer and the Prison Officers ran the wing on a full regime, from unlock in the morning to lock up in the evening. Many prisoners and staff complained about the lack of management support and direction, and said senior managers rarely visited the wing.

E Wing

2.78 The atmosphere on E Wing was relaxed and cordial. Although the staff team from HMP Rochester was previously unknown to prisoners, and vice versa, they had quickly built a good rapport. There was a great deal of interaction and good-natured banter between them, and officers mingled easily with prisoners outside their offices. Prisoners regularly approached officers for information or assistance, as well as to talk.

2.79 Prisoners told us of the support and assistance they had received from officers. In one instance, there had been an error in prisoners' money. Although staff were not conversant with the Wormwood Scrubs system, they persevered until the matter had been resolved. Notwithstanding this, staff were aware of their responsibilities to keep control and, in this context, they knew their prisoners well.

2.80 Officers on E Wing said that they felt isolated from their home prison as well as the host establishment. It took time for them to become familiar with the regime

and local practices and they described themselves as “working blind”. We felt that this was an apt description of their situation.

Conclusions

2.81 There were some interesting comparisons to be drawn across the wings in terms of staff-prisoner relationships and the feelings of staff, and how these affected the running of the wings. On all wings, there were some staff who were more resistant to change or who were so demoralised that they felt unable to operate as effectively as they would wish. The following comments reflect an overall view of individual wings.

2.82 A Wing came across as staff doing what they felt they could, given the upheavals of central detailing, Minimum Staffing Levels and staff investigations. There was limited interaction with prisoners and prisoners themselves accepted what staff told them about staffing problems. Of all the wings, A Wing staff seemed the most disgruntled and disaffected.

2.83 Prisoners on B Wing portrayed a picture of staff who were neutral in their dealings with them. There was little interaction with prisoners and no evidence of warmth in staff contacts with them. B Wing staff observations were generally about the difficulties in managing a wing when officers were not regularly on duty there.

2.84 C Wing staff and managers displayed a positive approach to running the wing irrespective of the turmoil created by central detailing and Minimum Staffing Levels. Most prisoners on C Wing felt that staff were approachable and helpful.

2.85 On D Wing, the relationships were informal and good but they did not extend to staff engaging to any significant degree with prisoners. Lack of management supervision was an important issue for staff and prisoners on D Wing.

2.86 Probably the most interesting findings emerged from E Wing. Here was a group of prisoners, mainly from another prison, who were being managed by staff

from a third prison. It could be argued that a shared feeling of isolation contributed to what seemed to be the most successful partnership in terms of staff-prisoner relationships. Staff needed help in familiarising themselves with local practices.

Recommendations

- 2.87 Staff should be led and encouraged to interact more positively with prisoners.**
- 2.88 Staff should use opportunities to create an atmosphere in which there is regular contact with prisoners.**
- 2.89 Wing senior managers should visit their wings more frequently and consideration should be given to locating them on the residential wings.**
- 2.90 Managers should ensure that the visiting staff on E Wing are given help and support to enable them to carry out their duties effectively.**

Personal Officers

2.91 The personal officer scheme did not formally operate, landing officers taking this role on all wings. They were the first point of contact for prisoners and dealt initially with applications and any problems. Since there was little continuity of staff, the opportunity for building up any bond with prisoners was limited. Many staff said that they had insufficient time to devote to individual prisoners in this way. None of the officers on A Wing had undertaken personal officer training while at Wormwood Scrubs. One view expressed by a manager on B Wing was that prisoners were not held long enough on the wing for a personal officer scheme to be effective. The current effects of central detailing meant that staff were not regularly on the wing either. Prisoners on D Wing had personal case officers (see more in the section on lifers).

2.92 The quality and frequency of entries on history sheets was variable. Those we looked at on A Wing contained such entries as, “No management problems”, “No

discipline problems” and “Gets on well, loves to talk”. These reinforced our view of the dispassionate stance adopted by some staff. The regularity of recordings showed that officers were making an effort to write in prisoners’ history sheets as part of their routine duties, and this was a positive step.

2.93 On one landing on B Wing, there were only 24 personal records present for the 42 prisoners on that landing. Most of the entries were negative comments. On another landing, one prisoner who was on F2052SH⁴ was not identified as such on the wing board in the office. Record keeping on the wing was generally poor.

2.94 Entries on C Wing prisoners’ history sheets were informative, although subsequent action on some of that information was not always recorded. Background information contained on E Wing prisoners was scant and the quality of entries was poor. Consequently, there was very little information that identified specific needs or goals.

Conclusions

2.95 There was no proper personal officer scheme in place, although the landing officer to some extent became the first point of contact for prisoners. This was a good basis on which to build relationships but it had little chance while the current daily allocation of staff continued. Entries on wing history sheets needed to be more frequent and more balanced to provide a true picture of prisoner behaviour and particular needs.

Recommendations

2.96 **An effective Personal Officer Scheme should be introduced.**

2.97 **The quality and frequency of recording information in prisoners’ wing history sheets should improve.**

⁴ A form alerting staff to the fact that a prisoner is judged to be in danger of harming him or herself or could be suicidal. Also known as a Self-Harm At-Risk Form.

Applications, Requests and Complaints

Applications

2.98 Prisoners requiring any specific services or permission to undertake even routine needs had to make a formal, and usually written, application to their landing officer. Blank applications were kept in wing offices. Once completed, they were posted in a box on the landing, which staff opened each morning. Many prisoners complained to us of inordinate delays in obtaining replies to applications or of no response at all. Prisoners on B Wing suggested that staff should carry a notepad, as many prisoners asked them things as they patrolled the landings.

2.99 On all wings, we observed landing staff working through written applications. They were also dealing politely and efficiently with a steady stream of spoken applications and requests from prisoners coming into the office. Some prisoners, especially those who had not received induction or who did not understand English, did not know how the applications system worked. There was no evidence of any method of appeal against a decision on an application. Any prisoner on D Wing who asked what had happened to his application was told to reapply.

2.100 The logging of applications varied across wings and depended on who was dealing with applications on any particular day. Applications on C Wing were generally dealt with promptly and recorded in landing office books with details of where any applications had been forwarded. There were few entries in these books that indicated the outcome or decision on these applications.

2.101 Some officers on A Wing told us that shift paperwork took priority. Others said that they could not adequately supervise prisoners as well as complete routine office tasks. The previous designated role of Inmate Services Officer, who dealt with applications, had been removed. Instead, wing officers were expected to deal with routine applications. Some officers on A Wing felt that dealing with applications was the job of an Inmate Services Officer, who had been profiled as the 11th officer. Consequently, when staffing levels fell below 11, they argued that the Inmate

Services job would be the first task to be dropped. Staff on A Wing were using Minimum Staffing Levels as a reason for abdicating responsibility.

Requests and Complaints

2.102 Prisoners wanting to make a formal Request or Complaint had to complete a separate application form in order to obtain the form for making a Request or Complaint. The application had to be authorised by the wing Principal Officer or a senior manager. The intention was to avoid unnecessary waste of time and paperwork if the matter could be resolved in another way. Prisoners felt that it imposed an additional hurdle for them to overcome. Since the initial response times of staff varied considerably, this procedure simply lengthened the process for prisoners. On B Wing, we were told that there was a record kept of all the Request and Complaint forms asked for and issued by the wing but we found no such record. One prisoner, also on B Wing, said that that the only time he had used this system, he had waited six weeks for a reply.

Conclusions

2.103 The speed and success with which wing applications were dealt with depended on individual landing staff. Applications were not being routinely logged nor were the outcomes being recorded. There was a clear and general lack of trust and confidence in the Request and Complaint Procedure. Prisoners complained that responses did not arrive, or were 'lost' in the system. Wing display boards contained no information about this system or about avenues of appeal with bodies other than the prison.

Recommendations

2.104 **When a recorded application remains unresolved, it should be pursued by landing staff and regularly checked by wing managers.**

2.105 **Prisoners should be allowed to have a Request or Complaint form without the need for approval before the form is issued.**

2.106 **Managers should regularly monitor wing procedures for applications, Requests and Complaints.**

2.107 **Information about the use of Request and Complaint forms, including the right to confidential access and avenues for appeal, should be publicised on wing notice boards.**

Safety

2.108 Some prisoners on all wings said that they felt safe on their residential units but this did not mean that there were times when they felt unsafe from the actions of other prisoners. Newly arrived prisoners were not risk assessed before cell allocations.

2.109 The table below compares the prisoners' responses to the questions in our questionnaire for this inspection and the previous one on how often they felt unsafe in Wormwood Scrubs.

Frequency	February 2000	December 2001
Most of the time	4%	12%
Often	3%	1%
Sometimes	13%	17%
Rarely	9%	5%
Never	69%	51%
Missing	1%	15%

2.110 Throughout the day on A Wing, the sound of in-cell emergency call bells could frequently be heard. Staff told us that prisoners used their emergency call bells routinely when they were locked up during the day if they wanted attention and that these were rarely emergencies. A Wing prisoners agreed that they used their cell-bells for non-emergencies. It was, they said, because of the long hours spent locked up and they became frustrated. Staff on A Wing responded to these bells but as a

routine task and not an emergency. The same was true to a lesser degree on B Wing. Cell bells were normally responded to within 5 to 10 minutes during the day but more speedily after evening lock up.

2.111 There were times during wing regimes that could prove unsafe for prisoners, such as association and when meals were served. There were also areas on the wings that needed more staff supervision because they were potential sites for bullying and assaults between prisoners. Showers were a prime example of this need but were never supervised by staff.

2.112 Like other wings, C Wing had treatment periods at least twice each day. Health care staff dispensed medication from the treatment room on the ground floor of the wing. The treatment room had a stable-type door, from behind which a nurse dispensed medication. We were told that treatment periods were rarely supervised by staff and that, over the six weeks before this inspection, there had been two incidents involving patients. On 3 November 2001, a patient in the queue outside the treatment room had seized a bottle of medicine that had just been given to another patient and made off with it to his cell. By the time staff had responded, the bottle had been emptied. On another occasion, 6 December 2001, a patient had vaulted over the lower section of the stable door and had grabbed various medicines. He had smashed equipment in the treatment room while doing this but had not assaulting the nurse. We were told that staff shortages meant that treatments could not always be supervised. On the occasions we observed treatments being dispensed, only once was a member of staff anywhere near the treatment hatch.

2.113 We inspected residential areas on one night during this inspection. The prison was supervised by a Senior Officer assisted by an Officer. Each wing except E Wing had an Officer and an Operational Support Grade (OSG). E Wing had one Officer.

2.114 Knowledge of where suicide kits were located and how to use them in an emergency varied considerably. Some staff had them to hand and ably demonstrated their use, others were unclear and, in one instance, an officer said he had never heard

of them. All the water hose reels on the wings were locked and staff had difficulty unlocking them and demonstrating how to use them. When staff were asked about the use of the cell-door inundation hole, they did not know its function or how to release it.

Conclusions

2.115 Most prisoners regarded residential units as being safe environments but the proportion who did not was higher than in February 2000. New prisoners were not risk assessed before being allocated a cell. There were problems about the improper use by prisoners of cell bells. Staff were not patrolling areas that were likely to be used by prisoners to intimidate other prisoners or visiting staff such as nurses. Safety awareness at night was patchy.

Recommendations

- 2.116 **All new prisoners arriving on residential units should be risk assessed before being allocated to cells.**
- 2.117 **The use of cell call bells for routine issues should be looked into.**
- 2.118 **Staff should particularly supervise showers and other important communal areas.**
- 2.119 **Staff should supervise prisoners when medication is being dispensed to patients on residential wings.**
- 2.120 **Management should ensure that all staff undertaking night duties are trained in the use of self-harm response kits.**
- 2.121 **Consideration should be given to unlocking wing water hoses before evening duty staff go off duty. All staff undertaking night duties must be trained in the use of water hoses.**

2.122 **All staff who undertake night duties must be trained in the use of cell door inundation holes.**

Vulnerable Prisoner Unit

2.123 The Vulnerable Prisoner Unit was still at one end of B Wing, with 33 cells. On one day of this inspection, 34 prisoners were held in the Unit. They comprised 18 determinate-sentenced prisoners, 10 life-sentenced (including 2 sex offenders) and 6 remand prisoners.

2.124 Single cells continued to appear cramped and the closeness of lavatories to beds emphasised this. Our previous recommendation on cell occupation had not been adopted and some cells had two occupants. A good standard of housekeeping prevailed in cells and across the unit as a whole.

2.125 Staff told us that the Vulnerable Prisoner Unit regularly took in new prisoners (“lodgers”) arriving at Wormwood Scrubs. (See also the section on First Night Arrangements). This created additional anxiety for all prisoners. Staff had the additional burden of ensuring that these temporary occupants received association and exercise outside the constraints of the Vulnerable Prisoner Unit.

2.126 Co-operation between staff of the Vulnerable Prisoner Unit and the adjoining mainstream B Wing enabled lodgers to join B Wing for association. This was potentially disruptive. For instance, if an incident on B Wing required prisoners to return to cells, the lodgers would be immediately returned to the unit. Genuine Vulnerable Prisoners would then need to be locked up to prevent contact with the returning lodgers. We heard that on one occasion, Vulnerable Prisoner Unit staff had not been alerted to the return of lodgers and only prompt action by a regular Vulnerable Prisoner Unit officer prevented escalation of the situation.

2.127 Our recommendation from the last inspection that Vulnerable Prisoners should receive Induction had not been met. Regular Vulnerable Prisoner Unit staff said that informal structures ensured that some information and advice was given to new

prisoners. We saw these in operation to good effect but their effect relied heavily on the personalities and availability of staff on a given day. It was not a proper substitute for a formal and consistent programme.

2.128 Staff who worked regularly on the Vulnerable Prisoner Unit had a good working knowledge of the prisoners on the unit but this did not apply to cross-deployed staff. A designated Senior Officer had charge of the wing with oversight and support from the B Wing Principal Officer. The links between these two wing managers were positive and enthusiastic and this transmitted itself to other staff. There was a good relationship between prisoners and staff. The wing was clean and tidy.

2.129 The deployment of staff across the prison had similar consequences for the running of the Vulnerable Prisoner Unit. Inadvertently or otherwise, some staff conveyed an impression of indifference and lack of interest. At best, they were unfamiliar with unit routines. Consequently, most tasks were carried out by the few regular staff on duty. Prisoners, too, were quick to observe these matters and consequently reserved their queries or communications for the regular staff. This, in turn, added further to the overload. On some days, this appeared to have a debilitating effect on otherwise keen and committed officers.

2.130 Regime activities were also affected. Our recommendation that Vulnerable Prisoners should be able to dine in association had not been adopted, and all meals were taken in cells. Another recommendation regarding the cancellation of activities had little chance of implementation given the current staff deployment system. During one day of the inspection, we noted that the Vulnerable Prisoner Unit had not enjoyed evening association for the preceding ten days. Decisions to cancel activities were taken at wing level once the staff availability was known.

2.131 Despite the current circumstances, the wing Senior Officer and staff often arranged to provide impromptu association and to facilitate telephone time, to compensate prisoners for loss of regular association. We applaud their initiative. It

reflected the caring atmosphere created by the regular staff. We also recognise a unit staff initiative in opening a “charities workshop” to offer work, largely to the life-sentenced prisoners in the Vulnerable Prisoner Unit.

2.132 Our recommendation to review the applications procedures had been put into practice and these were consistent with systems across other wings. Wing files continued to be of variable quality. It was not always possible to identify which member of staff made entries on the history sheet. There was no evidence of managers’ checks of history sheets, which for the most part recorded negative incidents and “problems”. There was no Personal Officer Scheme in place but unit officers took on this role.

2.133 At the time of the inspection, there were ten life-sentenced prisoners in the Vulnerable Prisoner Unit. Although many of them had been accepted by the main lifer wing in Wormwood Scrubs on transfer, within hours of arrival they had been relocated in the unit. From then on, it appeared that nothing was being done to effectively progress the Life Sentence Plans of these men. Their only work activity was in the charities workshop, which was regularly shut down as a result of staff shortage. Offence-related issues were not being tackled. These prisoners were effectively disowned by the main lifer wing and placed in the care of a unit that was insufficiently resourced to meet their needs properly.

Conclusions

2.134 The Vulnerable Prisoner Unit provided a generally caring environment and its regular staff were committed to the general well being of prisoners. The practice of placing new arrivals on the unit was unhelpful and dangerous. No prisoners on the Vulnerable Prisoner Unit had received a formal Induction programme. Regime activities were affected by the central detailing arrangements and Minimum Staffing Levels. Unit staff initiatives had provided periods of association and other out-of-cell activities, including employment on the Unit. There was little for life-sentenced prisoners, who should have been on a lifer wing.

Recommendations

- 2.135 **Cells designed for single occupancy should not house additional prisoners.**
- 2.136 **The Vulnerable Prisoner Unit should not be used as temporary overspill accommodation.**
- 2.137 **All prisoners on the Vulnerable Prisoner Unit should receive Induction.**
- 2.138 **Vulnerable Prisoners should dine in association within the unit.**
- 2.139 **Only senior managers should make decisions to cancel wing activities.**
- 2.140 **Prisoner history files should be maintained systematically and consistently and should be subject to regular, recorded monitoring by managers.**
- 2.141 **The practice of placing Life Sentenced prisoners for long periods in the Vulnerable Prisoner Unit should cease.**

Lifers

2.142 Wormwood Scrubs had shared responsibility with Swaleside prison for taking all prisoners in southern Britain who had been newly sentenced to life imprisonment. This first stage meant that the prison had to undertake a full assessment of each of these prisoners. It then had to place them in an environment that would provide them with help in coming to terms with their sentence. At this time, prisoners would have no indication as to when they would be released. Most life-sentenced prisoners were located on D Wing but some had been housed in the Vulnerable Prisoner Unit.

2.143 There were two other categories of lifers that were not solely held on D Wing but had links with it. The first was prisoners recently sentenced to life imprisonment and awaiting allocation to a lifer centre, possibly within Wormwood Scrubs itself. Allocation could take several months. The other group consisted of prisoners who

had received mandatory life sentences for repeat offending. These prisoners would normally serve shorter sentences and would have different needs from the other life-sentenced prisoner categories we have mentioned.

2.144 Details of D Wing staffing and daily routines have been incorporated into the main section on the residential units earlier in the chapter. What are covered in this section are matters specifically related to lifers.

Personal Case Officers

2.145 Prison officers on D Wing each had a number of prisoners allocated to them as personal case prisoners. They were expected to get to know these prisoners, to act as their mentor and their first point of contact for resolving problems. They were also expected to write reports on the prisoners. History sheets were kept on each landing for recording contemporaneous notes on prisoners. We found that entries were sporadic and the observations superficial. There was little to indicate that the prison officers were engaging with prisoners at the level expected when dealing with life-sentenced prisoners. When we asked staff why they were not carrying out these tasks, we were told that they had not been trained in lifer work or in the construction of reports. In the last year, no prison officer had been trained for lifer work.

2.146 Case officers also told us they were not profiled time to do this work. Despite this, some found the time to make relevant entries on history sheets and to compile reports that were meaningful and insightful. The fact that some prison officers, although perhaps self taught, managed to perform their role as personal case officers says as much about their attitude to the work as it did of the other case officers.

Probation Contribution on D Wing

2.147 Four Probation Officers were permanently attached to D Wing. Each had a caseload of about 40 prisoners and offered an excellent service to prisoners. They worked with them on individual offence-related work, offence analysis and their own risk assessment. Probation Officers also offered unaccredited courses in anger management and alcohol abuse. They also met statutory requirements for the

completion of life sentence plans and constructing F75 reports⁵. It was clear, through the quality of their work and the high regard that staff and prisoners had for them, that they were a committed group of people.

Lifer Assessment

2.148 Despite a previous recommendation that psychometric assessment of lifers should be reintroduced, this still was not taking place; although prisoners who participated in Enhanced Thinking Skills Courses were assessed. Psychologists wrote lifer reports, but these rarely included the results of any formal testing. We welcome the fact that the Prison Service new Life Sentence Plan will require a psychological screening and prompt further psychometric assessment where indicated. Lifers beginning their sentences in dispersal prisons are subject to a full assessment battery that helps to clarify the motive for the offending, where this resides in individual personality factors or emotional dysfunction. Psychologists in Wormwood Scrubs should also be providing this assessment.

Lifer Liaison

2.149 The Lifer Liaison Officer (LLO) was a Principal Officer. He had an office above C Wing and had clerical assistance. The Lifer Clerk ran the unit efficiently and all reports were completed on time. There was a good tracking system in place to ensure reports were not lost or delayed. Life sentence plans were up-to-date and neatly filed.

2.150 The Lifer Liaison Officer was responsible for all matters relating to life-sentenced prisoners and was the liaison point for the Lifer Unit in Prison Service headquarters. The Lifer Liaison Officer completed risk assessments but complained that he could not complete them on time. He often had to wait a long time (in one case, up to three years) for the confidential summary dossier to arrive from LU. He was unaware of the new arrangements for the receipt of offence

⁵ These are sentence planning and assessment reports on lifers that go to the Lifer Management Unit at Prison Service headquarters

information directly from the Police. Life-sentenced prisoners on D Wing and the other wings told us that they did not have regular contact with the Lifer Liaison Officer.

Newly-sentenced lifers

2.151 The Prison Service had introduced new responsibilities towards potential lifers and newly-sentenced lifers for local prison staff. These included liaison with the senior investigating officer from the local police force handling the case immediately after sentence, receipt of information about the offence and the opening of the new Life Sentence Plan. This was a crucial development, which followed recommendations made in the Joint Thematic Review of Lifers⁶. Training had been available to all local prisons for the introduction of this duty from January 2002. Wormwood Scrubs staff had not been trained and were not aware of their new responsibilities.

Conclusions

2.152 Life-sentenced prisoners on D Wing and elsewhere at Wormwood Scrubs were not receiving the level of service from staff that we expect. Case-workers had not been trained and some took the view that they had not been profiled for this work. The quality of Probation work and the commitment of Probation staff on the lifer wing was particularly good. Prison staff were not trained for their new responsibilities with potential and newly-sentenced lifers. The Lifer Liaison Officer was not up-to-date with current procedures and was not keeping in touch with his charges across all wings.

Recommendations

2.153 **Prison officers who work with lifers should be properly trained.**

2.154 **Psychological services to lifers at Wormwood Scrubs should be clarified.**

A lead on this should be provided by the Lifer Unit at headquarters.

⁶ *LIFERS: A Joint Thematic Review by Her Majesty's Inspectorates of Prisons and Probation, 1999*, Home Office, London: The Stationery Office.

- 2.155 **All staff dealing with newly-sentenced lifers should receive training in their new responsibilities.**
- 2.156 **The Lifer Liaison Officer should hold a weekly surgery on D Wing.**
- 2.157 **The Lifer Liaison Officer should visit life-sentenced prisoners located on other wings more often.**

Foreign Nationals and Detainees

2.158 At the time of this inspection, Wormwood Scrubs held 439 foreign nationals, of whom 45 were detainees. They represented 40% of the total population of the prison and 60% of the populations of A, B and C Wings, where foreign prisoners were effectively in the majority. This proportion reflected the proximity of the prison to Heathrow airport and the high number of arrests for importing drugs and illegal immigration. There was a large number of Jamaican prisoners who were able to understand English, though the patois they spoke made communication with some people difficult.

2.159 A senior manager had been given responsibility for the needs of foreign nationals. There was evidence of much recent work and of new systems being put into place to improve the service to foreign prisoners. We mention, in particular, a recent impressive and comprehensive guide for staff working with foreign nationals. Its statement of intended purpose was, “to assist staff by providing basic information about accessing facilities and services for foreign nationals, special arrangements in place to meet their needs, and a brief overview of some of the legal issues surrounding their situations”.

2.160 A Senior Officer on B Wing had produced a first-night information sheet and induction pack translated into 15 languages. He got help from various embassy staff in this. The guide was almost ready for issue.

2.161 Meanwhile, there was no routine system in place to ensure that prisoners without English arriving in prison in England for the first time were able to understand what was happening to them. Although there were translation tapes available in several languages to reception staff, these had fallen into disuse. A system was being introduced to pay prisoners as translators for notices and handouts. Currently, there was little material available in other languages.

2.162 For the first time, there was a separate budget to provide works in foreign languages for the library; £1,000 had recently been spent on books in Albanian, Arabic, Romanian, Spanish, Turkish and Russian. The additional money would also cover the use of Language Line⁷, translators and interpreters, as well as a one-day-a-week service from the Detention Advisory Service (DAS). We found very little use of any of these services other than the last.

2.163 There were separate groups running on B Wing for Jamaican and Spanish prisoners, and the Chaplaincy ran a general group for foreign nationals in the Education department one evening a week. The prison had established a half-day induction, and relevant regular assistance with these groups from the local probation staff. This was specifically for newly-sentenced foreign prisoners with no United Kingdom address who had been convicted at Uxbridge or Isle worth Magistrates courts. It was impossible to determine what proportion of foreign prisoners this service reached, although it was likely that many foreign prisoners fell into this category.

2.164 The provision of telephone calls for foreign prisoners and detainees was problematical. Under prison rules, these are permitted instead of visits for prisoners without a United Kingdom address. Such prisoners were, in theory, allowed to have a five-minute telephone call at public expense if they were unable to pay for telephone calls. These were not taking place regularly. Prisoners had to make a formal application for this and the application would be checked against their record of visits and private cash. If they were eligible, they were called up and allowed to use an

⁷ A national subscription service giving translations into English from other languages by telephone.

official telephone. Calls were made through the switchboard so that the cost could be calculated for those able to pay. The switchboard was not staffed in the evenings when it was most convenient from the regime point of view to make the calls. Time differentials often meant that evenings in the UK were not suitable times for overseas families to receive calls. There was a backlog of applications for telephone calls, dating back several months.

2.165 We were told that calls could not be made during the day because of the lack of staff. A Chaplain's assistant had recently been asked to help with making these calls, to reduce the backlog. At other prisons, phonecards are issued every month to those who are eligible. This does not meet the prohibitively high charge levied by the current supplier for overseas calls made from prison pay telephones.

2.166 There were some signs that the service to foreign nationals was beginning to improve, although the arrangements at the time of our inspection were inadequate. There was some evidence that medical needs were disproportionately high among foreign prisoners. Diversity and racial tolerance and cultural awareness training should be particularly provided to staff having regular prisoner contact.

Conclusions

2.167 There was a very high number of foreign nationals at Wormwood Scrubs. Senior managers had recognised that it was time to make specific provision for them in places such as Reception and the wings. A separate budget had been allocated for this and there were some separate groups for foreign nationals. A major concern was the bureaucracy involved in providing a telephone call for a foreign national who did not have the money to purchase telephone cards.

Recommendations

2.168 **Senior managers should urgently review the current arrangements for foreign nationals to be able to contact their families abroad at cheap rates.**

2.169 Diversity and cultural awareness training should form part of the weekly training programme for staff.

CHAPTER THREE

DUTY OF CARE

Anti-bullying

3.01 At the time of the last inspection in February 2000, a revised anti-bullying strategy had been running for two months. It had had a promising start and was to be based on a prisoner questionnaire about bullying that had recently been administered. These findings were not available at the time.

3.02 Almost two years on, we found that anti-bullying monitoring and methods had largely fallen into disuse. In July 2001, another prisoner survey had been conducted and its findings were published the following October. Clearly, much work had gone into the survey and analysis of results. The survey covered 210 (20%) of the population, although the poor response meant that 94 questionnaires (roughly 10%) were the basis for the analysis. Some of the main findings of the report were that victimisation and bullying were not prevalent at Wormwood Scrubs. D Wing (Lifers) was the most likely location for any bullying that took place. The report recommendations were predictable: staff awareness through training, use of anti-bullying posters, training in the use of Bullying forms and prisoner representation at meetings of the anti-bullying committee.

3.03 At the time of this inspection, a new anti-bullying policy document had been drafted. It was in its final stages of approval before being sent to the Area Manager for comment. The draft document set out four stages of strategy. These, in essence, dealt with warnings, specific paperwork, and the responsibilities of landing officers, wing managers, Security, Physical Education and psychology staff. It was a helpful document and set the framework within which bullies could be tackled and victims helped.

3.04 Two other initiatives tied in with this work. One was a questionnaire for new prisoners. It asked them whether this was their first time in prison and their fears about being there. For relevant prisoners, it asked how well they interacted with other prisoners during other times in custody. This questionnaire would be completed during the induction period after the revised induction package had been implemented.

3.05 The other initiative was a Social Awareness course designed for participation by 12 prisoners and two staff as facilitators. It was based on the model already run at HMP Brixton. The funds for this had been secured and a Physical Education Officer was taking the lead in starting it. Before the course could be introduced at Wormwood Scrubs, identified staff required training as facilitators. We were told that this depended on staff being released for initial training.

3.06 An Anti-Bullying committee, chaired by the Head of Operations, met infrequently, every two or three months. Minutes of these meetings showed regular attendance by the Head of Operations, the manager of A Wing and the Samaritans. Other departments rarely attended. There was no link between this committee and the group that convened to discuss suicide and self-harm.

3.07 The long period of police investigations into staff brutality, with some convictions thereafter, had had an effect. This was evident in the preceding section of our prisoner questionnaire titled 'Your Relationship with Staff' which asks, "If you were treated badly what would you do?". Where prisoners were prepared to do something, almost 50% more would consult their solicitors or speak to their families.

3.08 The section on 'Personal Safety' in our prisoner questionnaire provides ample evidence that prisoners felt less safe now than in 2000 (see also the section on Residential Units). Most of the respondents who felt unsafe and had encountered problems came from A, B and D Wings, the Vulnerable Prisoner Unit and the two Health Care units. These problems did not necessarily arise on their own residential wings.

3.09 In answer to the question: “Have you been hit, kicked or assaulted by other prisoners since you have been here?”, prisoners said:

<i>Wormwood Scrubs 2000* (n=75)</i>		<i>Wormwood Scrubs 2001 (n=110)</i>	
<i>Wing/Unit</i>	<i>Yes</i>	<i>Wing/Unit</i>	<i>Yes</i>
<i>A wing (32)</i>	3% (n=1)	<i>A wing (n=21)</i>	14% (n=3)
<i>B wing (25)</i>	4% (n=1)	<i>B wing (n=15)</i>	20% (n=3)
<i>E wing (18)</i>	11% (n=2)	<i>C wing (n=17)</i>	6% (n=1)
-	-	<i>D wing (n=18)</i>	22% (n=4)
-	-	<i>Health care 2 (n=4)</i>	25% (n=1)
-	-	<i>Health care 3 (n=8)</i>	25% (n=2)
-	-	<i>VPU (n=6)</i>	17% (n=1)
-	-	<i>Max Glatt unit (n=10)</i>	0% (n=0)
-	-	<i>Segregation (n=2)</i>	0% (n=0)
-	-	<i>Missing location (n=9)</i>	0% (n=0)
Total (75)	5% (n=4)	Total (n=110)	14% (n=15)

3.10 In answer to the question: “Have you been hit, kicked or assaulted by any member of staff since you have been here?”, prisoners said:

<i>Wormwood Scrubs 2000* (n=75)</i>		<i>Wormwood Scrubs 2001 (n=110)</i>	
<i>Wing/Unit</i>	<i>Yes</i>	<i>Wing/Unit</i>	<i>Yes</i>
<i>A wing (32)</i>	0% (n=0)	<i>A wing (n=21)</i>	10% (n=2)
<i>B wing (25)</i>	8% (n=2)	<i>B wing (n=15)</i>	0% (n=0)
<i>E wing (18)</i>	6% (n=1)	<i>C wing (n=17)</i>	0% (n=0)
-	-	<i>D wing (n=18)</i>	0% (n=0)
-	-	<i>Health care 2 (n=4)</i>	0% (n=0)
-	-	<i>Health care 3 (n=8)</i>	25% (n=2)
-	-	<i>VPU (n=6)</i>	17% (n=1)
-	-	<i>Max Glatt unit (n=10)</i>	0% (n=0)
-	-	<i>Segregation (n=2)</i>	0% (n=0)
-	-	<i>Missing location (n=9)</i>	11% (n=1)
Total (75)	4% (n=3)	Total (n=110)	5% (n=6)

3.11 In answer to the question: “Have you had any insulting remarks made by other prisoners about you, your family or friends since you have been here?”, prisoners said:

<i>Wormwood Scrubs 2000* (n=75)</i>		<i>Wormwood Scrubs 2001 (n=110)</i>	
<i>Wing/Unit</i>	<i>Yes</i>	<i>Wing/Unit</i>	<i>Yes</i>
<i>A wing(32)</i>	3% (n=1)	<i>A wing (n=21)</i>	24% (n=5)
<i>B wing (25)</i>	16% (n=4)	<i>B wing (n=15)</i>	13% (n=2)
<i>E wing (18)</i>	22% (n=4)	<i>C wing (n=17)</i>	12% (n=2)
-	-	<i>D wing (n=18)</i>	11% (n=2)
-	-	<i>Health care 2 (n=4)</i>	25% (n=1)
-	-	<i>Health care 3 (n=8)</i>	13% (n=1)
-	-	<i>VPU (n=6)</i>	33% (n=2)
-	-	<i>Max Glatt unit (n=10)</i>	50% (n=5)
-	-	<i>Segregation (n=2)</i>	0% (n=0)
-	-	<i>Missing location (n=9)</i>	22% (n=2)
Total (75)	12% (n=9)	Total (n=110)	20% (n=22)

3.12 In answer to the question: “Have you had any insulting remarks made by any member of staff about you, your family or friends since you have been here?”, prisoners said:

<i>Wormwood Scrubs 2000* (n=75)</i>		<i>Wormwood Scrubs 2001 (n=110)</i>	
<i>Wing/Unit</i>	<i>Yes</i>	<i>Wing/Unit</i>	<i>Yes</i>
<i>A wing(32)</i>	16% (n=5)	<i>A wing (n=21)</i>	19% (n=4)
<i>B wing (25)</i>	20% (n=5)	<i>B wing (n=15)</i>	27% (n=4)
<i>E wing (18)</i>	33% (n=6)	<i>C wing (n=17)</i>	0% (n=0)
-	-	<i>D wing (n=18)</i>	28% (n=5)
-	-	<i>Health care 2 (n=4)</i>	25% (n=1)
-	-	<i>Health care 3 (n=8)</i>	50% (n=4)
-	-	<i>VPU (n=6)</i>	33% (n=2)
-	-	<i>Max Glatt unit (n=10)</i>	0% (n=0)
-	-	<i>Segregation (n=2)</i>	0% (n=0)
-	-	<i>Missing location (n=9)</i>	22% (n=2)
Total (75)	21% (n=16)	Total (n=110)	20% (n=22)

3.13 It should be noted that in the survey made in 2000, for all these questions, prisoners were asked about occurrences in the previous 12 months.

3.14 From July to December 2001, there had been nine Security Incident Reports (SIRs) on prisoners who were currently at Wormwood Scrubs that were specifically and solely about bullying. Other identified bullies were no longer in the prison. There were substantially more Security Incident Reports that linked bullying to drugs.

3.15 Of the nine Security Incident Reports, nine were on named bullies and three were on named victims. Two bullies and two victims were on A Wing, two bullies and one victim were on B Wing, one bully was on the Vulnerable Prisoner Unit and four bullies were on C Wing. We looked at the wing history sheets of all these prisoners. In the case of four bullies and one victim, there was no entry whatsoever about the incident. In two cases, bullies had been subject to proper measures and the Bullying Form 1 had been comprehensively completed and behaviour closely monitored. These were rare examples of what should have been common practice. In other cases where bullying had been identified in these Security Incident Reports, wing staff displayed a complete disregard of the possible consequences of inaction.

3.16 The following examples are based on the evidence derived from entries in wing history sheets.

Example 1: No record of specific bullying but several recorded examples of aggressive and other bad behaviour on the wing. The prisoner was on Enhanced level of Incentives and Earned Privileges and was employed as a wing cleaner.

Example 2: The details contained in the Security Incident Report were recorded on this prisoner's wing history sheet. Entries in his file in the month of this inspection (December) described him as "surlly, threatening, difficult to deal with". When he was warned by an officer, he was verbally aggressive towards him and rude. The history sheet also records the wing governor saying after another bout of poor behaviour, "that man has an attitude problem". This prisoner was also on Enhanced level of IEP and employed as a wing cleaner.

Example 3: Involves two Spanish speaking co-defendants located in the same cell. One was identified in a Security Incident Report as a bully and the other as his victim.

(a) the bully – history sheet records him as wanting to speak to the Governor about bullying. This took place with a Listener as translator. The wing governor's comments are recorded thus, "Matter trivial and related to a disagreement between two Spanish speaking prisoners – must resolve it themselves"

(b) the victim – history sheet states, "upset because he feels he cannot go to education because co-defendant is intimidating him and attempting to make him plead guilty. Security Incident Report submitted." 14 days later another entry: "did not go to education again this morning. Asked to see a Listener, in a low mood".

Conclusions

3.17 Our Expectations on anti-bullying require prisoners to feel safe and for staff to ensure that, as far as possible, prisoners can survive on residential units and elsewhere without fear of intimidation and assault. There was no discernible policy at Wormwood Scrubs and the establishment was in-between policies. There was little

evidence that staff prevented bullying. In addition, in the examples above, the continuing employment of some prisoners as wing cleaners knowing their unsuitability allowed these violent men to prey on others at will. Consequently, the statement that bullying and intimidation was not accepted at the prison was largely meaningless.

3.18 The stated purpose of the recent prisoner survey was to provide a measure of the extent and nature of bullying in the prison. This would provide a baseline to compare against the results of future surveys. Evidence showed that the establishment had failed to sustain the momentum provided by a promising new strategy supported by a previous survey. In the circumstances we wondered how the new findings of the in-house prisoner survey and proposed approach would result in a better outcome for prisoners. There were questions as to whether staff time would be found to get the Social Awareness course off the starting block. It would take time for the new policy to be finalised and agreed and, thereafter for staff training to be implemented. In the meantime, staff were failing to act even when they had all the evidence necessary to tackle bullies and help victims.

Recommendations

- 3.19 **The new policy on anti-bullying should be published as soon as possible but its implementation should begin now.**
- 3.20 **Heads of Security and Heads of Residential wings should review Security Incident Reports weekly. They should ensure that named bullies and victims are known to wing staff and that appropriate action is taken and is recorded.**
- 3.21 **All wing managers should complete a review at least once a month on the suitability of prisoners employed on the wings in the context of their behaviour.**
- 3.22 **Wing staff must supervise showers and treatment times.**

3.23 **Wing staff must be more vigilant, particularly during association, exercise and mealtimes.**

3.24 **Wing managers should encourage staff to report and record incidents in history sheets.**

Prevention of Self Harm and Suicide

3.25 Examination of the injury report forms (F213), showed that by far the commonest cause of injury was self-harm (44%), followed by fights and assaults (34%). This is notably different from two other local prisons we have visited recently where self-harm accounted for only 33% of injuries.

3.26 The previous inspection found that although efforts were being made to improve awareness of self-harm and suicide, more commitment by staff was required to ensure continuing vigilance. We also recommended the recruitment of more Listeners and checks on the contents of self-harm response kits. When we returned in December 2001, there had been some progress. A "Policy Document 2000" included a Policy Statement and Terms of Reference for the Suicide Awareness Team. It also set out the responsibilities of staff in recording information on prisoners regarded as being at risk of self-harm (F2052SH procedures) and the role of Listeners. A self-audit action plan had recently been completed and target dates to achieve compliance with national policy had been set for the early months of 2002.

3.27 The Psychology and Health Care departments had researched the reasons why prisoners felt the need to inflict injuries to themselves. For example, it was suggested that prisoners harmed themselves as a manipulative gesture to be admitted to the health care centre. Elsewhere it was suggested that this might be because prisoners are lonely, as officers did not have the time to talk to them. Relationships, attitudes and cultures differ in each prison. They also vary with time. These are significant factors to be addressed in creating a safe environment for prisoners.

3.28 The work being undertaken by Psychology and Health Care in creating a profile of self-harm in the prison is commended and should be developed further. This work could contribute significantly to the development of local policy. Senior managers should also recognise that the existing arrangements for First Night care and Induction were poor. These failed to provide the level of care that was essential for prisoners who were liable to injure themselves.

3.29 The Head of Residence chaired the Suicide Awareness Committee. We attended one meeting and looked at the minutes from the preceding five months. The meeting we observed was generally well attended by a range of disciplines, including escort contractors and a Listener. There were no representatives from Education and Reception and a member of the CARATs⁸ team was present for the first time. The findings of the research undertaken by the Psychology and Health Care departments could also feed into the project currently under way by the Safer Custody Group on the definition of self-harm. One of the aims of this is to help prisons to record incidents in a more consistent way. The project will also gather qualitative information from prisoners. Active Suicide Prevention Teams already know that showing concern for prisoners and listening to them can be therapeutic in itself. It minimises the risks of an act of self-harm or, in its extreme form, suicide. The questioning process also informs staff when planning for suitable and appropriate prevention measures.

3.30 We were told that 91 staff, including the chairman of the Suicide Awareness Committee, had received suicide prevention training. In fact, current training records showed 52 who had completed this training over the previous 12 months, with a further 100 staff on the waiting list. There was one suicide prevention trainer. We met a number of staff in residential areas, Health Care and from other disciplines, who had had no recent training in suicide prevention. On our night visit during this

⁸ Counselling, Assessment, Referral, Advice and Throughcare services – part of the Prison Service drug strategy.

inspection, we found that some night staff on wings did not know where the self-harm response kits were located or how to use them. One officer said that he had never heard of them.

3.31 A central register that recorded all prisoners on F2052SH procedures was held in the Segregation Unit. Staff there had been instructed to ensure that F2052SH reviews were completed on time. There were some doubts as to whether the Segregation Unit was the best place to keep the register or to monitor the F2052SH process and this was being reviewed. Since January 2001, 410 forms had been opened, 25 of which were open at the beginning of this inspection. Eight of these prisoners were located in Health Care and seven on B Wing (Remand and Induction). Eighteen were convicted or sentenced, six were on Remand and one was a detainee. Three-monthly reports identified the number of incidents, the location and time of the incident and the methods used to self-harm. The reports also served to highlight the dangers of dismissing some self-harm behaviour. They questioned the over-reliance by wing staff on Health Care staff to deal with these prisoners. Ironically, we found that most incidents of self-harm had taken place in Health Care, which had no resident Listener. Some new prisoners arriving at the prison had been located there without any subsequent induction.

3.32 There had been little improvement in the quality of entries in the F2052SH forms since the previous report. There were many short entries that did not indicate whether staff had spoken to the prisoner and most were simply recording staff observations. We did, though, find some very good entries on the F2052SH forms made by senior managers and we liked the checklist attached to each F2052SH. To encourage staff, managers should provide written comment in the daily supervision and support record about the quality staff's entries on the form. On some wings, we found F2052SH records lying on desks among other paperwork. A new initiative had recently been started whereby a CARATs worker saw every prisoner on whom a F2052SH had been opened.

3.33 There was no co-ordinated system on residential units for F2052SH reviews. Wing Principal Officers usually chaired these reviews and some reviews were beyond their target date. The meetings were rather haphazard, with no regular attendance across the various disciplines that should have been contributing to the review process. Involvement by the prisoner's family did not appear to have been an option. Ideally, a wing officer, preferably the prisoner's personal officer, should have spoken to the prisoner before the review and prepared him for the meeting. The two of them should attend the review, together with all relevant contributors. Thereafter, the personal officer should reinforce any care plan. The prisoner would then know what had taken place and could raise any questions outside the meeting if he wished.

Example 4: We observed one F2052SH review on B Wing. We were told that it was difficult to get other disciplines to attend. An Officer from the landing had been invited but he said that he did not know the prisoner and did not attend. A psychologist came but said that she was not routinely involved in reviews. There was no one from Health Care, although the prisoner had been prescribed medication. From the meeting and written information, the prisoner's vulnerability to self-harm had been heightened because of bullying and because this was his first time in prison. He had missed canteen because of moves between wings and had only recently been able to contact his mother. After ten days, he had not yet had any induction. The simple assurances that the Principal Officer was able to give this prisoner, along with the promise of some support from Psychology, were enough significantly to reduce his anxiety. Somebody had listened to him.

3.34 The Listener Suite was in the Health Care Centre and its use was properly recorded. The suite had been used on 18 occasions in the ten weeks before this inspection. In most cases, prisoners remained there for one to two hours but there had been occasions when they had stayed there overnight with two Listeners. The prisoner needing help and both Listeners needed to be escorted to the suite and although this had posed problems after lock-up hours, matters had improved. Listeners said that they experienced delays in returning them to their wings once the session had been completed and this should be addressed.

3.35 There were seven Listeners; a further three were being trained. These were located on two residential wings and there were none in the Vulnerable Prisoner Unit or in Health Care. Listeners worked in Reception thus providing new prisoners with access to some support. Although the number of Listeners had increased since the last report, this was still insufficient. The Listeners we spoke to felt supported by a weekly meeting with the Samaritan prison support officer. They thought that, in the main, staff accepted them, although one or two officers still struggled with the confidentiality requirement under which they worked. There were Samaritan posters displayed next to all telephones but there had been long-standing technical problems with the Samaritans' direct telephone line. There was scope for promoting the work of the Listeners throughout the prison and this should be considered. In a recent death in custody, the Samaritans had not been informed and they should be included in published arrangements.

Conclusions

3.36 Overall, there had been limited improvements in the approach to managing and minimising self-harm. An active Committee and recent in-house research would pave the way for future interventions. The continuing use of Listeners in Reception and their inclusion on the Committee were all positive steps. The link with drugs so that CARATs workers saw all prisoners who had an open F2052SH was a good initiative. It indicated to us that self-harm and suicide mattered very much to staff and managers at Wormwood Scrubs. Against that must be set the poor levels of training and the more worrying aspect of night staff not being fully prepared in case of an incident.

Recommendations

3.37 **All staff should have current training in suicide prevention. Priority should be given to residential, reception, induction and Health Care staff, as well as those working with prisoners who are withdrawing from drugs.**

3.38 **All night staff must be trained in the use of self-harm response kits.**

- 3.39 **A system should be developed to ensure that F2052SH reviews take place on time and are multi-disciplinary.**
- 3.40 **Each landing office should have a readily identifiable and accessible place to keep open F2052SH records.**
- 3.41 **More Listeners should be recruited and ways explored for recruiting prisoners from ethnic minority groups.**
- 3.42 **Consideration should be given to appointing a Listener liaison officer who could also promote the work and recruitment of Listeners.**
- 3.43 **In taking Suicide Prevention forward, the prison should seek the support of the Area Suicide Prevention Co-ordinator.**
- 3.44 **The prison should be funded for a full-time and dedicated suicide prevention co-ordinator to support its current efforts.**

Race Relations

3.45 Aspects of race relations were covered under the overall heading of 'Foreign Nationals' in our previous report. The two subjects are dealt with separately here. In February 2000, we had found a much improved and positive approach to the understanding and acceptance of diverse cultures. The significant recommendation at that time was to improve training and awareness. Compared with last time, when the percentage of minority ethnic prisoners was 41%, this had increased to around 62% in November 2001. Nine per cent of respondents to our prisoner questionnaire said that they met racism from other prisoners and 9% from staff.

3.46 The total number of staff employed at Wormwood Scrubs on 3 December 2001 was 553 of whom 453 (82%) described themselves as white. The number of

ethnic minority staff was higher than we had found in many establishments. The distribution of ethnic minority staff among prison officer grades was as follows:

Grade	Staff in post	Ethnic minority staff
Senior Manager	10	0
Principal Officer	19	1 (5%)
Senior Officer	39	1 (2.5%)
Prison Officer	271	24 (9%)
Operational Support Grade	56	18 (32%)
TOTAL	395	44 (11%)

3.47 Given these statistics, consideration should be given to positive action to help ethnic minority staff achieve promotion.

3.48 The Race Relations Management Team (RRMT) met monthly, and was chaired by a member of the senior management team. We looked at the minutes of five team meetings in the period June to November 2001. They contained scant information and recorded little depth of discussion. The quality of the minutes was poor, statements were unattributed and plans were left unactioned. We found the Race Relations Management Team undirected, uncoordinated and unsure of its role. There was no evidence of policy in the making and there was little to suggest the driving forward of a culture of diversity.

3.49 We saw statistical information provided for the Race Relations Management Team. It covered details of the numbers of minority ethnic prisoners accommodated on the various wings, the numbers who worked as orderlies, as mess workers, kitchen workers and as cleaners. There were some gaps in information where “no data was available”. These gaps applied to the use of Control and Restraint, Incentives and Earned Privileges, use of gymnasium and Education, CARATs, Release On Temporary Licence, Home Detention Curfew, transfer out of the establishment and transfers under the Mental Health Act. In these circumstances, there was insufficient information to decide whether any remedial action needed to be taken.

3.50 Although the Race Relations Liaison Officer (RRLO) was not available, we did meet the Assistant RRLO. He had been suitably trained for this role and was himself a trainer. He was keen to implement a comprehensive and wide-ranging race relations policy across the establishment. He possessed a sound grasp of the wider implications of race, diversity and equality and was highly suitable to take matters forward.

3.51 The Race Relations Action Plan 2001-2002 was a comprehensive and well laid out document with clear targets and objectives. Many of its timescales were unspecific and stated as 'ongoing'. They should have staged deadlines that can be monitored. An audit of the Action Plan (titled Annexe II) was attached to the minutes of the Race Relations Management Team meeting held on 15 November 2001. Regrettably, some items in this document were shown as meeting the required standards although this was not the case. An example was the requirement to publish the name of the Race Relations Liaison Officer to staff and prisoners.

3.52 Noticeboards throughout the establishment should display the names, photos and responsibilities of the Race Relations Liaison Officer, the Assistant RRLO and chair of the Race Relations Management Team. This simple, yet fundamental, requirement had not yet been achieved and a target date of 31 March 2002 had been set. The same date required information to be provided throughout the establishment in a range of languages. Many prisoners were unaware of the existence of the Race Relations Liaison Officer, Race Relations Management Team or the means to complain about discrimination. Many staff had not received any race awareness training during their induction period, although it had been recorded as achieved on the Action Plan audit.

3.53 Even prisoners who knew about how to make a formal complaint said that they did not have confidence in the complaints procedure. They felt that nothing would be done and that they risked being transferred to another prison. There were locked boxes on wings in which prisoners could post completed complaint forms; blank forms were available next to these boxes. The Race Relations Liaison Office

collected completed forms. We were not confident that prisoners who did not understand English would receive help from staff in the event that they wanted to make a complaint. Prisoners described their experiences as ‘no better or worse’ that that faced in the wider community.

3.54 The library displayed some information in other languages, but this was limited and the selection of books did not adequately reflect the various nationals who were currently in the prison (although see paragraph 2.162). Meals provided for Muslim prisoners during Ramadan were generally satisfactory, although a salad was hardly a substantial meal when breaking a fast.

Conclusions

3.55 We found national and local policy statements on race relations displayed at various points in the prison. Despite this, there was limited evidence of the establishment having embraced the concept of equal opportunities, race relations, and diversity. The drive and energy to promote good race relations at a strategic level had dwindled. The impetus to keep it alive rested in the hands of some keen and committed race relations staff and others, rather than promulgation of action based on policy and operational guidance from senior managers.

3.56 From the time they arrived at Wormwood Scrubs, there were inadequate arrangements for Foreign Nationals in particular. First Night measures and Induction should be included in planning for the special needs of this group of prisoners. A greater commitment in actions as well as words was required from all senior managers and real direction from the Race Relations Management Team.

Recommendations

3.57 **The role of the Race Relations Management Team should be re-examined. Its membership should contain representation from across all departments of the prison and include wider representation from the community.**

- 3.58 **All members of the Race Relations Management Team should receive full race and diversity awareness training, and race relations management team training.**
- 3.59 **Minutes of Race Relations Management Team meetings should properly record the gist of discussions and any outcomes and decisions reached. Action points should also be followed up at subsequent meetings until they have been accomplished.**
- 3.60 **The Race Relations Management Team should regularly be provided with a full set of statistical information to inform monitoring across time and to enable remedial action to be taken where necessary.**
- 3.61 **Names, photos and responsibilities of the Race Relations Liaison Officer, the Assistant RRLO and chair of Race Relations Management Team should be displayed on noticeboards throughout the establishment.**
- 3.62 **Race relations and diversity training should be delivered to all grades of staff regularly and without exception.**

CHAPTER FOUR

HEALTH CARE

Introduction

4.01 At our last inspection in February 2000, we were pleased to find a health care service that had improved in significant respects since our visit in March 1999. On this occasion, we found a service that had deteriorated from this level in many ways. Particularly, we were disappointed to find that improvements based on joint working between prison and the National Health Service were much less apparent at Wormwood Scrubs. This collaboration is now becoming the norm in prisons across the country. The failure to progress and, indeed, the regression that we found seemed to us to be based on a failure of leadership in the health care service.

4.02 The task of leading the health care service to a better standard was made infinitely more difficult by the failure of the National Health Service (NHS) to provide adequate supporting clinical services to the prison. Large numbers of patients with serious mental illness, who should have been in-patients in the NHS mental health service, were admitted from the courts to the health care centre at Wormwood Scrubs. There they remained for weeks or months before a suitable National Health Service bed became available. This left the prison trying to do the National Health Service's work without its skills and resources, a situation that cannot but impair the outcome for these seriously ill patients. We refer to this in more detail below.

Staffing

4.03 There were five full-time doctors headed by a senior medical officer. Two were trained as general practitioners, two had experience in psychiatry but had not completed specialist training and one, a locum, had surgical experience. There was also a half-time National Health Service general practitioner. We were not convinced

that, either in numbers or in a mixture of skills, the medical establishment was suited to the needs of the patients at Wormwood Scrubs.

4.04 At the time of this inspection, the clinical nurse manager (a Registered Mental Nurse) with responsibility for inpatients had just begun a secondment to the National Health Service. A Health Care Senior Officer (a Registered General Nurse and Registered Mental Nurse) was temporarily promoted to Health Care Principal Officer to fulfil this role. In addition, there were two more Health Care Principal Officers, one with responsibility for operational management, the other with a remit for policy and clinical audit and other nursing issues as well as primary care and treatment clinics. There were four Health Care Senior Officers, two of whom had both general and mental health qualifications. Of the 12 Health Care Officers, three had general nurse qualifications and three were trainees. There were six F grade nurses. The nursing establishment should have included 46 E grade nurses but there were 14 vacancies, which we were told, was an improvement since the beginning of the year. An agency nurse had been on night duty for three and half years. Inevitably, the nursing staff were stretched to fulfil just the minimum staff level which quite clearly had a detrimental effect on patient care. In addition to these problems sickness rates appeared to be a problem with six staff being absent during our inspection. Doctors and nurses were assisted by administration staff comprising an Executive Officer, an Administrative Officer, two SGB2s and one medical typist.

Continuing professional development

4.05 All registered health care professionals are required to keep their skills up to date as a condition of continued registration. We were pleased to see that the doctors had formal training plans as part of their annual appraisals and we were told that time and money were both available for continued training. There was, in our view, some doubt as to whether all the medical staff were fully trained for the type of work they were required to do.

4.06 Nurses were able to fulfil their continuing professional development and some had completed degree and diploma courses. Links had been made with the National

Health Service Education Confederation and nurses were proposing to attend courses on coronary heart disease and epilepsy. In addition, three Health Care Officers were attending courses at Broadmoor Hospital.

Clinical Governance and Audit

4.07 Until five months before our visit there had been little work in this area. We were very pleased to find that a newly promoted Principal Officer had taken on this role and had started to develop an interesting programme of audit. Already some interesting findings were emerging which, if acted on, should significantly improve practice.

Health Needs Assessment and working with the National Health Service

4.08 In common with other London prisons, Wormwood Scrubs had conducted a simple health needs analysis (HNA) two years ago. These early analyses were limited in scope. The new Principal Officer, who had conducted some preliminary audits, had also conducted a more extensive health needs analysis in consultation with the local health authority. At our last visit, we saw imaginative plans to develop both primary care and mental health care jointly with the local National Health Service. It was disappointing to find that no further progress on either project was apparent.

Management of health care

4.09 In both our previous reports, we recorded our concerns about the management of the health care service. We noted the complexity of the service and recommended appointing a single overall manager. This person would need high clinical and management skills and the vision to improve services to patients and develop joint working with the National Health Service. There was a single overall manager for health care in post at the time of the inspection. He was not clinically qualified but was assisted by three nurse qualified Principal Officers.

The Health Care Centre

4.10 The health care centre was on two floors. The lower was divided between an out-patient area and a ward mainly for physically ill patients. The upper floor was a ward for mentally ill patients. The out-patient area was clean and tidy and generally suited to its purpose. Closer attention was needed to checking that everything worked. We found that the hand dryers in the patients' toilets were broken.

H2 Ward

4.11 The ward that housed physically ill patients was in an appalling state. It was untidy and the floors and walls were far from clean. The toilet annexes in the wards were dirty and rubbish was strewn on the floor. Mattresses were stained and distorted by long use, the sheets and pillows were stained and the blankets torn. Not all patients had lockers and we were told that, if a patient broke one, it could take up to three months for the prison to provide a replacement. One patient had vomited on the floor and the vomit had not been cleared up. Staff said that the patient had refused to use a vomit bag or bowl but we saw none by his bed for him to use if he changed his mind. Storage cupboards in the ward servery contained several loaves of bread past their 'use by' date.

4.12 In short, there was a clear lack of clinical leadership aimed at maintaining basic standards and, overall, a prison seemingly incapable of maintaining an acceptable supply system. This was partly through the lack of staff. It also resulted from the continued use of beds in this ward for 'lodgers' and new receptions until they could be located on the main part of the prison. A shortfall of nursing staff meant that nurses were taken from this ward to work in other areas, so that there was rarely a full complement. This was demoralising to staff and provided poor care to patients. The F grade nurse was also required to undertake office duties as shift co-ordinator. These included making telephone calls, dealing with transfers and other administrative duties which could equally have been undertaken by an unqualified Health Care Officer leaving the nurse to utilise her clinical skills to nurse patients.

H3 Ward

4.13 This upper ward was cleaner and tidier, although again there were problems in replacing broken furniture. We were told that better bedding was to be provided but had been delayed through a service-wide misunderstanding about providing safer bedding for patients. As well as the mentally ill patients in H3 ward, this floor contained an eight-bedded detoxification unit, comprising two single rooms and a six-bedded dormitory. The unit was staffed by one F grade nurse and two E grade nurses.

Regime for In-Patients

4.14 There was little for the men in the detoxification unit to do and they spent most of the time lying on their beds locked up. The exercise area for all in-patients was unsatisfactory being simply an enclosed tarmac area. There was nothing therapeutic for patients to do except walk around and nowhere for frailer patients to sit.

Day Care Service

4.15 At our last visit, we were told of proposals to convert the top floor of the health care centre into a day hospital, mainly for patients with minor mental illness. If day care support were available, they could be managed on general location rather than as in-patients. We had supported this proposal. It was therefore disappointing on this visit to find that nothing more had been done and that this ideally suited area had been taken over by education. Many other prisons have found the benefits of providing day care. We were pleased to find that the psychiatric nursing outreach service was still running but with only one nurse.

Wing Treatment Rooms

4.16 In our previous reports, we were critical of the wing treatment rooms. We were glad to see on this occasion that the rooms, used for nursing treatments and doctors' surgeries, were much improved. The only unsatisfactory one was on E Wing and this was not being used at the time of our visit; it should remain out of use. Prisoners were unlocked for treatments according to the list prepared by the co-ordinator. The list was frequently out of date, which meant that prisoners could miss

their medication. Our prisoner questionnaires showed that 42% of respondents were taking prescribed medication. Of these, 33% had experienced problems in receiving their medication. Respondents also commented on having to wait too long, lack of communication or information, rude night staff and getting the wrong medication.

The In-Patients

4.17 When we inspect prisons with an in-patient unit, we briefly assess the clinical needs of the current in-patients to decide where they should best go. At Wormwood Scrubs, we assessed the medical records of 31 patients – 19 on H3 and 12 on H2. In our view, 12 of the 19 patients on H3 should have been in National Health Service psychiatric care, mainly in medium secure beds. Four of these patients were on the waiting list for transfer to the local forensic psychiatric service but reports to the court recorded that ‘no bed was likely to be available in the near future’. Two further patients, one on H3 and one on H2, would have been suitable for day care while on general location if this had been available. We were told that, in addition, there was a patient placed in the segregation unit in the longer term who was awaiting transfer to one of the high security hospitals.

4.18 In short, 45% of in-patients should not have been in the health care centre. Thirty-nine per cent appeared to have health care needs best met in the National Health Service secure mental health service. These figures are similar to those we have found in other local prisons. The shortage of secure psychiatric beds left staff at Wormwood Scrubs trying to manage an impossible combination of patients. The same staff had to nurse patients requiring secure psychiatric care and those with serious physical illness, including one patient awaiting a heart and lung transplant. Even with separate wards, this mixture would be almost impossible to deal with. We were assured that additional secure psychiatric beds had been provided. From our perspective, this had had no significant effect on the numbers of mentally ill people inappropriately detained in prisons.

Conclusions

4.19 The health care provision had deteriorated from the promising start in February 2000. Staffing levels and the appropriateness of qualifications and training in the context of what staff were doing were still a problem. The pressing need for a clinical manager had not been addressed. The physical condition of in-patient wards was appalling and patient regimes, including those who were undergoing detoxification, were highly unsatisfactory. The additional burden of having to care for patients requiring proper psychiatric care in National Health Service hospitals was a drain on an already under staffed department. There were good signs that audits and health needs assessments could inform development plans but these required proper resources to be effective.

Recommendations

- 4.20 **The number of doctors and the skills they need should be reviewed in light of the findings of the recently-completed health needs analysis. This review must recognise that primary care in prisons must be given by doctors trained in primary care. It also must recognise that, in accordance with the health care standards, the care of mentally ill prisoners should be under the direction of a psychiatrist on the relevant specialist register.**
- 4.21 **Recruitment and retention of nursing staff should be discussed with local National Health Service nurse managers and the Task Force.**
- 4.22 **To ensure that they can meet the needs of their patients, all directly employed medical staff should assess their need for further professional development. They should seek the advice of the relevant National Health Service regional Postgraduate Dean in doing so.**
- 4.23 **A nursing strategy should be developed taking into account current nursing practice developments and the required education and training programmes.**

- 4.24 **The health needs analysis should form the basis for future developments in the health care service.**
- 4.25 **The plans for the development of primary care and mental health care should be re-examined.**
- 4.26 **We repeat our previous recommendations to appoint a senior clinical manager who has an understanding of the needs of a community hospital as well as an in-patient psychiatric unit. The Governor should at least involve the regional health care task force in evaluating the existing management structure and identifying gaps in management expertise.**
- 4.27 **There should be regular checks on the functioning of equipment in the health care centre and any repairs should be made promptly.**
- 4.28 **Health care beds should be removed from the Certified Normal Accommodation.**
- 4.29 **The number of admissions to H2 ward should take account of the staffing level so that nursing care is not compromised.**
- 4.30 **The role of the shift co-ordinator should be reviewed.**
- 4.31 **A suitable regime should be designed for the detoxification unit.**
- 4.32 **The in-patient exercise area should provide occupation and diversion and should cater for frail as well as able patients.**
- 4.33 **We repeat our support for developing a day care service. This service should be reviewed in light of the health needs assessment.**

- 4.34 **The provision of treatment lists should be reviewed.**
- 4.35 **There should be urgent discussions between the Prison Service and the Department of Health on the clinically suitable location of mentally disordered people who come before the courts.**
- 4.36 **The causes and locations of injuries should be audited and the findings regularly reviewed.**

Good Practice

- 4.37 *A Principal Officer had been appointed to undertake clinical audits.*

Pharmacy

4.38 The pharmacy department continued to provide a good standard of pharmaceutical care, building further on the progress made following the previous two unannounced inspections. Two of the most recent recommendations had been put into practice. On the remaining two recommendations, drug charts were still not being completed or correctly endorsed when medication was either issued or administered to patients by nursing staff at the wing treatment rooms. Systems were in place to account for the access to drugs out of hours. The logging of keys and items taken from the emergency drug cupboard were not routinely followed. This caused auditing problems for the pharmacy staff although any removal of medication without the suitable recording requirements was now pursued formally.

4.39 We looked at treatment rooms. The one on A Wing had been provided with running water. The drug cupboards in some rooms had been left unlocked and some had defective locks thus making them difficult to secure.

4.40 The pharmacy staff hoped to be able to influence developing health services in the future. Since the last visit, the pharmacist had completed the prescribing formulary. Pharmacy staff appeared to be more accepted and they were actively

involved as members of the health care team at the prison. This would undoubtedly benefit the provision of health care to patients in Wormwood Scrubs.

Conclusions

4.41 The pharmacy department continued to provide a good service and pharmacy staff played an active part in the overall development of health care provision.

Recommendations

4.42 **Drug charts should be completed whenever medication is issued, including for special sick. An entry should be made to reflect medication that is due but has not been issued, either because the patient refused treatment or did not collect it.**

4.43 **The pharmacy, in conjunction with the Head of Health Care, should ensure rigorous security systems and accountability for drugs.**

4.44 **All drug cupboards should be locked when not in use and defective locks should be reported and repaired immediately.**

Dental Services

4.45 Our inspection of the dental facilities was constrained by the absence of the practitioner, who was not on duty on the day selected for the inspection. Further, the keys to the dental cabinetry were held by the practitioner and health care staff were unable to find duplicates.

4.46 Fifty-nine per cent of respondents to our prisoner questionnaire had not found it easy to see the dentist. Of those who had received dental consultation, 34% found the quality of treatment to be good and 30% said that it was neither good nor bad. Two of the three recommendations contained in the previous inspection report had not been achieved. These required re-siting the emergency call button and improvements to the patients' waiting area. We repeat these recommendations below.

4.47 Dental care was provided under the National Health Service's General Dental Services regulations. The dental surgeon attended for six sessions per week and the waiting list for treatment appeared to be reasonable, under two weeks. Emergencies were seen at the next available session. Out of hours emergencies were seen either by the practitioner, or in her absence, by someone from her practice. We were told that a full course of treatment for oral health was offered to all patients sentenced to over six months' imprisonment. This was in accordance with present policies.

4.48 These dental facilities had been inspected by Hammersmith, Ealing and Hounslow Health Authority over the previous 12 months. The Dental Adviser to the Health Authority expressed satisfaction with the facilities for providing dentistry under the General Dental Services regulations. Sterilising of instruments was by autoclave. Certification of the equipment, including radiographic, was complete and current. The floor and parts of the dental unit were dirty with accumulations of debris.

Conclusions

4.49 Dental services at Wormwood Scrubs provided a range of treatments. Waiting times did not reflect the dissatisfaction expressed by some respondents to our prisoner questionnaire.

Recommendations

4.50 **Duplicate keys for the dental surgery cabinetry should be kept in the Health Care Office.**

4.51 **The emergency call button must be moved to a more suitable position easily accessible from the operating area.**

4.52 **The waiting area for patients should be improved and health and dental education material should be displayed.**

4.53 A protocol for the thorough cleaning of the floor and the dental unit should be agreed with health care managers.

CHAPTER FIVE

ACTIVITIES AND SERVICES

Education

5.01 In our prisoner questionnaire, 45% of respondents had received some education or training at Wormwood Scrubs. Amersham and Wycombe College had held the contract for educational provision since 1999.

Staff and Managing Education

5.02 The Education Manager was part of the management team and was able to link with other departments in the prison. The education department consisted of 5 full-time and 41 part-time staff. All were suitably qualified and well motivated but there was long-term sickness as well as problems in recruiting staff. Local pay rates outside the prison were said to be significantly higher. All staff had a training plan and one teacher had just completed training for work with dyslexics. An educational programme for the wider prison population was being introduced, mainly on literacy, numeracy, information technology, and life skills. Staff had had much to learn and there were signs of strain.

5.03 Contract compliance had been generally good and accreditation had been reaching the Key Performance Targets. As we have pointed out in numerous inspection reports on prisons up and down the country the emphasis on Level 2 targets did not reflect the attainment profile of the students or their likely length of stay. There had been many new developments, some of which were being well managed with targets and action plans. The new Pathfinder programme was well organised and managed. An appropriate programme of English for speakers of other languages had been developed, with new examination targets. Other developments lacked action plans and staff were becoming overloaded. The implementation of a Self-Assessment

programme was well under way. Classroom observation of tutors had started but was not keeping to time. The renewal of the Basic Skills Agency's Quality Mark ('Q Mark') was also well behind time.

Induction

5.04 There were twice-daily induction sessions for education but attendance was poor and much time was lost. We observed a session in a small room on a residential wing. Only 4 of the 14 listed attended and of those, only 1 thought he had been on the main prison induction programme beforehand. The tutor spent an excessive amount of time tracking down absent students, which meant the session started very late. Diligent chasing paid dividends and nearly all prisoners eventually went through the education induction session.

5.05 After an initial briefing, students undertook the Basic Skills Agency tests. They were then individually given an informal interview and invited to apply for education. Because of the shortage of places on courses, students were advised that they would be placed on a waiting list for many subjects, especially computing. Some were advised to apply for work in the interim. On the last day of the inspection, there was a waiting list of 99 for various classes. A simple leaflet listed the courses available but it had not been translated into other languages.

5.06 The assessment results portrayed a diverse population with many low achievers in literacy and numeracy. In the preceding six months, 58% had been assessed as at being only at Entry level or below and only 27% were above level 1. No follow-on diagnostic tests were used to identify causes such as dyslexia.

Daytime and Evening Classes

5.07 The main daytime curriculum was neither broad nor balanced. It provided insufficient opportunity for expressive or creative work, or for higher level work. It was narrowly focused on accredited basic skills, key skills, English for speakers of other languages, information technology and life skills including some art. There was very little provision at all for the substantial population of lifers, just a few externally-

funded distance learning courses plus a few places in the basic classes. Some outreach work was provided for patients in the hospital wards and for vulnerable prisoners. The morning programme catered for about 100 at a time, in 12 classes. Additionally, small numbers were provided for in the vulnerable prisoners' wing and the hospital. The afternoon programme catered for 80.

5.08 The daytime programme included four classes on a new, externally-funded Pathways programme in basic skills. Three-week courses for those with greatest literacy and numeracy limitations introduced basic skills and key skills. These classes were effectively 'roll-on roll-off' workshops. Longer courses, lasting nine weeks, were more stable and offered progression. There was a sound, progressive scheme of English for speakers of other languages (ESOL), which included individual tuition as well as classes leading to the English Speaking Board accreditation. Students could also progress to basic or key skills classes. Evening tuition offered a wider range, with only limited opportunities for expressive and creative work. This catered for about 60 students.

5.09 The amount of education on offer was much less than the identified needs, even for the limited curriculum. The prison population was almost 1,000 and, at a maximum, there were spaces in education for fewer than 260 students per day. The tuition was mostly in half-day programmes, amounting to either 12.5 hours or 11.25 hours weekly.

Quality

5.10 The quality of the work seen was mostly good and appreciated by students. Sixty per cent of respondents who were attending education and training found the quality to be good. There were varied activities, including group, pair and individual work, class or small group teaching. There was a sense of purpose, and students and staff worked well together. The range of resources in use was narrow with no information technology and few books, magazines or newspapers. We did not see any use of video. Students had personal folders with completed action plans, although

some targets were far too general to guide their work. The system of ticking against a heading “Listening Skills” provided too little detail.

5.11 In the best classes, planning and record keeping were sound, staff had established excellent relationships with their students involving mutual respect and work was done intensively throughout lengthy sessions. Success was praised and there was a proper ceremony when certificates were awarded. Students responded well and many were working enthusiastically and taking work back to their cells between sessions.

5.12 In classes with weaknesses, staff were less prepared for their particular students or the resources available were poor. Some classes had several teachers during a week and continuity was not always well enough managed. Too much of the content in both basic skills and key skills was mechanical and lacked the stimulus of relevant contexts. The department was not involved in preparation for release or resettlement.

Attendance at Classes

5.13 The greatest problem in delivering a proper education programme undoubtedly lay in the inability to get students to classes on time, students failing to attend and classes being cancelled. Prisoners told our inspectors that residential staff did not always unlock for classes and that classes, especially evening ones, were regularly cancelled. For prisoners who worked during the day, evening classes provided the only opportunity for education and accreditation.

5.14 During this inspection, cancellations were above average and included the loss of one complete day and two evenings. One wing had not delivered any students for an afternoon’s programme. Afternoon classes were prone to start late; nearly a quarter of the planned time was lost on one session. Classes we observed contained an average of 5 students, reflecting about 40% of those expected by the tutors although registers listed more. In practice, the Education department tried to compensate for this by calling for higher numbers than they could accommodate. An

example of this occurred one morning when the total roll number for education was 177. Up to 16 students were called for classes that could only accommodate 10. The final attendance in total amounted to fewer than 100. Evening classes were particularly likely to be cancelled. Class registers confirmed that this was common.

Accommodation

5.15 The main education programme and induction were delivered in a coherent suite of 12 good-sized rooms and in a classroom in the kitchen area. Furnishing and storage were adequate but some of the lighting was poor. Display was limited and there was a dull quality to the setting. Space used for outreach varied from a sparsely supplied art room – a small, inadequately furnished side-room on a wing – to an open corridor area where other prisoners came to listen or join in. There were plans to create an additional suite of rooms for education.

Resources and Information

5.16 The costs of the growing assessment programme had left the budget depleted for buying-in learning resources. There were too few books, practical materials and materials relevant to the students' interests. Information technology provision was poor and there was little to support the wider curriculum. Laptop computers had been provided to support outreach work but the specialist information technology groups were short of printers and CD-ROM drives. Software was adequate for the information technology curriculum but there were few materials to supporting the rest of the curriculum. The photocopier was unreliable.

5.17 Overall, management information was not robust enough to monitor effectively trends and patterns that would assist in modelling the curriculum to the needs of the potential students. There was no system that accurately monitored the loss of teaching time through lateness and partial attendance or to identify the reasons for this so that they could be dealt with. There was insufficient information to allow the length of courses to be related to students' length of stay.

Conclusions

5.18 The education department continued to provide classes for prisoners who had little or no achievement in literacy and numeracy. The curriculum was heavily biased in favour of these people. Prisoners who had reached higher levels of educational attainment found little in the curriculum to entice them. Life-sentenced prisoners, Vulnerable Prisoners and patients in the hospital wards did not receive a comparable level of attention to prisoners on the main residential wings. Although the department was integrated into the work of the prison, it had not figured in any plans to resettle or reintegrate prisoners back into society. The most significant barrier to education at Wormwood Scrubs came from the failure to get students to classes in time and the cancellation of classes.

Recommendations

- 5.19 **Level 2 targets and the education contract should be reviewed in the light of students' needs.**
- 5.20 **The balance of full-time to part-time staff should be reviewed.**
- 5.21 **The induction process should be reviewed and it should include more comprehensive assessment and more multi-lingual materials.**
- 5.22 **The contract and the curriculum should be reviewed in the light of the published assessed needs.**
- 5.23 **Individual Learning Plans should be more specific, making them a useful information tool to plan future learning.**
- 5.24 **Consideration should be given for greater use of interesting projects, library and computing resources.**
- 5.25 **The education department should be included in providing information and courses that prepared prisoners for release and resettlement.**

5.26 Arrangements to get students from residential wings and into classes should be reviewed.

5.27 Attention should be given to the information systems, to ensure they provide accurate relevant information for the management of education by the establishment or the department.

Library

5.28 Twenty-six per cent of respondents to our prisoner questionnaire said that they had trouble in getting access to the library. This difficulty had been noted in our last inspection report.

5.29 There continued to be two libraries – the main one and a smaller one on B Wing for remand prisoners. The professional librarian was on duty for 30 hours weekly. In addition, there were two officer librarians and four orderlies, with an additional orderly for the B Wing library. There was a timetable of planned access to the libraries. This made provision for vulnerable prisoners and in-patients in the hospital wards. All movements to the library were dependent on the availability of residential staff and figures showed irregular attendance, poor attendance and a low level of borrowing by prisoners.

5.30 The main library was adequately stocked with a range of books for borrowing, although shortages of non-fiction were reported. There was an adequate range of books in the smaller library on B Wing. Effective efforts had been made to respond to the constantly changing language materials needed by the population of foreign nationals, partly through consortium arrangements with other London prisons, and partly through contact with embassies. There had been special events, too. The limited space for research and for study limited the use made of the library as a learning resource.

Conclusions

5.31 There were continuing difficulties in getting prisoners unlocked for their allocated library periods. Poor attendance and the failure to develop the library as an effective learning resource left it underused. On the positive side, there had been considerable achievements in providing suitable reading material for the culturally diverse prisoner population.

Recommendations

5.32 **All prisoners should have equal and regular access to the library.**

5.33 **The library should be developed to support the necessary developments in the education curriculum.**

Employment

5.34 Under “Purposeful Activity”, our prisoner questionnaire showed that 42% of respondents reported having jobs in the prison. Forty-nine per cent said they had no job; twenty-two per cent had applied for jobs. Fifty-four per cent of prison jobholders said that the jobs did not provide skills and experience that would be useful to them on release.

5.35 The Head of Residence was responsible for education, work and skill training. The Industrial Manager had day to day responsibility for work and training activities. There were approximately 1,000 opportunities for purposeful activities and, on average, 80% of places were regularly taken up. In addition to full time education and training, prisoners also worked as wing cleaners, orderlies, garden workers and servery assistants. Prisoners over the age of 55 were considered to be retired and were therefore not counted as participating in purposeful activities.

5.36 Although the intention was to provide the maximum number of employment opportunities, some jobs were clearly over-staffed. For example, 13 prisoners were employed as servery workers on C Wing. At one time, nine of them were behind the servery. This posed safety problems and caused confusion and slow service.

5.37 New arrivals at Wormwood Scrubs were given a basic skills assessment and then referred to the Sentence Management Unit for allocation to education or employment. Although the prison attempted to meet the preferences of prisoners, there were instances where prisoners were referred to unsuitable employment. One prisoner had metal plates in his arms, making him incapable of lifting, but was placed in the aluminium assembly and fabrication workshop. In another instance, a prisoner with arthritis was placed in a similar workshop. The results of initial assessments were not routinely communicated to workshop or training staff and therefore did not inform individual training plans. Training activities were properly recorded. Prisoners who continued to benefit from training were allowed to remain at Wormwood Scrubs to continue that training.

5.38 Six workshops provided employment opportunities. They consisted of a laundry, a tailor's workshop and four workshops devoted to the assembly and fabrication of primary and secondary glazing units for use in prisons. The standard of health and safety was good and most prisoners had been trained in the wearing of protective clothing. There was adequate training in the use of equipment in all working areas and this was recorded. Relationships between staff and prisoners were excellent and clearly contributed to the high level of motivation exhibited.

5.39 Many prisoners attending full time employment were unable to attend education during the working day. There was little support for those requiring basic education and there was an over-reliance on workshop staff to provide it. This was especially evident where basic numeracy was needed in the assembly and fabrication workshop. When there were staff shortages, prisoners could not go to work. This time could be usefully put towards additional education.

Conclusions

5.40 There was a reasonable amount of employment for prisoners. Where specific skills were being provided, achievements were properly recorded. Relationships between workers and trainers were very good, providing the motivation for the acquisition of certificated skills for those who wanted them. Workers who needed help in basic learning skills were not properly being identified and helped.

Recommendations

5.41 **The retirement age should be reviewed to allow prisoners over the age of 55 to take part in purposeful activities.**

5.42 **The allocation of prisoners to employment should be reviewed to ensure realistic numbers at any one time.**

5.43 **The initial assessment process should include some form of assessment of manual skill.**

5.44 **The results of initial assessments should routinely be communicated to workshop or training staff, to enable prisoners' individual training plans.**

5.45 **The prison should have arrangements whereby prisoners can develop basic skills in the workplace.**

5.46 **Consideration should be given to using the time that would have been spent in workshops towards additional education provision.**

Good Practice

5.47 *Prisoners who continued to benefit from skill training were allowed to remain at Wormwood Scrubs to continue that training.*

Skills Training

5.48 At the previous inspection in February 2000, we found no strategy for developing National Vocational Qualifications and key skills within the prison. Almost two years later, although there had been meetings and informal discussion, there was still no formal strategy for implementation. Some progress had been made and staff had attended a course provided by an external institution to raise awareness of National Vocational Qualifications. There was a clear intention to develop these activities but they were a long way from being developed and implemented.

Catering Training

5.49 Of the 42 prisoners working in the kitchen, only 4 were working towards achieving a qualification. Prisoners on the National Vocational Qualifications programme were progressing well and working to a high standard. Training had been developed to meet their specific and individual needs. Kitchen staff had a positive and committed approach to learning. They worked with the education department to provide basic skills training. Thus, excellent support was being given to those who could not read or write. This learning opportunity was open to all prison workers. Learning materials for basic skills had been designed around aspects of the kitchen. The course was run in the kitchen classroom, with a separate study room that was also used by students and assessors to discuss their progress. Portfolios were well developed and of good quality.

Industrial Cleaning

5.50 The plans to introduce an industrial cleaning course had materialised. The area used for training was well supplied, with a wide range of equipment and training materials. There was only one member of staff suitably experienced and trained but there were plans to recruit an additional trainer. Prisoners followed the British Institute of Cleaning Services (BICS) Cleaning Operators Proficiency Certificate at levels 1 and 2. Most course completions were at levels 1 and 2. More significantly, several prisoners were qualified to assessor standard and were used in this capacity. The staff trainer regularly attended conferences to ensure that work practices were up

to date and that industrial standards were being maintained. Externally certificated courses in biohazard decontamination had also been provided for prisoners.

Laundry

5.51 The laundry serviced the whole prison. There were now only two members of staff. Consequently, a maximum of 30 prisoners could be employed at any one time. No recognised qualification was on offer and there were no plans to introduce any formal training. At the time of this inspection, one member of staff was on leave and therefore numbers working in the laundry were further reduced. Safety should be monitored. We found that prisoners were allowed to dispense with protective overalls and one prisoner was wearing shorts.

Tailoring

5.52 Facilities in the tailoring workshop were good and the prison had contracts for the production of curtains for other prisons. This gave prisoners the opportunity to learn cutting and sewing. Other tasks included making pillowcases. There was also a contract for the refurbishment of audio headphones for an airline. Although this work was mundane, involving replacing sponge earpieces, coiling cables and packaging, prisoners could earn up to £35 a week. Not surprisingly, there was a waiting list for this work and prisoners often transferred from other work areas to do it. There were two qualified and experienced members of staff in this workshop. A City and Guilds 7802 in fashion was offered to prisoners, one member of staff being responsible for teaching theory in the evenings and on one morning per week. The standard of portfolios and practical work was of an extremely high quality and six prisoners had achieved the qualification each year for the last two years.

Aluminium Assembly and Fabrication

5.53 Four workshops produced aluminium glazing units. Most were well equipped but storage areas were limited. New storage areas were in various stages of construction. One workshop was used for cutting and the other three for the assembly of a range of primary and secondary glazing windows and door units. The finished products were for use in other prisons. Most staff had a background of precision

engineering and experience in the production of glazed units. Consequently, high quality work was being produced and there were good quality assurance arrangements in place. One prisoner with previous toolmaking experience was allowed to use tool setting equipment to produce jigs for window fabrication. This was supervised and encouraged the prisoner to further develop his skills and improve his employment opportunities on leaving prison. No recognised qualification was being offered but there were plans to introduce an National Vocational Qualifications level 2 qualification in the Production of Glass Supporting Fabrications as approved by the Glass Qualifications Authority. Good links had been forged with the material suppliers, some of whom had promised opportunities for employment to prisoners on release.

Conclusions

5.54 There was still no formal strategy for the development and implementation of National Vocational Qualifications and key skills. The work and effort that went into the available certificated training was excellent. The possibility that prisoners working in the aluminium assembly workshops could be offered employment on release was very encouraging.

Recommendations

- 5.55 **A strategy for developing and providing National Vocational Qualifications and key skills within the prison should be produced as soon as possible.**
- 5.56 **The kitchen should increase the number of prisoners on its National Vocational Qualifications programme.**
- 5.57 **Consideration should be given to using the industrial training area to train wing cleaners.**
- 5.58 **Attention should be paid to safety and the use of suitable personal protective clothing in the laundry.**

5.59 New storage areas for the aluminium assembly workshops should be built as soon as possible.

5.60 Plans should be expedited to introduce a National Vocational Qualifications level 2 qualification in the production of glass-supporting fabrications.

Physical Education

5.61 There was a continuing good range of physical education facilities, which included a sports hall, fitness and weight training rooms and a training classroom. There were good storage and shower facilities but no outdoor recreational facilities. Physical education staff were keen and well motivated and those prisoners attending physical education enjoyed the opportunity for exercise.

5.62 Respondents to our prisoner questionnaire showed that 38% of prisoners did not go to the gymnasium. Prisoners on most wings were offered regular sessions of recreation and some evening and weekend programmes were also available. Evening sessions were limited, as only two PE staff were available at any one time. Vulnerable prisoners were allocated sessions two or three times a day.

5.63 The physical education department offered a certificated eight-week vocational physical education course. There were many takers and prisoners gained a range of achievements such as the Community Sports Leaders Award and British Amateur Weight Lifters' Association award. Kinetic Lifting and Emergency Aid programmes were also provided. A bonus of £20 was given to prisoners on successful completion of the course and families were invited to attend award ceremonies. There was a well-publicised Sportsman of the Month award and prisoners contributed regularly to a monthly newsletter. Staff and prisoners participated in a charity 'Row

the Atlantic' simulation. The prison had teams in the local county volleyball and basketball leagues and regularly provided facilities for people with disabilities from the local community.

5.64 The department had also initiated a two-day programme of team building exercises in an attempt to reduce anti-social behaviour. One course had run and had successfully integrated prisoners and members of staff into the learning experience. All of them felt that they had benefited from the programme.

Conclusions

5.65 We were pleased to see that the commitment to providing a range of physical education activities encountered at the last inspection had continued unabated. The exclusion of remand prisoners and partial exclusion of full-time workers had to be remedied. The involvement in rehabilitation of offenders was an excellent initiative.

Recommendations

5.66 **All prisoners, including remand prisoners, should be offered gymnasium sessions.**

5.67 **There should be arrangements in place that make special provision for full-time workers.**

5.68 **Consideration should be given to providing additional evening sessions for physical education.**

Faith and Religious Activities

5.69 There were two recommendations in our last report and neither of them had been implemented. Muslim vulnerable prisoners could not attend their communal prayers because, we were told, no separation in the prayer room was currently possible. At many other prisons, although separate arrangements are made for vulnerable prisoners for chapel services, Muslim vulnerable prisoners come together for prayer without any problems arising from this arrangement.

5.70 The second recommendation reflected regimes that clashed with religious services. We were told that this was still the position. Cancellations of activities at short notice were also causing problems for the Chaplaincy team. We observed one such example where an evening group had been cancelled on the day it was to be held. A concert was held in the chapel during this inspection and 250 prisoners had signed up to attend. Arrangements had been made that 100 of them would be sent over for the concert but in the event only 36 were unlocked to attend. Another example involved an evening concert, for which a message had been left on the Chaplaincy answering machine at 3.00 pm to cancel the event. The message had not been picked up and a group of visitors who had travelled from Chelmsford to attend had made the journey for nothing. Starting time for groups and services was always dependent on unlocking and staff bringing prisoners to services and meetings. We were told that it was not uncommon for prisoners to arrive at 6.45 pm or 7.00 pm for an event that was scheduled to start at 6.00 pm. External speakers were no longer invited because of these delays. These were highly unsatisfactory instances and reflected the general trend of last minute decisions, poor communications and failure by staff to unlock prisoners for activities.

5.71 The Chaplaincy team was supplemented by many volunteers from Christian denominations. Some volunteers represented the Chaplaincy for specific prisoners. They visited prisoners identified as being at risk of self-harm, they ran two Alpha courses and one attended the Foreign National Throughcare Committee meetings. On one occasion, the Pentecostal minister came in to help one wing that wanted to enable some prisoners to make telephone calls abroad.

5.72 The needs of other religions appeared to be properly catered for. Arrangements within the Chaplaincy team were that all Chaplains would work with prisoners of the individual Chaplain's faith and denomination. Statutory daily duties such as attending Reception, Health Care, Segregation Unit and the Vulnerable Prisoner Unit were shared by all the team. The chapel was in poor repair and its

windows, in particular, needed attention. The Chaplaincy team did not appear to be properly integrated into the work of the prison, as the examples given above suggest.

Conclusions

5.73 The active Chaplaincy team was clearly frustrated in their work because of the failure to provide prisoners for services and meetings at scheduled times. The team itself managed to see most prisoners but they seemed to work as individuals, dealing with matters concerning their own faith and denominations.

Recommendations

- 5.74 **Muslim vulnerable prisoners should be enabled to attend communal prayers.**
- 5.75 **Prisoners should be able to attend religious services on time and without missing other formal activities.**
- 5.76 **Senior managers should ensure that the Chaplaincy team is fully involved in the work of the prison and is included in the various committee meetings.**

Catering

5.77 Our main recommendations from the previous report covered the need for kitchen workers to have time for separate exercise and access to other activities. The condition of wing serveries was also a cause for concern. Neither of these recommendations had been put into effect.

5.78 The prison kitchen was managed by a Principal Officer, and staffed with 1 Senior Officer, 6 Officers, 4 chefs and 42 prisoners. The kitchen was well organised and standards of hygiene were good. Prisoners working in the kitchen found it difficult to have a shower at the end of their shift. Time was limited and they were forced to either use that time to shower or to telephone home.

5.79 The food was generally tasty, usually served in good portions and there was a wide choice of food items. Prisoners could select meals one week in advance. Satisfactory arrangements were made for Muslims, vegetarians, vegans and those on pork-free diets. The kitchen had received the Heartbeat Award for its healthy menus. The menu choices included low salt and low fat options, but the selection of vegetables was limited to tinned or frozen varieties. The quality and nutritional content of such vegetables was low and unacceptable as a permanent option. Furthermore, their quality further deteriorated by being too long on the hotplate.

5.80 There was a shortage of freezer space in the kitchen, five freezers having been found unfit for use. Frozen food was stored on the floor of working freezers and other items in the freezer could be reached only by climbing over boxes of food. Generally, maintenance of equipment and flooring in the kitchen and serveries was poor. We found delays in reporting faults and subsequent repairs. Metal plates were sticking up and trolleys had sheets of metal coming away from the sides. Wing serveries were poorly maintained. Lights did not work, doors were missing and sneeze screens were opaque because prisoners had cleaned them with scouring pads.

5.81 The service of food was generally disorganised. In one wing, 13 prisoners served food to 262 prisoners. This caused confusion and provided potential for accidents. There were also consequences for evening activities, which were delayed because of this disorganisation.

5.82 Wing staff did not effectively supervise the serving of meals. We observed small portions of a popular potato dish being served. Servery staff told other prisoners that this was because the kitchen had failed to send sufficient quantities. When all prisoners had received their meals, there were still nearly two trays of potatoes remaining and these were shared between the servery workers.

5.83 Temperatures of food and food trolleys were taken and recorded before the food left the kitchens but food and hotplate temperatures on residential wings were not taken or recorded. The practice varied across wings, often being regarded as an

optional task and left up to the decision of wing staff on duty at the time. In addition, the method of temperature probing on the serveries was unsatisfactory. Inaccurate temperatures from an infra-red probe were being recorded. Our inspectors tested both the kitchen probe and the infra-red probe on several dishes and there were temperature variations of 20 degrees Celsius.

5.84 Prisoners did not dine in association. In double cells, the table was small and it was not possible for two prisoners to eat at it at the same time. The single cells on D Wing had no partition between the toilet and where a prisoner might eat. Their tables were also too small and was used for storage.

Conclusions

5.85 The prison continued to provide good, standard-quality meals for prisoners. Serving of meals on the wings was not properly managed; there were often too many servery workers and food temperatures were frequently not being tested or recorded. The eating of meals in cells was unhygienic and prisoners in double cells were cramped for space.

Recommendations

5.86 **Kitchen workers should be given time to shower without having to miss other activities as a result.**

5.87 **More fresh vegetables should be included in main meals.**

5.88 **More freezers should be purchased.**

5.89 **Repairs to kitchen equipment and trolleys should be dealt with promptly.**

5.90 **Servery sneeze screens should be of clear plastic that should not be cleaned with abrasive materials.**

5.91 **Meal times and the serving of food should be properly supervised by staff.**

- 5.92 **Servery staff should record the temperatures of food and hotplates when food arrives at the wing. Records of temperatures should be sent to the Kitchen Manager.**
- 5.93 **Consideration should be given to using the same type of temperature probe as used in the kitchen. If necessary, two probes should be provided to each servery, one to be used solely for halal food.**
- 5.94 **Prisoners should have adequate table space to eat their meals and in-cell toilets should be partitioned off.**

Prison Shop

5.95 In February 2000, the prison shop had been contracted out to Aramark. At that time, we found its service to be efficient, responsive to prisoners' needs and providing a broad range of services. Ethnic minority products were provided on request and newly-arrived prisoners could buy goods the following day.

5.96 On this inspection, the shop was still in the prison, and orders were taken, packed and delivered to wings. There was plenty of space and good storage systems. An effective Aramark Shop Manager was trained and knowledgeable about food safety, hygiene and various religions. Under her management, the shop was properly run. She was committed to providing an excellent service in all those areas in her direct control. We found her approach to be efficient and she was willing to be flexible in sorting out prisoners' queries and complaints.

5.97 The Prison Shop team was aware of the ethnicity and culture-specific needs for those prisoners at Wormwood Scrubs. The team was mainly from ethnic minority groups and spoke a number of dialects and languages. Of the ten Aramark staff permanently working in the canteen and on the wings, three were black, four were Asian, two were white and one was Chinese. The Prison Shop Manager attended the Race Relations Liaison meeting regularly and reviewed the range of products

quarterly. Nevertheless, prisoners told us that they needed ethnic minority products that were not on the standard shop list.

5.98 Prisoners arriving on a Friday or Saturday would not have canteen until the following Monday, or later, and then only if there was money in their account. There could be a nine-day delay in delivery of orders from time of arrival. We were told this would be solved by the imminent introduction of the new Induction packs. Many prisoners told us of delays in the transference of money into their accounts. This often was days after postal orders had been delivered by hand at the prison gate. Aramark confirmed that this was a major cause of complaint to them. Another major complaint was that prisoners' finance records were not kept up to date; they needed their earnings and allowable private cash to be available to spend as soon as possible. We were told that prisoners attending Education and other work would often not have the correct pay transferred for some time.

5.99 New remand and convicted prisoners who arrived without private cash did not receive an adequate advance of pay with which to order or buy goods from the shop. There were also 25 prisoners known as "no pay" prisoners. They included prisoners who had refused assessment for education if they could not read or write. Any prisoner not receiving pay was likely to get into debt and, with no means of repayment, would ultimately become vulnerable.

5.100 Another cause for prisoners' complaint related to their shop orders that had not yet been filled at the time they were notified that they were shortly to be transferred to another establishment. Some prisoners were told that an officer would collect their order for them on the morning of transfer. In practice, officers would often be busy or away from the wing that morning. Consequently, prisoners would leave without receiving the items they had paid for. This caused great frustration and anger. There were many instances where officers went to great lengths to work with the Shop Manager to solve these problems.

5.101 All prisoners were able to receive items from the shop irrespective of court dates and other authorised absences. This was organised by the Prison Shop Manager, who either delivered purchases to the prisoner on return or delivered the sealed package to a prisoner's cell on the signature of an officer.

5.102 Price increases were published and described as new "National Prices" when, in fact, they were the contractor's own national prices. Prisoners purchasing items from Argos catalogues were levied a fee of 50p for each order. Only two (related) hobby products were included on Aramark's standard list; these were matchsticks and wood glue. It was possible to order other items from a hobbies catalogue, but this also attracted a fee of 50p.

5.103 Aramark told us that prisoners were able to purchase newspapers and magazines from the Library. This caused some confusion, since the charges for these items were shown on prisoners' accounts at different times, making it difficult for them to reconcile their bills. A further problem about billing related to the tax element on Aramark receipts. Although this was simply part of Aramark's own accounting, prisoners believed they were being charged an additional tax.

5.104 The system of delivering bagged orders was wasteful of people's time and energy. Deliveries were made while wings were locked up and required the assistance of between two and four officers for each landing. These wing staff escorted Aramark staff to cells where prisoners were unlocked to take delivery of their goods. With the volume of deliveries, there was no time for staff to wait until individual prisoners checked that their orders had been properly filled. In the event of any queries or discrepancies, prisoners had a further wait until Aramark staff could be escorted to cells to talk to the prisoner. The arrangements for other units, such as the Vulnerable Prisoner Unit were much better. There was less tension, as prisoners either came to a central point for collection or, if items were delivered to their cell or dormitory, they could query orders immediately.

5.105 During our inspection, 42% of prisoners said that the shop did not sell a wide enough variety of products. When asked what else they would like to see, prisoners said:

- greater variety of food products (17%)
- fresh fruit or vegetables (13%)
- more products for ethnic minorities, including Afro combs, and foods and skin products (13%)
- a wider range of toiletries (9%)

5.106 Many other products were also mentioned, in smaller percentages.

Conclusion

5.107 The service provided by Aramark was satisfactory and many problems were resolved by the team on site. Problems reconciling receipts of private cash and earnings continued. The system for delivering orders varied across wings and demanded too much time from wing staff.

Recommendations

5.108 Consideration should be given to increasing the range of ethnic minority products regularly available from the shop.

5.109 Arrangements for the transfer of prisoners' private money into their prison account should be reviewed to ensure that the transfer is expedited.

5.110 All prisoners should receive some form of pay in order to make essential purchases at the shop and thus avoid getting into debt with other prisoners.

5.111 Prisoners transferred at short notice should have an immediate and routine way of receiving shop items that they had purchased.

- 5.112 **The range of hobby products on Aramark's standard list should be increased.**
- 5.113 **Consideration should be given to a simpler and quicker system of delivering shop purchases to prisoners. Options could include using hours when prisoners were unlocked or dispensing orders from a central point on the wing.**
- 5.114 **The tax element of Aramark receipts to prisoners should be clarified.**
- 5.115 **Consideration should be given to including prisoner representation at shop meetings.**

CHAPTER SIX

GOOD ORDER

Introduction

6.01 The essential elements of good order in a prison are to be found in the way that staff deal with prisoners. Prisoners should be able to expect that they will be treated fairly and impartially by staff in accordance with well-defined rules. Although staff have considerable discretion in the application of these rules, this should be properly exercised so that any individual needs can be considered and legitimately met. A healthy staff-prisoner regime includes an understanding of this dynamic and it should form the bedrock for a well-ordered and productive regime. Prisoners should be able to feel safe. This includes safety from the aggression of staff and from arbitrary decision taking. It also means safety from other prisoners and from the worst excesses of the psychological impact of imprisonment. (See also the sections on safety on the Residential Units chapter and on Anti-Bullying).

6.02 Since publication of the reports on our inspections of Wormwood Scrubs in 1999 and February 2000, officers have been tried and some of them punished for criminal acts against prisoners. In both reports, we recorded the strenuous attempts made by managers to ensure that staff-prisoner relationships were put on a healthy footing. Their efforts appeared to have been fruitful. During this inspection, in December 2001, our Inspectors observed no brutality nor were any instances of it reported to us by prisoners or others. In fact, many staff were hypersensitive to the whole question of the use of force and some were reluctant to use Control & Restraint (C&R) even when it was warranted.

6.03 Handling prisoners who required a legitimate use of force was properly carried out and the written authorisation for all Control & Restraint had been properly completed. The information was kept by the Residential Unit and, where relevant, Segregation Unit managers.

6.04 The table below provides an extract from the register of restraints for the period 20 September to 20 November 2001

Date	Removed from	Removed to	Control & Restraint Used
September			
20	H2	H3	No
26	H3	Segregation Unit	No
27	Health Care	C& R team, to enable injection	Yes
October			
4	Reception	Segregation Unit	No
5	Health Care	C& R team, to enable injection	Yes
9	C Wing	Segregation Unit	No
13	Segregation Unit	Segregation Unit	Yes
14	H3	Segregation Unit	No
28	A Wing (2 prisoners)	Segregation Unit	Yes
November			
4	B Wing	Segregation Unit	No
9	C Wing	Returned to own cell	No
17	H3	H3	No
18	Visits	Health Care	No
20	H3	H3	No

6.05 We looked at whether prisoners felt intimidated by staff. Some prisoners believed that if they complained, they would be moved from Wormwood Scrubs where they were near to family and friends or had access to legal representation. Other prisoners did not feel this constraint and said that staff-prisoner relationships were good. This was certainly what many prisoners across most wings conveyed to us. We concluded that intimidation by staff was not part of the normal experience of prisoners. However, positive relationships had yet to develop fully. Staff were more

comfortable in being supervisors rather than agents for change and it was not just a matter of confidence. Shift systems worked against staff continuity on the wings and elsewhere.

Conclusions

6.06 The improvements in relationships between staff and prisoners that were present at the last inspection were still in evidence. Some staff were reluctant to intervene when minor incidents occurred. The use of Control & Restraint was correctly applied and properly documented. However, positive staff-prisoner relationships had yet to develop. Prisoners were generally content that staff treated them properly but they, too, commented on the lack of continuity of regular officers on residential wings.

Incentives and Earned Privileges Scheme

6.07 The general rule for applying levels of Incentives and Earned Privileges to individual prisoners was that they all started on Standard level. The exception was if they came to the wing having already achieved Enhanced level, whether at another prison or on another wing. On A Wing, 23 prisoners and on B Wing fewer than 5% of the prisoners were on Enhanced level; most were on Standard level. No prisoners on A, B or C Wings were on Basic level, although some clearly deserved to be because of their behaviour. (See the section on Anti-Bullying).

6.08 Prisoners wanting Enhanced level made applications that were considered by the Wing managers. Depending on the wing, either a Principal Officer or a Senior Officer chaired a board every month to consider these applications; the outcome of the board was recorded. Regressive moves on the Incentives and Earned Privileges scheme could only be authorised by a Principal Officer.

6.09 There was no regular review of Incentives and Earned Privileges and there was no attempt to link them to behaviour or to sentence plan targets. Wing history sheets sometimes recorded changes in Incentives and Earned Privileges level and some recorded oral warnings to prisoners. Some staff said that operating Incentives

and Earned Privileges on the wing was difficult because all double cells had television and there was little they could do to implement a basic regime. Enhanced prisoners were entitled to an extra visit and there was little additional incentive for them.

Another reason given by some staff was that any option to provide extra association for enhanced prisoners required more staff. On A Wing, we were told that because the turnover of prisoners was so great, prisoners did not really stay long enough for an Incentives and Earned Privileges system to be valuable.

6.10 Prisoners knew little about the Incentives and Earned Privileges scheme other than what had been given to them on induction. There were some notices that told prisoners what they could lose under the scheme for not attending work or education to which they had been allocated. For many prisoners, Incentives and Earned Privileges were unrelated to life on the wing. Some prisoners as well as one officer said that enhanced level was more about officers having 'favourite' prisoners. Generally, prisoners did not believe that the opportunity to become an enhanced prisoner was available to everyone. In our discussions with them, we gained the impression that the Incentives and Earned Privileges scheme acted as neither an incentive nor a deterrent. Prisoners' view of the operation of the scheme overall could best be described as neutral.

Conclusions

6.11 The Incentives and Earned Privileges scheme had a significant role to play in both the maintenance of good order and discipline and in motivating prisoners to take an active part in regime activities. Despite a recommendation to that effect, there had been no improvement between the differentials of the Incentives and Earned Privileges scheme. Many staff either had ignored the scheme or were doing the minimum in terms of deciding applications for enhanced level. Incentives and Earned Privileges were the casualties of staff deployments across residential units.

Recommendations

6.12 **There should be clear differentials between the levels of the Incentives and Earned Privileges scheme.**

6.13 The Incentives and Earned Privileges scheme should be promoted and publicised and staff should be required to engage with the scheme.

Segregation Unit

6.14 The single recommendation contained in the last inspection had been achieved. A register of restraints was being maintained and it provided an audit trail of all occasions where the legitimate use of force (Control & Restraint) had been used. In the three months preceding this inspection, the maximum daily occupancy of the Segregation Unit was six. Of the 14 prisoners who had entered the unit during that period, only three had been escorted there under Control & Restraint. There was no indication that prisoners from particular wings tended to be put in the Segregation Unit.

6.15 In our prisoner questionnaire, 18% of respondents had spent a night in the Segregation Unit. Of these, 40% said that they had been treated well by Unit staff, 25% had been treated neither well nor badly and 35% said that staff had treated them badly.

6.16 The Segregation Unit was located at one end of B Wing and was situated on the ground and first landing areas. The unit comprised 16 cells including two Special Cells and one cell to accommodate any incidence of “dirty” protest. All cells for occupation were on the first landing. There were four showers but all segregated prisoners showered alone under supervision. The ground floor contained offices, an adjudication room, the food servery and stores. Three ground floor cells were used as holding rooms to accommodate up to three prisoners each before adjudications. These holding rooms each contained three cardboard chairs and tables.

6.17 The Unit was staffed by one SO and four officers but there were plans to reduce this complement under recent proposals contained in the MCS review. Cross-deployment of staff to the Segregation Unit meant that inexperienced and untrained staff were in charge of particularly difficult prisoners. The Principal Officer was

helpful, enthusiastic, and led by example. The recently appointed regular SO was seeking to consolidate existing good practice and was committed to a policy of improvement. We found that all unit staff contributed to creating a non-oppressive and positive atmosphere. Orderlies worked in the servery and on domestic duties.

6.18 At the time of the inspection, there were three prisoners in the unit. We spoke to each individual and each was satisfied with the fairness and respect with which they had had been treated in the Segregation Unit.

6.19 A life-sentenced prisoner, who had been in several prisons and in special hospitals, presented volatile and unpredictable behaviour and had conducted a “dirty” protest some weeks earlier. He was awaiting further psychiatric assessment with a view to further hospitalisation outside the prison system. During the week of the inspection, he was in a more stable phase and staff dealt with him with a balance of sensitivity and firmness that appeared appropriate to his condition.

6.20 A prisoner was on 14 days cellular confinement, having been found in possession of a weapon made from a piece of wood. He had a record of violent offending and acknowledged his internal offence but saw this as ‘part of prison life’. He seemed largely unconcerned about his circumstances.

6.21 A prisoner was in the unit for his own protection having become ‘vulnerable’ in the Vulnerable Prisoner Unit. He was awaiting transfer out of the establishment. Delays in securing a transfer out of the establishment were frustrating for him and challenging for staff who could not provide an appropriate regime for this man.

6.22 The Segregation Unit was frequently expected to house prisoners who had just arrived in Reception. Records showed that it was not uncommon for up to eight new receptions to be thus accommodated daily. This duty was a major pre-occupation for staff and detracted from their primary duties.

6.23 We saw regular file entries by members of the Board of Visitors and noted that the Board normally assessed prisoners on Rule 45⁹ at seven-day intervals.

6.24 Staff-prisoner relationships were generally positive and these extended to prisoners on adjudications. The manner in which medical checks were made on prisoners due for adjudication that morning was unsatisfactory. The medical officer checks before adjudications were undertaken on each prisoner within the sight and hearing of other prisoners. This could undermine free discussion and compromise confidentiality, especially if a prisoner was displaying symptoms of drug withdrawal or mental illness.

6.25 We observed a number of adjudications and found that prisoners were treated courteously and fairly with adequate explanations of the process. The adjudicator offered proper opportunities for representations or mitigation. Prisoners did not have facilities to make notes. There was some inconsistency in the awards handed down by different adjudicators for similar offences – in the particular instance, refusing to transfer out of the prison when ordered.

6.26 Prisoners' wing records did not accompany them to the Segregation Unit and temporary history sheets were raised for the time spent in segregation. Photocopies of these temporary records were eventually sent with the prisoner to his post-segregation location. This was to enable the wing staff and Segregation Unit staff to retain their own 'originals'. We were told that this preoccupation with retaining originals as evidence was the result of staff anxiety in the wake of the ongoing police investigations. Whatever the reasons, some troubled and potentially disruptive or dangerous prisoners were arriving in the Unit without adequate records and this compromised the safety of staff and prisoners. Entries by Segregation Unit staff on prisoner history sheets were generally good. However, we saw no evidence that managers examined entries or checked that action was taken because of observations.

⁹ Rule 45 of *The Prison Rules 1999*. This says, in part, "Where it appears desirable, for the maintenance of good order or discipline or in his own interests, that a prisoner should not associate with other prisoners, either generally or for particular purposes, the governor may arrange for the prisoner's removal from association accordingly".

6.27 We watched the removal of two prisoners to the Segregation Unit. In the case of a prisoner from A Wing, we saw officers calmly escorting the prisoner off the wing and without the need to use Control & Restraint techniques. The other prisoner was removed from the visits room on suspicion that he had taken a substance by mouth. Staff took great care that he was not in danger as a result. On this occasion, staff handled the incident calmly and without using Control & Restraint. The rules of the unit were explained to him, as was the need for an obligatory strip search.

Conclusions

6.28 Overall, the unit was safe, clean and functioning satisfactorily in sometimes testing circumstances. Although staff clearly felt under considerable scrutiny, they continued to run the unit in an efficient and humane manner. New prisoners arriving at Wormwood Scrubs were unnecessarily located in the unit, which was particularly poor first night practice. Wing records were not accompanying prisoners to the unit and staff were consequently not fully informed of the nature and history of the person they were expected to manage. Managers also needed to be more proactive in monitoring entries in prisoners' history sheets.

Recommendations

- 6.29 **The Segregation Unit should not be used for accommodating overspill population.**
- 6.30 **Consultations between doctors and prisoners in the Segregation Unit should be conducted individually and in private.**
- 6.31 **Guidelines on adjudication awards should provide consistency and fairness.**
- 6.32 **Prisoner records should always accompany them to their current location immediately.**

6.33 **Managers should regularly read a sample of records and history sheets, and sign the documents to this effect.**

Public Protection

6.34 The establishment had effective systems to enact the two main provisions of Prison Service Order (PSO) 4400. These deal with the protection of persons from harassment by prisoners and the protection of child visitors from prisoners known to pose a potential threat to them

6.35 There was an effective system for child protection. The Custody Office identified those prisoners to whom these measures applied and there was generally a high level of awareness. We found good communication and liaison between caseworkers, administration staff, visits staff, the Vulnerable Prisoner Unit and other residential units. The way in which details of specific children were obtained was an example of good practice. Relevant prisoners were promptly notified in writing of the procedures, the right of appeal and of the consequences for their case management. There was no overall team that managed this subject and monitored operational procedures.

6.36 There were few such nominated child visitors and, at the time of the inspection, only one prisoner was receiving such visits. Twelve prisoners were awaiting clearance of their applications, which depended on the outcome of risk assessments. We spoke to a number of prisoners subject to child protection measures. They said that the system “was too much hassle”, that it “caused too much grief” and “I am innocent, why should I go through that?” There were, then, some inherent difficulties in facilitating authorised contact with families. This could be looked at by a Public Protection Committee.

Conclusion

6.37 The arrangements for public protection were handled satisfactorily and sensitively.

Recommendations

6.38 **A Public Protection Committee, chaired by a senior manager, should be set up.**

6.39 **Steps should be taken to reduce the delays in returning risk assessments in child protection cases.**

Good Practice

6.40 *The Administration Officer established personal contact with the responsible adult visitor at the outset. He was present at individual appointments, during which nominated children were positively identified and photographed. The co-ordinator copied the evidence of identification and kept it on individual case files.*

Categorisation

6.41 Proper security categorisation, classification, allocation and transfer procedures assist prison managers and staff to function effectively and sentence plans to be implemented. At Wormwood Scrubs, we found well-organised arrangements in place to carry out Initial Categorisation and Allocation (ICA) procedures.

6.42 Initial Categorisation and Allocation was undertaken by the Sentence Management Unit (SMU) that had been established in 1999 to meet the formal sentence- planning requirement for prisoners with sentences longer than 12 months. We were told that ICAs were being completed for all sentenced and convicted prisoners, not just for those prisoners serving over 12 months, as required.

6.43 It was the aim of the Sentence Management Unit to complete an initial sentence plan on all eligible cases before the prisoner was transferred to a training prison. In addition, Initial Categorisation and Allocation documentation had to be completed within seven days of the prisoner's reception at Wormwood Scrubs. Priority was given to potential Category D prisoners, for whom the target was three days. There were only four Category D prisoners held within the establishment at the time of the inspection. These were all for legitimate reasons.

6.44 A Principal Officer and four Officers were assigned to this work as well as dealing with transfers and all sentence planning. The newly introduced minimum staffing levels (MSL) reduced numbers to a Principal Officer and one Officer. Staff were frequently being withdrawn to cover shortfalls elsewhere in the establishment without prior notice. Staff complained that this led not only to a lack of job satisfaction, disruption and continuity in their work, but also meant that scheduling and planning was almost impossible.

6.45 Such frequent redeployment meant that Sentence Management Unit had not been able to undertake any work relating to sentence planning for six months. This clearly affected Initial Categorisation and Allocation and progressive movement. It also affected the three-day target for completing initial sentence plans.

6.46 On the occasions when the unit was reduced to the minimum staffing level, they were told by Population Management at Prison Service headquarters, to give priority to co-ordinating transfers from over-crowding drafts. Staff estimated that they routinely dealt with a weekly average of 30-60 transfers arising from overcrowding drafts. There had been 41 during the week of the inspection.

6.47 As many as 80% (approximately) of prisoners transferred out from Wormwood Scrubs went out on overcrowding drafts, and the rest were planned progressive moves. Furthermore, these prisoners frequently received less than a day's notice of their imminent transfer. They were usually short-term Category C prisoners who were frequently relocated far from home. When faced with overcrowding drafts the establishment routinely sought volunteers. Thereafter, the most likely to be transferred would be prisoners who had refused work or to take part in regime activities without good cause. Inevitably, residual numbers would be arbitrarily chosen without their individual needs and priorities being met.

6.48 The Sentence Management Unit produced weekly statistical reports to the Governor of the number of unallocated prisoners. This incorporated a detailed

breakdown of prisoners not eligible for transfer and allocated sentenced prisoners on hold normally targeted for transfer, stating the reasons for holding them. This report also included the number of sentence plans not completed by their due date. This data was well presented and useful for monitoring purposes.

6.49 Statistics for the first week of the inspection revealed 90 prisoners unallocated. The total number of prisoners at that time shown as being unavailable for transfer was 914 out of a total prison population of 989. Reasons for ineligibility for transfer included almost one third who were remand prisoners or were awaiting trial. Around one sixth of the prison's population had been sentenced and allocated to Wormwood Scrubs. There were 188 life-sentenced prisoners and 57 prisoners normally targeted for transfer. Both groups were kept at the prison for medical reasons or to enable them to complete courses they had started. As far as possible, prisoners currently on courses were not transferred until they had completed them.

6.50 Being in central London with good transport links, Wormwood Scrubs was easily accessible for the families of many prisoners. Many prisoners were, unsurprisingly, reluctant to co-operate with planned moves to training prisons, although these had been based upon an assessment of their needs. They would have meant moving further away from home. Nonetheless, a number of prisoners requested transfers, for a variety of reasons. Notices displaying inter-prison transfer opportunities were posted on residential wings every week and prisoners were able to request a transfer at any time using a pro-forma devised for the purpose.

6.51 We liked the procedures and documentation that had been developed to ensure that Initial Categorisation and Allocation included an individual interview with each prisoner. This meeting told prisoners about the purpose of transfers and the links with sentence planning. It gave them general information about the various categories of prisons for which prisoners were eligible for transfer. Staff also used this interview to identify and refer prisoners to CARATS workers and to the Max Glatt Centre. We

were told of a prisoner at risk of self-harm who had been so reassured by his Initial Categorisation and Allocation interview that he had no longer given staff cause for concern.

6.52 We looked at a sample of Initial Categorisation and Allocation decisions and found them to be clear, objective and fair, following the procedure outlined above. Decisions were explained to the prisoners in person by Sentence Management Unit staff and this was subsequently confirmed in writing. Prisoners were recategorised whenever there was a clear change in risk factor. On average, 12 to 20 recategorisations were completed each month. There was very little Release on Temporary Licence at Wormwood Scrubs and prisoners were consequently being denied the opportunity to be considered for Category D status.

Conclusion

6.53 The Initial Categorisation and Allocation process was capably managed by the Sentence Management Unit staff and prisoners were sensitively handled at this difficult time. However, staff redeployment elsewhere had meant that no sentence planning work had been done for six months. Overcrowding drafts and depleted staffing were hampering the efforts of this hard-working team. It was creditable that, as far as possible, prisoners currently engaged on courses at Wormwood Scrubs were excluded from overcrowding drafts to other prisons.

Recommendation

6.54 **Staff in the Sentence Management Unit should not be redeployed to other duties.**

CHAPTER SEVEN

RESETTLEMENT

Visits

7.01 Many of the improvements in the visits system noted in our last inspection had been maintained. Comments from visitors and the visitor centre showed that the improvement in staff attitudes remained. There had been an increase, though, in dissatisfaction expressed in our questionnaire with the way prisoners felt they and their visitors were treated. Those regarding it as bad or worse had gone from 4% to 17%. This may have reflected that, last time, there had been training of visits staff, obviously committed to changing their previously poor reputation. In contrast, many of the staff we spoke on this inspection were not regularly based in visits and clearly preferred to be in their normal jobs.

7.02 The visitors' centre outside the main gate was still providing an excellent service despite lack of space. It was succeeding in its aim of providing a welcoming atmosphere and a comfortable place where visitors could spend time before and after their visit as well obtain information and guidance. The provision of lockers, refreshments and toilets all contributed to this positive experience.

7.03 Visitors' complaint forms were still available and visitors were encouraged to use the forms to make positive or negative comments. What caused most complaints by both visitors and staff was the visits booking system. This had recently been altered to allow visitors for remand prisoners to book their next visit while at the prison. Although this had improved matters, visitors were still experiencing major problems in getting through to the prison on the telephone. A system that allowed call waiting on that line would allow visitors to hold, rather than getting the engaged signal.

7.04 The psychology department had surveyed prisoners' and visitors' views in December 2000. The results revealed delays of between 10 and 20 minutes in opening times for visits. On the day we watched visits, the delay was 15 minutes. Staff told us that it was because they had to supervise movements within the prison instead of preparing for visits. Because of staffing shortages the same day, a decision had been made that property brought in by visitors for prisoners would not be accepted. There was no prior notification to the prisoners or their visitors. This caused frustration and disappointment, especially for some visitors who had made special trips in order to deliver property. Staff told us this was a common event.

7.05 The atmosphere of the main visit room was relaxed but well supervised and all the visitors with whom we spoke felt comfortable. Special family visits were held in the downstairs visit room. There was an excellently furnished and equipped crèche. It was closed both times we went to look at it in operation because there were not enough staff. The same reason was cited for its closure. Visitors were allowed to purchase refreshments for themselves and their prisoners from a canteen in the visit room. Since the canteen did not open until 10.00 am, the first group of visitors were unable to buy any drinks or snacks.

7.06 The fabric and furnishings in the main visit room were well maintained and contributed to a generally pleasant environment. This was in sharp contrast to the closed visits area, which was undecorated. Ineffective acoustic barriers between the cubicles meant little or no privacy for different sets of visitors.

Conclusions

7.07 There was a continuing commitment to providing arrangements that would make visitors to prisoners at Wormwood Scrubs feel welcome. The conclusion from our last inspection still held, that the experience for visitors had been "transformed". The lack of numbers and consistency in the staffing of visits was in danger of undermining what had been a significantly improved booking system.

Recommendations

- 7.08 **Accommodation in the visitors' centre should be increased.**
- 7.09 **Senior managers should ensure that the range of services potentially on offer for visiting times is regularly available.**
- 7.10 **The crèche should be properly and regularly staffed at all visiting times.**
- 7.11 **Consideration should be given to providing refreshments for sale throughout visiting times.**
- 7.12 **The closed visits area should be refurbished and redecorated.**

Management of Resettlement

7.13 Resettlement services and the development of resettlement policies for the whole prison had suffered from a lack of consistent management. At senior management level, responsibility for resettlement issues had changed eight times in the previous five years. Without a clear resettlement strategy, each change represented a setback in the development of services, as each new manager had to start afresh.

7.14 The current Head of Resettlement had been appointed only a short time before our inspection. She retained a large number of other responsibilities and had taken over resettlement for the time being. There was no job description for the post. The prison had completed a self-audit on resettlement that had identified any existing gaps and inadequacies. Resettlement meetings, chaired by the Head of Resettlement had last met in February 2001. Despite the recommendation in our last report, minutes of the last two meetings recorded little improvement in attendance, particularly by wing or other discipline staff. In our staff interviews, some staff expressed frustration at the lack of resettlement help that they could offer.

7.15 The systems for managing Home Detention Curfew (HDC), Release on Temporary Licence (ROTL) and Parole were impressive and administered by well-informed and efficient staff. Efforts were made to ensure that all eligible prisoners were assessed in good time and that they were kept informed of the progress of their cases. The workload was not high and there was scope for increasing the use of Home Detention Curfew and Release on Temporary Licence. During 2001, 662 of all prisoners received by the prison had been eligible for HDC; of these, 128 cases were considered and 41 granted. Although the number of applications for ROTL had increased since our last inspection, they were still comparatively low at 70 in 2001. Of the eligible prisoners, 38% were granted Release on Temporary Licence. Apart from one late return, there had been no Release on Temporary Licence failures.

Conclusions

7.16 The area of resettlement required its own manager, directly responsible to the Governor. Lack of progress on providing a strategy on resettlement was severely retarding progress in this area of work.

Recommendations

7.17 **Resettlement policies should be developed in response to the identified needs of each separate category of prisoner held at Wormwood Scrubs.**

7.18 **Membership of the Resettlement meeting should include all those necessary to ensure delivery of a resettlement strategy.**

Planning for the return to the community

7.19 There were some excellent, high-quality projects that involved the use of voluntary organisations in helping to meet the social re-integration needs of prisoners. The Revolving Doors Agency linked outreach workers to prisoners with mental health

problems. The Society of Voluntary Associates (SOVA) worked with the local Probation Service to provide post-release support to prisoners serving less than 12 months.

7.20 In our prisoner questionnaire, 56% of respondents who were due to be released soon said they had nowhere to live on release with a further 22% who did not know whether they had accommodation. Of these, 43% said that no one had spoken to them about housing problems. Seventy-eight per cent expected to be unemployed and none of these claimed to have had help finding a job.

7.21 The National Association for the Care and Rehabilitation of Offenders (NACRO) and the Citizens' Advice Bureau (CAB) both provided advice, help and support to prisoners on aspects of reintegration, such as housing, finances and employment. Prisoners could apply for these services or were referred by staff. Citizens' Advice Bureau workers participated in induction and visited a different wing each day, making their service available to all prisoners, including detainees and foreign nationals. The NACRO office was on C Wing. Over three-quarters of referrals to it came from sentenced prisoners on that wing. Access by prisoners located elsewhere was restricted.

7.22 Access to services varied with demand and relied on the prisoners to seek help. Support from Personal Officers in this context would have been helpful. Prisoners who were less aware of what help was available could have been advised by staff. In our staff interviews, one person said, "I would like more training on resettlement issues. At the moment, housing etc. is referred to outside agencies. If I could help with issues on the first night then that would solve a lot of problems with prisoners".

7.23 Prisoner needs were not monitored to help plan and allocate services. A needs assessment of unsentenced and short-sentenced prisoners conducted in January 2000 had not been repeated. No mechanism existed for routinely checking the circumstances of all prisoners before their release and no information had been

obtained on prisoners' progress or take up of services afterwards. Other members of staff in our interviews said, "The most you might help with is, 'where are you going? Here is a list of useful addresses for that area'". "We are nowhere near resettlement here. We just sort them out, put them on the track to addressing offending behaviour. Mainly informal chatting on the wing."

7.24 The joint thematic review of resettlement by the Inspectorates of Prisons and Probation highlighted "the potential of local prisons to carry out a particular role in the resettlement of prisoners from the immediate locality". It recommended that, where appropriate, prisoners should be located nearer to home in the months before release. Wormwood Scrubs continued to discharge a significant number of men back into the local community; 43 were due to be released in the 6 weeks from 1 December 2001. The diverse functions of the prison meant that the very prisoners who might benefit from such a strategy, especially those serving short sentences, were the least likely to remain in the prison. They could not therefore benefit from any resettlement services. (See also the section on Categorisation, especially about overcrowding drafts).

7.25 Wormwood Scrubs had retained a large seconded Probation team, allegedly one of the largest in the country. The team comprised one Senior Probation Officer; 9.8 Probation Officer posts; one Bail Information Assistant and one accredited group work tutor (of Enhanced Thinking Skills). Nearly 40% of the Probation Officer posts were allocated to work with lifers. The contract review report dated November 2001 reflected the wide range of activities undertaken by Probation staff, of whom one was attached to each residential wing or unit. As with the voluntary organisations, there was a sense that the Probation department was left to manage itself. Although the prison would give support and encourage developments and initiatives, there was no strategic planning or leadership.

7.26 We were told of significant changes in the way the London Probation Area planned to structure its resources and deliver its services in the community. These

changes would affect the way the prison prepared its prisoners for release and how it structured its own resettlement work, including risk assessment and sentence planning.

Conclusions

7.27 There were efforts by NACRO and the CAB to ensure that prisoners being released from Wormwood Scrubs were given some help to enable them to survive their return to society. However, the prison still had no overall resettlement strategy and many prisoners who needed help were being missed.

Recommendations

7.28 **There should be better co-ordination in the management and support of resettlement projects such as Citizens Advice Bureaux (CAB) and the National Association for the Care and Rehabilitation of Offenders (NACRO).**

7.29 **Identification of need and access to relevant services should be more systematic and the circumstances of each prisoner should be checked before release.**

7.30 **The prison's function in relation to the resettlement of prisoners serving fewer than four years should be clarified, especially for those released after a sentence of a few weeks.**

7.31 **The prison's resettlement strategy should be developed in conjunction with the local London Probation Area to ensure compatibility with local provision in the community, and continuity in delivery of services.**

Sentence Planning

7.32 The Sentence Management Unit (SMU) was made up of one Principal Officer, seven full time officers and two administrative staff. Since the officers worked normal wing shift patterns, no more than two were available on any one day for SMU

duties. Unit staff were regularly put to other tasks and, on three days during our inspection, only one member of staff was present in the unit. (See also the section on Categorisation, especially on the work of the Sentence Management Unit.)

7.33 The Sentence Management Unit's involvement in work with lifers was limited to Section 2 cases (automatic life sentence) and prisoners who had been out on licence but had been recalled. Wing staff completed the sentence plans for prisoners on C Wing. Staff of the Unit and the Head of Regimes acknowledged that it was not able to function effectively, and that a backlog of sentence planning work had developed throughout the prison. No one was able to predict when this situation might improve.

7.34 At the time of our visit, the prison held 188 lifer prisoners and 254 determinate-sentenced prisoners, all subject to formal sentence planning. There were 98 Automatic Conditional Release (ACR) and 156 Discretionary Conditional Release (DCR) prisoners. Local monitoring showed that eight lifer reports had not been completed by the due date. It also showed that sentence plans or reviews were overdue in 64% of the ACR cases and 52% of the DCR cases. Examination of a random sample of 20 case files revealed only one sentence plan prepared by staff at Wormwood Scrubs. We are unable therefore to make any comment on the quality of sentence plans.

7.35 There was little to indicate systematic case management of individuals. It was left to individual prisoners to decide whether they wanted help and information from outside providers. This individuality of approach meant that needs could easily be missed from sentence plans or equivalent tracking systems in order when formally offering help to prisoners.

Conclusions

7.36 There were considerable problems with providing sentence plans. Not only had a backlog built up, but also continuing re-deployment of Sentence Management Unit staff made any catching exercise impossible. There was no evidence of systematic case management of individual prisoners.

Recommendation

7.37 Sentence plans should be the vehicle for individual case management and should be completed on time with the quality of plans being routinely monitored by managers.

Offending Behaviour Work

7.38 In our prisoner questionnaire, 44% of respondents said that they had received no help in addressing their offending behaviour.

7.39 The prison ran one accredited group work programme, the Enhanced Thinking Skills (ETS) course. The aim was to run five courses each year, with ten prisoners attending each course. Although courses had run with mixed groups, priority was given to lifers and particularly Section 2 lifers. The programme was managed by a psychologist (Treatment Manager), Governor grade (Programme Manager) and Probation Officer (Throughcare Manager). In January 2001, the programme had failed to achieve an acceptable rating in its audit but considerable remedial work had resulted in the award of a satisfactory audit result in December 2001. A bid had been made for funding to increase the number of courses each year to ten.

7.40 A number of non-accredited courses was provided, again with the emphasis being on D Wing lifers. On other residential units, the initiative for much of the group work development had come from probation staff, many of whom were trained and skilled group workers. As well as making use of their skills, group work was seen as a more effective and expedient way of dealing with issues than resource-intensive individual sessions. All the programmes being considered had course manuals and were being delivered in other prisons or in the community. Decisions about which courses to introduce at Wormwood Scrubs were not based on an objective needs analysis nor were there any agreed criteria for determining which were appropriate. There was insufficient formal work on offending behaviour to meet the needs of all who could benefit.

7.41 There was a lack of effective multi-disciplinary work. Outside of ETS the psychology and probation departments worked with little reference to one another. Although different disciplines came together for individual projects, there was no forum for ongoing collaboration and there was no resettlement strategy which leant coherence to their activities.

Conclusions

7.42 The accredited Enhanced Thinking Skills programme had not been sufficiently well delivered to receive a reasonable rating until recently. We were pleased that non-accredited work was also being done. All offending behaviour courses should serve the needs of as many prisoners who would benefit from them in the time they spent in prison. There was no evidence that the current provision reflected the current need.

Recommendations

7.43 **A range of programmes, courses and help from external and internal agencies should be identified to meet the diverse needs of the prison population.**

7.44 **The resettlement strategy should be based on an annual needs analysis and identify a greater role for the psychology department within an effectively managed multi-disciplinary team.**

Max Glatt Centre

7.45 This self-contained unit for 30 prisoners operated as a therapeutic community for prisoners with longstanding habits of drug or alcohol abuse or both. The particular treatment model used was democratic, with small group psychotherapy as the medium of change. A new manager had been in post for eight months and was striving to develop the treatment to a standard that would earn accreditation from the Joint Accreditation Panel. There were plans to introduce Narcotics Anonymous (NA) and

Alcoholics Anonymous (AA) groups that could provide a bridge between treatment inside and outside prison. There would also be regular staff supervision and training, and relapse prevention work.

7.46 Specialist staff are needed to run such a unit and the full involvement of uniformed staff is crucial. The unit consisted of two psychotherapists, a drama therapist, a probation officer, supposedly with two Senior Officers and ten prison officers. This complement of uniformed staff was rarely provided, which meant that the officers were rarely able to attend small groups. They had consequently become divorced from the process of therapy.

7.47 Figures for the two months preceding this inspection showed many cancellations:

- therapy groups – twice
- community groups – three times
- Narcotics Anonymous and Alcoholics Anonymous groups – ten times
- evening education – five times
- evening association – six times
- other complementary treatment groups – five times.

7.48 Although therapy groups usually continued because of the input from psychotherapists, other complementary activities were regularly dropped. Casework meetings and staff supervision were also affected. This was unsatisfactory for both patients and staff and undoubtedly detracted from the effectiveness of therapy.

7.49 However, it was impossible to find out whether therapy was being compromised, as no monitoring or evaluation of treatment was taking place. There was no input from psychologists in this respect. The unit was isolated from other activities in the prison, including the drug strategy with which one might have expected some linkages. There was no awareness training about the unit for the benefit of other staff and staff outside the unit knew little about what went on there.

7.50 The Max Glatt centre stood to benefit from being accredited. It would demystify its role and it could, conceivably, protect its staff from being put elsewhere. Accreditation would require guaranteed commitment to the various elements of the treatment process, such as regular staffing and staff support, casework management, monitoring and evaluation. The integration of treatment into other elements of the prisoners' sentence plans and the essential aftercare to prevent relapse would also be requirements of the unit.

Conclusions

7.51 Despite the clear skill and commitment of the centre manager and her staff, the Unit was isolated from the rest of the prison.

Substance Use

7.52 There had been little progress in the development of the Drug Strategy since our last visit, apart from the work being undertaken by the contracted specialist agencies. Many of the issues we had raised had not been considered and our recommendations had not been put into practice.

7.53 In contrast to this, there were some promising signs of progress in the near future. Appointing an enthusiastic and skilled Principal Officer to co-ordinate the Drug Strategy had created some productive activity. In addition, the Area Drug Co-ordinator (ADC) was getting more directly involved in making sure that the prison was meeting its obligations. We hoped that implementation of the Management Consultancy Service review would ensure that staff were not continually put to other duties.

7.54 The prison had undertaken a Drug Needs Analysis survey of prisoners in November 2000, which was being repeated at the time of our visit. Findings revealed substantial problems related to drug use among prisoners. The facts that 47% of respondents had used crack cocaine and 42% had used heroin reinforced the need to develop support and treatment services.

7.55 The prison's written Drug Strategy was in the process of being updated and brought into line with the overall Area Drug Strategy. It detailed all the various initiatives that were taking place within the prison, each having individual performance targets. The Drug Strategy Group and the Area Drug Co-ordinator monitored these through monthly meetings and return forms. Minutes of the monthly meetings of the Drug Strategy Group showed that it knew the prison was failing to meet its targets in many areas.

7.56 The situation regarding Mandatory Drug Testing had scarcely altered since our last visit. The prison was not getting close to its target of 5% random testing and in some months was achieving less than half this number. While the value of random testing was debatable, more worryingly there was very little 'on suspicion' testing taking place. From August to October 2001, only two tests had been undertaken. At the time of our visit we were told that 46 'on suspicion' tests were outstanding and these were unlikely to be done. The CCTV system in the visit area had been upgraded but the use of the prisons drug dogs had continued to be irregular. It was generally accepted that the continuing failure to meet the agreed performance targets for supply reduction was due to the consistent re-deployment of staff.

7.57 The Voluntary Drug Testing (VDT) scheme was floundering. There had been plans to set up VDT and Voluntary Testing Units (VTUs) on all wings, to be run by trained and profiled staff and supported and co-ordinated by a VDT officer. These plans had hardly materialised. The only wing on which this was operational to any extent was C Wing, where the drug rehabilitation programme was being run. The failure to implement Voluntary Drug Testing was also attributed to the re-deployment of staff. It was also clear that there was little incentive for prisoners to engage with the scheme. Voluntary Drug Testing was coming nowhere near meeting its targets and, on some wings, neither staff nor prisoners appeared aware of its existence or purpose.

7.58 The detoxification (detox) unit had been decorated since our last visit. Work was due to start in the near future on making a group work and activities room for the

patients housed there. It was also planned to provide a daily programme tailored to the needs of patients undergoing detoxification. This would support their psychological well-being and motivate them in making changes to their way of life. The recruitment of some new and enthusiastic staff had given the unit a fresh impetus. The operation of the unit was supported by the prison Probation Department, which had an officer doing individual work with patients.

7.59 Since the detoxification unit could house only eight patients, almost all medical detox was taking place on the wings. There was little support offered to these patients. The existing detoxification nurses were fully occupied in running the unit and ensuring that medication was correctly dispensed to patients who were detoxifying on the wings. Matters were made worse by the patients being scattered around the wings. This made it impossible to provide any group support or to target resources in any one location. The prison had been allocated extra funding for two outreach detoxification nurses to provide a better service to those undergoing detox in the main prison.

7.60 The medical detoxification for opiate users was still based mainly on the use of dihydrocodeine. There was limited use of methadone for those assessed as appropriate under Prison Service Order 3550 'Clinical Services for Substance Misusers'. The inadequacy of dihydrocodeine as a detoxification agent is well known and it is not licensed as such outside prison. Staff told us that many drug users were consequently not declaring their dependency on entering the prison, preferring to go straight on to the wings. This was a matter for concern. These prisoners were either going through the trauma of detoxification without any support or were becoming involved in obtaining and using illegal drugs with all the associated dangers. To deal with this, new funding had been found to allow the prescribing of lofexidine as an alternative. It has been our experience from other prisons that lofexidine is as ineffective as dihydrocodeine and was unlikely to prove any more popular among drug users.

7.61 With the large numbers of prisoners requiring detoxification, there needed to be a more realistic approach to providing them with adequate treatment. We have seen models of good practice in detox using methadone or Subutex elsewhere in the prison system, including in the London Area.

7.62 The Turning Point drug-rehabilitation programme had moved from its original location on B4 to the 4s landing on C Wing. Although participants were not kept separate from the main population of the wing and had inadequate space for group work, we were told they preferred it to being on B Wing. The programme was designed to work with a maximum of 12 participants and had a target of 54 men starting in a full year. The programme was running as planned and had been developed to include a module on offending behaviour run by the Probation Department. Staff were undertaking a consultative process with the lifer population in order to tailor a programme specifically for their needs.

7.63 All those involved in the rehabilitation programme believed it was an effective intervention. This was despite work still being needed to increase the number of beneficiaries and to evaluate the outcomes of the programme. There were inherent problems, which we had noted on our last inspection, that still needed to be resolved. There was:

- no separation of the programme from the rest of the wing, and indeed its participants were not necessarily even on the C4 landing.
- insufficient space for group activities, which militated against increasing the number of participants.
- no involvement from prison staff. The constant re-deployment of wing officers meant that it could not be guaranteed that those on the wing were sympathetic to the aims of the programme.

7.64 The CARAT team was operating across the prison, providing assessment group work and individual support sessions as needed. It now included a worker to provide support services specifically for crack cocaine users. It was, however, struggling to meet its target of 1,073 full assessments per year. This was partly due to

the lack of referrals from the detoxification unit and partly to the failure of the Induction Programme to run as planned. The team had resorted to interviewing all new prisoners in order to originate referrals. We were disappointed to find that, since our last inspection, the scheme to train staff to support the CARAT strategy and in particular to become Wing Liaison Officers had faded out. The failure of prison staff to become involved in the delivery of the CARAT strategy limited its development potential.

Conclusions

7.65 We were disappointed with the failure to make any significant progress following the recommendations contained in our last report. Drug strategies were still in their infancy, despite targets not being met. Unless patients undergoing detoxification were in the health care unit, those on the wings received little help and support. The main initiative that was meeting prisoners' needs was the Turning Point rehabilitation programme. This, too, had problems, identified in our previous report but not yet addressed. Re-deployment of prison staff affected work on substance use and the scheme to train them as CARAT Wing Liaison Officers had not materialised.

Recommendations

7.66 **The Drug Strategy Group should review the prison's failure to meet its targets for supply reduction and ensure that adequate resources are allocated for this work.**

7.67 **The Area Drug Co-ordinator, with the Drug Strategy Group, should review the role of Voluntary Drug Testing in the prison. He should ensure its availability as a positive option for those who require support in remaining drug-free.**

7.68 **Consideration should be given to housing all those undergoing medical detoxification in the same location.**

- 7.69 **The Area Drug Co-ordinator, with the prison medical staff, should research various models of good practice elsewhere to ensure that appropriate and effective detoxification treatment is offered.**
- 7.70 **The problems in the delivery of, and arrangements for, the rehabilitation programme should be looked into by the Drug Strategy Group.**
- 7.71 **The Drug Strategy Group should look at ways in which prison staff can be encouraged to become involved in the delivery of the CARAT strategy.**
- 7.72 **The Drug Strategy Group should ensure that all prisoners who need CARAT services can be identified at an early stage and referred to the CARAT workers.**

CHAPTER EIGHT

MANAGEMENT AND STAFFING

Senior Management Structures and Continuity

8.01 Inspectorate reports do not normally contain a specific section on management and staffing. However, the Chief Inspector's terms of reference include the impact of organisational and resource management on prison conditions and the treatment of prisoners. Given the immediate past history of Wormwood Scrubs, we considered it important in this inspection to take the views of a sample of staff and to examine the prison's management structures and systems.

8.02 Prison Service establishments have to perform many different functions according to the categories of prisoners they hold. Wormwood Scrubs was a very large and complex prison and served the public by holding a particularly diverse population of unsentenced and sentenced prisoners. It was also exceptional in that it had a lifer and a therapeutic unit and held around 40% foreign nationals, with one wing holding up to 60% of them. It was an old, traditional local prison that had taken on some of the Prison Service's initiatives as part of its natural development. Good management and organisation is always important to the positive outcomes for prisoners but at Wormwood Scrubs it was essential.

8.03 Management structures vary and are often based on the preferred model of the chief executive of an organisation - the Governor, in this case. At Wormwood Scrubs, the management structure had been organised within a six-tier hierarchical structure that split much of the direct responsibilities between the Governor and his deputy. Thus, responsibility for most discipline staff and strategies relating to the welfare of prisoners fell to the Deputy Governor. The Governor controlled the overall staff and financial systems.

8.04 In the past Wormwood Scrubs had suffered from frequent changes of Governors and acting governors. More recently, the Governor brought in to turn the prison round, and the majority of his Senior Management Team, had left and a new Governor, with a virtually new SMT, was six months in post. We welcomed his assurances that he proposed to stay for five years and hope that this will be allowed to happen. However, in the meantime, stability and continuity were undermined (as witness the drift on implementation of or agreement on the MCS report). This was a view shared by staff, prisoners and particularly by the Board of Visitors.

8.05 Apart from the disruption such changes cause, they expose the organisation to the possibility of an alternative power structure. This is of particular concern in a prison like Wormwood Scrubs, which has had to eradicate a deep and resistant negative culture. The fact that that culture still lingered is evident in the attitude of the staff association, and many staff, to senior managers; and the fierce resistance, from some staff and middle managers, to any change or progression for the prison. In such a culture, managers need support, experience and time if they are not to be worn down by trench warfare on major and minor issues.

8.06 The present Governor had been in post for about six months. He told us that management changes had been unsettling for the prison and that some of the improvements were fragile. For example, regime activities that should have taken place either did not or were delayed. Prisoner activities therefore depended on which staff were on duty and what they felt like doing. This reinforced the inconsistency resulting from central staff detailing as described later. For that reason, he had introduced minimum staffing levels in the week of our inspection.

8.07 The past and continuing allegations against staff created a backdrop which made management more difficult. Considerable management time had been devoted to dealing with high levels of staff sickness, lateness and some poor staff attitudes. Added to this were the problems of re-integrating 27 staff who had been suspended from duty, as well as dealing with outstanding allegations. The Governor was planning the implementation of the December 2000 Management Consultancy

Services report to coincide with the reopening of all the prison. He would also be reviewing the work achieved so far and would produce a plan of where he wanted the prison to be in the next six months. Despite these intentions, it was disappointing to find that very little had been done to improve outcomes for prisoners since our last inspection.

8.08 Since that inspection, there had been significant and widespread changes to the management team and an almost complete change of senior managers, including a new Governor and Deputy Governor. The governor expressed his concern to us about the unsettling effect this had upon the prison, and the need to strengthen the SMT and ensure continuity. From our interviews with them it was clear that managers had their own views of what they saw as the prison's problems. We urged the Governor to set out his vision and direction for the future in order to create a shared recognition of or consensus on the important issues and, therefore, a corporate vision for the short and medium term.

8.09 We were surprised to find poor information systems in place. Although information collection systems had recently been introduced, we found poor quality and inaccurate material being collected. We sampled four weeks' regime monitoring returns and found that inaccurate information had been sent to head office. Whether this had been signed off or checked beforehand by senior managers, we could not tell. This meant that headquarters were therefore not in a position to credit staff at Wormwood Scrubs with the work that had been achieved because it had not been properly recorded. Poor information systems also concealed weaknesses such as insufficient purposeful activity.

8.10 For the efficient operation of a prison of this size and complexity, Wormwood Scrubs needed good communications between its managers, staff and prisoners. We found that the prison had all its mandatory meetings in place and that these were generally minuted. Although we were told that these minutes were copied to the wings, we could not find many of them there and staff complained they had not received them.

8.11 These are some of the comments made by staff in our individual interviews with them:

Sort the senior management team out. Get decent governors with some experience who stay here for a few years

I have had three line managers in three months. I see them for less than 10% of the time; it chops and changes all the time

I don't even know who is the Wing governor. They don't stay long here

There are very few wing meetings. All the managers want are the figures, how many on exercise etc

Managers don't seem to know themselves. They change the goal posts all the time

We need a clear vision for the future. We need to have more staff meetings where ideas can be aired and problems discussed. The only meetings we have are where orders are given and details of the day. They are not interactive meetings.

Middle Managers

8.12 To encourage Principal Officers (POs) to have a stake in the operational activities of the prison, the Governor had begun to invite them all to a short daily morning operational meeting. The idea was to invest in them as leaders in the prison and to improve the efficiency of the prison by better communications. It was disappointing to find that some Principal Officers regularly failed to attend these meetings and no senior manager appeared to have addressed this.

8.13 There was general confusion as to who ran the residential wings. Over a period, different models had been operated, with governors being located on the wings and then off the wings. This uncertainty had undermined the legitimate authority of Principal Officers, who had been criticised for not managing effectively.

We were given examples of staff pushing decisions up the line to governors. They, in turn, were frustrated at having to manage simple affairs that should have been made at Principal Officer and Senior Officer levels. There had been recent improvement but some Principal Officers were still failing to take the lead in their areas, relying on senior managers to make their decisions.

8.14 We were told of a culture of stand-off between residential wing managers and managers at Principal Officer and Senior Officer levels. On the one hand, Senior Managers told us that initiatives that they wanted to introduce were being blocked. Conversely, Principal Officers and Senior Officers said that, in their opinion, some of what managers were requesting would not work without adjustments being made. Senior managers regarded this as procrastination, while the middle and junior managers saw it as a process of negotiation and implementation. There were hugely complex staff cultural issues that needed bridging between all managerial levels in order to improve relationships and get things done.

8.15 Although written policy strategy documents were in place, they were not operational and staff had been allowed to select what they wanted to do. Even some strategies that were operational had fallen into disuse. Almost certainly, this was a consequence of the lack of management oversight and regular monitoring systems, which we would describe as poor. Poor management supervision had prevented the creation of a predictable regime. Staff made decisions for managers, creating disparity in regime provision and timing of activities across the wings. Staff manipulated this situation by late unlocks and early lockups. Various tasks were dropped with little or no notice. There was no consistent routine day for prisoners and they were highly frustrated with this situation. They could not tell from one day to the next what would happen. There was no predictability in their lives and it created havoc with maintaining contacts with families outside.

8.16 Senior Officers and Officers were able to decide what or what not to deliver. They used the fact that they were not trained as a justification for not carrying out core duties such as personal officer work, suicide prevention and anything else they

preferred not to do. We found apathy among some staff that militated against any positive outcomes for prisoners. That it went unchallenged by managers simply reinforced staff complacency.

8.17 Staff told us:

Some Senior Officers are good and some not so. There is a lack of management support for me, no rewards for good work but plenty of criticism when things don't go well. I have been told if I didn't like it I should get out – they are not trying to encourage me or be positive

In meetings, I feel I am given direction but in general no I don't feel supported. We never know where we are going to be working in the prison either, which doesn't help.

Staffing Levels

8.18 The prison was experiencing major problems as a consequence of the failure to drive through agreement and implementation on the MCS proposals of 12 months previously. For the previous year, staffing levels had been allowed to drop to something closer to the MCS recommendations, but this had not been accompanied by any change to staff profiling. The prison had therefore been running a shadow regime, for which it did not have the agreed staff levels as reflected in current profiles. We had some sympathy with staff and management, who were frustrated at this state of affairs, which was in no-one's interest. Following a recent failure to agree new profiles and plans, the new Governor had imposed minimum staffing levels during the week of our inspection as an attempt to break out of this impasse. We do not believe that matters should have been allowed to drift that far and for so long, and that the Prison Service should have taken action to support the prison and its senior managers in driving through appropriate staffing levels to ensure the delivery of a full and reliable regime. In our view, the failure to do so was an important factor in the dysfunction of the prison and the regime.

8.19 The high levels of sick leave, staff suspensions from duty and detached duty commitments were tormenting factors, which had compounded this situation. Duty managers began every day by checking and, in some cases, negotiating with the central detailing office what activities would be provided. This was a by-product of the imbalance between work and previously agreed staffing levels.

8.20 Much of the prison's time was spent in daily crisis. Managing staff deployment was wearing down both the staff and managers, as was the need to work additional hours just to provide basic services. The average additional time worked throughout the prison at the time of inspection was around 21 hours per officer. This would at some time have to be repaid by time off in lieu (TOIL). We met staff who had accrued over 100 hours. They were depressed at the lack of scope for repayment of hours worked and they also said that there was little chance of taking legitimate leave.

8.21 The organisation of staff to work was established through a central detailing system and was tracked through Central Allocation of Man Management Systems (CAMMS). Although at this time it made some sense to maintain this system, in the long term we believed it was not good in establishing good quality work. We spoke to staff who worked in areas where they were detailed, but these were not their regular workplaces. They had no investment or ownership of the work they did while they were redeployed in this way.

8.22 Many members of staff did not feel managed or supported correctly because of the central detailing features. There was lack of continuity throughout the prison, where accountability and ownership had been lost and the consistency of work patchy. Many junior managers were not managing their staff well. We observed Senior Officers being told by Officers what was happening on the residential units or what they were going to do. A Senior Officer said, "I just let them get on with it, as they know better than me what is required, particularly when I work in unfamiliar areas of the prison".

8.23 We analysed two days' central detailing. Thirty per cent of Senior Officers and 25% of Officers had been cross-deployed and were working in parts of the prison that were not their normally allocated area. These arrangements did not provide stability for prisoners nor did they provide staff with the incentive to engage with prisoners. Group working arrangements would provide better continuity and ownership and would encourage managers to accept accountability and responsibility in their role.

8.24 Most of Wormwood Scrubs' serious problems had come to light from prisoner complaints to solicitors. Many of these complaints had been dealt with and many more were still being investigated. We were pleased to see a more rigorous approach being adopted by the Prison Service to the investigation of all allegations. The current Area Manager had put in a specially selected team, who were following up all allegations and investigations to ensure they were being, or had been, thoroughly investigated.

8.25 Staff said:

Things are slowly improving since the introduction of the new regime. However, some staff are resistant due to their perception of low staffing levels

I would have liked to have had more involvement in what to do with returning officers from suspension – I am not consulted, just told you are getting officer X on Monday

Increase the staffing levels. We must address staff sickness, some officers are taking advantage – suddenly they are well if there is any overtime – they need to be disciplined to stop others

On this wing there will be over 200 prisoners, the size of a small prison in itself but with one Senior Officer running it, there just isn't the time to do the things to the quality you would like.

Recruitment and Training

8.26 Overall, training within the prison was poor, which in part was the result of the current staffing situation. The prison was failing to meet its mandatory training targets and, more significantly, not carrying out staff development. In October 2001, 72% of staff appraisals and career development procedures had not begun. By the end of November, this had fallen to 60%.

8.27 Historical *in situ* promotions had conceivably not helped in taking the junior managers forward. We found that three-quarters of Senior Officers had been promoted from within Wormwood Scrubs from the Officer grade and half of Principal Officers from the internal Senior Officer grade. No career development or management training was in place and it was not surprising to witness some junior and middle managers failing to operate as managers.

8.28 The full time Fire Officer was providing a good service. Training of staff in fire protection and awareness was better than most other training that was not associated with Control and Restraints. We visited the prison one night. We were concerned that the Senior Officer in overall charge of the prison for the 11-hour shift had only a superficial knowledge of basic fire drills and other contingency plans. Other night staff knew little or nothing about what to do in the event of an emergency. They were unaware of the existence of self-harm response kits and fire inundation points. We were concerned that senior managers had not raised this as a training need, since they must have reached similar conclusions during their own night visits.

8.29 We recognise that, like other London prisons, Wormwood Scrubs suffered from the constant battle for the recruitment and retention of staff. No prison managers had expressed interest in previously advertised posts. This may explain the dearth of experience within the management team. Accelerated Promoted Scheme (APS) managers had been encouraged and allowed, along with other newly-promoted

managers, to use the prison to gain experience. The flow of middle managers using Wormwood Scrubs as a stepping stone to other posts elsewhere was unhelpful and counter-productive.

8.30 The negative effect on the prison was reflected in the attitudes of some staff towards managers. For staff who wanted to do as little as possible, it was simply a matter of waiting until the manager moved on. There was little incentive for staff to co-operate with initiatives, since experience had shown them that these initiatives would probably evaporate as soon as the manager had left.

8.31 The management of the Health Care Department relied heavily on costly agency workers. We estimated that the £500,000 predicted overspend was probably a direct consequence of this approach. We were dismayed to find that some Prison Service nursing staff were also being used and paid for as agency cover, which was wholly wrong. The Prison Service code of discipline does not cover a Prison Service worker in his or her capacity as an agency nurse. Consequently, if their performance fell below the accepted standard while working for the agency, any sanctions under the code of discipline could not be implemented against them. We were also told that staff could finish a prison shift and then continue to work on as an agency nurse; this could breach health and safety safe systems of work.

8.32 Some staff we interviewed said that they did not want to take part in training – they were coming up to retirement or had other things in their lives that occupied their time.

8.33 Other staff said:

Any courses, hungry to get on courses, leadership, teamwork, hostage negotiation, capable managers

I believe this training is just a short cut to say that they are doing training when they are not really. Need an update on lifer training

Finance

8.34 The Financial Manager spoke of the odd way in which the prison was funded, being given money throughout the year piecemeal. He felt that this prevented the prison from making good quality medium and long-term plans or decisions based on known cash budgets. The prison had been given a budget of £20.8 million at the beginning of the year. This had risen to £22.5 million with the granting of additional funding needed to run the prison but not included in setting the budget.

8.35 The closing and opening of wings and mid-year changes to the indicative budget baselines made it impossible to predict and plan sensibly, making delivery uncertain. An arbitrary budget cut of £300,000 for the next financial year did not seem a sensible way of supporting a prison that was trying to make progress.

8.36 We were told that, as a direct result of a ministerial visit to the Health Care Centre, it was told to change its operation to that of a Grade 4 unit¹⁰. This required significant additional resources. No extra money was made available for this and a predicted £500,000 overspend had to come from existing resources. How the prison was to achieve this was not made clear to us, but the matter was causing local management concern.

8.37 In attempting to improve work-based activities, the prison had provided some additional activities for prisoners and provided National Vocational Qualification (NVQs) in these areas. This worthy initiative was also not properly funded. It attracted an operating cost of £428,000, against an available £378,000. We were told that the money from the Private Enterprise Scheme had been used up and the prison did not have enough money to buy materials. The upshot was that there would be no work for prisoners or trainers. This would need to be resolved, but again we were not told how.

¹⁰ Health Care Centres are of four types: Type 1 provides daytime cover, generally by part-time staff; Type 2 provides daytime cover, generally by full-time staff; Type 3 provides in-patient facilities, with 24-hour nurse cover; and Type 4 is as Type 3 but also serves as a national or regional assessment centre.

Conclusions

8.38 The frequent changes in the Senior Management Team (SMT) resulted in lack of stability and continuity. The past and continuing allegations against staff were a significant barrier to effective management. There was no shared recognition of or consensus on the essential issues and, therefore, no corporate vision for the short and medium term. Poor information systems did not reflect true achievements and concealed unacceptable levels of regime provision. In these circumstances, it was unsurprising that little had been done since our last inspection to improve outcomes for prisoners.

8.39 There was little, if any, co-operation between residential wing managers and their Principal Officers and Senior Officers. Wing staff often made decisions for managers and poor supervision had allowed the regime to become unpredictable. Failure to agree on the Management Consultancy Services proposals led to great frustration. The daily management of staff deployment was itself a drain on resources. Staff continually had to work additional hours simply to provide the basic services and there was little chance of taking annual leave. The current staff allocation arrangements did not provide stability for prisoners nor did they provide staff with the incentive to engage with prisoners.

8.40 Staff training was poor and the prison was failing to meet its mandatory training and staff development targets. The extended use of prison service health care staff as agency staff was contrary to regulation. Night staff were untrained in basic safety precautions for prisoners and the building itself. It was difficult to comprehend all the finer points of the prison's budgetary systems but it was clear that the prison was having trouble meeting its budget.

8.41 Our interviews with individual staff showed that they found it difficult to detach themselves from the history of the allegations and investigations. It permeated all their answers and many were anxious about possible future allegations.

8.42 Staff felt that their senior managers did not trust them to deliver the changes that were necessary. More worryingly, they did not believe that senior managers had the capacity to put things right either. Most staff (80%) felt they were failing to meet their responsibilities towards prisoners. We concluded that staff needed stronger leadership and direction from their senior managers to help them recover their confidence and efficiency. This required a line to be drawn under the events of the past and the articulation of a clear new vision for the future.

Recommendations

8.43 **The Governor should communicate his vision and focus for the prison as soon as possible to the Senior Management Team and to junior managers.**

8.44 **The Senior Management Team should be strengthened.**

8.45 **A staff deployment system should be introduced, with sufficient staff to ensure that prisoners receive a properly-regulated regime and that there is consistency of staffing on the wings.**

8.46 **Information should be accurately recorded and reported and used as the basis for decisions.**

8.47 **Staff should receive the minutes of all relevant meetings.**

8.48 **All available Principal Officers should regularly attend operational meetings.**

8.49 **Principal Officers should receive career development training and be given clear guidance on what is expected of them as residential wing and specialist managers.**

8.50 **Consideration should be given to providing team building work and management training for all managerial levels.**

- 8.51 **Managers should control the timing of regime activities and should ensure that staff abide by these timings. No task should be dropped without permission from the duty governor.**
- 8.52 **Managers should more vigorously challenge and change any aspects of an intransigent staff culture by making overt management checks.**
- 8.53 **Consideration should be given to operate group-working arrangements when the profiles are realigned.**
- 8.54 **Future promotions should take into account the difficulty of promotions *in situ*.**
- 8.55 **The prison should open all staff appraisal forms and manage staff by quality objectives and good supervisory skills.**
- 8.56 **All managers should receive formal management training and career planning. There should be succession planning.**
- 8.57 **All staff working on night duty must have basic contingency training, which includes fire and suicide prevention, before starting their duty.**
- 8.58 **Prison staff should not work as agency nurses; more full-time nurses should be appointed.**

EXECUTIVE SUMMARY

Arrival in custody

ES1 We found that the team of reception-based officers working in reception were dedicated and very professional and took great pride in their work. Other officers who were equally committed but had not been reception-trained and did not often work in reception sometimes undermined this good work. Reception was considerably cleaner than at our previous inspection and meal arrangements had improved. Respect and consideration were evident in the continued presence of Listeners and the removal of unnecessary barriers to interaction with prisoners. On the other hand, there had been a diminished provision in the reception process. Staff were no longer regularly providing briefing sheets to help first-time prisoners through this difficult period. Hours spent in holding rooms were devoid of stimulation, men new to prison were not being identified and offers of a telephone call had dropped considerably. Previous arrangements for prisoners without English had all but fallen into disuse.

ES2 We are at a loss to know why the establishment had so clearly failed to make proper provision for prisoners, especially those new to prison, on their first night there. The new First Night Officer scheme had yet to get off the ground. Even in its infancy, there were signs that its future depended on whether there was sufficient commitment from staff and managers to make it work. In our estimation, not only were there no proper arrangements but the locations in which some prisoners were housed were positively dangerous. The proposed solution for induction cells had hardly materialised. Many staff continued in their failure to recognise, or to care about, the effect of imprisonment on many of these individuals.

ES3 Many prisoners were not receiving Induction. A one-day programme, which included some risk assessment, was not long enough to make judgements on whether prisoners were settling in. The promising start made to Induction during our last inspection had not been sustained. If anything, matters had slipped and staff were

being moved to other duties, making any catching up exercise an impossible task. Participating departments were still not regularly attending Induction sessions and there was little or no provision for prisoners who did not speak English. This was yet another initiative that had failed to deliver.

Residential units

ES4 Single cells continued to be used for two prisoners and sanitary arrangements in these circumstances were highly inadequate.

ES5 The standards of cleanliness in cells and in communal areas varied across the wings and within the wings. On some, prisoners had difficulty in getting cleaning materials. Most prisoners had daily showers and could change their clothes every week. The amount of prison clothing issued to prisoners was not necessarily seen by them as sufficient. Wing laundries were well used, although remand prisoners were excluded from this facility.

ES6 Most prisoners spent much of their day locked up in cell. Even those who had some purposeful activity still spent far too long in cell. Time out of cell was even less than prisoners experienced in February 2000.

ES7 There were regular exercise periods every day. No records were kept of cancelled sessions, so there was no way of telling how often this occurred. Although most prisoners said that cancellations were rare, the opportunities for daily exercise had diminished since the last inspection.

ES8 There was significantly less association and time out of cell than during our last inspection. When evening association and the daytime 'domestic' periods did take place, they were relaxed affairs in which staff and prisoners integrated freely. There were particular problems on A Wing, where meal serving arrangements resulted in curtailing the precious time available for association. Prisoners on most

wings had difficulty in holding telephone conversations, since few telephones had privacy hoods. Recreational facilities, with in-cell television, appeared sufficient to meet most prisoners' needs.

ES9 There were some interesting comparisons to be drawn across the wings in terms of staff-prisoner relationships and the feelings of staff, and how these affected the running of the wings. On all wings, there were some staff who were more resistant to change or who were so demoralised that they felt unable to operate as effectively as they would wish. The following comments reflect an overall view of individual wings.

- A Wing came across as staff doing what they felt they could, given the upheavals of central detailing, Minimum Staffing Levels and staff investigations. There was limited interaction with prisoners and prisoners themselves accepted what staff told them about staffing problems. Of all the wings, A Wing staff seemed the most disgruntled and disaffected.
- Prisoners on B Wing portrayed a picture of staff who were neutral in their dealings with them. There was little interaction with prisoners and no evidence of warmth in staff contacts with them. B Wing staff observations were generally about the difficulties in managing a wing when officers were not regularly on duty there.
- C Wing staff and managers displayed a positive approach to running the wing irrespective of the turmoil created by central detailing and Minimum Staffing Levels. Most prisoners on C Wing felt that staff were approachable and helpful.
- On D Wing, the relationships were informal and good but they did not extend to staff engaging to any significant degree with prisoners. Lack of management supervision was an important issue for staff and prisoners on D Wing.

- Probably the most interesting findings emerged from E Wing. Here was a group of prisoners, mainly from another prison, who were being managed by staff from a third prison. It could be argued that a shared feeling of isolation contributed to what seemed to be the most successful partnership in terms of staff-prisoner relationships. Staff needed help in familiarising themselves with local practices.

ES10 There was no proper personal officer scheme in place, although the landing officer to some extent became the first point of contact for prisoners. This was a good basis on which to build relationships but it had little chance while the current daily allocation of staff continued. Entries on wing history sheets needed to be more frequent and more balanced to provide a true picture of prisoner behaviour and particular needs.

ES11 The speed and success with which wing applications were dealt with depended on individual landing staff. Applications were not being routinely logged nor were the outcomes being recorded. There was a clear and general lack of trust and confidence in the Request and Complaint Procedure. Prisoners complained that responses did not arrive, or were 'lost' in the system. Wing display boards contained no information about this system or about avenues of appeal with bodies other than the prison.

ES12 Most prisoners regarded residential units as being safe environments but the proportion who did not was higher than in February 2000. New prisoners were not risk assessed before being allocated a cell. There were problems about the improper use by prisoners of cell bells. Staff were not patrolling areas that were likely to be used by prisoners to intimidate other prisoners or visiting staff such as nurses. Safety awareness at night was patchy.

ES13 The Vulnerable Prisoner Unit provided a generally caring environment and its regular staff were committed to the general well being of prisoners. The practice of placing new arrivals on the unit was unhelpful and dangerous. No prisoners on the Vulnerable Prisoner Unit had received a formal Induction programme. Regime

activities were affected by the central detailing arrangements and Minimum Staffing Levels. Unit staff initiatives had provided periods of association and other out-of-cell activities, including employment on the Unit. There was little for life-sentenced prisoners, who should have been on a lifer wing.

ES14 Life-sentenced prisoners on D Wing and elsewhere at Wormwood Scrubs were not receiving the level of service from staff that we expect. Case-workers had not been trained and some took the view that they had not been profiled for this work. The quality of Probation work and the commitment of Probation staff on the lifer wing was particularly good. Prison staff were not trained for their new responsibilities with potential and newly-sentenced lifers. The Lifer Liaison Officer was not up-to-date with current procedures and was not keeping in touch with his charges across all wings.

ES15 There was a very high number of foreign nationals at Wormwood Scrubs. Senior managers had recognised that it was time to make specific provision for them in places such as Reception and the wings. A separate budget had been allocated for this and there were some separate groups for foreign nationals. A major concern was the bureaucracy involved in providing a telephone call for a foreign national who did not have the money to purchase telephone cards.

Duty of care

ES16 Our Expectations on anti-bullying require prisoners to feel safe and for staff to ensure that, as far as possible, prisoners can survive on residential units and elsewhere without fear of intimidation and assault. There was no discernible policy at Wormwood Scrubs and the establishment was in-between policies. There was little evidence that staff prevented bullying. In addition, as shown in the report, the continuing employment of some prisoners as wing cleaners knowing their unsuitability allowed these violent men to prey on others at will. Consequently, the statement that bullying and intimidation was not accepted at the prison was largely meaningless.

ES17 The stated purpose of the recent prisoner survey was to provide a measure of the extent and nature of bullying in the prison. This would provide a baseline to compare against the results of future surveys. Evidence showed that the establishment had failed to sustain the momentum provided by a promising new strategy supported by a previous survey. In the circumstances we wondered how the new findings of the in-house prisoner survey and proposed approach would result in a better outcome for prisoners. There were questions as to whether staff time would be found to get the Social Awareness course off the starting block. It would take time for the new policy to be finalised and agreed and, thereafter for staff training to be implemented. In the meantime, staff were failing to act even when they had all the evidence necessary to tackle bullies and help victims.

ES18 Overall, there had been limited improvements in the approach to managing and minimising self-harm. An active Committee and recent in-house research would pave the way for future interventions. The continuing use of Listeners in Reception and their inclusion on the Committee were all positive steps. The link with drugs so that CARATs workers saw all prisoners who had an open F2052SH was a good initiative. It indicated to us that self-harm and suicide mattered very much to staff and managers at Wormwood Scrubs. Against that must be set the poor levels of training and the more worrying aspect of night staff not being fully prepared in case of an incident.

ES19 We found national and local policy statements on race relations displayed at various points in the prison. Despite this, there was limited evidence of the establishment having embraced the concept of equal opportunities, race relations, and diversity. The drive and energy to promote good race relations at a strategic level had dwindled. The impetus to keep it alive rested in the hands of some keen and committed race relations staff and others, rather than promulgation of action based on policy and operational guidance from senior managers.

ES20 From the time they arrived at Wormwood Scrubs, there were inadequate arrangements for Foreign Nationals in particular. First Night measures and Induction

should be included in planning for the special needs of this group of prisoners. A greater commitment in actions as well as words was required from all senior managers and real direction from the Race Relations Management Team.

Health care

ES21 The health care provision had deteriorated from the promising start in February 2000. Staffing levels and the appropriateness of qualifications and training in the context of what staff were doing were still a problem. The pressing need for a clinical manager had not been addressed. The physical condition of in-patient wards was appalling and patient regimes, including those who were undergoing detoxification, were highly unsatisfactory. The additional burden of having to care for patients requiring proper psychiatric care in National Health Service hospitals was a drain on an already under staffed department. There were good signs that audits and health needs assessments could inform development plans but these required proper resources to be effective.

ES22 The pharmacy department continued to provide a good service and pharmacy staff played an active part in the overall development of health care provision.

ES23 Dental services at Wormwood Scrubs provided a range of treatments. Waiting times did not reflect the dissatisfaction expressed by some respondents to our prisoner questionnaire.

Activities and Services

ES24 The education department continued to provide classes for prisoners who had little or no achievement in literacy and numeracy. The curriculum was heavily biased in favour of these people. Prisoners who had reached higher levels of educational attainment found little in the curriculum to entice them. Life-sentenced prisoners, Vulnerable Prisoners and patients in the hospital wards did not receive a comparable level of attention to prisoners on the main residential wings. Although the department was integrated into the work of the prison, it had not figured in any plans to resettle or

reintegrate prisoners back into society. The most significant barrier to education at Wormwood Scrubs came from the failure to get students to classes in time and the cancellation of classes.

ES25 There were continuing difficulties in getting prisoners unlocked for their allocated library periods. Poor attendance and the failure to develop the library as an effective learning resource left it underused. On the positive side, there had been considerable achievements in providing suitable reading material for the culturally diverse prisoner population.

ES26 There was a reasonable amount of employment for prisoners. Where specific skills were being provided, achievements were properly recorded. Relationships between workers and trainers were very good, providing the motivation for the acquisition of certificated skills for those who wanted them. Workers who needed help in basic learning skills were not properly being identified and helped.

ES27 There was still no formal strategy for the development and implementation of National Vocational Qualifications and key skills. The work and effort that went into the available certificated training was excellent. The possibility that prisoners working in the aluminium assembly workshops could be offered employment on release was very encouraging.

ES28 We were pleased to see that the commitment to providing a range of physical education activities encountered at the last inspection had continued unabated. The exclusion of remand prisoners and partial exclusion of full-time workers had to be remedied. The involvement in rehabilitation of offenders was an excellent initiative.

ES29 The active Chaplaincy team was clearly frustrated in their work because of the failure to provide prisoners for services and meetings at scheduled times. The team itself managed to see most prisoners but they seemed to work as individuals, dealing with matters concerning their own faith and denominations.

ES30 The prison continued to provide good, standard-quality meals for prisoners. Serving of meals on the wings was not properly managed; there were often too many servery workers and food temperatures were frequently not being tested or recorded. The eating of meals in cells was unhygienic and prisoners in double cells were cramped for space.

ES31 The service provided by Aramark was satisfactory and many problems were resolved by the team on site. Problems reconciling receipts of private cash and earnings continued. The system for delivering orders varied across wings and demanded too much time from wing staff.

Good order

ES32 The improvements in relationships between staff and prisoners that were present at the last inspection were still in evidence. Some staff were reluctant to intervene when minor incidents occurred. The use of Control & Restraint was correctly applied and properly documented. However, positive staff-prisoner relationships had yet to develop. Prisoners were generally content that staff treated them properly but they, too, commented on the lack of continuity of regular officers on residential wings.

ES33 The Incentives and Earned Privileges scheme had a significant role to play in both the maintenance of good order and discipline and in motivating prisoners to take an active part in regime activities. Despite a recommendation to that effect, there had been no improvement between the differentials of the Incentives and Earned Privileges scheme. Many staff either had ignored the scheme or were doing the minimum in terms of deciding applications for enhanced level. Incentives and Earned Privileges were the casualties of staff deployments across residential units.

ES34 Overall, the Segregation Unit was safe, clean and functioning satisfactorily in sometimes testing circumstances. Although staff clearly felt under considerable scrutiny, they continued to run the unit in an efficient and humane manner. New prisoners arriving at Wormwood Scrubs were unnecessarily located in the unit, which

was particularly poor first night practice. Wing records were not accompanying prisoners to the unit and staff were consequently not fully informed of the nature and history of the person they were expected to manage. Managers also needed to be more proactive in monitoring entries in prisoners' history sheets.

ES35 The arrangements for public protection were handled satisfactorily and sensitively.

ES36 The Initial Categorisation and Allocation process was capably managed by the Sentence Management Unit staff and prisoners were sensitively handled at this difficult time. Overcrowding drafts and depleted staffing were hampering the efforts of this hard-working team. It was creditable that, as far as possible, prisoners currently engaged on courses at Wormwood Scrubs were excluded from overcrowding drafts to other prisons.

Resettlement

ES37 There was a continuing commitment to providing arrangements that would make visitors to prisoners at Wormwood Scrubs feel welcome. The conclusion from our last inspection still held, that the experience for visitors had been "transformed". The lack of numbers and consistency in the staffing of visits was in danger of undermining what had been a significantly improved booking system.

ES38 The area of resettlement required its own manager, directly responsible to the Governor. Lack of progress on providing a strategy on resettlement was severely retarding progress in this area of work.

ES39 There were efforts by NACRO and the CAB to ensure that prisoners being released from Wormwood Scrubs were given some help to enable them to survive their return to society. However, the prison still had no overall resettlement strategy and many prisoners who needed help were being missed.

ES40 There were considerable problems with providing sentence plans. Not only had a backlog built up, but also continuing re-deployment of Sentence Management Unit staff made any catching exercise impossible. There was no evidence of systematic case management of individual prisoners.

ES41 The accredited Enhanced Thinking Skills programme had not been sufficiently well delivered to receive a reasonable rating until recently. We were pleased that non-accredited work was also being done. All offending behaviour courses should serve the needs of as many prisoners who would benefit from them in the time they spent in prison. There was no evidence that the current provision reflected the current need.

ES42 Despite the clear skill and commitment of the centre manager and her staff, the Max Glatt Centre was isolated from the rest of the prison.

ES43 We were disappointed with the failure to make any significant progress in substance use work, following the recommendations contained in our last report. Drug strategies were still in their infancy, despite targets not being met. Unless patients undergoing detoxification were in the health care unit, those on the wings received little help and support. The main initiative that was meeting prisoners' needs was the Turning Point rehabilitation programme. This, too, had problems, identified in our previous report but not yet addressed. Re-deployment of prison staff affected work on substance use and the scheme to train them as CARAT Wing Liaison Officers had not materialised.

Management and staffing

ES44 The frequent changes in the Senior Management Team (SMT) resulted in lack of stability and continuity and some of the SMT were inexperienced in prison management. The past and continuing allegations against staff were a significant barrier to effective management. There was no shared recognition of or consensus on the essential issues and, therefore, no corporate vision for the short and medium term. Poor information systems did not reflect true

achievements and concealed unacceptable levels of regime provision. In these circumstances, it was unsurprising that little had been done since our last inspection to improve outcomes for prisoners.

ES45 There was little, if any, co-operation between residential wing managers and their Principal Officers and Senior Officers. Wing staff often made decisions for managers and poor supervision had allowed the regime to become unpredictable. Failure to agree on the Management Consultancy Services proposals led to great frustration. The daily management of staff deployment was itself a drain on resources. Staff continually had to work additional hours simply to provide the basic services and there was little chance of taking annual leave. The current staff allocation arrangements did not provide stability for prisoners nor did they provide staff with the incentive to engage with prisoners.

ES46 Staff training was poor and the prison was failing to meet its mandatory training and staff development targets. The extended use of prison service health care staff as agency staff was contrary to regulation. Night staff were untrained in basic safety precautions for prisoners and the building itself. It was difficult to comprehend all the finer points of the prison's budgetary systems but it was clear that the prison was having trouble meeting its budget.

ES47 Our interviews with individual staff showed that they found it difficult to detach themselves from the history of the allegations and investigations. It permeated all their answers and many were anxious about possible future allegations.

ES48 Staff felt that their senior managers did not trust them to deliver the changes that were necessary. More worryingly, they did not believe that senior managers had the capacity to put things right either. Most staff (80%) felt they were failing to meet their responsibilities towards prisoners. We concluded that staff needed stronger leadership and direction from their senior managers to help them recover their confidence and efficiency. This required a line to be drawn under the events of the past and the articulation of a clear new vision for the future.

SUMMARY OF RECOMMENDATIONS

To the Home Secretary

1. We invite the Home Secretary to consider how to develop and use transparent and independent investigations to report quickly on serious allegations, or incidents, which go to the heart of the running of a prison: how this might be achieved under existing powers, what additional powers it might require and, in parallel, how to ensure that any police inquiries that are necessary are conducted quickly, effectively and with perceived independence.

To the Director General

Healthy Prison Summary

2. The Prison Service should inform policy and expedite implementation of relevant services for unsentenced prisoners, using the findings and recommendations in the thematic review ‘Unjust deserts’. (15)

Arrival in Custody

3. Consideration should be given to installing and wearing seat belts in cellular vans. (1.21)
4. There should be one set of definitions of a Foreign National and it should be used consistently across departments in Wormwood Scrubs and throughout the Prison Service. (1.26)

Residential Units

5. Cells designed for one occupant should not be used as double cells. (2.13)

Health Care

6. There should be urgent discussions between the Prison Service and the Department of Health on the clinically suitable location of mentally disordered people who come before the courts. (4.35)

Activities and Services

7. The retirement age should be reviewed to allow prisoners over the age of 55 to take part in purposeful activities. (5.41)

Management and Staffing

8. The Senior Management Team should be strengthened. (8.45)
9. All managers should receive formal management training and career planning. There should be succession planning. (8.57)
10. Prison staff should not work as agency nurses; more full-time nurses should be appointed. (8.59)

To the Area Manager

Resettlement

11. The Area Drug Co-ordinator, with the Drug Strategy Group, should review the role of Voluntary Drug Testing in the prison. He should ensure its availability as a positive option for those who require support in remaining drug-free. (7.67)
12. The Area Drug Co-ordinator, with the prison medical staff, should research various models of good practice elsewhere to ensure that appropriate and effective detoxification treatment is offered. (7.69)

To the Governor

Healthy Prison Summary

13. Proper First Night arrangements should be provided for all new prisoners. (6)
14. All prisoners should be properly inducted soon after arrival, irrespective of where they are located. (6)
15. Effective anti-bullying measures should be put into place. (6)
16. All staff should have current training in suicide prevention. (6)
17. Prisoners should have more constructive time out of cell and all prisoners should be offered daily exercise and daily association. (15)
18. A Personal Officer Scheme should be introduced. (15)
19. There should be a clear definition of “Foreign National” and these prisoners should receive additional support as required for their particular situation. (15)
20. All staff should receive training in understanding race relations and diversity. (15)
21. Health care services and specific needs for mental health patients should be urgently improved and should be consistent with National Health Service standards. (15)
22. There should be a reliable and accurate system to record regime activities, the number of prisoners participating in each activity and any cancelled sessions. (18)

23. The education curriculum should be enriched. (18)
24. Courses leading to the award of National Vocational Qualifications should be developed. (18)
25. All prisoners should have the opportunity to have Physical Education. (18)
26. Resettlement policies should be developed and implemented in response to the identified needs of each category of prisoner held at Wormwood Scrubs. (22)
27. All prisoners being discharged should be offered individual help and advice beforehand. (22)
28. Sentence plans should be relevant and should be completed on time. (22)
29. Relevant recommendations on the treatment of life sentence prisoners contained in the joint thematic report 'Lifers' by the Prison and Probation Inspectorates should be introduced. (22)
30. The Drug Strategy Group should ensure that it meets its targets for supply reduction. (22)
31. The Governor should communicate his vision and focus for the prison as soon as possible to the Senior Management Team and to junior managers. (25)
32. A staff deployment system should be introduced, with sufficient staff to ensure that prisoners receive a healthy regime. (25)
33. Information should be accurately recorded and reported, and used as the basis for decisions. (25)

34. Principal Officers and Senior Officers should receive management training and should be given clear guidance on what is expected of them as residential wing and specialist managers. (25)
35. Managers should rigorously control the timing of regime activities. No task should be dropped without permission from the duty governor. (25)
36. Managers should more vigorously challenge and change any aspect of an intransigent staff culture by making overt management checks. (25)

Arrival in Custody

37. The number of reception-based and reception-trained officers should be increased. (1.19)
38. The explanatory briefing sheet should be reinstated and provided in as many languages as necessary. (1.20)
39. There should be proper arrangements to identify people who had not been in prison before. (1.22)
40. All staff working in reception should have race relations training. (1.23)
41. Almost all translated material should be easily accessible and all officers working in reception should know about and use them. (1.24)
42. Several working cassette players should be available in reception. (1.25)
43. Information taken at reception should include a prisoner's first language and, where relevant, whether communication in English is possible. (1.27)

44. Information should be displayed in all reception holding rooms in the languages identified most often as the first language of prisoners arriving at Wormwood Scrubs. (1.28)
45. Consideration should be given to providing reading material in English and other languages in the holding rooms in reception. This could be supplemented with video information about reception and other prison procedures. (1.29)
46. All newly-arrived prisoners should be automatically offered a phonecard. Arrangements for Foreign Nationals should be made to enable them to contact their families overseas soon after arrival in the prison. (1.30)
47. Ligature points in the holding rooms and shower areas in reception should be assessed as soon as possible. (1.31)
48. Immediate steps should be taken to provide proper First Night arrangements. These should include close management of the First Night Officer system through its initial implementation and the issue of a First Night Pack to all new prisoners. (1.46)
49. Risk Assessment Forms should be attached to Personal History sheets and they should be held on the wing. (1.47)
50. The use of inappropriate and possibly unsafe locations for first night prisoners should cease immediately. (1.48)
51. In the interim, wing managers and their staff should make it their responsibility to speak to all prisoners arriving on the residential unit and to deal with any immediate problems raised by them. (1.49)

52. Night staff on all residential units must know whether any prisoners were spending their first few nights in custody and in which cells they had been placed. (1.50)
53. All prisoners should be provided with writing material and some reading material in English and other languages, to help them through their first night in custody. (1.51)
54. Staff should be trained to work as Induction Officers. (1.65)
55. Life-sentenced prisoners should be given a formal induction course. (1.65)
56. All prisoners should be properly inducted, irrespective of where they are located and soon after arrival. (1.67)
57. The prison should consider giving the Bail Information Officers their own office. (1.68)
58. Efforts should be made to ensure that Bail Information Officers see all potential candidates for bail. (1.69)
59. We repeat the recommendation that more care should be taken during induction training to ensure that prisoners who do not speak English can understand what is going on. (1.70)
60. Consideration should be given to extending Induction for at least two days during which time prisoners should be closely observed. (1.71)
61. Induction staff should not be put to other duties. (1.72)

62. The prison should seek the advice and assistance of the Safer Custody Group in developing a model for the Reception, First Night and Induction of prisoners. (1.73)

Residential Units

63. Prisoners who share a cell should have toilet facilities that are fully screened. (2.14)
64. There should be a clear policy on offensive displays, applied across the wings. (2.15)
65. A smoking policy on residential wings for both prisoners and for staff should be drawn up and implemented. (2.16)
66. The standards of cleanliness on all wings should be improved and cleaning schedules should be adhered to. (2.25)
67. Consideration should be given to making the baths on A Wing functional again or otherwise taking them out. (2.26)
68. The shower recesses on E Wing should be renovated. All wing shower units should be repaired as required and regularly maintained. (2.27)
69. The amount of clothing issued to prisoners should be adequate for their use and should fit them properly. (2.28)
70. Remand prisoners should be allowed to use the wing laundry. (2.29)
71. Cleaning equipment should not be stored in wing cleaners' cells. (2.30)
72. Prisoners should be encouraged to keep their cells clean and they should be regularly provided with cleaning materials. (2.31)

73. Prisoners should have the opportunity of spending at least ten hours out of cell each day on relevant constructive activity. (2.38)
74. Prisoners should be offered daily exercise in the fresh air and be supplied with weatherproof clothing and shoes for outdoor exercise in bad weather. (2.43)
75. Mealtimes and movements of prisoners should be co-ordinated and organised in such a way that it does not delay mealtimes or affect association periods. (2.57)
76. Managers should ensure that prisoners reach off-wing activities on time and that wing domestic times and association should be provided every day. (2.58)
77. Consideration should be given to providing a separate room on A Wing for prisoner association. (2.59)
78. All wings should record daily activities and whether any had been cancelled, with reasons for this. (2.60)
79. Recreational equipment should be in working order and repairs to pool tables should be carried out as soon as possible. (2.61)
80. Additional seating should be provided on all wing association areas. (2.62)
81. All wing telephones should be in booths or have privacy hoods fitted. (2.63)
82. Staff should be led and encouraged to interact more positively with prisoners. (2.87)

83. Staff should use opportunities to create an atmosphere in which there is regular contact with prisoners. (2.88)
84. Wing senior managers should visit their wings more frequently and consideration should be given to locating them on the residential wings. (2.89)
85. Managers should ensure that the visiting staff on E Wing are given help and support to enable them to carry out their duties effectively. (2.90)
86. An effective Personal Officer Scheme should be introduced. (2.96)
87. The quality and frequency of recording information in prisoners' wing history sheets should improve. (2.97)
88. When a recorded application remains unresolved, it should be pursued by landing staff and regularly checked by wing managers. (2.104)
89. Prisoners should be allowed to have a Request or Complaint form without the need for approval before the form is issued. (2.105)
90. Managers should regularly monitor wing procedures for applications, Requests and Complaints. (2.106)
91. Information about the use of Request and Complaint forms, including the right to confidential access and avenues for appeal, should be publicised on wing notice boards. (2.107)
92. All new prisoners arriving on residential units should be risk assessed before being allocated to cells. (2.116)
93. The use of cell call bells for routine issues should be looked into. (2.117)

94. Staff should particularly supervise showers and other important communal areas. (2.118)
95. Staff should supervise prisoners when medication is being dispensed to patients on residential wings. (2.119)
96. Management should ensure that all staff undertaking night duties are trained in the use of self-harm response kits. (2.120)
97. Consideration should be given to unlocking wing water hoses before evening duty staff go off duty. All staff undertaking night duties must be trained in the use of water hoses. (2.121)
98. All staff who undertake night duties must be trained in the use of cell door inundation holes. (2.122)
99. Cells designed for single occupancy should not house additional prisoners. (2.135)
100. The Vulnerable Prisoner Unit should not be used as temporary overspill accommodation. (2.136)
101. All prisoners on the Vulnerable Prisoner Unit should receive Induction. (2.137)
102. Vulnerable Prisoners should dine in association within the unit. (2.138)
103. Only senior managers should make decisions to cancel wing activities. (2.139)

104. Prisoner history files should be maintained systematically and consistently and should be subject to regular, recorded monitoring by managers. (2.140)
105. The practice of placing Life Sentenced prisoners for long periods in the Vulnerable Prisoner Unit should cease. (2.141)
106. Prison officers who work with lifers should be properly trained. (2.153)
107. Psychological services to lifers at Wormwood Scrubs should be clarified. A lead on this should be provided by the Lifer Unit at headquarters. (2.154)
108. All staff dealing with newly-sentenced lifers should receive training in their new responsibilities. (2.155)
109. The Lifer Liaison Officer should hold a weekly surgery on D Wing. (2.156)
110. The Lifer Liaison Officer should visit life-sentenced prisoners located on other wings more often. (2.157)
111. Senior managers should urgently review the current arrangements for foreign nationals to be able to contact their families abroad at cheap rates. (2.168)
112. Diversity and cultural awareness training should form part of the weekly training programme for staff. (2.169)

Duty of Care

113. The new policy on anti-bullying should be published as soon as possible but its implementation should begin now. (3.19)

114. Heads of Security and Heads of Residential wings should review Security Incident Reports weekly. They should ensure that named bullies and victims are known to wing staff and that appropriate action is taken and is recorded. (3.20)
115. All wing managers should complete a review at least once a month on the suitability of prisoners employed on the wings in the context of their behaviour. (3.21)
116. Wing staff must supervise showers and treatment times. (3.22)
117. Wing staff must be more vigilant, particularly during association, exercise and mealtimes. (3.23)
118. Wing managers should encourage staff to report and record incidents in history sheets. (3.24)
119. All staff should have current training in suicide prevention. Priority should be given to residential, reception, induction and Health Care staff, as well as those working with prisoners who are withdrawing from drugs. (3.37)
120. All night staff must be trained in the use of self-harm response kits. (3.38)
121. A system should be developed to ensure that F2052SH reviews take place on time and are multi-disciplinary. (3.39)
122. Each landing office should have a readily identifiable and accessible place to keep open F2052SH records. (3.40)
123. More Listeners should be recruited and ways explored for recruiting prisoners from ethnic minority groups. (3.41)

124. Consideration should be given to appointing a Listener liaison officer who could also promote the work and recruitment of Listeners. (3.42)
125. In taking Suicide Prevention forward, the prison should seek the support of the Area Suicide Prevention Co-ordinator. (3.43)
126. The prison should be funded for a full-time and dedicated suicide prevention co-ordinator to support its current efforts. (3.44)
127. The role of the Race Relations Management Team should be re-examined. Its membership should contain representation from across all departments of the prison and include wider representation from the community. (3.57)
128. All members of the Race Relations Management Team should receive full race and diversity awareness training, and race relations management team training. (3.58)
129. Minutes of Race Relations Management Team meetings should properly record the gist of discussions and any outcomes and decisions reached. Action points should also be followed up at subsequent meetings until they have been accomplished. (3.59)
130. The Race Relations Management Team should regularly be provided with a full set of statistical information to inform monitoring across time and to enable remedial action to be taken where necessary. (3.60)
131. Names, photos and responsibilities of the Race Relations Liaison Officer, the Assistant RRLO and chair of Race Relations Management Team should be displayed on noticeboards throughout the establishment. (3.61)
132. Race relations and diversity training should be delivered to all grades of staff regularly and without exception. (3.62)

Health Care

133. The number of doctors and the skills they need should be reviewed in light of the findings of the recently-completed health needs analysis. This review must recognise that primary care in prisons must be given by doctors trained in primary care. It also must recognise that, in accordance with the health care standards, the care of mentally ill prisoners should be under the direction of a psychiatrist on the relevant specialist register. (4.20)
134. Recruitment and retention of nursing staff should be discussed with local National Health Service nurse managers and the Task Force. (4.21)
135. To ensure that they can meet the needs of their patients, all directly employed medical staff should assess their need for further professional development. They should seek the advice of the relevant National Health Service regional Postgraduate Dean in doing so. (4.22)
136. A nursing strategy should be developed taking into account current nursing practice developments and the required education and training programmes. (4.23)
137. The health needs analysis should form the basis for future developments in the health care service. (4.24)
138. The plans for the development of primary care and mental health care should be re-examined. (4.25)
139. We repeat our previous recommendations to appoint a senior clinical manager who has an understanding of the needs of a community hospital as well as an in-patient psychiatric unit. The Governor should at least involve the regional health care task force in evaluating the existing management structure and identifying gaps in management expertise. (4.26)

140. There should be regular checks on the functioning of equipment in the health care centre and any repairs should be made promptly. (4.27)
141. Health care beds should be removed from the Certified Normal Accommodation. (4.28)
142. The number of admissions to H2 ward should take account of the staffing level so that nursing care is not compromised. (4.29)
143. The role of the shift co-ordinator should be reviewed. (4.30)
144. A suitable regime should be designed for the detoxification unit. (4.31)
145. The in-patient exercise area should provide occupation and diversion and should cater for frail as well as able patients. (4.32)
146. We repeat our support for developing a day care service. This service should be reviewed in light of the health needs assessment. (4.33)
147. The provision of treatment lists should be reviewed. (4.34)
148. The causes and locations of injuries should be audited and the findings regularly reviewed. (4.36)
149. Drug charts should be completed whenever medication is issued, including for special sick. An entry should be made to reflect medication that is due but has not been issued, either because the patient refused treatment or did not collect it. (4.42)
150. The pharmacy, in conjunction with the Head of Health Care, should ensure rigorous security systems and accountability for drugs. (4.43)

151. All drug cupboards should be locked when not in use and defective locks should be reported and repaired immediately. (4.44)
152. Duplicate keys for the dental surgery cabinetry should be kept in the Health Care Office. (4.50)
153. The emergency call button must be moved to a more suitable position easily accessible from the operating area. (4.51)
154. The waiting area for patients should be improved and health and dental education material should be displayed. (4.52)
155. A protocol for the thorough cleaning of the floor and the dental unit should be agreed with health care managers. (4.53)

Activities and Services

156. Level 2 targets and the education contract should be reviewed in the light of students' needs. (5.19)
157. The balance of full-time to part-time staff should be reviewed. (5.20)
158. The induction process should be reviewed and it should include more comprehensive assessment and more multi-lingual materials. (5.21)
159. The contract and the curriculum should be reviewed in the light of the published assessed needs. (5.22)
160. Individual Learning Plans should be more specific, making them a useful information tool to plan future learning. (5.23)

161. Consideration should be given for greater use of interesting projects, library and computing resources. (5.24)
162. The education department should be included in providing information and courses that prepared prisoners for release and resettlement. (5.25)
163. Arrangements to get students from residential wings and into classes should be reviewed. (5.26)
164. Attention should be given to the information systems, to ensure they provide accurate relevant information for the management of education by the establishment or the department. (5.27)
165. All prisoners should have equal and regular access to the library. (5.32)
166. The library should be developed to support the necessary developments in the education curriculum. (5.33)
167. The allocation of prisoners to employment should be reviewed to ensure realistic numbers at any one time. (5.42)
168. The initial assessment process should include some form of assessment of manual skill. (5.43)
169. The results of initial assessments should routinely be communicated to workshop or training staff, to enable prisoners' individual training plans. (5.44)
170. The prison should have arrangements whereby prisoners can develop basic skills in the workplace. (5.45)

171. Consideration should be given to using the time that would have been spent in workshops towards additional education provision. (5.46)
172. A strategy for developing and providing National Vocational Qualifications and key skills within the prison should be produced as soon as possible. (5.55)
173. The kitchen should increase the number of prisoners on its National Vocational Qualifications programme. (5.56)
174. Consideration should be given to using the industrial training area to train wing cleaners. (5.57)
175. Attention should be paid to safety and the use of suitable personal protective clothing in the laundry. (5.58)
176. New storage areas for the aluminium assembly workshops should be built as soon as possible. (5.59)
177. Plans should be expedited to introduce a National Vocational Qualifications level 2 qualification in the production of glass-supporting fabrications. (5.60)
178. All prisoners, including remand prisoners, should be offered gymnasium sessions. (5.66)
179. There should be arrangements in place that make special provision for full-time workers. (5.67)
180. Consideration should be given to providing additional evening sessions for physical education. (5.68)
181. Muslim vulnerable prisoners should be enabled to attend communal prayers. (5.74)

182. Prisoners should be able to attend religious services on time and without missing other formal activities. (5.75)
183. Senior managers should ensure that the Chaplaincy team is fully involved in the work of the prison and is included in the various committee meetings. (5.76)
184. Kitchen workers should be given time to shower without having to miss other activities as a result. (5.86)
185. More fresh vegetables should be included in main meals. (5.87)
186. More freezers should be purchased. (5.88)
187. Repairs to kitchen equipment and trolleys should be dealt with promptly. (5.89)
188. Servery sneeze screens should be of clear plastic that should not be cleaned with abrasive materials. (5.90)
189. Meal times and the serving of food should be properly supervised by staff. (5.91)
190. Servery staff should record the temperatures of food and hotplates when food arrives at the wing. Records of temperatures should be sent to the Kitchen Manager. (5.92)
191. Consideration should be given to using the same type of temperature probe as used in the kitchen. If necessary, two probes should be provided to each servery, one to be used solely for halal food. (5.93)

192. Prisoners should have adequate table space to eat their meals and in-cell toilets should be partitioned off. (5.94)
193. Consideration should be given to increasing the range of ethnic minority products regularly available from the shop. (5.108)
194. Arrangements for the transfer of prisoners' private money into their prison account should be reviewed to ensure that the transfer is expedited. (5.109)
195. All prisoners should receive some form of pay in order to make essential purchases at the shop and thus avoid getting into debt with other prisoners. (5.110)
196. Prisoners transferred at short notice should have an immediate and routine way of receiving shop items that they had purchased. (5.111)
197. The range of hobby products on Aramark's standard list should be increased. (5.112)
198. Consideration should be given to a simpler and quicker system of delivering shop purchases to prisoners. Options could include using hours when prisoners were unlocked or dispensing orders from a central point on the wing. (5.113)
199. The tax element of Aramark receipts to prisoners should be clarified. (5.114)
200. Consideration should be given to including prisoner representation at shop meetings. (5.115)

Good Order

201. There should be clear differentials between the levels of the Incentives and Earned Privileges scheme. (6.12)

202. The Incentives and Earned Privileges scheme should be promoted and publicised and staff should be required to engage with the scheme. (6.13)
203. The Segregation Unit should not be used for accommodating overspill population. (6.29)
204. Consultations between doctors and prisoners in the Segregation Unit should be conducted individually and in private. (6.30)
205. Guidelines on adjudication awards should provide consistency and fairness. (6.31)
206. Prisoner records should always accompany them to their current location immediately. (6.32)
207. Managers should regularly read a sample of records and history sheets, and sign the documents to this effect. (6.33)
208. A Public Protection Committee, chaired by a senior manager, should be set up. (6.38)
209. Steps should be taken to reduce the delays in returning risk assessments in child protection cases. (6.39)
210. Staff in the Sentence Management Unit should not be redeployed to other duties. (6.54)

Resettlement

211. Accommodation in the visitors' centre should be increased. (7.08)

212. Senior managers should ensure that the range of services potentially on offer for visiting times is regularly available. (7.09)
213. The crèche should be properly and regularly staffed at all visiting times. (7.10)
214. Consideration should be given to providing refreshments for sale throughout visiting times. (7.11)
215. The closed visits area should be refurbished and redecorated. (7.12)
216. Resettlement policies should be developed in response to the identified needs of each separate category of prisoner held at Wormwood Scrubs. (7.17)
217. Membership of the Resettlement meeting should include all those necessary to ensure delivery of a resettlement strategy. (7.18)
218. There should be better co-ordination in the management and support of resettlement projects such as Citizens Advice Bureaux (CAB) and the National Association for the Care and Rehabilitation of Offenders (NACRO). (7.28)
219. Identification of need and access to relevant services should be more systematic and the circumstances of each prisoner should be checked before release. (7.29)
220. The prison's function in relation to the resettlement of prisoners serving fewer than four years should be clarified, especially for those released after a sentence of a few weeks. (7.30)
221. The prison's resettlement strategy should be developed in conjunction with the local London Probation Area to ensure compatibility with local provision in the community, and continuity in delivery of services. (7.31)

222. Sentence plans should be the vehicle for individual case management and should be completed on time with the quality of plans being routinely monitored by managers. (7.37)
223. A range of programmes, courses and help from external and internal agencies should be identified to meet the diverse needs of the prison population. (7.43)
224. The resettlement strategy should be based on an annual needs analysis and identify a greater role for the psychology department within an effectively managed multi-disciplinary team. (7.44)
225. The Drug Strategy Group should review the prison's failure to meet its targets for supply reduction and ensure that adequate resources are allocated for this work. (7.66)
226. Consideration should be given to housing all those undergoing medical detoxification in the same location. (7.68)
227. The problems in the delivery of, and arrangements for, the rehabilitation programme should be looked into by the Drug Strategy Group. (7.70)
228. The Drug Strategy Group should look at ways in which prison staff can be encouraged to become involved in the delivery of the CARAT strategy. (7.71)
229. The Drug Strategy Group should ensure that all prisoners who need CARAT services can be identified at an early stage and referred to the CARAT workers. (7.72)

Management and Staffing

230. The Governor should communicate his vision and focus for the prison as soon as possible to the Senior Management Team and to junior managers. (8.44)

231. A staff deployment system should be introduced, with sufficient staff to ensure that prisoners receive a properly-regulated regime and that there is consistency of staffing on the wings. (8.46)
232. Information should be accurately recorded and reported and used as the basis for decisions. (8.47)
233. Staff should receive the minutes of all relevant meetings. (8.48)
234. All available Principal Officers should regularly attend operational meetings. (8.49)
235. Principal Officers should receive career development training and be given clear guidance on what is expected of them as residential wing and specialist managers. (8.50)
236. Consideration should be given to providing team building work and management training for all managerial levels. (8.51)
237. Managers should control the timing of regime activities and should ensure that staff abide by these timings. No task should be dropped without permission from the duty governor. (8.52)
238. Managers should more vigorously challenge and change any aspects of an intransigent staff culture by making overt management checks. (8.53)
239. Consideration should be given to operate group-working arrangements when the profiles are realigned. (8.54)
240. Future promotions should take into account the difficulty of promotions *in situ*. (8.55)

241. The prison should open all staff appraisal forms and manage staff by quality objectives and good supervisory skills. (8.56)

242. All staff working on night duty must have basic contingency training, which includes fire and suicide prevention, before starting their duty. (8.58)