REPORT ON

A FULL ANNOUNCED

INSPECTION OF

HM PRISON WHITEMOOR

6-15 NOVEMBER 2000

BY

HM CHIEF INSPECTOR OF PRISONS

PREFACE

WHITEMOOR will, in the annals of the Prison Service, always be synonymous with PARKHURST and the resultant Woodcock and Learmont inquiries into high-profile escapes in 1994-5. Because of the high profile nature of the political response, and, in particular, the subsequent successful, but expensive, drive to improve security throughout the Service, it is inevitable that the staff of HMP WHITEMOOR should be particularly sensitive about its history, and nervous about the results of any future failure. When this sort of situation occurs, it is often followed by people adopting an attitude of looking over their shoulders the whole time, and ignoring present needs. But it is a tribute to the staff at WHITEMOOR that this did not seem to be the case, and that, thanks, in particular, to the leadership of successive Governors, and support from successive Directors of the Dispersal and then High Security Prison estates, there is so much innovation and good practice, across a wide range of the prison's activities, that is catalogued in this long, detailed and very complimentary report. This does not just happen - it has to be worked for and earned, and I hope that all concerned will feel the same satisfaction at seeing this reported as that felt by the Inspection team in learning and recording it.

Indeed it is the attitude of the vast majority of staff to their task, and, in particular their attitude to relationships with prisoners, revolving around treating every individual as an individual, that encourages me into making some demanding recommendations affecting some of the most difficult and high risk prisoners in the system. They concern prisoners whose escape could embarrass Ministers more than any other event involving the Prison Service. They concern prisoners whose release back into society requires sophisticated risk assessment as well as careful preparation. They concern prisoners whose treatment in prison makes more demands on staff than almost any others in the system.

Because it is so current an issue I begin with those classified as suffering from Dangerous and Severe Personality Disorder (DSPD). It has been estimated that, of the approximately 2500 in this category in the country, 1400 are in prison, 400 in special hospitals and 700 in the community. Until now there has been no structured

attempt to identify those in this group who are in prison, in other than custodial terms. The pilot assessment programme at WHITEMOOR, in which volunteer prisoners were put through a three month, multi-disciplinary course, required staff to work alongside staff from Rampton special hospital, psychiatrists and psychologists, and was clearly proving to be a success, both with prisoners and staff. Prisoners told me proudly of what they had achieved, and the relationships they now enjoyed with staff with whom, previously, they would not have passed the time of day. Staff could not believe the transformation that they were seeing in previously difficult prisoners.

But we were concerned that no follow-up was currently planned or available, so that the immediate future for the volunteers was not appropriate treatment, but return to previous location. In order to confirm the detail of the assessment programme, my medical inspector and I visited Rampton special hospital after the inspection, and spoke with some of the nurses whom we had seen at WHITEMOOR. They confirmed what we had feared, namely that a number of prisoners had self-harmed, and protested volubly and violently, when they realised that no immediate progression was available. I hope that their motivation is not lost, and that they will return when that opportunity arises in October 2001, as currently planned. The lesson though must be the old one – assessment and subsequent action must be planned simultaneously and not as separate ventures, to maintain momentum.

The Prison Service has now set up new arrangements for treating another sub-set of the DSPD population, namely those held in Close Supervision Centres because of the danger they present to staff and other prisoners in particular. This too includes individual assessment. Rampton will be the national DSPD assessment centre, from where individuals will be sent to appropriate treatment places. There is talk currently of forming a third force to look after DSPD sufferers in the community. The lesson of WHITEMOOR to me is the need to co-ordinate all the assessment and treatment of DSPD wherever and by whoever this is conducted. I have always recommended that there should only be one 'force' in this - the NHS - assisted by appropriate other staff wherever the individual concerned is held, to avoid there being too many different processes, creating bureaucratic cracks, through which individual cases could fall. Examination of cases that result in public embarrassment invariably includes failure to pass on details between Agencies. Individuals will pass between hospitals, prisons

and the community, and it is essential that there should be continuous and consistent assessment of and monitoring of their progress, or otherwise, as well as their needs.

WHITEMOOR also holds two other groups of prisoners who need special consideration, which is discussed in the report. Firstly, in its Special Secure Unit (SSU), it holds some high profile prisoners, convicted of the most serious crimes, whose escape really would present a risk to the public. Their custody is a most demanding task, and is something that must be kept under close scrutiny not only in the prison but also by the Prison Service. Characteristically they are demanding and manipulative, and their progression from the SSU must be carefully planned. Until recently their number also included a number of Irish terrorists, whose attitude to custody is different. But the regime must be designed around criminals and criminal behaviour, and staff trained to and supported in making it as purposeful as possible.

The second are those serving very long sentences, including whole life tariffs. Sentence planning and management for members of this group is not easy, because of the time involved, and, inevitably, will involve moves between a number of prisons, where different facilities are available. This is where long-term activities such as translating text and other books into Braille are so valuable, and I applaud whoever had the foresight to encourage one particularly notorious prisoner to describe scientific diagrams, making them available to blind children for the first time. Their number includes an increasing number of elderly prisoners, who appear to age more quickly in prison than they might outside. This too is a matter requiring consideration, as the elderly are a group for whom the Prison Service does not, at present, make adequate arrangements.

I draw attention too to the need to examine re-categorisation. At £52,500 per prisoner per year – twice the national average – HMP WHITEMOOR is not cheap, and prisoners should be moved on to lower category training prisons, where other activities are available, as soon as they are assessed as being ready, rather than have to apply for consideration only at set times of the year. Staff should be able to make this assessment as a result of their work with prisoners.

At the same time, I draw attention to the need to examine the numbers who are released straight from Category A accommodation, without preparation. Probation staff in particular are carrying out some excellent public protection work, but the subject as a whole needs attention at Prison Service Headquarters because release of such prisoners from prisons other than WHITEMOOR is involved. There is a certain illogicality about releasing prisoners, assessed as being of such high risk to the public that they must be held in Category conditions, straight from that, back into society.

A number of other initiatives are also in need of examination both to learn lessons and consider improvement. For example, I applaud the structured Dispersal Prison Induction Assessment, but believe that more work is needed in connection with subsequent needs assessments, which will condition both re-categorisation and release.

I also applaud the High Security Estate Substance Abuse Rehabilitation programme, but believe that there is a need to examine the Voluntary Testing programme in prisons other than WHITEMOOR as well. I am disturbed at the conflicting messages that are given to the public by Mandatory Drug Testing (MDT) results and what prisoners tell us. It is important that rehabilitation plans enjoy the trust of those on the receiving end, and this is not currently the case. Reports made by prisoners of the amount of heroin use in the prison, do not sit comfortably alongside alleged and publicly pronounced reduction in substance abuse. Voluntary Testing Units should be used as places to challenge the habits of those who are being persuaded to change them, as well as safe havens for those who wish to remain free of drugs.

Amongst wider concerns that I have is the provision of Offending Behaviour Programmes (OBPs), of which there are not enough at WHITEMOOR. In particular I would like to see resumption of Sex Offender Treatment Programmes (SOTP), not least because the required, and expensive, PPG equipment is already installed, and lying idle. Also it makes no sense to send prisoners to WHITEMOOR, needing to complete an OBP in order to progress through the system and towards parole, only to find that that programme is not available. The Catch 22 situation of not being able to move on until a programme is completed, but not being able to complete the

programme because it does not exist, is again an expensive misuse of WHITEMOOR accommodation.

All these recommendations, as well as those covering the re-examination of the role and use of the innovative Protective Care Facility, require sophisticated response both by the Prison Service and within the prison. Less sophisticated and immediate response is needed to resolve the problems in the inadequate Health Care Centre, particularly regarding staff numbers, and the fact that 57% of prisoners are more than 100 miles from their homes. There will always have to be a balance in the High Security estate, because there are many factors to be considered in determining where, within it, prisoners should be held. But, considering the problems that this poses for families, I believe that, on the surface, this is an undue proportion.

HMP WHITEMOOR is a good and well-run prison, in which a difficult task is being performed well. Of course, as in every establishment, there is room for improvement, but that is maintaining momentum, and exploiting what has been achieved, not seeking to rectify poor provision. The fact that this is a description that fits prisons in the High Security estate demonstrates, yet again, the benefit of single focus direction, and the enforcement of common standards. But delivery depends on the commitment and the skill of Governors and staff, and it is what they have achieved that deserves to be brought to public attention.

Sir David Ramsbotham **February 2001**

HM Chief Inspector of Prisons

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EXECUTIVE SUMMARY

ES1 Whitemoor first started taking prisoners in September 1991. Since this date, the establishment had had a number of significant events and changes in ethos. In its first few years, it had a particularly turbulent time, in common with many new prisons, and because of the difficult and disruptive nature of some of the prisoners arriving at Whitemoor. This turbulence included major disturbances and regular violent incidents across the establishment.

ES2 In September 1994, the escape of six prisoners from the Special Secure Unit (SSU) had profound consequences for the confidence of the establishment in its ability to provide secure accommodation for dangerous prisoners. Following the inquiries into these escapes and those from Parkhurst prison, major changes to the security arrangements for dispersal prisons and Category A core local prisons were made across the prison estate. By the time of this inspection, Whitemoor had successfully fulfilled all the requirements of the Woodcock report and had received considerable extra funding both in capital and running costs in order to put these requirements into effect.

ES3 The establishment had developed a generally safe environment for the prisoners and staff who were there. The escape was clearly still very much in the minds of staff, and there was very properly a reliance on strict adherence to written security procedures and regulations.

ES4 We were generally impressed with what we found at Whitemoor. Relationships between staff and prisoners were, in the main, good and in the last five years staff and management had succeeded in turning around what had previously been a very difficult and problematic establishment.

Tests of a Healthy Prison

ES5 This summary takes the form of an appraisal of the establishment's performance against the model of a healthy prison as described in the thematic review "Suicide is Everyone's Concern" published by HM Chief Inspector of Prisons in June

1999. From our discussions with prisoners and staff and from our own observations, we are confident of the following conclusions.

Test 1 – All prisoners are safe

- The results of our questionnaire stated that 73% of prisoners never or rarely felt unsafe in the establishment in contrast to 18% of prisoners who stated that they sometimes or regularly felt unsafe. Thus, we can conclude overall that the prison was in general a safe place to be for both prisoners and staff. We had some concerns however about the safety of prisoners and staff in the SSU and this is discussed elsewhere in the report.

- Anti-bullying procedures were generally effective.

- The approach to suicide awareness was a mixed picture with many good processes in place but for vulnerable prisoners a lack of access to Listeners during the evenings.

- There were very few prisoners applying for Rule 45 segregation for their own protection but the prison did have the option of locating A and B wing prisoners onto one of the vulnerable prisoner wings - C or D wings.

- The effectiveness of the Incentives and Earned Privileges Scheme was impressive but we had some concerns about the treatment of black prisoners within the scheme; this needs to be examined. It is discussed in further detail in the section of this report which deals with Race Relations.

- There was evidence to suggest that heroin was available in the establishment and indeed that some prisoners were using heroin for the first time at Whitemoor as a way to fit in with their peers. We were pleased to see a number of positive aspects of the Drug Strategy and these are expanded on in the section dealing with Substance Use.

Test 2 – Prisoners are treated with respect as individuals

- As mentioned above, staff and prisoner relationships were generally good.

- We had a significant number of complaints from prisoners from all races including white prisoners that some staff were racist.

- Standards in the living accommodation were extremely good. Units were mainly clean and maintained to a high standard.

- Access to cleaning equipment and kit was generally good.

- We had concerns that in trying to ensure that staff working in the SSU were never compromised. Managers were running an inhumane regime for the prisoners who were incarcerated there. **We recommend that the treatment of prisoners in the SSU be reviewed.**

- The food was served long after it was prepared in the kitchen, particularly the evening meal, and food could stay in a hotplate for over two hours before being served to prisoners. The pre-ordering system could be speeded up to advantage so that prisoners do not have to order their food a week in advance.

- We were pleased to see that prisoners could cook their own food in the wing kitchens but concerned that there was a lack of hygiene training for prisoners.

- Some prisoners were able to dine in association, which was good practice.

- We were particularly concerned about the lack of sufficient trained staff in the Healthcare Centre and felt that this had a profound influence on the ability of staff to care for prisoners properly in this unit. It also had implications for the safety of both staff and prisoners. **We recommend the reduction of places in the Healthcare Centre until the staffing problems are resolved.**

- The Personal Officer Scheme was seen to be in fairly good shape with pockets of particularly good practice around the establishment.

- Arrangements for visits and the treatment of visitors were respectful.

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

- There was more or less full employment with approximately 30 prisoners who were considered unemployable.

- Vulnerable prisoners on C and D wings had access to a range of good quality work including staffing the kitchen.

- Education was generally of good quality but we were concerned that classes in the evening had been stopped. Furthermore, prisoners attending education full time were paid less than if they worked in production workshops which was a disincentive for them to go on classes. Even some prisoners undertaking part time education found that they would lose their bonuses by attending classes.

- There was competition between activities offered in the evenings; for example on a Monday night there was a Listeners' debrief, Roman Catholic Mass, Library visits and shop visits all planned for the same period.

- Facilities for PE were good but the department had an ethos targeted towards recreation rather than in helping prisoners gain qualifications.

- Overall, prisoners had plenty of time out of cell, exercise and association although evening association was not available to prisoners on Saturdays and Sundays.

- There were insufficient offending behaviour courses for prisoners. This is discussed in further detail in the section of the report dealing with Prisoner Programmes.

- The quality of sentence planning was generally good but we were concerned that prisoners were being given targets to complete offending behaviour courses that were not available at Whitemoor and which were not linked in with transfers to establishments where such courses were available.

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

- Significant numbers of prisoners were released from Whitemoor; approximately 50 per year. We were surprised at this given the high security level of the prison. Dispersal prisoners have not traditionally been seen to require preparation for release as the assumption has been that they would progress to Category B training prisons, Category C training prisons and then perhaps to open prisons to be released from an environment in which release on temporary licence and pre release courses are available. For this and other reasons Release on Temporary Licence was virtually never granted from Whitemoor and no Pre Release Courses were available.

- Between 15 and 20 of the prisoners released annually from Whitemoor were still Category A prisoners. We were surprised to come across two prisoners who had been released on parole who, up to their release, had been classed as Category A prisoners. This sort of care may make logical sense in terms of Prison Service security but we cannot believe that it is in the best interests of preventing the next victim once such prisoners are released.

- Probation staff had an excellent Preparation for Release Strategy, and were clearly trying to do what they could to assist each discharge to prepare them for release.

- Other forms of public protection work were very efficient.

- Contact with family and friends was encouraged and the management of the Visits Area was excellent. The use of a passive dog was sensible but the isolated location of the establishment meant that some prisoners were unable to receive

visits. Prisoners from the north found it particularly difficult to get accumulated visits at the prisons local to their families, as most of these local prisons were overcrowded.

- Arrangements for sending and receiving mail were generally good and likewise access to card telephones. We were concerned that free phone calls for foreign nationals had recently been stopped and this is discussed further in the section about Foreign Nationals. We were also concerned that there were no Protection from Harassment Procedures pertaining to letters and phone calls.

Conclusion

ES6 Overall, we were very impressed with conditions for and treatment of prisoners at Whitemoor. The Senior Management Team and its predecessors had commendably turned around what had been an unsafe and insecure prison into one that was generally safe for prisoners and staff, where good order was apparent, where the regime was active for prisoners and accommodation was suitable and clean. A number of significant initiatives and examples of good practice were in place and are recorded in the report.

ES7 The Senior Management Team now has the challenge to improve the areas where we have identified problems and to develop the excellent initiatives such as the treatment of disordered prisoners.

ES8 There was a need for the establishment to continue to develop its work with and therefore meet the needs of an ageing dispersal population, sex offenders, particularly those in denial of their offences, those with severe personality disorders and those from ethnic minorities.

ES9 There was a need to more thoroughly integrate the different parts of the establishment to provide a still more effective regime for high security prisoners. But Whitemoor has become an establishment of which the Prison Service can be justifiably proud.

FACT PAGE

Task of establishment:

Whitemoor is one of the five Dispersal prisons in the Directorate of High Security. The establishment holds Category A-high risk, Category A-standard and Category B prisoners.

Prison Service Operational Area:

High Security Prisons

Number held:

407 prisoners were being held at Whitemoor at the time of the inspection.

Cost per place per annum:

Baseline CNA £40,011.26

In use CNA £47,139,96

Certified Normal Accommodation:

532

Operational Capacity:

532

Last full inspection:

The last full inspection was conducted in 1994.

The last short unannounced inspection was conducted on the 16 & 17 September 1996.

Description of residential units:

A and B wings accommodate normal location standard dispersal type allocations. Each wing has three spurs (known as Red Green and Blue) of 42. There is a separate purpose-built Special secure Unit (SSU) with a capacity for 14 Exceptional Risk prisoners. The current population is 7.

C and D wings accommodate vulnerable prisoners, and have separate movement times and regime activities from A and B wings. A programme of refurbishment to the residential units to deliver in cell electricity and TV had been completed in September 2000.

CHAPTER ONE

INTRODUCTION

History

1.01 Whitemoor prison is a modern, purpose built establishment occupying part of the site of the former railway marshalling yard near March in Cambridgeshire. It was originally intended to serve as a Category B training prison but the decision was taken before construction was completed to upgrade physical security to allow it to operate as a dispersal prison. The prison was built in one phase and the first prisoners were received in late 1991.

The prisoner population

1.02 At the time of this full announced inspection of HMP Whitemoor the total prisoner population was 407 all of whom had been convicted and sentenced. Ages ranged from 20 to 74 years, the greater percentage of the prisoner population being between 30 and 40 years. 34% of prisoners were serving life sentences and nobody had a sentence of less that 4 years. 24% had been convicted of murder, with 20% serving time for drug related offences.

CHAPTER TWO

ADMISSION ARRANGEMENTS

Reception

2.01 Prisoners were greeted by name in a courteous manner by confident and competent staff. Information about prisoners was handed over by escorting staff immediately on arrival at reception, checked and responded to appropriately by prison staff. Prisoners experienced a clean and welcoming Reception environment with efficient routines. The Reception area, however, was very small and the holding rooms were essentially small cells. Only one of these holding rooms had the advantage of integral sanitation. Usually receptions arrived in small numbers, i.e. individually or in pairs. However, on the occasions that prisoners arrived in larger numbers, the lack of holding room space and access to toilets meant that prisoners had to be moved from holding room to holding room when they required the toilet facilities.

2.02 Each of these holding cells had cardboard furniture and was sparsely decorated. None of the cells had posters on the wall or any reading material, information booklets or televisions to occupy prisoners while they waited. Reception staff informed us that prisoners usually spent less than half an hour in these cells. **However, the cells should be redecorated and reading materials should be provided.** This was particularly important as prisoners reported in our questionnaire that the length of time spent in Reception varied from under an hour to six hours for someone who was going to the Segregation Unit. Over half of the respondents said they had spent two hours in Reception before being moved to the wings.

2.03 Prisoners' immediate individual needs could be identified on arrival in Reception as only small numbers of receptions were received at any one time and all prisoners were seen individually. It was usually known in advance what type of accommodation prisoners would require i.e. if they would require location on one of the vulnerable prisoner units or could be moved directly onto normal location.

However, if prisoners required protection they could be given information quickly and confidentially about segregation and be located appropriately.

2.04 Some receptions at Whitemoor were located directly into the Segregation Unit by prior arrangement. We saw the reception of one prisoner from the Woodhill Close Supervision Centre (CSC) who did not go through Reception but was taken directly to the Segregation Unit for location. A Reception Officer was properly available in the wing during the prisoner's arrival so that his warrant and other paperwork could be checked properly and prison kit could be issued to him. The way this potentially disruptive prisoner was handled on his arrival at Whitemoor and by Segregation Unit staff was impressive.

2.05 Anyone identified as at risk of self-harm or suicide was risk assessed in Reception and a support plan prepared. All new receptions were seen by a Healthcare Officer or nurse at the front desk. If there were particular medical in confidence issues they could be seen in one of the holding cells. These arrangements were not satisfactory and **we recommend that a separate room be identified for the use of healthcare staff in Reception so that healthcare staff can see all new receptions in private.** A doctor saw all new receptions within 24 hours of their arrival.

2.06 Some information was available for new prisoners but this was not locally produced or locally relevant; for example the reception questionnaire was available in 34 different languages which included tapes in 34 different languages. However, there was no information that specifically pertained to Whitemoor issued at this stage. **We recommend that local information be given to prisoners in Reception to help them cope with the first 24 hours of custody. Information should include visiting arrangements, a copy of the local privileges (DPP) list and rules about the retention of property in possession.**

2.07 Some information was available on the walls of the Reception area and this included a poster advertising the Prisoner Information book, a poster about the CARAT worker and the Race Relations Policy Statement.

2.08 *Prisoners who did not speak English were notified by Reception staff to the Sentence Management Unit. This was good practice* but ought to be extended to other areas of the prison for example the Chaplain, wing staff and Education Department.

2.09 There were no prisoner showers in the Reception area, but prisoners could take a shower on the wing, once they were located.

2.10 The confined nature of the Reception Area did have one advantage in that it meant that prisoners were all effectively supervised during their time in reception. The small numbers of receptions at any one time meant that prisoners could be located separately, usually in the holding cells. This prevented bullying amongst prisoners but could be problematic for those who were suicidal or at risk of self-harm. However, we believe that the individual care prisoners received reduced this risk.

2.11 On arrival, prisoners were given a cup of tea and sometimes a meal from the Kitchen depending on the timing of their arrival. All property brought in by prisoners was X-rayed and checked using a passive drug dog. Volumetric controls were in place at the establishment and excess property had to be handed out within 28 days of reception. Property could be handed in or handed out in the Visitors Centre. *All electrical equipment was PAT tested by Works Department staff and, once checked, sealed with individually numbered property seals. This was good practice and helpful as part of the anti-bullying strategy in place in the prison.*

2.12 All prisoners were photographed using a digital camera and photographs were sent to various different departments in the establishment.

2.13 Strip-searching was carried out properly and privately. Clean towels were placed on the floor and we received no complaints from prisoners about how the reception strip- searches were carried out.

2.14 As mentioned above, the Reception area was clean and was kept so by a civilian cleaner who was employed five days a week for two to three hours daily. No prisoner orderlies were allowed to work in Reception. There was no phone available for the use of prisoners in Reception and prisoners were not provided with a free

telephone call on arrival. We discuss these arrangements further in the section below about First Night arrangements.

2.15 Prisoners had access to some property not held in possession. They did complain however that some property rules were inconsistent and harsh. Examples given included the fact that there were items not allowed that had been allowed in other dispersal prisons, blue tracksuit bottoms were not permitted but were seen in the possession of various prisoners across the prison, and pre-recorded tapes were not allowed. **There should be consistency across the dispersal estate in terms of property allowed in possession.**

2.16 Glass items were not allowed but *Reception staff issued prisoners with plastic containers in which to put the contents of any confiscated glass containers. This was an example of good practice.*

2.17 Any excess property was sent to the Prison Service main store at Branston after the 28 day period had expired. *All receptions had a new property card filled out for them when their property was checked. This was good practice as was the photocopying of property cards on a prisoner's discharge from the establishment, as this helped staff deal with any future property queries that might arise.* Prisoners, who arrived late in the evening, were located on their wing and their property dealt with the following day.

Discharges

2.18 We saw one prisoner being discharged from the establishment following an inter-prison visit (IPV) with his father who was permanently located at Whitemoor. All prisoners being discharged from the establishment were double handcuffed on their way out. The particular prisoner we saw, a Category C young offender, was double handcuffed to walk from the Reception door to the waiting taxi in the secure compound just outside Reception. Whilst we understand the reason for double

cuffing certain prisoners on discharge, **we consider that the need for double cuffing should be on the basis of individual risk assessment by the discharging Principal Officer.**

First Night

2.19 Once located on the wing (A and B wings for general population prisoners and C and D wings for vulnerable prisoners), prisoners were usually able to talk to a member of staff for five to ten minutes to receive a verbal explanation of immediate wing routines, for example the application procedures and the breakfast arrangements. They received nothing in writing at this stage. **We recommend that prisoners be issued with an initial induction pack to include information such as wing routines, how to apply for work or education and the other services available within the establishment.**

2.20 Initial kit was issued in Reception and further clothing was obtained the day after reception from the Clothing Exchange Store. Tea packs were usually issued on the first night and included tea, coffee, milk and salt etc. Reception packs were also issued from the Canteen (prison shop) usually on the prisoner's first night and these were available for smokers and for non-smokers respectively. However, we were surprised to discover that no phonecards were included in these reception packs. **Phonecards should be included in the initial reception packs issued to prisoners.**

2.21 Other than the arrangements above, there were no other specific first night procedures. The wing managers were not consistently interviewing prisoners individually although wing managers with whom inspectors spoke said that they could see the usefulness of such an arrangement. **The wing manager should interview all new receptions separately and in private during their first night.**

2.22 During the inspection, we came across a particularly worrying case that could have been avoided by such a procedure. A prisoner had been moved from Long Lartin prison some months previously following an allegation that other prisoners had assaulted him. One of the alleged perpetrators of the offence had then been transferred to Whitemoor during the week of the inspection and located on the same wing as the alleged victim. This potentially disastrous mistake was not identified

until the day after this prisoner's reception by which time he had been spotted by the victim and a number of prisoners who supported the victim and some who supported the alleged perpetrator. Information received suggested that certain prisoners had taken weapons onto the exercise yard because trouble was expected between the two groups of prisoners. Thankfully, the mistake was spotted and the new prisoner removed from the wing before any trouble between the two groups of prisoners emerged. If the alleged perpetrator had been interviewed by a wing manager on his first night and his record properly scrutinised at this stage, the two prisoners would not have been located in such close proximity to each other.

2.23 We were surprised to be informed that on very rare occasions, prisoners arriving from establishments a long distance away, for example HMP Frankland and HMP Full Sutton arrived during the evening. This was neither helpful to the prisoners involved nor the staff, by this time reduced to evening duty levels, who were receiving them.

2.24 **Consistent first night procedures should be in place to welcome new receptions on the wing and these should include prisoners being allowed to make essential contacts with family and friends before being locked up for the first night.**

2.25 Prisoners' access to Listeners during the evening and night was limited. This is discussed in further detail in the section of this report entitled Suicide Awareness.

2.26 Despite our reservations about the absence of first night arrangements, we noted that 84% of the prisoners who were questioned in our questionnaire reported that they felt safe on their first night at Whitemoor.

Induction

2.27 Prisoners were not seen by an admission/reception board. Prisoners received some information during their first week at the establishment but some departments did not ensure that they saw all new receptions at the earliest possible opportunity after they arrived in the establishment. The Chaplain attempted to see all new

receptions, as did a member of Education staff. But, for example, CARAT workers and wing managers did not see all receptions.

2.28 Vacancies in work places were advertised on each wing but information about work places was usually gleaned verbally from staff or other prisoners on the wing. **Prisoners should receive and be helped to understand detailed information on prison life through a comprehensive, multidisciplinary, induction programme.** This should include for example information about anti-bullying, applications, association, bail information, basic rules of the prison, the Board of Visitors, compacts, inter-prison transfers, drugs awareness, education, exercise, fire precautions and evacuation procedures, grievance procedures, equal opportunities and race relations, health and safety, healthcare, health education, housing, hygiene facilities, Incentives and Earned Privileges, legal aid, Library, the Listeners scheme, offending behaviour programmes, Personal Officers, PE, shop, sentence planning, sources of support, spiritual activities, suicide awareness, letters, telephones, visits, work and training available in the prison.

2.29 **Separate arrangements should be made for prisoners who cannot access the normal induction programme to ensure that they too are effectively introduced to the establishment. These include prisoners directly located into the Segregation Unit or the Healthcare Centre on arrival into the establishment.**

2.30 *There was evidence that non-English speakers were, if possible, located in spurs with other prisoners who could speak the same language.* We were pleased to be informed that two staff on one wing had been given a Performance Planning and Review Record **(**PPRS) objective to produce Induction packs for prisoners. **We recommend that an induction programme be consistently introduced across the establishment for new receptions and induction information be issued both in writing and verbally.**

2.31 In the questionnaire that we issued to prisoners, 78% of those questioned reported that they had not been on an induction course as such. Comments made by respondents pointed out that there was not an induction course but that during the first week of arriving at the prison, prisoners would see most departments and talk to the

staff. We were concerned that despite being told that a Chaplain would see all new prisoners, 22% reported that they had not seen one since arriving. Although 89% of prisoners reported that they had a Personal Officer, only 36% of those having one stated that he/she had introduced him/herself to them when they arrived on the wing.

2.32 46% of the prisoners who were questioned stated that they had problems that needed dealing with when they first arrived at the establishment and 59% of these prisoners said that they felt these problems had been dealt with.

Legal Aid

2.33 Two Prison Officers undertook work relating to legal services at Whitemoor; there was also a third member of staff who acted as a relief. All had received legal aid training but had not undertaken the new Prison Service legal services course. **Arrangements should be made for them to undertake the legal services course as a matter of urgency.**

2.34 Legal Services Officers also worked as Library Officers. We were told that there was no conflict between the roles as two members of staff were always on duty, allowing one member of staff to focus on each role. *The legal services staff were on a separate attendance pattern, from other Prison Officers, which enabled legal services to be available during the main day Monday to Friday: this was an example of good practice.*

2.35 Prisoners gained access to legal services through the application procedures and we were told that Legal Services Officers interviewed all new receptions during their Induction programme. *New prisoners were also given a booklet relating to legal services had been produced by Legal Services staff; this was good practice* but was marred by the fact that it was not available in any foreign languages. **The information booklet should be made available in other languages.**

2.36 We were told that 15 – 20 applications were received each week for legal services. Prisoners with whom we spoke during the inspection were aware of how to gain access to legal services and said that they were pleased with the assistance they received from legal services staff.

2.37 A log was kept of all work undertaken by Legal Services Officers and a verbal handover of ongoing work was given to staff taking over legal services duties. All the original applications received were kept and filed

2.38 *As Legal Services Officers were based in the Library they were well resourced including their own computer. Legal reference books were available including a copy of Archibald's on CD Rom. Generally the provision of legal services was well organised and staff with whom we spoke appeared dedicated and enthusiastic about their work.*

CHAPTER THREE

RESIDENTIAL UNITS

Residential Accommodation

3.01 There were four main wings at Whitemoor. A and B wing each held a maximum of 126 sentenced adults, one to a cell. C wing held a maximum of 126 adult sentenced vulnerable prisoners. D wing held a maximum of 124 prisoners with one spur (red spur) being used for prisoners undergoing personality disorder assessment, the other two spurs being assigned to vulnerable prisoners. The establishment also had a number of other accommodation areas. E wing held a maximum of 16 prisoners described as having long-term control problems. The SSU held up to 14 extreme risk Category A sentenced prisoners. The overall Operational Capacity of the establishment was 532 prisoners. Accommodation not included in the Operational Capacity of the establishment was:

3.02 All cells were properly certified within the cell certificate schedule. This had been updated on the 16 October 2000 i.e. just a few weeks before the inspection. Despite a clear management policy that wing managers should interview new receptions individually once received on the wing, this was clearly not being carried out in all cases.

3.03 Prisoners had access to in-cell emergency call bells that worked and were generally responded to promptly. The establishment had the benefit of an auditable cell call system. However, our estates inspector asked to see the records of the cell bell use which recorded both the time cell bells are pressed and when they are answered. He found that despite this extremely useful management tool being in place, managers were not able easily to access this information and only the Head of the Works Department seemed to be able to do so. **We recommend that the auditable cell call system be used properly as a management tool to check that cell bells are being responded to promptly in all areas.**

3.04 Observation panels in cell doors remained free of obstructions in all cases observed.

3.05 There was no specific accommodation for prisoners with physical, sensory or mental disabilities; however, most prisoners in these categories were located in the Healthcare Centre. Prisoners with mobility problems would have to be located on the ground floor in the normal location wings. However, there were no alterations to cells, for example widened doors and handrails, or to other facilities in the wings, for example showers etc. to allow prisoners in wheelchairs to remain on normal location. **As there is an ageing population of Lifers and other long-term prisoners in the prison estate, Whitemoor needs to address this issue and find ways of allowing prisoners with mobility problems to live on normal location.** The accommodation and facilities available for prisoners in the Healthcare Centre are discussed elsewhere.

3.06 The establishment had a clear policy on offensive displays, although this was not consistently enforced across the establishment. Some staff claimed that they were not aware of the offensive display policy and others stated that prisoners could display any pictures that they could buy off the top shelf in a newsagent. **We recommend that the offensive displays policy is relaunched in the establishment and that it is made clear to staff and prisoners what form of displays are acceptable.**

3.07 We were impressed by the calm, relaxed and generally noise free residential units at Whitemoor. This was particularly apparent when we visited the establishment during the night and were told that whilst a number of prisoners were still watching television or listening to radios, little noise could be heard coming from any cells.

3.08 As far as was possible ligature points in cells and ablution areas were eliminated or reduced.

3.09 Residential accommodation was generally well decorated, decently furnished, clean and free from graffiti. We were surprised however, to see notable differences between wings in terms of landing and other communal area cleanliness. Whilst B wing was clearly the cleanest in these areas, C wing and the SSU were much less clean. C wing staff told us that no prisoners had been trained in industrial cleaning for

some time but training had recently recommenced. They were hopeful that this would improve the overall appearance of communal areas. SSU staff, however, told us that there was very little time for prisoners to carry out cleaning on the wing with only half an hour or so at the beginning and end of each day not already taken up by other activities. We do not accept this. At the time of the inspection there were seven prisoners in this unit and even with each of these prisoners carrying out half an hours cleaning per day, we would expect a much cleaner unit. **The cleanliness of the SSU should be improved. All units should aim to achieve the level of cleanliness seen in B wing.**

3.10 A, B, C and D wings were of the same design with 42 prisoners per spur on A, B and C wings and on D wing 42, 42, and 40 per spur respectively. Each wing had a red, blue, and green spur. In A and B wings one spur was put aside as a voluntary testing unit (VTU). On D wing, one spur (red spur) was assigned as the Dangerous and Severe Personality Disorder assessment unit (DSPD).

3.11 Each of these four wings had showers on the ground floor and on the second floor (known as the ones and the threes respectively). We were surprised to see that none of the showers had shower mats, hooks for hanging dressing gowns etc. or benches to sit on. **Showers should be equipped with shower mats, and somewhere to hang dressing gowns/towels when prisoners are in the shower.** Some shower rooms had peeling paint on the ceilings and cracked tiles around the bath areas. **These defects should be remedied.**

3.12 There were design problems with many of the showers on the ground floor in that flooring that sloped away from the drainage. Thus pools of water were found in many of them and some were completely unusable (for example on A wing where a couple of inches of water lay stagnating in one of the ground floor shower rooms). The problem had been identified by residential and works department staff and some work was being carried out on this problem at the time of the inspection. **All ground floor shower rooms should be re-floored where necessary so that water can properly drain out of these areas.**

3.13 Each spur also had a self-catering prisoner kitchen, extremely well equipped and kept clean by the prisoners themselves, and two association rooms. Each had two large chest freezers located on the ground floor. These were used to store prisoners' own food bought from the prison shop. Many of these had clearly not been defrosted for some time. We suggest that these chest freezers be audited as part of the monthly kitchen audit.

3.14 The ground floors also had a well-equipped mini gym facility. Despite being told otherwise, we were concerned that not all prisoners were being adequately trained to use these facilities before they did so. **The prison should ensure that all prisoners are given proper training before they are allowed to use the mini gym facilities on the wings.**

3.15 Every spur was also equipped with pool and table tennis tables and the VTU spurs had the extra facility of a snooker table. Association rooms were also well equipped with new, clean, comfortable chairs and televisions.

3.16 Each cell was well furnished with a cabinet, table, and bed with a mattress in good condition, shelving and a television along with a toilet and sink. No toilets had privacy screens. **Prisoners' in-cell sanitary arrangements should be effectively screened.** Cell lockers should all have been equipped with keys but these had been lost and not replaced in many cases. **All lockers should have keys so that prisoners can safely store their valuable possessions**. Cells also had a kettle and in-cell electricity.

3.17 The supervision of prisoners was adequate to preserve safety and good order in residential wings. Staffing levels were more than sufficient to make sure that prisoners were able to attend all parts of the regime and to properly access all the facilities on the wing. Prisoner access to cleaning materials was also good as was evidenced from the cleanliness of the majority of the cells inspected. Each wing had a wing launderette equipped with washing machines and dryers where prisoners' personal kit could be laundered.

3.18 The wings were arranged around a centre office on the twos landing and were a cross shaped design. Three spurs of the cross were residential accommodation as mentioned above and the fourth comprised on the ground floor a servery area where meals were served and on the second floor, a number of offices, including the Senior Officer's office and other rooms for specific workers such as drug support workers, Probation Officers, Residential Governor Grades, staff rooms, and staff toilets.

3.19 Also available on each residential spur were rooms available for classrooms or other group work. Each wing was equipped with an ironing board and iron and a drying room.

Clothing and Possessions

3.20 Prisoners could generally wear their own clothing. However, we had some complaints from prisoners that some of the rules about clothing were rather petty and inconsistently applied from prisoner to prisoner. For example some prisoners had been allowed to have navy tracksuit bottoms and others had not. **The rules about clothing should be properly and consistently applied across the population.** Prisoners' responsibility for and entitlement to 'in possession' items, including those linked to the Incentive and Earned Privileges Scheme, were specific and published in a privileges list available on each wing. Prisoners were asked on reception if they needed prison kit and if they did were asked to fill in a form ordering the numbers of items and the sizes of such items. There were no problems in getting such property except for unusual sizes, for example, wide fitting shoes, and very small clothing. At the time of the inspection, one prisoner who was 6' 9" had no problems receiving prison clothing but one prisoner who was 4' 11" had to make a special order to receive items such as new jeans. There were plenty of basic standard sized items of kit such as underwear and socks.

3.21 There also appeared to be very few difficulties in obtaining bedding. *Initial bed packs and toiletry/catering packs were given to prisoners on their first night and prisoners were usually given a new pillow and new mattress on their arrival to the establishment. This was extremely good practice which was financially possible because of the length of time that prisoners stayed at Whitemoor.* We were impressed by the access to pillows, sheets and blankets and found that the quality of such items,

including mattresses, was generally of a high standard. This was not the case in the Segregation Unit, however, where we found worn mattresses and some inadequate bedding. **Mattresses and bedding in the Segregation Unit should be replaced when they become worn or stained.**

3.22 Each wing had a kit orderly and a prisoner who staffed the wing launderette. *Prison kit was marked with prisoner unique numbers so that if a prison kit was laundered it could be returned to the correct person. This was also good practice and meant that prisoners could hold on to well fitting items of prison kit that also prevented undue waste.*

3.23 Prisoners had access to property not held in possession but as mentioned above, there were complaints that some items were not allowed in possession and that decisions from Reception were sometimes inconsistent in that some prisoners were allowed certain items and others were not.

3.24 Prisoners' property held in storage was secure. We were impressed with the standard of record keeping as far as prisoners' property held in Reception was concerned and with the storage arrangements for property held there. Volumetric controls were in place and prisoners were asked to sign disclaimers for items of particularly valuable property if they wished to hold them in possession. As far as we could tell prisoners were fairly compensated for lost clothing and possessions held in possession.

Hygiene

3.25 Prisoners had access to adequate supplies of personal hygiene requisites such as toothpaste, soap and shampoo. However, many preferred to buy these items from the Prison Shop. Baths and showers were available on each wing as mentioned above and access to these facilities was good on the main wings.

3.26 We received a number of complaints from prisoners that staff would barge into their cells without knocking which was particularly embarrassing if they were using the toilet at the time. **Unless necessary for security reasons, staff should**

knock before entering prisoners' cells in order that they can make themselves decent avoiding embarrassment for both the member of staff and the prisoner.

3.27 Each wing had a colour coding system in place. This included signs and colour coded equipment. Despite the system being in place, items of equipment were not always being used as per the colour coding system. Thus, for example, mops were seen being used in the wrong areas of the wing. **Colour coded equipment should be used properly as per the system laid down.** COSHH arrangements were also in place and *we were particularly impressed to find out about the weekly descaling of toilets that took place, carried out by the Cleaning Officer and a cleaning orderly. This was an example of good practice.*

3.28 Each wing was also equipped with a number of large items of cleaning equipment i.e. two water vacuum cleaners and at least two floor polishers. Wing painting arrangements were in place in many of the wings, which ensured that communal areas and cells were kept well decorated.

3.29 The number of card telephones varied between normal location (A and B wings) and vulnerable prisoner accommodation (C and D wings). This is discussed further in the section of this report entitled Mail and Phones.

CHAPTER FOUR

LIFE FOR PRISONERS

Anti-Bullying Strategy

4.01 A comprehensive anti-bullying strategy was in place at Whitemoor (called the Anti-Intimidation Strategy). A Principal Officer known as the Anti-Intimidation Co-ordinator managed the strategy. *An Anti-Intimidation Committee, which included members of the Senior Management Team, met bi-monthly to examine all reported incidents of bullying/intimidation or violence; this was an example of good practice*. The Anti-Intimidation strategy statement of purpose was also displayed clearly around the establishment.

4.02 The co-ordinator investigated all incidents brought to his attention and information copied to the Security department. The strategy employed a three-stage procedure for alleged/identified bullies:

- Stage 1 — If a prisoner was suspected of bullying, information was circulated to all areas in a yellow folder to all relevant areas for staff to be extra vigilant in observing his behaviour. (over a two week period)
- Stage 2 — If anti-social behaviour was observed the prisoner was taken to the Segregation Unit and interviewed by the wing manager. He was then relocated to a different unit and required to sign a compact agreeing not to accept canteen from other prisoners, go in their cells or have any property belonging to other prisoners. The prisoner was also subject to a regime level review.
- Stage 3 — If the prisoner continued with his anti-social behaviour he was relocated to the Segregation Unit for a period of readjustment, during which a member of the Psychology department would see him.

4.03 Victims of bullying were supported through bi-monthly sentence planning reviews although the detailed components of the support given were not clear. Perpetrators were also reviewed through bi-monthly sentence planning reviews but remained on stage two of the procedures for at least six weeks. We were concerned that there were no specific programmes to support victims (assertiveness, self awareness etc) or any interventions developed for confronting bullies. We were told that the Psychology department was developing programmes but that these would be sometime in the future. **We recommend that programmes be developed as a matter of urgency.**

4.04 Staff were informed of the details and revisions of the Anti-Intimidation strategy through daily briefing delivered by wing managers. No formal training had yet been undertaken. **We recommend that all staff should receive formal training in respect of the Anti-Intimidation procedures**. We were told that prisoners received information about the Anti-Intimidation Strategy during their induction programme and through Prisoner Information Notices. However, the copy of the Prisoner Information Notice given to inspectors was dated 3 December 1998; **this should be updated as the strategy has been revised since that date.**

4.05 The Anti-Intimidation Co-ordinator produced a monthly report for the committee. This was of a high quality and not only measured the incidents of violence/ intimidation across the prison and in which areas it occurred but also measured the trend over a number of months. *The co-ordinator was able, for instance, to correlate a high number of incidents with a period when a high number of prisoners had been received from a particular establishment; this was an example of good practice.*

4.06 An Anti-Intimidation questionnaire had been attempted in February 2000 but less than 4% had been returned. **Other ways should be sought to undertake this valuable piece of work.** *Generally we were impressed with the procedures for Anti-Intimidation at Whitemoor. They had been well thought out and the co-ordinator was enthusiastic and knowledgeable about the subject.*

Substance Use

Introduction

4.07 Whitemoor's written Drug Strategy Document 2000 was a very comprehensive aspirational document detailing all initiatives that took place with clear performance indicators for each key element of the strategy. **The strategy should be developed to include an action plan with time bounded monitoring and reviews, identifying those responsible for each area and quality assurance mechanisms.**

4.08 A multi-disciplinary Drug Strategy Meeting chaired by the Head of Residence (East) was held regularly. Designated staff attended a number of external meetings within the Directorate of High Security Prisons. The prison was represented on the local Drug Action Team. The Drug Strategy Co-ordinator was the Governor responsible for Prisoner Management East. The Drug Support Co-ordinator was a Senior Officer who in partnership with the Drug Treatment Manager supervised the day-to-day management of the strategy.

4.09 Between June and September 2000, Whitemoor along with the rest of the dispersal estate undertook *a needs analysis of substance use amongst its prisoners. This was to inform the development of the proposed Directorate of High Security Substance Abuse Rehabilitation programme.* 15% (89) of Whitemoor's population was randomly selected and three questionnaires plus a short interview were held. 70 of the 89 prisoners selected agreed to take part. Six members of the CARAT Team, and a Psychologist conducted the interviews. The analysis of the responses was still being carried out at the time of our inspection. However, it was clear that there was a high level of suspicion and mistrust amongst those who refused to take part.

4.10 In our own confidential prisoner questionnaire responses 20.6% (20) prisoners said they had used drugs at sometime but no one said they still had a problem with drugs. This was unusual and probably indicated a lack of trust in the process, especially given the use of heroin in Whitemoor. 14% (5) said they had received help for their drug problem, 8% (3) had received no help and 73% (27) said that help was not applicable to them.

4.11 A Healthcare needs analysis that would include questions on drug and alcohol use, was to be undertaken in the first week in December 2000. This would provide further information for informing the development of the Drug Strategy.

4.12 Prisoners and staff told us that heroin was relatively easy to acquire within the establishment and two prisoners said they had first tried heroin while in custody. Prisoners also told us that they did not trust the system in place in Whitemoor for working with drug users. Some said they felt that seeing a drug worker meant they would be targeted under the Mandatory Drug Testing suspicion testing.

4.13 It was within this context that a number of new developments had taken place in the six months prior to our visit, including the setting up of the Voluntary Testing Units and the start of the full Counselling, Assessment, Referral, Advice and Throughcare (CARAT) service.

Healthcare

4.14 Those prisoners requiring detoxification were cared for under a 'shared care' protocol between the Healthcare Department and the CARAT Team. Procedures were in place for the use of lofexidine and inpatient treatment was provided as necessary. Although only eight prisoners had been assessed as needing detoxification in the previous twelve months, *this detoxification provision with its partnership approach was good practice.*

Communicable Diseases

4.15 There was a comprehensive Hepatitis B immunisation programme in place. Hepatitis C and HIV testing were through the Genitourinary Medicine Clinic provided by an external specialist. Proposals to offer a blood borne virus clinic as part of the Well Man Clinic were under consideration. *Management of HIV+ prisoners appeared to work well as internal confidentiality was maintained and access to outside services facilitated.*

4.16 The Communicable Diseases Management Team was no longer functioning effectively, partly due to the loss of key members and the workload of the Clinical Services Manager. Given the prevalence of Hepatitis C amongst injecting drug users

and the rise of drug resistant tuberculosis in the community, it is important to provide a regular forum to monitor and manage communicable diseases.

Voluntary Testing

4.17 The Drug Support Co-ordinator was responsible for oversight of Voluntary Testing throughout the establishment. Voluntary Urinalysis was being offered in a number of areas, a spur on A Wing, the enhanced spur on B Wing, a spur on C Wing and non-location based on D Wing. There were distinct prisoner groups within Whitemoor and the Voluntary Testing had been set up to meet their different needs. The arrangements for participating in voluntary testing varied between the Units, and prisoners themselves were unclear as to "how it worked."

4.18 In light of the recent Prison Service Order and following this initial development period, **we recommend a review of the role of voluntary testing in Whitemoor** in order to identify the target groups, and what the most effective balance between nonusers and users on the Spurs might be. How the Voluntary Testing Units fit together and what support can be offered to substance-using prisoners on them, in addition to individual CARAT work, needed consideration.

4.19 These Units were potentially the only "safe" places in the prison for drug users to go if they wanted a supportive environment in which to make changes. This was essential for those prisoners who had undergone detoxification. Therefore a strategy for ensuring the speedy removal of non-using drug dealers needed to be implemented as soon as possible. As there was no residential rehabilitation facility within Whitemoor the success of the voluntary testing programme in underpinning treatment was crucial.

4.20 The policy of an individual case review in relation to a positive urine test case review should be formalised and procedures put in place to work with those prisoners in order to prevent ongoing relapse. In line with the establishment's written drug strategy **all staff involved in work on the Voluntary Testing Units should be volunteers and receive training in working with substance users.**

4.21 There was no underpinning relapse prevention/support programme and no clear policy for working with those removed from the Units. While we recognise that not all prisoners want to stop using drugs, given that continued relapse is an integral part of the change process, there were insufficient structures in place to support those who did. Prisoners themselves told us that they thought voluntary testing was "a good idea" but that it was not working properly, i.e. lack of support and lack of clarity and consistency in the procedures.

CARATS

4.22 The Counselling, Assessment, Referral, Advice and Throughcare (CARAT) service was provided by a multidisciplinary team and had been developed since October 1999. There were seven staff comprising three full time CARAT workers and a Team Leader from the external provider Compass, two full-time Prison Officers and a half-time administration assistant. The full CARAT Team was in post from May 2000.

4.23 In the six-month period May to October 2000, the Team had received 59 referrals of which 33 were self-referrals. Of the 57 who were fully assessed, 31.6% reported cocaine as their preferred drug, 29.8% heroin and 24.5% cannabis. The different patterns of drug use between stimulant and opiate users should be considered when designing interventions. Of the 57, 31.5% identified themselves as being from minority ethnic groups and 15.7% as Foreign Nationals.

4.24 Apart from individual assessments and counselling, the CARAT Team provided a low threshold eight-week 'CARAT Intro Group' on an alternate basis to A/B Wings and C/D Wings. There were two sessions per week, one of group work to identify individual patterns of behaviour in relation to drug use and to find coping strategies for dealing with these. The Physical Education Department ran the second session in the gymnasium. This course was originally conceived as a gateway to the Substance Abuse Rehabilitation Programme, planned to start in March 2001, that the Directorate for High Security was developing from a Medium Intensity Model designed for the Correctional Service of Canada. In addition to this function, the "CARAT Intro Course" could be developed to provide **an appropriate intervention for those prisoners who were still using drugs and those who would not fit the**

criteria for the Rehabilitation Programme. We were concerned that within the current focus on breaking the re-offending cycle the specific needs of individual prisoners should not be forgotten and that there was a clear strategy for offering harm education.

4.25 The CARAT Team also offered auricular acupuncture clinics twice weekly, which provided a low threshold contact point. There were plans to develop a Peer Education/Support Programme. The Team was aware of the tensions inherent in working in a high security establishment with the need to balance clinical confidentiality with security requirements. They understood the difficulty some prisoners had in accessing the service and were keen to find ways to address this.

Alcohol

4.26 A local outside agency, 'Drinksense', had provided a service to the prison but its contract had finished, as there had been a drop in referrals to them. In responses to our prisoner questionnaire 16% (6) prisoners described alcohol as causing a problem for them. Of these, two said they had received help in custody, one did not want help and two did want help but had not received any. The CARAT Team had seen two prisoners who said alcohol was their main drug of choice.

4.27 The December healthcare needs assessment; the analysis of the Rehabilitation Programme Questionnaire responses and information from sentence planning should underpin the development of a local alcohol strategy.

Education/Prevention

4.28 There was a Social and Life Skills Course running as part of the education programme. The drug and alcohol module of this course is a valuable component of the Drug Strategy as it provides an education/prevention element that is accessible for all prisoners. However it should not be used to fulfil the sentence planning requirements of those with drug and alcohol problems or dependency.

Physical Education Department

4.29 Offering a gym session within the "CARAT Intro Group" was good practice. However although the Physical Education Instructors were keen to be involved in this

work, they **needed further training in order to offer appropriate health promotion** alongside this physical fitness programme. This element of the course should be properly integrated with the CARAT group work session.

4.30 The Physical Education Department also has a crucial part to play in providing general education to all gym participants in relation to the use of steroids and bodybuilding substances. Training should be provided to allow the department to fulfil this role, especially given the population of Whitemoor.

Drug Importers Course (Foreign Nationals)

4.31 The Probation Department had developed this course in order to meet an identified gap in interventions for non-using drug importers. The content was devised with the needs of a mixed group of foreign nationals in mind, taking into account different levels of English spoken language and literacy.

4.32 It initially focused on participants developing an awareness of "risk factors" and considering those factors which might apply to them and then identifying ways of reducing these. The first course in January 2000 consisted of three two-hour sessions. Eleven men started it and ten completed. In response to their feedback, a fourth session, which directly addressed their offence, was added to the second course in August. This course had seven participants who all completed. A third course was planned for the special secure unit prisoners in November.

4.33 The feedback from participants had been positive and the possibility of offering it to other drug importers within Whitemoor apart from Foreign Nationals was being considered. *This was a good initiative supported by the Senior Management Team*. **Further development of this Drug Importers Course to include work on victim awareness and to be extended to all appropriate prisoners is recommended.**

Security

4.34 The Mandatory Drug Testing (MDT) suite was purpose built and clean. The partial redecoration needed completion and the holding room, which was small and claustrophobic, needed ventilation fitted. The suite was next door to the Drug Support

Unit, which had implications for the prisoners' perception of the relationship between security and support services. The Drug Support Co-ordinator had oversight of the Mandatory Drug Testing which was carried out by two very competent and committed full-time officers.

4.35 For the first 6 months April to September 2000 MDT random positives were averaging 10% per month. Whitemoor's Key Performance Target was 8%. However the impact of the same persistent drug users being thrown up on random sampling and other contextual issues needs analysis alongside the statistics. August results were 10% (2) positive, and September 0% positive. Suspicion positives for the same period ran at an average of 44% for the first 6 months. August results were 50% (1) positive and September 25% (4) positive. There were 21 prisoners undergoing the Frequent Testing Programme with 31.5% (6) positive out of 19 tested in August and 43.7% (7) positive out of 16 tested in July. Some reception testing was also carried out during the first six months. The vast majority of positive results in Whitemoor were for heroin.

4.36 In relation to positive MDT results and the adjudication process there were no formal procedures in place for liasing with CARAT staff or referring on to them. Information was provided to prisoners about the CARAT service on all the MDT paperwork. *Where prisoners were actively working on their drug problem, the MDT Award Guidelines for Adjudicating Governors suggested the use of suspended awards.*

4.37 During our visit we spoke to prisoners who had been long-term drug users in the community and one who had been a notified addict since his early teens. It was clear that within Whitemoor there were some prisoners for whom adjudication awards were not an effective deterrent. One prisoner thought he had had about 27 positive results through MDT, all resulting in punishment.

4.38 **Where a prisoner has had a long well established pattern of drug use and is unable to make or maintain a short-term transition to abstinence, longer-term prescribing should be considered.** This removes the prisoner from both the health

and punishment consequences of illegal drug use and from the drug culture within the establishment.

4.39 Where all other options have been tried and it is clinically indicated, longer-term reduction prescribing in the context of regular urine testing, counselling and support with clearly defined goals may provide the necessary bridge to abstinence. Such prescribing is in line with the Department of Health's 1999 Guidelines on the Clinical Management of Drug Misuse and Dependence, and Prison Service Healthcare Standard 8.

Reducing the Supply of Drugs

4.40 The Operations and Security Department were clear about the resources and procedures needed to provide this element of the Drug Strategy.

4.41 Whitemoor had its own Drug Dog Team of seven active drug dogs and three passive drug dogs. A strategy was in place for responding to passive drug dog indications, which included non-contact visits, targeted seating and police attendance. CCTV cameras were in place in the Visits area and regularly monitored. There were plans to install further cameras in adjacent areas. Searching in the past 12 months had resulted in 119 drug-related finds.

Summary

4.42 Management and staff recognised the need to tackle the ongoing heroin use in Whitemoor within the context of a climate of suspicion and mistrust. Some prisoners referred to the CARAT staff as "spies" and saw them as too closely aligned with security. The levels of prisoner suspicion are confirmed in the responses to our questionnaire, in some of the reasons given for refusing to take part in the rehabilitation questionnaire and in the slow uptake of the CARAT service.

4.43 **We recommend a review of how the security and treatment elements of the Strategy fit together and the development of procedures to make treatment more accessible to more prisoners.**

Equal Opportunities

4.44 The establishment had an Equal Opportunities Committee but this dealt with staff issues rather than those for prisoners. The Race Relations Liaison Officer was included in the Equal Opportunities Committee, which had been set up in March 1999. It was however pointed out that the role of the Equal Opportunities Officer was primarily to deal with employment law and staff complaints. Despite a multi-disciplinary team being set up at this time and a number of meetings of the Equal Opportunities Committee taking place in 1999, it appeared that no meetings had taken place during the year of 2000. It seemed that the profile of equal opportunities for staff needed to be raised in the establishment. It was also apparent that equal opportunities for prisoners needed to be looked at too and not just the issue of race which was being dealt with by the Race Relations Management Team.

4.45 It had been recognised by the establishment that the population of prisoners was an ageing one and that this brought with it its own particular challenges, for example the provision of accommodation for prisoners with mobility problems. At the time of the inspection, prisoners in wheelchairs were being located in the Healthcare Centre (one prisoner at this time). Even this area was not ideal in that there was a step up to the bathroom in the Healthcare Centre that made access difficult. For wheelchair bound prisoners to be located on normal location, some alterations would be necessary including the widening of doors and a provision of ramps. Some parts of the establishment already had such facilities and a ramp was seen up to the Reception door for example. Access to the Visits Area was also good.

4.46 There was a small number of disabled staff at the establishment and the prison had made some alterations and bought new equipment to cater for these staff. A lift was available to take staff or prisoners from the secure walkway up to the next floor. It was possible that the establishment did more equal opportunities/cultural diversity promotion than was evident and needed **to raise the profile of such work**, particularly bearing in mind the provisions of the Disability Act and population changes such as the ageing Lifer and long term population across the estate.

4.47 Only about 10% of prison staff had been trained in Equal Opportunities identifying a need for training to be ongoing and to meet mandatory training requirements.

4.48 We were pleased to see that a relatively large proportion of staff were women. At the time of the inspection, 180 or 25% of the total staff in post figure were women (these figures included all staff directly employed by Whitemoor but did not include Probation or Education staff). However, only one member of the Senior Management Team was female. The largest groups of female staff were in the Administration Department and within the Operational Support Grades (OSG). 11.4% of Officers were women.

4.49 Despite an acknowledgement that some prisoners were engaging in homosexual activities, no condoms were being issued to prisoners either within the establishment or on discharge. **We recommend that prisoners be issued with condoms both within the establishment and on discharge.**

4.50 **The profile of equal opportunities and other issues of diversity needed to be improved at Whitemoor. A member of staff should be identified as the Equal Opportunities Officer for prisoners and a policy should be written and promoted dealing with equal opportunities for prisoners.**

Race Relations

4.51 The Governing Governor had provided a practical example of his personal commitment to good race relations by becoming the Chair of the Race Relations Management Team meetings in April 2000. In this initial meeting, he gave his full commitment and backing to race relations and described a measured approach as the way forward. The Race Relations Management Team was multi-disciplinary and included representatives from the staff of each wing and, at the time of the inspection, from the prisoner population of A and B wings. The prisoner representative for C wing had left the prison shortly before the inspection and a replacement was being sought. The population in D wing was temporarily reduced and a representative was not in place for this wing. **We recommend a prisoner representative for D wing is appointed as soon as possible. We also recommend that where possible a**

prisoner representative from the Healthcare Centre, E wing or the Segregation Unit be appointed to represent the prisoners in these Progressive Care Facility areas.

4.52 The establishment had a Race Relations Liaison Officer and two Deputy Race Relations Liaison Officers all of whom had completed the Race Relations Liaison Officer course and Presentational Skills Training; this enable them to carry out local race relations training for staff.

4.53 At the time of the inspection the establishment's Training Department was trying to schedule race relations training once a week. The department was concentrating on training Prison Officers first before other members of staff. The Race Relations Liaison Officer was himself a wing based Prison Officer. One of the Deputy Race Relations Liaison Officers was based in the Segregation Unit and the other was a Senior Officer in the SSU. This was advantageous as it ensured that race relations' issues were given a high profile in these somewhat isolated areas currently without prisoner representatives. **We recommend that a prisoner representative be appointed for the SSU, and whilst we recognise that this prisoner would not be able to attend Race Relations meetings, he could raise any issues of concern with the Deputy Race Relations Liaison Officer located on this wing.**

4.54 Whilst in their day to day duties and approach to their work, most staff demonstrated respect for prisoners, other staff and prisoners from ethnic minorities, we did receive a significant number of complaints from prisoners that some staff were to varying degrees racist.

4.55 Whitemoor is located in isolated fen land where we were told "someone from Peterborough is considered exotic". Though there were significant ethnic minority populations in Peterborough, about thirty miles away, there were few members of ethnic minorities living in the immediate vicinity of the prison. The majority of the 730 staff in post were white, only four staff were black, six staff were Asian and five from other ethnic groups. Thus the staff in no way reflected the prisoner population.

4.56 The establishment had carried out some proactive recruitment including a job fair that had taken place in the staff mess in order to improve the numbers of staff from ethnic minorities. Job vacancies had been advertised in the surrounding counties and in the ethnic minority press, both locally and nationally. The prison had liased with the Police Service, the Fire Service and the Armed Forces to see if resources could be combined for such recruitment. It was estimated that out of the 400 people that had attended the job fair, 5% came from ethnic minorities. Only three (1%) out of the 300 applications received were from ethnic minorities. This suggests to us that arrangements were not particularly effective in continuing the interest shown by the ethnic minorities who had attended the fair. To further complicate the problem, the Prison Service area in which Whitemoor was situated had a surplus of staff, which was going to further delay the recruitment of new minority ethnic staff.

4.57 Although the recruitment of staff from ethnic minorities is no panacea we believe that until the number of staff from ethnic minorities is improved, much of the problem of unconscious racism amongst prison staff will remain. In the meantime, **we suggest that more intensive ongoing training takes place and the active assistance of outside groups is sought in order to help promote cultural diversity in the establishment.**

4.58 We were pleased to see that the Race Relations Management Team meeting had representatives from each function of the establishment. However, members of

the team came from outside the establishment. The prison had approached the Black Prisoners Support Group and was hopeful that members of this group could attend from either their Leicester or Nottingham offices. The establishment had also contacted other people from outside for advice; for example the Prison Service Muslim Advisor. **We urge that the establishment redouble its efforts to recruit members of outside organisations to attend the Race Relations Management Team meetings.**

4.59 Some prisoners clearly knew the identity of the establishment Race Relations Liaison Officers and other members of the Race Relations Management Team, and this was most apparent on the wings where prisoner representatives were in place. However, this was not consistently the case across the establishment. **We recommend that the profile of the Race Relations Liaison Officer, his Deputies and the prisoner representatives be raised so that all prisoners are aware of who they are and how they can be contacted.**

4.60 We were pleased to see that there were yellow boxes on A, B, C and D wings for racial incident forms. These boxes could be accessed by the Race Relations Liaison Officer and his Deputies only. Unfortunately there were no such boxes in the Segregation Unit, the SSU, E wing, and the Healthcare Centre. Instead prisoners on these wings could put racial incident forms into a sealed envelope addressed to the Race Relations Liaison Officer.

4.61 We came across some evidence that prisoners were unwilling to ask staff for racial incident forms as there was some stigma attached to doing so. This had been discussed at the Race Relations Management Team meeting in June 2000. It was agreed that the prisoner representatives on each wing should keep a handful of racial incident forms so that prisoners need not ask staff for them. This was a good idea and highlights the need for prisoner representatives across the establishment and not just on certain wings.

4.62 We inspected a number of racial incident reporting forms and the reports of subsequent investigations. We were satisfied with the quality of the investigation work seen and the responses given to prisoners following their complaints. The Race

Relations Liaison Officer had investigated all complaints thoroughly and made an effort to discuss the issues with the complainants and any other staff or prisoners involved.

4.63 If prisoners wished to, they could apply to see the Race Relations Liaison Officer in person. Prisoners sometimes used Request and Complaint forms to make racial incident complaints. It had been decided that one particular member of the Senior Management Team was to deal with investigations into staff in future.

4.64 *We commend the establishment for hosting a One World Week in 1999.* This is discussed in the section of this report about Foreign Nationals. This was clearly an example of positive action aimed at promoting the cultural diversity of the establishment and included world music, and other arts events along with a number of foreign dishes being offered through the Kitchen. Another such event was planned for April 2001. There were plans to put some of the Foreign National prisoners into the Kitchen for this period of time in order to cook some foreign dishes not usually on the menu.

4.65 In common with the Race Relations Management Team, we felt that the ethnic monitoring figures as they stood were inadequate and could have been presented in a more comprehensive way. We discussed the use of percentages and range setting with the Deputy Race Relations Officer during the course of the inspection and could see from the minutes of the Race Relations Management Team meetings that this had also been done before the inspection. **We recommend that ethnic monitoring figures be more comprehensively presented using percentages to highlight any disproportional figures and setting ranges where there are very small numbers involved. We also recommend that the areas monitored be expanded so that, for example, recategorisation applications and successful recategorisation is monitored, use of the Gymnasium and other activities etc. is monitored by ethnic group.**

4.66 One of the areas already monitored, was the position of prisoners in the Incentives Scheme. We were very concerned to see that approximately half of white prisoners but only a third of black prisoners were on the Enhanced level of the regime.

The Race Relations Management Team had already identified this issue. **We urge that the reasons for such a difference be examined. We also recommend that the number of prisoners segregated for reasons of good order or discipline is racially monitored along with the transfer of prisoners for disciplinary reasons.**

4.67 We were told by staff within the Activities Function that no monitoring took place. Such monitoring did in fact take place but information from this work was not passed on to the staff working within these areas. There was clearly a need to disseminate the information to the staff in all parts of the prison so that this information can be used effectively.

4.68 Non-English speaking prisoners did not always have access to translators in their early days in the establishment and whenever necessary thereafter. This issue is discussed further in the section of this report about Foreign Nationals.

4.69 All prisoners' religions were positively catered for and the establishment had good multi-faith facilities. We were also pleased to hear that a wide range of visiting ministers attended the establishment and that the Muslim Imam was particularly active, given the significant number of Muslim prisoners in the establishment.

4.70 The Prison Shop was very impressive in that it held a range of over 500 items and this included a large number of items aimed at minority ethnic prisoners.

4.71 We were concerned to hear about a racist incident that involved 'staff on staff' abuse. The Governor referred to the incident in his full staff briefing in September 2000. We were pleased to note that he condemned the totally unacceptable behaviour brought to light by this incident and pointed out that anyone found to be responsible for these racist slogans and abuse would be dismissed. In this way the Governor had clearly shown his personal commitment to eradicating racism in the establishment not only between prisoners, between prisoners and staff but between staff and staff.

4.72 In the questionnaires prisoners made a number of comments about race relations at the establishment. The worst were "most racially tense prison I have been to and it needs to be addressed", "staff need to be sensitive and co-operative with

ethnic minorities, treat all prisoners with the same respect" and "I feel non-white people are treated differently" but these comments were tempered by others stating that staff and prisoner relationships had improved over the years and that Whitemoor compared favourably with other dispersal prisons.

Foreign Nationals

4.73 At the time of the inspection there were 86 Foreign Nationals at Whitemoor. There was clearly a problem with the definition of 'Foreign National' for some prisoners. Some British passport holders had families who lived abroad and these prisoners felt aggrieved that they did not receive the same privileges with regard to phone calls etc. as those who were defined as Foreign Nationals did.

4.74 The provision for those defined as Foreign Nationals was in many ways good. The establishment's Foreign Nationals Liaison Officer was the Roman Catholic Chaplain who had initiated a Foreign Nationals Group that had initially met every two to four weeks and was meeting about every six weeks at the time of the inspection. All Foreign Nationals were invited to come to the meeting and about 35 prisoners usually attended. The Foreign Nationals Liaison Officer wrote to all Foreign Nationals once a year sending each a Foreign Nationals newsletter and form for prisoners to apply to come onto the Foreign Nationals Group.

4.75 The Foreign Nationals Group was held on a Monday afternoon and sessions were said to be well supported by the establishment; having never been cancelled. A number of people had been asked to talk to the group including members of the Senior Management Team and staff from outside organisations including the Detention Advice Service, and the Repatriation Unit of the Home Office. Others who had attended included a Senior Officer from the Kitchen, staff from the prison shop, the Race Relations Liaison Officer, an Education Officer, a Probation Officer, a member of the Board of Visitors, and the Head of Psychology. Notes were taken of each meeting. *The Foreign Nationals Group at Whitemoor was an example of good practice and to be commended.*

4.76 We were pleased to be given a copy of *the Rainbow, a newsletter designated for Foreign Nationals at Whitemoor*. This was written by Foreign Nationals for

Foreign Nationals and the October issue included an article on the attendance of the Deputy Director of the Immigration Service at the Foreign Nationals Group meeting, and notes about the Samaritans, the Legal Aid Department, and the Listeners. Also advertised was the next Foreign Nationals Group at which a member of Prison Service Headquarters was to be speaking about the Human Rights Act, a note about the One World Week planned for April 2001, a list of the Race Relations Management Team wing representatives and a recipe. *This publication was also an example of good practice.*

4.77 Some Foreign Nationals had significant communications difficulties. This was evidenced by the poor quality of some DCR reports, when the Officers clearly could not understand what the prisoner was saying, and the apparent need to use prisoners to translate for other prisoners. Prisoners felt that their access to offending behaviour programmes was limited and that if they took English classes in Education they would suffer a drop in wages. A number of these Foreign Nationals had very little private cash so felt obliged to work in the highest earning occupations. At least ten prisoners were regularly sending money home to their impoverished families.

4.78 Prisoners were issued with one airmail letter free per week in lieu of the ordinary free letters received by other prisoners. However, there was concern that they had recently lost the privilege of free phone calls in lieu of visits. The establishment had previously allowed a five minute phone call in lieu of visits per month and this was funded from the General Purpose Fund. **We recommend that this provision be reinstated.**

4.79 There were problems getting specialised foreign foods through the Prison Shop, as the shop's wholesalers were not willing to send small quantities of such items to the prison.

4.80 The ethnic meals offered by the main Kitchen were described as mainly curries. Bearing in mind that the largest Foreign Nationals group was the Irish, followed by Turks and Turkish Cypriots, this was clearly not appropriate. The problem was also identified during the last Ramadan period when food was sent from the London Central Mosque and consisted of mainly Asian dishes. Most Muslims in

the establishment were Turks or Turkish Cypriots. This year there was a plan to try and get Muslims into the Kitchen to cook food for Ramadan.

4.81 As stated above religious facilities generally were excellent. There were two well-equipped multi-faith rooms and a good range of religious ministers of all faiths. The Imam took a clear pastoral interest in all Muslims in the prison. All meat served through the kitchen was halal and this avoided the often seen problem of keeping halal and non-halal meat separate from each other.

4.82 The establishment had promoted its multi-cultural policy through the One World Week it hosted in August 1999. This included international food and sports, story telling events, a dance group, etc. A further One World Week was planned for April 2001. Prisoners on C and D wings felt that they had not been fully included in the event as they were unable to go to the Education Department where many activities were taking place. However, they did have a number of activities that took place on their wings.

4.83 There was no Foreign Nationals Management Committee. **We recommend that Foreign Nationals become a standing item on the Race Relations Management Team so that issues raised at the Foreign Nationals Group can be fed into these meetings and dealt with.**

4.84 A number of foreign language newspapers were available and received on the wings weekly. These included a Turkish paper, an Arabic paper, and publications such as The Voice and Ireland's Own.

4.85 Despite the Library having made extensive efforts to obtain foreign language books the Cambridgeshire Library Services which ran the prison's library was clearly not geared up for the population at Whitemoor. A number of foreign national books had however been obtained but there was a need to expand the range of books and the languages available. Some prisoners were at Whitemoor for up to five or six years and so could easily read through the Cambridgeshire Library Service's collection in their own language.

4.86 The prison was training some staff to speak foreign languages. Prisoners were also being used to interpret for other prisoners. There are many incidences where prisoners need to be able to have confidential interviews with professionals such as their legal advisors, with healthcare staff and when doing offending behaviour work. **The prison needs to address how such confidential matters can be dealt with. It would be inappropriate for members of staff or other prisoners to interpret for non-English speaking prisoners.**

4.87 SSU prisoners were required to talk on the phone to their families in English or via an interpreter. Every two weeks on opposite weekends a Turkish and a Spanish interpreter would visit the prison. They were then able to interpret phone calls made by the Turkish and Spanish-speaking prisoners on the SSU. **Arrangements should be in place to deal with any ad hoc problems that may arise in between these two weekly sessions.**

4.88 Some Foreign Nationals felt disadvantaged when it came to parole and general preparation for release. There were clearly problems with Probation Officers writing Home Circumstance Reports for Foreign National Lifers and those going for parole. Also raised were the cultural assumptions made within some of the prisoner programmes such as ETS and its perceived message about relationships with women which was seen by some Muslims as incompatible with their religion.

4.89 Other Foreign Nationals felt that some staff displayed an ignorance of their culture. Although we saw many examples of excellent relationships between prisoners and staff.

Suicide Prevention

Strategy

4.90 We concluded that at Whitemoor all staff were committed to caring for prisoners in distress and so reduce the risk of suicide or self-harm. As part of this commitment a message was given to all prisoners in Whitemoor that consisted of:

- acknowledgement that being in prison was stressful and could lead to depression and feelings of isolation

- aiming to reduce the stress on prisoners and to identify and support those prisoners who experience difficulty
- encouraging prisoners to talk about their feelings to either a member of staff or listener
- provision of a mobile telephone during the night for access to the Samaritans.

Policy

The key elements of the policy were:

- creating a safe environment and helping prisoners to cope with custody
- identifying and supporting prisoners in crisis and treating them with dignity
- caring for the needs of those affected by self-harm and suicide
- a community responsibility
- measures being taken to reduce the likelihood of self-harm.

Suicide Awareness Management Team

4.91 Suicide Awareness Management Team meetings were held every month and chaired by the Head of Residence West. The membership was made up of wing based Prison Officers, Healthcare, Probation, BOV, Chaplaincy, Samaritans, Suicide Awareness Liaison officers, Segregation, Education, Listener Co-ordinator and Listeners.

4.92 *The meetings considered ongoing agenda items such as training and all serious incidents in depth with a report on each new prisoner who had a F2052SH opened that month. This was good practice and made senior staff aware of the amount of distress in the prison.*

4.93 At the time of the inspection there were seven open F2052SHs. *A daily briefing note, which included the name, location and place of work, was presented to the Governor 4 who was responsible for policy. All closed F2052SHs were brought to the Chairman of the Suicide Awareness Management Team and were audited to improve the quality of the entries. This was good practice.*

4.94 In 1999 there had been 24 instances of self-harm, ranging from minor scratches to attempted hangings. It was noted that a fairly small group of prisoners had F2052SHs opened on more than one occasion. These tended to be located in the Progressive Care Facility (Healthcare Centre, E wing – identified for those prisoners who were identified as having problems in adjusting to prison life and the Segregation Unit).

4.95 *We were impressed that there was Listener representation at the meetings.*

Listener scheme

4.96 As in other establishments the Samaritans played an important role in suicide awareness. They also led the training programmes for listeners and ran the support group for Listeners. Listeners were encouraged to attend the Suicide Awareness Management Team meetings. to discuss their views. They had recently designed their own leaflet which if successful was going to be translated into the commonly found ethnic languages. Some Listeners who had been at Whitemoor for some time had produced a newsletter which also had details of the listeners scheme.

4.97 Listeners did not routinely submit statistics of the time spent in 'listening' or the number of prisoners this time is spent with. This was a missed opportunity to demonstrate the efficacy of the scheme and acknowledge the valuable contribution the listeners play in the management of self-harm and suicide awareness. **The Listeners' representative should present their statistics preserving anonymity.**

4.98 At the time of our visit 15 trained Listeners were located on A, B, C and D wings. Prisoners wishing to apply as a Listener were first screened by security staff prior to attending the training programme. Whilst we were at Whitemoor six new potential recruits were turned down by security and as a consequence a scheduled training programme was cancelled. Potential Listeners were interviewed by the Head of Education prior to attending the training programme which lasted over six weeks and was arranged and conducted by the Samaritans.

4.99 Listeners at Whitemoor did not wear a badge or anything else distinctive which identified them. Although this was different from other establishments

prisoners with whom we spoke said that they did not feel the need the need to wear anything.

4.100 A list of Listeners was kept on each of the wing offices. Listeners were only available during the hours of unlock. Experienced Listeners felt that was unsatisfactory as the times of greatest distress was routinely during the evening and over the weekend. Mobile telephones were available during this time but only four were available for the whole prison. **Further consideration should be given to this policy if only to increase the number of the telephones.**

Facilities

4.101 Listeners told us that sometimes it was difficult to find a suitable place to have confidential discussions with a distressed prisoner. **Care should be given to identifying appropriate rooms on each house block that neither stigmatised the individual in distress nor placed the Listener at risk.**

4.102 At the time of our visit there was no Crisis Suite although there had been one when the prison was opened. It was closed apparently through lack of use.

4.103 Listeners did not want and were not given any special privileges. This meant that they had to use their own tea, sugar and tobacco rations. **Consideration should also be given to an increase in the tea, sugar and perhaps a little extra tobacco so that providing this valuable service to other prisoners does not disadvantage Listeners.**

Staff training

4.104 Training for staff in 1999 had been almost non-existent. This was remedied by the setting up of an ongoing programme every Wednesday afternoon. The focus of the training was the use of F2052SHs and the appropriate documentation. It was suggested that 25% of all staff had attended the training.

4.105 *A monthly newsletter for staff had been introduced. This was used to reinforce the principles of suicide awareness and to keep staff up to date on changing policy*

e.g. The Human Rights Act and how it affected prisoners. Guidelines had been produced on how to complete F2052SHs. This was good practice.

Applications

4.106 A Prison Officer was detailed as the Admin. Officer every day, on each wing to deal with prisoner's applications. Whilst applications were not processed in exactly the same way on each residential unit, the differences were not significant. Each morning the Admin. Officer was available at around 08:30am to collect completed applications. Blank application forms were readily available on the wing for prisoners to complete anytime prior to the morning. Applications received were then recorded in a logbook and processed to the areas of concern. It was unclear whether any 'gate keeping' of applications was undertaken by staff i.e. whether staff spoke to prisoners to ascertain whether they could deal with issues raised or just simply passed them on to other departments.

4.107 The application logbooks showed a vast number of applications recorded and the reasons for the applications, but did not show what if any work had been done. One example showed only 'Probation' recorded for reason for the application. It could not be ascertained from this record whether a member of staff had interviewed the prisoner first or whether a member of the Probation Department had actually seen the prisoner. The member of staff who dealt with the application had also not signed the logbook. **A system of recording applications should be introduced which allows for a audit trail which ensures that application are dealt with at the lowest possible level in the chain and outcomes of action taken are recorded.**

4.108 We were told that prisoners were informed about the application procedures during the Induction programme. However, we were concerned that not all prisoners had undertaken an Induction programme (see section entitle Induction for details). We were also concerned that there were no Board of Visitors (BOV) applications boxes. **Boxes should be made available for prisoners to post applications directly to the Board of Visitors.**

Request and Complaints

4.109 Request and Complaint forms were issued with a reference number from the Custody Office following receipt of an application. *Prisoners were allowed to have up to four 'live' forms in-possession at any one time.* We were told that staff on the residential units generally did not interview prisoners once they had requested a request and complaint form as it was felt that it was too late once it had reached that stage; this should be reconsidered. Request and Complaint forms were recorded in a logbook on the residential units and also in the main logbook held by the Custody Office. We were concerned that the dates recorded in each logbook did not match and even allowing for some slippage through delays in the internal mail deliveries, date which were two-three days apart could not be accounted for. The significance of this is that on many occasions the main logbook showed that prisoners had received a reply to their request and complaint within the expected seven days whilst the wing logbook showed that they had not. **The Custody office should ensure that wing logbooks record the correct dates and that prisoners actually receive answers to their request and complaints on the dates recorded.**

4.110 About 50% of all request and complaints were dealt with within expected time targets and in cases, which fell outside of this, and interim reply was generally received. *All replies to request and complaints were typed to ensure that prisoners could read them. We were told that this did not delay replies. This was an example of good practice.*

4.111 We were concerned to find in logbooks a number of records in which prisoners had not returned forms and where no investigation had been made into why. Wing staff were unconcerned by this and the Head of Custody Office believed it to be the responsibility of the residential wings to follow up cases where forms had not been returned. We were also concerned that where records showed that request and complaints form had been withdrawn, the original forms issued were not routinely being returned and those that had been returned simply had 'withdrawn' written across them by staff or were left blank. **This was unsatisfactory; the Head of Custody Office should ensure that every form issued is followed up and either completed or returned signed by the prisoner stating that they wish to withdraw their application.** It would also be prudent to have a member of the Board of

Visitors follow up a sample of withdrawn request and complaint forms to ensure propriety.

CHAPTER FIVE

GOOD ORDER AND DISCIPLINE

Security

5.01 Our task during inspections does not include a close audit of security procedures, which task is carried out by the Prison Service's own internal audit teams. The most recent audit had concluded that security standards at Whitemoor were appropriate and nothing observed or experienced by inspectors during this inspection gave us any concern about this judgement. There was no doubt at all that staff at Whitemoor were being managed to ensure that their primary responsibility was towards effective physical and procedural security. Indeed, as should be expected, this dominated the lives of prisoners and staff. Dynamic security was satisfactory in residential areas except in the SSU.

Good Order

5.02 For a high security prison, holding many extremely violent prisoners, Whitemoor was commendably stable at the time of the inspection. This was in marked contrast to the volatile and dangerous establishment we found when last we carried out a full inspection in 1994, and demonstrates the progress that has been made within the high security estate since that time. Our report, produced after that inspection, records:

- "they (a high proportion of subversive men) refused to conform to the rules of the wings or indeed of the Segregation Unit where they invariably spent much of their time."
- "We found the atmosphere unsettled with conflict between the dominant prisoner culture and managers as to whose will would prevail, with wing staff caught in the middle."
- "It was reported that the Segregation Unit was always full."
- "The numbers of major incidents, drug finds and assaults were high."

- "Wings did not provide a safe environment for those prisoners who wanted to serve their sentences without trouble."

5.03 One of the most important aspects of a well run dispersal prison is that prisoners know the rules of conduct and that these are administered fairly and consistently by staff. Although there were differences in the way in which some of the wing arrangements operated most prisoners we met were clear about them and complaints about inconsistency were few. However, we did receive complaints about the attitudes of some young, inexperienced officers and flare-ups with individual prisoners were not uncommon; this is to be expected in an establishment holding prisoners who are serving long sentences. **Although most staff were seen as fair, a small number were identified as having racist views.** This serious matter needs thorough investigation and is dealt with elsewhere in this report.

5.04 In line with other high security prisons staffing levels on the wings were high in comparison with other types of establishment; thus there was ample opportunity for Prison Officers to have time to explain rules and procedures to prisoners. For the most part this appeared to be happening, while the general approach of staff towards prisoners was observed to be courteous. The establishment is to be commended for commissioning an independent study into staff/prisoner relationships at Whitemoor, which was produced in 1999. We highlight the following issues reproduced from the executive summary that we believe to be particularly important:

- There are different ways of being a good Prison Officer. Some good role models were found.
- Officers need to be experts in the boundaries and guided use of discretion.
- "Good" Prison Officer work should be identified, defined and rewarded.
- A principle of individuality should be applied to staff and prisoners.

5.05 *It was encouraging to find a management team that was genuinely interested in analysing and then developing the essential constituents of productive staff/prisoner relationships.*

5.06 Readers of this report must not be left with the impression that the prevailing atmosphere at Whitemoor was "cosy," nor were the arrangements without their rubbing points. Just before the inspection an incident had occurred on one of the wing spurs which was suspected to have been a form of protest against the method by which prisoners were located in the Segregation Unit. There were conflicting accounts about how these procedures were carried out. Managers, including the Director of high security prisons who had observed procedures on a recent visit to the prison, told us that whenever a prisoner was to be moved from his cell to the Segregation Unit, a fully equipped Control and Restraint Team from the unit carried out the action, but the team only used force if the prisoner indicated that he would resist being moved. The accounts that prisoners who had experienced the process gave to inspectors were significantly different in that they alleged that the first they knew of a staff intention to locate them in the Segregation Unit was when their cell door opened and they were faced with a control and restraint shield carried by a member of staff from the Segregation Unit. It was only then that they were asked whether they would walk of their own accord or be removed by force. Even if they indicated that they would go without a struggle they were handcuffed. It is obviously necessary for staff to be properly prepared for prisoners to resist being moved but in our view:

- **In every case a manager should assess the risk of a prisoner resisting the order to be located in the Segregation Unit, before there is any contact between the prisoner and the control and restraint team.**
- **Only when a manager of at least Principal Officer rank decides that force is necessary should a team be deployed.**
- **In every case a risk assessment as to the need for handcuffs should be made by the manager concerned who should then record in detail the reasons behind the judgement.**
- **Segregation Unit staff should not carry out the removal, but should receive the prisoner once he enters the unit.**

Violent Incidents

5.07 The forgoing does not imply that we thought that the number of incidents where control and restraint techniques had been used was high. In fact there had been 61 recorded incidents in the first 10 months of the year 2000, mostly in the Segregation Unit and involving a small number of difficult prisoners. *This reflected a reduction in the level of assaults on officers and other prisoners*. Statistics for the previous 3 years were as follows:

- 1998 assaults on officers – 37
  assaults on other prisoners – 11
- 1999 assaults on staff - 20
  assaults on other prisoners – 6
- 2000 assaults on officers – 15
  assaults on other prisoners – 5

5.08 Special cells in the Segregation Unit had been used 26 times during the first ten months of the year and records of their use were properly kept. Prisoners were only held in them until they had quietened down and unit staff looked for the first opportunity to relocate them in ordinary cells. We were surprised to hear that, along with the rest of the unit, these cells had been recently deep cleaned. **There was a stale smell in them and they were in need of repainting.**

Segregation Unit

5.09 There were two parts to the building. The first comprised the Segregation Unit itself and the second, E wing, was used as an experimental unit to help difficult prisoners to control their behaviour and eventually return to normal location. The design of both units avoided the creation of a claustrophobic environment in that sight lines for supervision of prisoners by staff were good. Facilities were satisfactory but **some parts, particularly some of the cells we saw, were in need of refurbishment and/or redecoration.** Window catches in several cells were broken and in need of replacement. Prisoners justifiably complained of uncontrollable draughts and of feeling unreasonably cold. A minority of mattresses were in poor condition and in

need of replacement, especially that in the cell used to hold prisoners awaiting adjudication. **There should be a review of facilities in all cells in the Segregation Unit.**

5.10 From our interviews we were satisfied that prisoners were properly received into the unit by staff. After being given a chance to settle down, staff explained the rules and the routine to new prisoners and there was no indication of intimidation in these processes or in the strip search procedures.

5.11 We were pleased to find that prisoners in segregation had sufficient items of clothing to enable them to change underclothes daily and to change other items twice weekly. On the other hand it was disappointing to learn that showers were only offered twice a week. **Prisoners in the Segregation Unit should routinely have the opportunity for a daily shower.**

5.12 Most of the daily routines were entirely satisfactory. Prisoners were served their meals at their cell doors by staff. Everyone had the chance of daily exercise, wherever possible in the company of at least one other prisoner. There was a roster for the use of the card telephone and prisoners normally met their domestic visitors in the main visits room. A Governor grade, Medical Officer and chaplain visited all prisoners every day and we were satisfied that if a prisoner wanted to see any of them in private they could do so. Nor was there any difficulty, as we have noted in some segregation units, over chaplains having access to prisoners. The only routine that concerned us was the rule that prisoners in their cells were required either to stand at the back wall or well back from the door when staff prepared to enter depending on a risk assessment. We prefer the routine observed in at least one other dispersal prison where prisoners are required to sit on their bed and show their hands to staff entering their cell.

5.13 The unit was managed by a Principal Officer and operated by a regular group of staff. We were impressed by the demeanour and attitude of staff to the prisoners in their care. *We were also impressed by the fact that Segregation Unit staff encouraged wing personal officers and other to visit prisoners during their time in the unit.*

5.14 *We were also impressed with the policy and practice of E wing. This was imaginative, courageous and in the best interests of the difficult to manage prisoners who were held there and for the good order of the prison. The idea was to attempt to help prisoners emerge from their patterns of unacceptable behaviour by giving them individual attention and as much trust as possible.* There had already been encouraging results and we commend the efforts of the managers and staff concerned.

Special Secure Unit

5.15 – 5.21

(Not for publication)

Adjudications

5.22 The number of formal charges against prison rules made against prisoners was also no greater than we would have expected given the nature of the prisoner population. There had been less than 200 in the previous quarter. The prison monitored adjudications carefully. Inspectors observed the conduct of 2 hearings. In both cases prisoners clearly understood the charges laid against them and proceedings were managed meticulously. Prisoners were listened to carefully and asked the type of questions that elicited relevant replies. Awards were made only after a full hearing and we concluded from these observations, and from what other prisoners told us, that adjudication procedures were transparent and fair.

Security Categorization, Allocation and Progressive Transfers

5.23 In its role as a dispersal prison, Whitemoor did not have to carry out the initial observation, classification and allocation functions seen in local prisons. However an important part of the running of any prison, particularly for prisoners serving long sentences, is proper security categorisation and transfer procedures that assist prison managers and staff to function effectively. These activities are vital to the organisation but their fair and proper functioning is also crucial to the well being of prisoners.

5.24 Prisoners were not being allocated to Whitemoor purely because of issues such as distance from home, healthcare needs, work and education needs and access to counselling. As a dispersal prison, local prisons allocated prisoners requiring

Category A and Category B security levels to the establishment. We were surprised that despite a number of dispersal prisons being located in the North of England, there were significant numbers of prisoners from this part of the country. **We recommend that as many prisoners as possible be located close to their home.**

5.25 There was evidence of some prisoners being transferred to Whitemoor to have their healthcare needs met. However when we looked at the prisoners in the Healthcare Centre itself, it was clear that a number of establishments had, we felt, inappropriately allocated prisoners to Whitemoor. At the time of the inspection, there were prisoners (including one Category C prisoner) who had been moved from other prisons including HMP Winston Green, and HMP Norwich. These establishments had the facilities of inpatient beds and full time Medical Officers. We could see no reason why prisoners should be allocated to Whitemoor to continue their care, particularly when the resources of the Healthcare Centre at Whitemoor were limited, due to the staffing problems discussed in more detail in the section of this report which focuses on Healthcare.

5.26 When we questioned a sample of prisoners using confidential questionnaires, we asked prisoners how far they were from their home area. 5% said that they were from less than fifty miles away, 35% said they were between 50 and 100 miles away, and 57% said they were over 100 miles from their home area. Not surprisingly, 60% of those questioned described it as being difficult for their family and friends to get to the prison to visit them. Only 5% described it as being easy.

5.27 We also found very little evidence that prisoners were being transferred to Whitemoor to meet offending behaviour needs. We were concerned that there was a large number of prisoners at Whitemoor who were sex offenders yet there was no sex offender treatment course available a the time of the inspection. 'Deniers' were able to settle at Whitemoor very comfortably and some were being released directly at the end of their sentence into the community having undergone no accredited offending behaviour work. These issues are further discussed in the section of this report entitled Prisoner Programmes.

5.28 The establishment had two wings put aside for more vulnerable prisoners including sex offenders. These prisoners were usually identified before being received at Whitemoor but there were examples of prisoners being found to be vulnerable on A and B wings and being moved to C or D wings for their own protection.

5.29 The establishment was not overcrowded at the time of the inspection and did not suffer from the need to move prisoners out speedily. However it was clear, as mentioned above, that some prisoners were moved from establishments that were local to their homes because these, usually Northern, prisons were overcrowded.

5.30 Prisoners requiring recategorisation could apply on the wing. The same system applied for prisoners wanting to be moved from the establishment. Transfer applications went straight to the prison's Population Management Unit, as did all applications for accumulated visits. These forms were sent from this unit with photocopies of six months of the prisoner's history sheet and sent to the establishment where the prisoner wished to go. It was clear that it was very difficult to get accumulated visits in many local prisons because of the pressure of numbers in these establishments particularly those in the Northwest. Prison Rules dictate that prisoners should be able to take accumulated visits in a prison near to their homes, every six months. Such a facility was clearly not in place at the time of our inspection at Whitemoor particularly for those prisoners from the North of England. **We urge that accumulated visits be facilitated for all prisoners in prisons near to their homes at six monthly intervals.**

5.31 Prisoners requiring categorisation were considered by a local recategorisation board consisting of a Governor 5, the Wing Principal Officer or Senior Officer, the prisoner's Personal Officer, and the prisoner if he wished to attend. The Security Department also attended on some occasions but usually provided a written report only. It was estimated that from January 2000 to the time of the inspection (a period of approximately 10 months) about 40 prisoners had applied for recategorisation from Category B to C. Out of these 40, only eight prisoners were successful. Category A boards were held on a two monthly basis with all Category A prisoners being reviewed annually by the Prison Service Headquarters Category A Section. It was

estimated that Category A Section reviewed approximately 40 prisoners every two months from Whitemoor. 20 of these prisoners were being reviewed for their normal annual review and 20 following recommendations for their progression from Category A to Category B status. About 15 prisoners were actually recategorised from Category A to Category B per year out of this annual number of approximately 240 reviewed prisoners.

5.32 We were surprised to discover that there was no automatic recategorisation review for prisoners of Category B or C status and the reviews were dependent on them applying. Furthermore, prisoners could apply as often as they wished and there was no rule, as seen in other establishments, about prisoners having to wait at least six months between recategorisation boards. **We recommend that prisoners not of Category A status, be reviewed for recategorisation at least every 12 months regardless of whether they have applied for recategorisation or not.**

5.33 We were pleased to see that the prisoner could attend boards and that the categorisation decisions followed consultation with staff who knew the individual prisoner, most notably the Personal Officer.

5.34 It was clear that prisoners' requests for certain prisons indicated a preference for certain Category B trainers over others. The Population Management Unit staff felt that there were not enough Category B or Category C trainer places available. Most transfers were facilitated by the Whitemoor Population Management Unit staff 'doing deals' directly with other prisons, sometimes swapping prisoners. Prison Service Headquarters' Population Management Unit did not usually arrange places for the establishment. Staff described their relationship with some prisons, particularly those in the private sector, as being very good, but generally felt that moving Category B and C prisoners was hard to do. Some of these Category B and Category C training prisons were, it appeared, suspicious of prisoners coming from dispersal conditions. The local Population Management Unit staff said that on occasions they would advise prisoners to move first to Category B training prisons and then to Category C prisons even if they were suitable to go directly from Whitemoor to Category C conditions, as so many Category C prisons were reluctant to take prisoners directly from Whitemoor. **Such national issues must be looked at by the**

Prison Service Headquarters Population Management Unit. At an annual cost of £52,000 per prisoner, **Whitemoor places must not be wasted on prisoners who are suitable for Category B and Category C trainer accommodation.**

5.35 We were also concerned about the numbers of prisoners who were being discharged directly into the community from the establishment. We discovered that on average 50 prisoners per year were being released from Whitemoor. As mentioned in the Executive Summary, Whitemoor was not geared up to provide pre-release courses and release on temporary licence to prepare such prisoners for release. Whilst we were impressed with the quality of preparation for release carried out by the Probation Department with these prisoners, we thought it wholly inappropriate that this number of prisoners were being released from such high security conditions. Whilst we understand the reasons why some Category A prisoners will remain so until they are released due to their danger to the public, the severity of the their crime and the embarrassment their escape would cause, **we are concerned that little support can be given to prisoners being released from Whitemoor without any experience of lower security conditions to lessen their institutional dependency and to prepare them for life outside. This issue must be addressed.**

5.36 A number of prisoners complained that they could not get recategorised to lower security conditions because their sentence plans had dictated that they carry out certain offending behaviour work before such transfers could take place. Whilst this is appropriate in some cases, we found a number of incidences where prisoners were being asked to complete offending behaviour courses that were not available at Whitemoor. Thus prisoners felt in a Catch 22 situation. They could not move from the establishment because they had not completed the required offending behaviour work, however the required offending behaviour work could not be carried out at Whitemoor. **This anomaly needs to be addressed.**

5.37 There were also a number of non-progressive transfers taking place every month and the Population Management Unit estimated this at between five and 15 per month. These were usually transfers for disciplinary reasons or to allow prisoners to be closer to home. On occasion, these were also to facilitate accumulated visits.

5.38 There did not appear to be any problems getting places in dispersals for accumulated visits for Category A prisoners but as discussed above prisoners were experiencing severe difficulties in getting accumulated visits in locals in the North.

Incentives and Earned Privileges Scheme (IEP)

5.39 The IEP scheme operated on three differential regimes:

- Basic
- Standard
- Enhanced

All prisoners being received at the prison started on, at least, the standard level, even where prisoners had been on a basic regime level at their previous establishment. Prisoners being received who were on an enhanced regime level maintained this status on arrival. Reviews were generally undertaken yearly or when required when a change in behaviour merited a change in regime level, either good or bad.

5.40 All prisoners on the standard or enhanced regime level had in-cell television. Other key earnable privileges related to:

- increased private spends (basic £2.50, standard £10, enhanced £15)
- additional visits: - basic – 2 x VO's, standard 2 x VO's & 2 x PVO's enhanced 2 x VO's & 2 x PVO's (may exchange 1 x VO for 2 x PVO's
- eligible for higher rates of pay
- additional in-possession property.

5.41 Prisoners on the basic regime level were reviewed every 28 days and we were pleased to find that prisoners being received in the Segregation Unit were not automatically being reduced to basic regime level. Prisoners were permitted to attend all review boards, which were chaired by a Principal Officer. They were also able to make written submissions. Decisions were given verbally and in writing. Appeals were heard by a Governor grade via the application procedures.

Vulnerable Prisoners

5.42 Certain groups of prisoners require particular attention if good order and discipline is to be maintained successfully. These are mainly prisoners who are labelled "vulnerable" in that they are judged to be at risk from other prisoners.

5.43 Vulnerable prisoners at Whitemoor were mainly located on C wing although a small number were also located on D wing. At the time of inspection there were 119 on C wing and approximately 30 on D wing.

5.44 The C wing population included 48 Category A prisoners, 2 of whom were high risk. Fifty four prisoners were serving life sentences mainly for sex offences. All prisoners were there because they feared for their safety if located on other wings. Reasons for their fear of other prisoners were mainly due to the nature of offences but also included debts to other prisoners and giving evidence against others. We were told that there was an increasing number of non sex offenders seeking protection offered by C wing.

5.45 We were pleased to note that the regime offered on C wing was at least as good as that offered on other wings. There was ample work in a variety of areas including the kitchen, laundry, 2 workshops, the clothing store and a number of cleaning jobs.

5.46 Those who worked in workshop 1 were the highest paid in the prison earning up to £30 on piece work by recycling CDs. Prisoners were also able to participate in education programmes although they were mainly confined to the wing rather than attending the education centre. This would shortly be rectified by the completion of a dedicated education centre in a converted workshop. **We recommend that the conversion of a workshop into an education centre for vulnerable prisoners should be completed as soon as possible.**

5.47 Vulnerable prisoners had access to the PE facilities on an equal basis with the rest of the prison. They also had access to a mini-gym on the wing. There was little available to address offending behaviour for prisoners on C wing. An Enhanced

Thinking Skills course was available but, as was pointed out to us by staff, this was not specifically offence related. Sex Offender Treatment Programmes were not currently available which was an omission given the nature of many of the population.

5.48 A dedicated worker was provided by the CARATS drug programme and the Psychology department contributed a Psychologist who undertook 1-to-1 work with some prisoners. Blue spur offered a voluntary drug testing unit with the incentives of additional recreational facilities for prisoners.

5.49 We were impressed by the philosophy of the wing manager who had fairly recently been transferred to C wing as he was endeavouring to make the regime at least equivalent to A and B wings.

5.50 Problem areas were still present but to a large extent, beyond the controls of local management.

5.51 Life sentenced prisoners with short tariffs were sometimes unable to address issues identified in sentence plans before consideration for parole. This was due to the already mentioned lack of offending behaviour programmes.

5.52 Equally worrying was that on occasions prisoners who were still in Category A had been released at the end of their sentences with no offending behaviour work having been carried out. Even those prisoners who had completed Sex Offender Treatment Programmes in other prisons were not able to participate in booster or relapse courses at Whitemoor in preparation for release. **We recommend that a greater range of offending behaviour courses should be available to vulnerable prisoners.**

5.53 The notoriety of many of the prisoners on C and D wings meant that it was difficult for them to lose the label of "vulnerable" either in Whitemoor or on transfer to other prisons. However, we were satisfied that they were at least being held in a safe and respectful environment with opportunities to engage in purposeful activities.

CHAPTER SIX

HEALTHCARE

Background

6.01 Healthcare at Whitemoor was provided by a type 3 service with primary care, an inpatient unit and a visiting specialist service. In July 2000 the Prison Healthcare Task Force visited Whitemoor and commented among other things on the management arrangements that seemed to them unclear and complex, since there was no single senior manager with overall responsibility for all aspects of the service. The Task Force recommended the appointment of a healthcare manager, who would report directly to the Governor, be a member of the Senior Management Team to and to be the managerial lead officer for all health facilities. **We endorse this recommendation that is central to improving healthcare at Whitemoor. Furthermore we recommend that the person appointed should have extensive experience in managing a complex network of health services and be a sufficient experience and seniority to command the respect of colleagues of all professional background both in the healthcare service and in the wider prison.**

Standards used in assessing the healthcare service

6.02 During our inspections of healthcare in prisons we make assessments of the scope and quality of healthcare provided against the standards set by the Prison Service in Prison Rules, Standing Order 13 and the nine Healthcare Standards. The Healthcare Standards stated objective is "To give prisoners access to the same quality and range of healthcare services as the general public receives from the National Health Service" and they are addressed to governing governors who have overall responsibility for the delivery of healthcare to prisoners and for the implementation of the standards. These Healthcare Standards were agreed in 1994 and should have been implemented by 1997. For areas not covered by the Healthcare Standards we make assessments against the standards that apply to the NHS. Other important standards were established following Ministers' acceptance of the report The Future Organisation of Prison Healthcare (FOPHC).

Staffing

6.03 The Governor told us that healthcare at HMP Whitemoor was in crisis caused by the acute and severe staff shortages. The senior Medical Officer (SMO) had been off sick for some weeks and at least three healthcare staff were on long term sick leave, some for considerable time. To alleviate the situation a Governor grade 4 member of the Senior Management Team had been seconded to take responsibility for day to day management of healthcare. We were impressed that when we conducted our inspection although she was only ten days into post and did not have a background in healthcare she had a very good understanding of what was required to continue a high quality service with regard to the staffing needs and external partnerships.

Medical staff

6.04 There was establishment for a full-time Senior Medical Officer (SMO) and a full-time Medical Office (MO). At the time of our visit the SMO had been on sick leave for several weeks and all medical work was being done by the MO. Although busy the MO did not appear to us to be greatly overstretched and as is usual in prisons some of the work the doctor was doing could equally effectively have been done by suitably trained and experienced nurses. Neither SMO nor MO was certificated in general practice.

Nursing staff

6.05 At the time of our inspection there was an establishment of 18 staff, nine healthcare officers and nine nurses but only 10 were available for duty. There were two Senior Healthcare Officers and three healthcare officers (one on detached duty because of the shortage of staff), two of whom had mental health nursing qualifications. The clinical nurse manager a 'G' grade nurse took the lead for all clinical matters and line managed the rest of the nurses of whom two were 'F' grade nurses and eight 'E' grade nurses. The nurse manager and one other nurse had been practice nurses and had further qualifications in asthma, diabetes as well as health promotion. In addition there were four discipline officers in the Healthcare Centre who took responsibility for movements and discipline duties. The nursing staff were divided between two working areas, the 12 bedded inpatient unit and the outpatient services which included reception and the wing based treatment sessions. The main

shift patterns in operation were, 7:30am until 5:00pm, 1:15pm until 9:00pm and 8:45pm until 7:45am. *At night there were always at least two people on duty, one of whom was always a qualified nurse. This was good practice and should be continued.*

6.06 **In our view the staff numbers available were insufficient to allow safe practice over the whole range of clinical practices in operation at Whitemoor**. Particularly we were concerned about the nursing care of the inpatients; nurses were doing all they could but numbers were simply insufficient. **Until the staffing level meets the required standard to safely manage seriously ill inpatients the use of beds should be restricted**. Some admissions to the Healthcare Centre could be avoided if day care facilities with medical, nursing, occupational therapy and psychology input were introduced. We were surprised to find that some inpatients in the Healthcare Centre of a high security prison were Category B or even C and were not originally from Whitemoor. One Category C patient had been transferred to Whitemoor from a local prison at the orders of Prison Service Headquarters. Such orders were, we were told, by no means unusual and at least three of the inpatients at Whitemoor had been transferred direct to the Healthcare Centre from other prisons. Standing Order 13 para 30 makes it clear that admission to a Healthcare Centre is at the sole discretion of the Medical Officer or a member of healthcare staff acting on his/her behalf. In all the cases we mention the Healthcare Centre at Whitemoor considered that they were under instructions from Headquarters to admit a patient transferred from other prisons however inappropriate they considered the transfer. **Admissions to healthcare should be restricted to the number that can be safely nursed there in light of the staff available. Only HMP Whitemoor prisoners should be considered for admission to the Healthcare Centre. Staff at all levels in the Prison Service must observe Standing Order 13 para 30; headquarters staff are badly placed and inappropriately skilled to decide on admissions to prison healthcare centres.**

Nursing staff vacancies

6.07 Although a couple of vacancies had arisen there were no long term problems with recruitment and retention of staff although security clearance nearly always meant that some candidates who were recommended for appointment never took up post because of the long drawn out process. The manager was confident that posts

would be filled at the next round of interviews. To offset the shortage of staff existing nurses were required to do overtime and it was reported to us that a nurse in the preceding month had completed at least 30 additional hours. This was poor practice and could lead to 'burnout' and should be discouraged. In the meantime however, two members of staff had been off sick and had disciplinary hearings pending which did not help with staff morale. **This situation should be resolved as soon as possible.**

6.08 *We were pleased to hear that negotiations had taken place which would lead to a joint 'nurse bank' with the local acute trust. This is good practice and when established should be extended to the local community health services.*

Clerical and administrative

6.09 The healthcare service had a full time AO and a full time AA. Despite this welcome support trained nurses spent much of their time on non-nursing duties. **We recommend that a skills audit is conducted alongside the assessment of the needs of healthcare patients with a view to having the appropriate skill mix to meet the needs of prisoners in Whitemoor.**

Clinical Supervision

6.10 Clinical supervision of nursing staff has been a requirement of the Healthcare Standards since 1997 and was in place. To date supervision had been provided by a Senior Healthcare Officer and the clinical nurse manager.

Continued Professional Development

6.11 All healthcare professionals are required as a condition of their continued registration, to keep their skills up to date. Additionally medical staff are required by the General Medical Council to take part in medical and clinical audit and to act on the results of the audit.

Doctors

6.12 The task force following their visit proposed ways in which the doctors at Whitemoor could improve their clinical skills to meet the needs of patients. These proposals should be implemented.

Nurses

6.13 Nurses have had a responsibility for their own continuing professional development since the UKKC published standards for Post-Registration Education and Practice in 1995. All the nursing staff were committed to ongoing education and many had completed appropriate educational programmes. We were told that training had not been a priority because of the staffing shortages. Attending ad hoc study days in the local trusts and attending specialist units e.g. the hospice and chest clinic kept staff up to date.

6.14 **All staff whether doctors, nurses or non-nurse trained healthcare officers should have a training plan aimed at enhancing their skills to meet the needs of patients. These plans should be reviewed yearly. The Healthcare manager when in post should complete a training needs assessment and individual staff members keep a training programme portfolio to ensure that all are to date in all aspects of current healthcare needs in prison.**

Audit and clinical governance

6.15 We were not told of any past or ongoing audits at Whitemoor. Prisons are likely to be required to designate a clinician responsible for ensuring systems of clinical governance are in place (FOPHC para 64). This had not been done at Whitemoor. **A quality assurance plan for the prison including clinical governance issues with annual objectives and an annual report on the progress**

made should be developed in conjunction with local NHS quality assurance work.

Needs assessment and commissioning Healthcare

6.16 Prison governors and health authorities are now required to work together to conduct an assessment of the need for healthcare and health promotion among prisoners and to ensure that the prison is included in the health authority's Health Improvement Programme with a target date of March 2001. Five meetings have now taken place between prison-based staff and the local health organisations to complete the needs analysis. Questionnaires, general and specific to alcohol and drug usage as well as mental health needs have been developed for prisoners to complete by the middle of December. Each prisoner will have two questionnaires to complete and sessions to explain the process to both staff and prisoners were arranged to ensure that there was a high percentage return and that prisoners who did not have English as their language were not disadvantaged.

6.17 **Once the needs analysis has been completed joint working should continue and be further developed to make sure that in addition to clinical services the educational and training needs of healthcare staff are taken into account when the Health Authority negotiates the contract with local NHS education providers.**

Services to patients

The Healthcare Centre

6.18 The Healthcare Centre, like the rest of the prison was relatively new and once again demonstrated that newly built Healthcare Centres often do not make for most effective nursing and observation of patients. Apart from the lavatories in patients' rooms the centre was clean but had been redecorated without apparent thought for the considerable improvement that could have been brought about by the use of colour and the creation of murals. **At the next redecoration more thought should be given to therapeutic décor.** *We were exceptionally pleased to find that in-room TV was available to all standard and enhanced regime patients; something that we have not found in other prisons. This is good practice*. The lavatories in the patients' rooms

were significantly less clean that others in the centre; **they should be cleaned and their condition regularly monitored.**

6.19 The treatment room in the inpatient unit could at best be described as a cupboard and was far worse that what would be expected in the NHS. It did not include a wash hand basin and, as a consequence nurses, were using surgical wipes between each patient. This room had never been properly decorated and did not have natural light. **The treatment room should be upgraded to meet modern standards.**

6.20 A patient room had been identified as suitable for suicide watch, with gated observation. However, it was not safe. The taps on the sink unit were not suitable for those patients at risk of self-harm. **Taps that do not offer ligature points should be fitted.** We were also concerned about the routine use of normal bedding for those at risk of suicide. While some patients may be assessed as suitable for normal bedding some patients in prison, like some in the NHS will require non-tear bedding. **The existing furniture and bedding in the gated room should be reviewed in light of experience in the NHS and in other Healthcare Centres.**

6.21 As in many other establishments there was a lack of modern equipment and aids for nursing staff to safely manage and handle ill patients. A portable ramp was all that was available to allow access to the bathroom, which was alongside the only sluice sink where disposable bedpans were dealt with. At the time of our inspection there was patient who had severe diarrhoea that necessitated staff to deal with copious amounts of liquid faeces. **Sluice and bathroom should be separated.**

6.22 **Work had already begun on a full clinical risk assessment of the inpatient unit facilities and we recommend that this be completed to identify the equipment required and the resultant training needs of staff in further risk assessment**

Reporting sick and primary care

6.23 Prisoners wanting to report sick filled in an application and a locked box on their wing. Healthcare staff collected the application and patients were seen, if non-

emergencies, by a nurse within 24 hours or by a doctor within four days, normally waits of four days occurred only at weekends. The reporting sick system appeared to work well. However, we were concerned to learn of problems in ensuring that patients in the special secure unit received medication promptly. During our inspection we saw a discipline officer refuse to bring medication to a patient in the SSU despite it being legally labelled and its transfer by discipline staff agreed by security. The officer insisted that this constituted secondary dispensing; it did not and we considered that this excuse covered other problems. **No patient, least of all one in the SSU, should have his treatment needlessly delayed.**

Daily life for inpatients

6.24 Whitemoor had come closer than many prison inpatient units to achieving the amount of time unlocked required by Healthcare Standard 4.2. Patients were unlocked for some 8 hours/day. Education had been available daily but this had recently been cut back to three times per week. **Therapeutic activity tailored to the needs and capabilities of individual patients should be available every day**

Specialist nurse led clinics

6.25 There had been a variety of nurse led clinics including an outreach psychiatric service to the wings. All had appropriate protocols. The current staffing situation had meant that many nurse led clinics had to cancelled and the nurses only attended the wings once a day.

6.26 **The nurse led clinics were good practice and should be resumed as soon as possible. They should be audited and evaluated in tandem with the Health Needs Assessment to ensure that the changing health needs of an ageing population and mental health issues are taken into account. The daily visit to the wings by nurses did not include the SSU; this should be reviewed.**

Nurses and healthcare officers and the administration of drugs

6.27 At the time of our visit nursing, medical and pharmacy staff had recently agreed a list of medications that could be supplied by nurses giving prisoners access to a specified range of medication for first aid intervention and the treatment of minor

ailments. **The operation of this nurse prescribing group protocol should be evaluated and any necessary change to the contents of the list made.**

Injuries to prisoners

6.28 As part of our inspections we, when possible, analyse the causes of injuries to prisoners as recorded in the F213s. At Whitemoor 10% of F213s gave the cause of injury as 'collapse' and described prisoners falling and apparently, in some cases, losing consciousness temporarily. This is unusual in our experience of analysis of 213s. **F213s should be audited regularly and unusual findings further explored.**

Pharmacy

Background information

6.29 The supply of pharmaceuticals to the establishment had been provided by Peterborough Hospital NHS Trust, about 23 miles away, for the past 5 years. The pharmacy services manager at Peterborough Hospital, was the responsible pharmacist. One MTO2 level technician visited the prison dispensary Monday to Friday between the hours of 10.15am to about 1pm to collect any new prescriptions, drop off dispensed medication from the previous day and do other routine work. On the day of the visit the technician was off sick and the Technical Services Manager from the hospital was present. The medicines were administered to the prisoners by nursing staff employed by the prison. The pharmacist never visited the prison, but did attend the Drugs and Therapeutic Meetings. The service provided by the hospital was limited to the dispensing of the prescriptions and maintenance of the stock in the dispensary. **The pharmacist should visit the dispensary at regular intervals and should be available for consultations.**

6.30 The dispensary was open when the technician was present, at all other times the out of hours procedures were used. There was only one treatment time in the day, due to staff shortages. Night-time doses of drugs not allowed in possession were handed to the prisoners loose or in a bag. **It is advisable to have more treatment times in the day so that night time doses are not handed out in the morning, inadequately packed, if at all, and labelled.**

Premises and Equipment

6.31 The dispensary was clean and tidy and was secured by an iron gate. Keys to the dispensary were held by the technician from the hospital, the head of healthcare, and two Senior Officers. When the dispensary was closed healthcare staff can gain access to the dispensary through these people. At night the keys were held at the gate; this system appeared secure.

6.32 The room used was small. The drug refrigerator did not have a thermometer and needed defrosting. **A maximum/minimum thermometer should be obtained and the range of temperatures should be monitored and recorded on a daily basis. The fridge should be defrosted at regular intervals.**

6.33 There was no computer in the dispensary; hence all records were kept manually. The Patient Medication Records were kept at the hospital. The prescription form used had been designed by one of the healthcare staff.

6.34 The reference sources available to the healthcare staff were out of date. **Current editions should be made available and kept updated in the future.**

6.35 Medicines were handed to the prisoners in the treatment rooms. There were two treatment rooms in the Healthcare Centre and four on wings A, B, C and D. The treatment rooms on the wings were previously storerooms, and were still sign posted as such, except the one on wing D. Nothing had been done to adapt them for their new role. There was a trolley used to store medicines in the room on wing B that could not be locked. The SSU medication box was not locked. **The treatment rooms must be cleaned and decorated, contain sinks with hot and cold running water and fridges with maximum minimum thermometers. All medicines should be stored in locked cupboards and the trolley should be replaced. The boxes that can be locked must be kept locked.**

Storage of Medicines

6.36 In the dispensary stock medicines were stored on shelves in boxes. A small selection of medicines were stored in a locked metal cupboard. **All medicines should**

be stored in locked cupboards and the level of stock medicines should be kept low. *Internal and external products were separated. Patient specific items were separated from stock items.*

6.37 In the Treatment Room cupboards internal and external medicines were not always stored separately. In a few cases tablets had been secondary dispensed into plastic cups ready for prisoners to collect. Some of the cups did not state the prisoner's name or the drug name. Cerumol ear drops belonging to an prisoner was stored in the staff office on C wing, as he was not allowed to have glass bottles in-possession. **Internal and external use products should be stored separately. Tablets should not be stored in plastic cups. All medicines should be labelled. All medicines should be stored in locked cupboards in the treatment rooms. It is not acceptable for non-healthcare staff to store and administer medicines to prisoners if the container is unsuitable for in possession. Treatment times should reflect the needs.**

6.38 There was evidence that in-possession returned medicines might be reused to keep costs low. **Patient returned medicines must never be reused**

Supply of Medicines

6.39 Medicines were supplied by the hospital pharmacy against the written directions of a doctor. The prescription and administration charts used by Whitemoor were generally being used properly. The charts were photocopied by healthcare staff, checked by the technician, the copies are taken to the hospital for dispensing, a further copy was made once it has been dispensed and this form was sent back to the prison with the medication the next day. The pharmacist never saw the original chart. The medicines arrived the next day, in the meantime, when patients could not wait for the treatment, the technician, or in her absence healthcare staff would dispense, from the pre-packed stock, enough tablets to last the rest of the day in a bag bearing an incomplete hand written label. **Faxing the charts to the hospital would reduce the workload and decrease waiting time for the medicines. The pharmacist should make regular visits to check the originals. The technician or healthcare staff should supply, in emergencies, the stock bottle bearing all the details and a system should be in place, for example dual labelling, so that the pharmacist can**

be sent the second label for her to be reassured the correct medication has been handed out. *Prescription sheets appeared to be reviewed regularly.*

6.40 Most of the medicines were dispensed into plastic bottles or the original packs were given to the patient. Few items were supplied in Venalinks. There appeared to be no formal In-Possession Policy but medicines were generally supplied in-possession, labelled up with directions and the prisoner's name where the medicine had been prepared by the hospital pharmacy. **A written In-Possession Policy should be drawn up.**

6.41 In addition to the prisoner specific supplies, pre-packed stock items of a number of regularly used drugs were supplied to the Healthcare Centre by the hospital pharmacy. Certain products, for example Gaviscon were dispensed into plastic bottles even though they were not going to be supplied to the prisoner as in-possession. These were available to be supplied by nursing staff to patients presenting as special sick. These appeared to be given out without adequate and more often than not with no directions for use. There was no Special Sick Policy although the staff told me that they knew which items they could supply without reference to a doctor these supplies were not recorded on the prisoners treatment chart, due to time restraints. **A formal protocol for special sick should be drawn up by the Medical Officer detailing the medicines that can be administered/issued as special sick and an appropriate treatment period. All medicines supplied to prisoners should be labelled up with the prisoners' details, the date of the supply and the directions for taking the medication. All medication given to prisoners as special sick should be noted on their charts.**

6.42 At the time of the visit we saw little evidence of Patient Information Leaflets (PILs) being supplied to prisoners with their medication, except when patient packs were dispensed. It is now a legal requirement that patients are supplied with PIL's with their medication and steps should be taken to ensure that this is complied with as soon as possible. **It is recommended that a notice should be displayed at the treatment room to ensure that prisoners are aware of the availability of the relevant leaflet for them to consult where a leaflet is not able to be supplied directly to them.**

Out of Hours Provision

6.43 Outside of the normal opening hours there was provision for care via the on call doctor service. The duty doctor had access to the dispensary and a written policy existed in relation to the procedure to be followed. In the case of less serious incidents it would appear that the duty officer had access to the drug cabinet in the treatment room for the purpose of administering such items as Paracetamol. There was a record book for staff to note any items taken and this appears to have be done satisfactorily.

Controlled Drugs

6.44 In the only locked cupboard in the dispensary there was a box of Pethidine and a box of Diamorphine. A register was kept but very few controlled drugs appeared to be in use.

Development of Pharmacy Services

6.45 At the time of the visit the Healthcare Centre at Whitemoor was suffering severely because of staff shortage. There also appeared to be very few formal procedures in place in relation to the supply of medicines within the prison.

6.46 The pharmacist did not visit the prison and the technician was only available for about 3 hours daily. There were no health promotion initiatives available. The prison paid the same price for drugs as the hospital and it appeared as if cost saving had been the priority. There is no log of errors or interventions kept. **It is recommended that the pharmacist gets involved in the development and drawing up of the much needed policies to improve the pharmaceutical service to the prisoners.**

Dental Care

6.47 The dental services are provided by a Practitioner under a private arrangement along with Bedford Prison and Leyhill Prison.

6.48 The Practitioner normally attended for 2 sessions a week of approximately 2 hour duration, longer sessions were not available due to the regime in the establishment. The dentist was able to provide extra sessions when necessary.

6.49 **It would be appropriate for a value for money exercise to be undertaken to ascertain the effectiveness of the contract.**

6.50 The Practitioner was working alone; this is not considered normal procedure for current dental practice. It would be more efficient for a surgery assistant to be present, as more patients could be seen per session.

6.51 It would be beneficial for a hygienist to be employed, this would allow further treatments to be provided and reduce the waiting list. If a hygienist is not employed, then, provision of an ultrasonic scaler is essential.

6.52 The equipment was generally satisfactory, however, the chair was in need of re upholstering and a 'reflux' system needs to be put in place for the water supply. Replacement of the unit would be desirable.

6.53 The taking and developing of radiographs was satisfactory, the measures in place were good practice.

6.54 **Emergency drugs and a positive pressure oxygen cylinder need to be provided in the surgery.**

6.55 The compressor needed to be checked and maintained according to the manufacturers instructions – if a new unit is to be provided, then a replacement compressor may be necessary.

6.56 It was understood that a lockable cupboard had been provided, however the shelves for the instrument trays had not been fitted, **this was necessary from a security point of view.**

6.57 Placement of towel dispensers on the wall above the sinks is required to assist cross infection control procedures. **Provision of further electrical sockets would aid cross infection procedures.**

CHAPTER SEVEN

ACTIVITIES

Education

7.01 The education provider at Whitemoor was Norwich City College. The links between the college and its staff in the prison were effective. The prison education department was well managed by a team of experienced full and part-time staff each with clearly identified areas of responsibility. The working relationship between teaching staff and students was of a high standard. Given the nature of this demanding environment, staff and students were enthusiastic with education providing a safe, secure, stable, and positive environment for long-term prisoners. Prisoners including those not presently taking education courses spoke positively of education.

7.02 The main education programme was almost entirely academic with just a small full-time art course for four students and a few other students taking GCSE Art. There was very little curriculum enrichment around the students' core programme and therefore a shortage of opportunities for expressive and creative work. There was the potential therefore for students and staff to become jaded and there should be planned breaks in either the whole programme or within each aspect of it, so that the student can broaden their education experience. The majority of the education programme was full-time. At present this was appropriate but as other programmes and initiatives across the prison are explored **the opportunity to develop a part-time integrated programme that uses the advantages of a stable population in a long stay establishment should not be missed.**

7.03 There was a good range of provision with progression routes from entry level to higher education courses. An element of choice was built in with students on three afternoons of the week able to choose from an options programme. The majority of students were working towards nationally recognised and accredited qualifications. Students' work was well matched to their level of ability and good records were kept of student progress. Tutorials were held regularly with a formal end of course review

and assessment of future needs. The department was very good at devising individual student programmes having carried out a thorough assessment of their needs. All prisoners were interviewed on induction and their levels of literacy and numeracy assessed. However the results of this assessment were not sent to the prisoner's workplace – **this is a practice that should be introduced.** The education department was not represented directly on the sentence planning board. **This is an omission that should be addressed given their role in the assessment process and their good review mechanisms.**

7.04 Eight students were using and developing their information technology skills within the Braille unit. Here the emphasis was on producing up-to-date material for the blind and partially sighted. The unit had been particularly successful in transcribing scientific and medical books where a technique for describing diagrams had been developed.

7.05 A good needs assessment had been carried out in the recent past. This showed that about 80% of the prisoner population had no formal qualifications, 10% at entry level and a further 40% at level one. However there was a problem of access to education which was particularly concerning in that in total there were only 93 student places available on full-time education courses 28 of which were for vulnerable prisoners, and 58 student places on part-time programmes. With full employment in the prison and education wages set at less than half other earnings there was thus a disincentive for students to attend. The education department had developed a strategy to deal with this whereby prisoners could receive basic skills help in their work place or they could attend the education department on one or two afternoons per week. However, this was not working well partly because workshops were reluctant to release prisoners to attend either facility or because if they did the prisoner often lost a productivity bonus resulting in a loss of earnings. **This situation needs to be addressed - it is another example where closer working and part-time provision could bring potential benefits.** The problem was exacerbated by the lack of an evening education programme which, had it been in place would have meant that there was some access to education for men at work during the day. **The provision of the evening education programme should be restored.**

7.06 The overall quality of teaching and learning was good and a variety of teaching methods was observed. The atmosphere in lessons was relaxed but purposeful with mutual respect and co-operation. The students' work that was seen had been promptly marked. Notes made on the work were constructive and aimed at helping the student to progress with their studies. Key skills were well developed and the introduction of Curriculum 2000 nationally had been used to good effect with the introduction of a level three course built around AS level Business Studies, English Language and English Literature. The prison had a large number of Foreign National who were encouraged on induction to attend basic education classes. The nature of the prison population was such that if the disincentives to attend education discussed earlier were removed it would be possible to run a discrete ESOL group.

7.07 The department generally made best use of the resources available to it. However there was a lack of display of students' work in classrooms with the result that they were generally uninspiring. There were good IT facilities with two rooms equipped with computers able to run up-to-date software. However there was no formal rolling programme for their replacement. This meant that the increasingly urgent need to replace the machines used on the Braille unit had not been met.

Library Services

7.08 The library provision was through Cambridgeshire Library Services. The library itself was well organised and equipped and staffed by two Prison Officer librarians who were also the Legal Services Officers. Since access to the library was good this arrangement seemed to work well. Interviews for the vacant post of professional librarian were to be held later in the month. This was to be a full-time post with sufficient hours allocated to the prison library to ensure that the person appointed would be on duty each evening during the working week.

7.09 There was effective management of the library through a committee structure. This consisted of a user group, with prisoner representatives from each of the wings, and a working group made up of the library and prison managers. Both committees met quarterly. In addition a policy group met annually to monitor and develop the library contract.

7.10 The level of book stock was good around 8500 volumes with a good selection, well matched to the requests of the prisoner population. The prison had experienced some difficulty meeting the needs of its ethnic minority population particularly since this was very different to that within the local community. However progress was being made and useful networks were being established. The reference section was quite comprehensive.

7.11 The level of book loss was relatively low and had been identified as occurring mainly when unplanned prisoner transfers occurred. Similarly the level of damage to books was low and the book stock itself was in good condition. One of the three library orderlies repaired books to a high and attractive standard. There was a small but adequate collection of books in the Healthcare Centre and each of the Segregation Units. Vulnerable prisoners were able to access the main library provision.

7.12 There was a good working relationship between the education department and the library with students able to use it both for study and research. It was also used as a centre for some of the external examinations.

Physical Education

7.13 The Physical Education Department was run by a Senior Officer assisted by eight PE Officers, although only seven were in post at the time of inspection. Furthermore long term sick was affecting staff making it difficult to sustain the programme on occasions. We were pleased to note that wherever possible discipline officers were used to cover shortfalls in PE staffing to enable the programme to continue.

7.14 We were pleased to note that the PE department was involved in wider regime activities. The Senior Officer attended the Drug Strategy group meetings, daily residential group meetings and Health and Safety meetings, although we were surprised that he was not a member of the Race Relations Management Team. Each PE Officer had been allocated areas of responsibility such as wings and workshops and this helped to provide good links. The department was also included in the sentence planning process and provided contributions whenever requested.

7.15 The facilities consisted of a well appointed weights room, a cardiovascular area, a very large sports hall and an astro turf pitch. The changing rooms and shower areas were very clean but not generally used by prisoners, who preferred to shower on the wings after activities. The staff agreed that showering in the PE department should be encouraged but felt that they could not insist.

7.16 A recently improved Induction Programme for new prisoners ensured that they were made aware of the facilities and how to apply to make use of them. On average 3 or 4 prisoners at a time were involved in the induction programme which included health and safety and rules abut the dress code. Every prisoner undertook a short course in safe lifting and handling. Additionally the PE staff gave instruction in the use of multi-gym and recorded this information for the benefit of wing staff so that prisoners could use the small exercise rooms on each wing.

7.17 The facilities were well used by prisoners during the day and on four evenings each week. Unlike in many other prisons, there were sessions built into the workshop timetables so that prisoners could attend the gym during the working day. Activities included badminton, fitness, weights, football and circuit training. Sessions for "remedial prisoners" were provided on Friday afternoons. It was also pleasing to note that there was a specific session for prisoners involved in the CARATS drug programme. We were told that the maximum number of sessions a prisoner could possibly attend in a week would be seven but on average 4/5 would be the norm.

7.18 Whilst we found no evidence that some individuals or groups of prisoners were dominating the use of the facilities at the expense of others, the system did have the potential for abuse. Staff in the department were confident that there was no domination but it became clear that their confidence was based only on anecdotal information rather than any analysis of attendance.

7.19 There was no management information regarding the attendance of individual prisoners, groups of prisoners or ethnic breakdown. We were particularly surprised at the latter since this type of information is usually required for analysis by senior managers and Race Relations Management Team. **We recommend that there**

should be monitoring of attendance at PE activities to ensure fair opportunities for all prisoners.

7.20 Although the programme specified the nature of activities for each session, prisoners themselves followed their own individual activities. PE staff gave some guidance and obviously provided equipment for prisoners but there were no structured teaching or coaching sessions. It was an unusual experience to find PE staff standing around observing activities taking place without taking any leading role. Staff themselves felt deskilled by this lack of involvement but we were left with the impression that this was the only way for them to deal with long-term prisoners. **There should be a greater range of structured classes.**

7.21 There were no opportunities for prisoners to achieve qualifications in any activity. We were told that there was a demand from some prisoners to pursue courses leading to nationally recognised qualifications and an acceptance by PE staff that these would be beneficial. Work was in hand to provide a classroom for theoretical work involved in gaining awards. **We recommend that there should be opportunities leading to qualifications in PE activities. The classroom should be completed as soon as possible.**

Employment

7.22 The Employment Manager was responsible for both education and work. We were told that there were enough activity places for the whole of the prison population to be employed in either work or education. Records showed that there were ten prisoners unemployed at the time of the inspection. There were also approximately 30 prisoners who were considered unemployable because of their health, security status or location etc.

7.23 The most lucrative areas of work were the production workshops where prisoners in workshop 1 could earn up to £30 with bonuses:

- Workshop 1 - CD Contract (recycling and destroying counterfeit CD's)

- Workshop 2 - Tailoring/Packing/Assembly (producing overalls and coats/packing machinery repair kits/assembling cables for safety systems company)
- Workshop 3 - Contract Services (assembling and packing work)

7.24 We were concerned that no NVQs (National Vocational Qualifications) were offered in any of the workshops and the reason given for this was that it would incur an additional cost for registration. **We believe that the small additional cost of registration was an acceptable reason for not providing prisoners with the opportunity to gain qualifications.**

7.25 Prisoners on A and B wing, with whom we spoke, were clearly annoyed that only prisoners on C wing (Rule 45) were allowed to work in workshop 1 and therefore earned the most money. There was a perception amongst these prisoners that prisoners on Prison Rule 45 had access to all the best jobs including the Kitchen and the stores; we believe the establishment had got the balance right. Other work that was available included: Painting & Decorating, Plastering, Braille, Furniture restoration, Bricklaying and a range of Orderly and Cleaners jobs.

7.26 The pay ranged between a maximum of £30 in workshop 1 to £3.50 for prisoners on the Induction programme. Prisoners who were retired received £3.50 per week and short term sick prisoners received £2.50. We were told that unemployed prisoners received £2.50 per week and those that were sacked or refused to work received nothing. We were concerned that education was amongst the lowest paid activity and would be a disincentive. **Prisoner pay for education should be reviewed and brought into line with other activities such as the Wing Orderlies.**

7.27 *Prisoners who were sacked from the job were permitted to apply for new employment immediately; this was good practice.* We were also told that it was not considered a problem if a prisoner wished to change their job.

7.28 Labour allocation was managed by the Principal Officer (PO) in charge of Sentence Management. We were surprised to find that the Employment Manager had

no input into this process. Vacancies were advertised on wing notice boards and allocated on a first come first served basis. It appeared that no matching was made of prior knowledge and the acquired skills of prisoners with the work that they were given. For example many of the wing cleaners had no basis hygiene or kinetic lifting qualifications, but were still required to work. **Prisoners should receive basic training in health and hygiene and kinetic lifting etc during the induction programme.** This would provide the establishment with a ready made skilled labour force that could meet the requirements of the work available; **this should be considered as an option.**

7.29 We thought it unfair that no waiting list was kept for vacancies in the best paid jobs and whilst it was said that no prisoner was forced in to any vacancy they were encouraged to accept what was available. There was no mechanism for prisoners accepting lower paid jobs to be promoted to a higher paid job when a vacancy arose. **A waiting list should be kept for prisoners wanting a higher paid job if they are prepared to accept other work in the interim.**

Training Provisions

Construction

7.30 Prisoners selected training courses during their induction following discussion with members of the education department. Prisoners were placed on a training course waiting-list and interviewed by a course instructor when a vacancy occurred. Prisoners were interviewed, given a full explanation of the course content and structure and instructors established any prior experience and achievement of the prisoners. Instructors, however, were not involved in the selection process or sentence planning for prisoners. All prisoners were initially assessed for basic skills in literacy and numeracy using the Basic Skills Agency (BSA) test and were assessed for dyslexia. Those identified as requiring additional learning support were recommended to attend basic skills support sessions, although attendance was on a voluntary basis. Key skills training did not form part of training programmes.

7.31 Training options included plastering, painting and decorating, bricklaying and furniture production. Prisoners were working towards City and Guilds basic skills

certificates in all disciplines. In addition, men who complete the basic skills qualification in painting & decorating and furniture production were given the opportunity to achieve an advanced qualification. *Instructors provided additional training and used their industrial experience to provide an extended training programme, allowing prisoners to gain skills exceeding the requirements of the basic qualification. This was good practice.*

7.32 Induction into the construction unit was well structured. There was a strong emphasis on health and safety. Prisoners in furniture production and painting and decorating followed an initial programme of basic training. This allowed them to develop hand skills in a controlled and safe manner. For example, prisoners in furniture produced an oilstone box to develop the use of hand tools. Instructors have produced handbooks, which supplement these introductory sessions. **It is recommended that this good practice be adopted across all construction departments.**

7.33 The quality of work being produced by prisoners was generally very good. *In some cases, particularly in painting and decorating and furniture production, some examples of exceptionally high quality work in completed practical tasks were seen.* In the furniture department prisoners were encouraged to design and manufacture items, which can be purchased by family members. This practice had a strong motivating effect for prisoners and provided them with a great sense of achievement and satisfaction. Prisoners designed and produced toys for the prison's visitors' centre as well as renovating furniture for local schools and colleges. There were many examples of prisoners' work displayed in the painting department. These demonstrated the high standard of skills achieved and motivated new prisoners to achieve similar levels of competence. Prisoners held very positive opinions of their training and achievements in the construction unit. In many cases men achieved formal qualifications for the first time and appreciated the opportunities given to them by prison regimes.

7.34 Each department accommodated a maximum of 12 prisoners and resources within the units adequately met the demands of training. In plastering and painting & decorating prisoners were allocated individual bays, for training and assessment

purposes. A wide range of textual and visual material supplemented these resources. Prisoners were encouraged to borrow textbooks for research and this facility was widely used. Warning notices were displayed around the workshops to enforce the use of personal protective equipment. Other safety equipment for use with machines, such as eye protection, ear defenders and dust masks, was available and its use was enforced. However, prisoners were not issued with overalls. This could lead to prisoners returning to their cells in clothes contaminated with sawdust, glue or other materials used in the workshops. **It is recommended that the wearing of overalls be introduced in all departments.** External verifier reports indicated no areas for concern. Copies of these reports were routinely passed to the employment manager. comments provided by the external verifier were very positive. The employment manager used these comments for discussion during staff appraisal. All instructors were qualified as assessors and internal verifiers and held the ENTO units D32, D33 and D34.

7.35 Prisoners regularly carried out construction work throughout the prison. This work included major alterations to production workshops and classroom facilities. However, there was no opportunity to achieve an NVQ and little use was made of this work for assessment purposes. **It is recommended that the training unit explore the possibility of introducing the Intermediate Construction Certificate (ICC) qualification,** a qualification for any trainee unable to meet the work-based requirements of the full NVQ. The introduction of this qualification would encourage the use of project work and maximise the effectiveness of the additional training provided by instructional staff. In addition, prisoners' likelihood of finding employment on release would be increased, by the achieving of a nationally recognised qualification directly related to the NVQ.

7.36 There was good additional learning support given to prisoners by instructional staff. Prisoners for whom English was a second language had been enabled to achieve through this support. Where instructors had identified prisoners' learning difficulties, prisoners were provided with additional support training, thereby enabling many prisoners to successfully complete courses and achieve qualifications. Although in many cases prisoners' additional support requirements were identified during initial assessment, instructional staff were not routinely informed of these additional needs.

We recommend that a formal link between education and training is established in order to disseminate information. Consideration should be given to establishing the participation of members of the instructional team in initial induction programmes.

7.37 Disruptions to training were caused by instructor absences, due to holidays, staff training and sick leave. In many cases prisoners suffered loss of enthusiasm and motivation as a result of cancellation of training sessions. Such learning packs could be used during staff absences when alternative supervision was not available. There were plans to combine the plastering, bricklaying and painting departments into a single multi-skills training unit. These plans included the construction of new classroom facilities for use by prisoners, when staffing levels prevent training in the workshop. **It is recommended that learning and assignment packs be provided to prisoners to enable them to acquire underpinning knowledge when workshops are closed.**

Letters and Telephone

Letters

7.38 Staff (Censors) were detailed each day to deal with prisoners' mail. All mail for Category A prisoners was read by the Censors and 10% - 20% of that for the rest of the population, although staff on C wing said that they read all mail. **Staff should not routinely read all prisoners' mail.** All mail was opened and checked for enclosures including legal letters, which were opened in front of the prisoner. Two mail delivers were made each day; similarly two collections of outgoing mail were made.

7.39 Prisoners were given one free letter per week and *foreign national prisoners were given an airmail letter; this was good practice.* Prisoners with whom we spoke to during the inspection generally reported that they had no difficulties with mail and that it was routinely delivered to them the day it arrived.

7.40 We were concerned that staff were not aware of prisoners subject to the Protection from Harassment Act and that there were no procedures in place to monitor

their mail. **A procedure to monitor the mail (incoming and outgoing) of any prisoner subject to the Protection from Harassment Act should be implemented as a matter of urgency.**

Telephones

7.41 Adequate telephones were provided on most residential units other than on C and D wings, which only had one phone on each spur. **This was insufficient to meet the needs of the population and should be increased**. None of the telephones observed had privacy hoods. Staff explained that they had previously been in place but had been destroyed by prisoners. Notwithstanding this **we recommend that privacy hoods be replaced**. *The telephone in the Segregation Unit was housed within its own kiosk; this was excellent and, finance permitting, this arrangement should be extended to all telephones in the establishment.*

7.42 Other than in the Segregation Unit prisoners had open access to the telephones. In the Segregation Unit prisoners were required to apply to use the phone. The number of calls the were allowed was based on their regime level:

- Enhanced 5 minutes each day (not on Fridays)
- Standard 3 x 5 minutes
- Basic 2 x 5 minutes

Prisoners elsewhere in the establishment could use the phone during unlock periods (except prisoners in the SSU):

- 11am – 12.15pm 3pm – 4.40pm 5.45pm – 7.45pm

7.43 All calls made by high-risk Category A prisoners were monitored and recorded as were calls made by prisoners in the Segregation Unit. High risk Category A were not allowed to keep their phone cards in possession and had to book times to use the phone. This alerted staff so that the monitoring of their calls could commence from the 'Centre office'.

7.44 We were again concerned that no procedures were in place to monitor telephone calls of prisoners subject to the Protection from Harassment Act. **A**

procedure, similar to that used for high-risk Category A prisoners, should be introduced for all prisoners subject to the Protection from Harassment Act as a matter of urgency.

Visits

7.45 The visiting room was spacious and well decorated. Fixed seating arranged around small tables were provided for prisoners to speak with their visitors. Prisoners were allowed up to three adult visitors and an unlimited number of children during each visit. The main visits hall was split into three sections; an area for the general prison population and one for prisoners on Prison Rule 45 was separated by an area used as a crèche. Visits staff and prisoners spoken to during the inspection were generally content with this arrangement and said that there were seldom any problems between the two groups of prisoners. A separate room was used for high-risk Category A prisoners. Only two booths were provided for professional visits and we were told that professional visits were occasionally arranged in the main visits hall during normal visits. **This was unacceptable; additional rooms should be made available for professional visits.** There were also 6 booths provided for prisoners on closed visits.

7.46 *A full-time voluntary crèche worker was arranged through the Probation Department; this was an example of good practice. There were also volunteers from the WRVS (Women's Royal Voluntary Service) who provided a shop. To use the shop visitors could purchase tokens in the Visitors Centre prior to entering the prison which could then be exchanged for goods to there value; we liked this arrangement.*

7.47 The Senior Officer (SO) in charge of visits was impressive and keen to provide the best service possible for prisoner's visits. He took a sensible approach to visitors who had been 'indicated' by the passive drug dog (it was accepted that certain "smells" could cause the drug dog to indicate on a visitor) balancing this with other intelligence available on the visitor and or the prisoner before taking a decision on whether the visit should be a closed one. Security generally within the visit room was high but discrete. Camera monitors were observed by a member of staff throughout the whole of the visiting period in a room adjacent to the visits hall. All prisoners were strip searched at the end of the visit and 10% of visitors received a rub down

search on leaving. We were told that Sikh visitor were asked to remove their turbans and Asian women asked to remove veils but that they were always offered the opportunity to do so in a private room with a single member of staff of the same gender. Having spoken to the visits staff responsible for carrying out these searches we were satisfied that they were carried out in a professional and sensitive manner.

7.48 The provision of visits was generous with prisoners receiving up to two hours each visit. Unfortunately because of the strict searching procedures on entry we were told that visits were routinely delayed, for some prisoners, by up to half an hour. The number of visits allowed to each prisoner per month was determined by his regime level although we found it peculiar that enhance prisoners on Blue spur on B wing were afforded one privilege visits (PVO) per month more than enhance prisoners elsewhere in the prison. **This was unfair; the number of visits should be standardised across the whole prison.**

7.49 *Every Tuesday was set aside as children's day and we were told that they was a good response from prisoners and visitors for this provision. A children's party had been arranged for Christmas. Sponsorship had been gained from local businesses to provide presents and a Father Christmas. Other entertainment was also to be provided.*

7.50 Wheelchair access was available for visitors but we were told that the doorways were too small for standard size wheel chairs. Visitors were required to use a chair supplied by the prison. The wheelchair supplied by the prison was old and dirty and should not be used. **A new, more suitable, wheelchair should be purchased for the use of visitors**

7.51 Good procedures for Schedule One prisoners were in place. A list of names was kept and each Schedule One prisoner was required to sign a compact agreeing not to have any children visitors. The SO checked this stringently each day.

Religious Activities

7.52 Over 75% of new prisoners to Whitemoor, prior to our visit, stated in questionnaires that they had had access to a chaplain, priest or imam. Prisoners took part in the religious activities of their preferred choice, as there were two multi-faith rooms as well as an attractive chapel. The facilities were in use every day either for worship or group education and discussions.

7.53 Whilst we were there we were only able to meet two Free Church Ministers and the full time Church of England minister. In all there were 13 visiting spiritual leaders including a Muslim Imam, Buddhist Rabbi, Jehovah's Witness, Sikh, Pentecostal and Baptist. In addition there were three full-time chaplains representing Church of England, Roman Catholic and Methodist spiritual needs.

7.54 Two leaflets were available in reception, one explaining all the Chaplaincy activities and another that outlined the special activities for Muslims, including the principles of Islam and preparation for prayers.

7.55 At the time of our inspection there were 70 Muslim prisoners and it was hoped to extend the hours that the Imam was able to attend the prison. When we visited he was in the process of completing his studies and was planning to increase his hours to eight per week. Whilst acknowledging that this was probably not enough time to meet the needs of Muslim prisoners the current Imam was very popular and so his need to complete his examinations was accepted by both prisoners and staff. *The Muslim prisoners had their own room for worship which was not used by other religious denominations. All of the pictures in the room were related to their own faith and the notice board was for their exclusive use. This was good practice. Compasses were available for prisoners who were not able to attend prayer sessions so that they could pray in their cells, as on some occasions there had been a shortage of space.*

7.56 The full time Methodist Chaplain was the Vice-Chairman of the Suicide Awareness Management Committee. Many of the clerical staff took part in the support plans associated with F2052SHs and the multi-disciplinary review meeting. The Methodist chaplain was also the tutor for the suicide awareness training

programme for the prison staff as well as providing training and ongoing support for prison visitors.

7.57 The Chaplaincy had developed and was holding three courses, Alpha, Insights and Discovery. The Imam was also developing courses to meet the needs of the Muslim population. The course 'Insights', developed locally, was already a target for sentence planning purposes and completions were recorded in sentence plans. Both courses were used to introduce prisoners to other courses such as Offending Behaviour or Enhanced Thinking Skills which were part of the Sentence Planning Structure. 'Discovery', also developed locally, was expected to be included in the Sentence Planning Structure.

7.58 There were links with the local community through jointly arranged and attended services being held in the prison chapel. Other visitors included bereavement counsellors. Should prisoners not have any visits, Prison Visitors were arranged by application to the Chaplaincy.

CHAPTER EIGHT

SERVICES

Catering

8.01 A temporary Senior Officer caterer and seven Prison Officers staffed the main kitchen. In addition, 18 prisoners were working in the kitchen. At the time of the inspection the kitchen was having new drains installed, which was causing major disruption. The general cleanliness and hygiene of the kitchen was satisfactory, and staff were coping well with the building work. All chilled, frozen and dry foods were stored appropriately in separate areas of the kitchen. Staff and prisoners we observed were appropriately dressed at all times.

8.02 Several of the Prison Officers working in the kitchen were qualified assessors for NVQs. In addition, one was working towards the internal verifier qualification. The prison had made recent application to an awarding body, to become an accredited NVQ centre for the delivery of training to prisoners in the main kitchen and was waiting for a visit by the awarding body. No prisoners in the kitchen were working towards NVQs, although several were interested in joining such programmes. Of the kitchen party only four had received training in food hygiene. Meals were served in the accommodation wings by officers or by prisoners supervised by officers. Only some of these prisoners and officers had been trained in food hygiene. **This was poor practice. Food hygiene training must be provided for all staff and prisoners who prepare, or serve, food.**

8.03 Breakfast at the prison was served between 07:40 and 08:10 and consisted of cereals and milk, and bread and preserve. On two weekday mornings prisoners were served porridge and eggs for breakfast. Lunch, served between 11:40 and 12:10, consisted of a selection of hot and cold food. Weekday evening meals provided a selection of hot food and was served between 17:40 and 18:10. These meal times changed at the weekends with the evening meals being served between 16:00 and 16:30 hrs. The food served during Sunday evenings was always a cold meal. There were vegetarian options available at both lunchtime and evening meals and cultural

and other dietary requirements were catered for. This included a range of identified healthy options and Halal dishes for Muslim prisoners. There was some confusion amongst prisoners, however, as to the diet assigned to them and the reasons for such assignment. Prisoners in the SSU, for example, complained that potatoes had not been served with a lunchtime meal. Kitchen staff confirmed that these prisoners had been placed on low fat diets and rice should have been served rather than sauté potatoes. Prisoners, however, were not aware of being placed on special diets and kitchen staff had not provided a suitable alternative to the potato dish. **The prison should review the dietary status of all prisoners and ensure that the kitchens supply appropriate alternatives to fried potatoes.**

8.04 The meals were conveyed from the main prison kitchen to the accommodation blocks in heated trolleys and food was immediately transferred to pre-heated serveries. Serveries were generally well appointed and a good standard of hygiene was maintained. Due to the daily regime and the high security arrangements in place, kitchen staff were placing food in the heated transport trolleys up to three hours before it was served to prisoners. Time delays between food preparation and serving had an adverse effect on the quality of taste and presentation of the food. During inspection it was observed that the smell and colour of diced vegetables being served was poor due to being left in water for up to three hours after cooking and presented a potential problem with food hygiene. **The practice of holding cooked food in heated trolleys for up to three hours prior to service was unacceptable. The prison should immediately review this practice and considerably reduce the time between cooking and serving food.**

8.05 Many prisoners had access to facilities to enable them to cook their own meals. Food was being purchased through the canteen facilities and each accommodation wing, including the SSU, had a fridge, freezer and cooker. Prisoners stored their own food in large bags and placed them on top of other bags in the fridges and freezers. There was no immediate way of seeing if food was being stored hygienically. The prison, however, had introduced a weekly audit and monitoring reports which examined the standards in hygiene maintained in the prisoners' kitchens. **This was good practice, but it is recommended that this practice be extended to systematic monitoring of the safe storage of prisoners' food.**

Prison Shop (Canteen)

8.06 The prison shop was contracted out to Sutcliffe Catering. A wide range of products was available including an extensive range of products for ethnic minority prisoners. *Some 500 items were available on the canteen list; this was impressive and the most comprehensive list of products available from any prison shop inspectors have found.*

8.07 Prisoners routinely had access to the shop twice a week, once for normal items and a second time for items from a specials list that included fresh meat and veg. Adequate refrigeration and storage for frozen products was available on residential units. *Thursdays were used for bagging up or putting in boxes items from the special lists and time permitting, prisoners (rotated by wing spurs) would be allowed to use the prison shop again; this was good practice.*

8.08 There had recently been a sharp increase in the price of some items in the shop (some items, we were told, had increased by up to 19p) and prisoners were, as would be expected, unhappy about this. It was explained by the Governor grade in charge of the prison shop that the establishment had previously been selling some goods at less than cost, and in that context, subsidising the prison shop. This was not allowed within the terms of the Prison Service finance manual and therefore prices had been adjusted. Whilst we understand that it was necessary to increase prices, all prisoners should have been forewarned of the price increases beforehand and that price increases should have been introduced in smaller amounts.

8.09 A number of prisoners with whom we spoke during the inspection said that they were concerned that they had ordered goods from the catalogue and had paid an additional fee for postage and packaging (p&p) so that their order would be processed immediately, but had still had to wait for several weeks before they received their goods. None of the prisoners had received a receipt for the p&p payment with the receipt for their goods. We discussed this with the Sutcliffe Catering manager who accepted that goods were mainly purchased in bulk order to avoid any additional payment for p&p. We were told also that prisoners could avoid waiting by paying their own p&p. However, if a prisoner had paid p&p and their order had gone out

with a bulk order, no repayments had yet been made although it was said that it had always been the intention to do so (it was also accepted that some of these claims were several weeks old). We were concerned that Sutcliffe Catering had not notified any prisoner of its intention to pay back the money. **We recommend that the Governor grade with responsibility for the prison shop investigates the significance of these claims and satisfies himself of the validity of Sutcliffe Catering's stated intention to repay the money.**

8.10 Prisoners were also concerned that money was being taken out of their accounts for goods that they had not received (sometimes for several weeks before they received their goods). The general perception was that Sutcliffe Catering was banking the money and gaining interest. However, this was not the case; indeed the money was not given to Sutcliffe Catering until it had actually purchased the goods. The prison settled their account on production of receipts. The money removed from the prisoners account was simply a computer transaction to stop them spending it again but was not actually taken from their account until they had received their goods. It is understandable why prisoners perceived things as they did because they were not told otherwise. **It should be explained to prisoners, as it was to inspectors how transactions for goods are made to avoid any further misunderstanding.**

8.11 During the inspection we had the opportunity to observe a routine conciliation meeting between the Governor grade with responsibility for the prison shop, Sutcliffe Catering manager and prisoner representatives. It was significant that prisoners also raised several of the issues that had been raised with inspectors during the week. Whilst the meeting were a good innovation it was unclear how much of the information was passed on to the rest of the prison population. No formal minutes were taken and prisoners were simply left to pass things on to their peers as they chose. **We recommend that minutes are taken of the meetings and posted on all residential units so that prisoners have access to information first hand.**

8.12 We were given a copy of the prison shop price list and two and half pages of the Recommended Retail Price (RRP) list used by Sutcliffe Catering as a guide. We were concerned to find that whilst a few items were priced below RRP, several were

priced above. In particularly a brand of cornflakes were priced 12p above the RRP. It is exploitative to charge prisoners above RRP for any items; **we recommend that all the prices charged on the canteen list are examined and revised so that none are priced above RRP.**

Maintenance of the Establishment

8.13 Whitemoor was built as a brand new prison on a greed field site and opened in 1992. It remained substantially as constructed and seen at the last Inspection. The only addition of any size was a single storey "quick build" unit providing accommodation for the Administration Department.

8.14 The buildings and grounds were generally in good condition and provided a pleasant environment for prisoners and staff.

Maintenance access

8.15 Almost all buildings had soft grassed areas right up to the external walls, without even an adjoining narrow concrete path. Where paved yards abutted walls the enclosing security fences had only personnel gates, with no access provided for vehicles. It was not possible to reach the buildings with any sort of vehicle, especially a high level access lift, for inspection or maintenance. We saw substantial, extensive vegetation growth in the roof rainwater gutters, which had clearly been overflowing for some years to the discomfort of anyone in the vicinity and to the detriment of the buildings. **Vehicle access should be provided to all the building elevations.**

Cell call recording system

8.16 The prison had been equipped with the new system for recording all use and cancellation of cell calls. We asked for a print out on a number of wings and found in each case that neither staff nor management had any idea at all as to how to operate the system. A valuable and expensive management tool was thus unavailable to the prison. Eventually the Head of Works took over and was able to obtain a print out in one wing. **The cell call recording system should be brought into use and the print out checked daily in each department.**

Small repairs

8.17 There were many small repairs to be seen about the prison. We found that staff were not reporting small repairs, nor progressing those reported. The standard Service repair request form was being used but completed forms were taking anything from two full days upwards to reach the Works Department. **The small repair system should be made to work effectively.**

Window catches

8.18 Throughout the prison, windows were fitted with the normal catch to secure them in the closed position. Many of the catches were broken, making it impossible to have the windows airtight when closed, with resultant draughts, waste of fuel and discomfort. **All window catches should be maintained in good working order.**

Window lintels

8.19 Over the windows pressed steel lintels had been used with brickwork facings. These facings had not been fixed securely when the buildings were constructed and they had become loose and displaced in many cases. Although there appeared to be little structural hazard, the bricks could easily fall away to the risk of passers by and they could be dislodged by prisoners in their cells. **Remedial work should be undertaken promptly to secure the bricks in the lintel facings.**

Shower floors

8.20 When the prison was built, the shower floors had been laid to fall away from the drains so that large pools of water formed when the showers were in use. Remedial work had been started by the Works Department, with one shower completed but many more awaiting action. The size of the project was too large to be undertaken by a Works Department sized only for operation and maintenance. **Rectification of the shower floor falls should be put to outside contractors for speedy completion.**

8.21 Rectification had started in a second shower but the Works Department had not fitted their own lock, so that although a Works area it remained assessable to all key holders. **Works areas should be secured by Works locks.**

Healthcare Centre

8.22 There was a very unsatisfactory Treatment Room in the Healthcare Centre. It was without a wash hand basin, any ventilation, or an outside window. We also saw that sluice room provision was inadequate. None of this accommodation began to conform to current medical standards as published by NHS Estates in Leeds. **The Healthcare Centre should comply in all respects with NHS Building Notes.**

Laundry store

8.23 Work coming in from HMP Wayland was offloaded into a store to wait processing in the laundry over the following 2-3 days. The store was unventilated and without any fire or smoke detectors. As dirty work was transferred to the laundry, the washed, clean work took its place in the same store, thus running a real risk of cross infection. **The incoming work store should have mechanical air extraction and be fitted with smoke and fire detectors.**

8.24 **A separate store similarly fitted, should be provided for the finished work.**

Arts and Craft Shop

8.25 Part of the workshop block was in the process of being altered to form an Arts and Crafts workshop for vulnerable prisoners for whom there were no other work facilities in the prison. Much alteration work had been done, but much remained to be done. **The Arts and Crafts workshop should be completed promptly and brought into use.**

8.26 It was proposed that a totally internal room in the shop be used for all the associated computer equipment. It appeared likely that the equipment and occupancy

heat gains would result in unacceptably high ambient temperatures for much of the year. **Heat gains should be checked and simple cooling provided from the start if required.**

Cell extract grilles

8.27 In common with many other prisons in almost all cases the cell extract grilles above the WCs had been blanked off by prisoners even though the ventilation systems were quiet in operation and caused no draughts. The Works Department had, quite rightly, fitted thermostats in some of the WC extract ducts to sense the cell air temperatures and use these to control the heating system. Blanking off the grilles not only nullified ventilation in the cells, but also adversely affected control of the heating system. **Ventilation grilles should be checked as part of the daily cell inspection by wing staff, and the grilles kept clear of obstruction.**

Main supply panel

8.28 The arrangements of the main electricity supply panel for the prison allowed interruption of the electricity supply to all the equipment in the Control Room. The prison had anticipated this and fitted a hand operated changeover switch. Operation of the switch re-energised the supply to the Control Room. Whilst very effective, it could take some time for a member of the Works staff to enter the switch room and operate the switch at night. **The hand operated supply panel switch should be replaced with an automatically operated unit.**

Sewing machine

8.29 In the furniture shop there was a sewing machine which we were told had been waiting connection to 3 phase supply for some time. There was no adjacent 3 phase supply. **The motor should be changed in single phase, connected up and brought into use promptly.**

Fire precautions

8.30 Fire precautions were generally in good order except for a few specific areas where the prison was failing to comply with legislation.

Staff training

8.31 Only about 30% of the staff had received the Fire Awareness training deemed to comply with legislation. **Fire Awareness training for all staff should be brought back on programme.**

SDBA

8.32 Only about 30 staff were up to date with SDBA training, even though the prison had assessed the need for at least 63 SDBA trained staff. **SDBA training should be brought back on programme.**

Evacuation exercise

8.33 About 90% of the departments had undergone evacuation drills during the past year, so the prison was substantially up to date in this respect. **All departments should have at least one evacuation drill each year, some of which should take place while the prison is in patrol state.**

Smoke and fire detectors

8.34 Although the equipment had been bought just prior to the Inspection, the extensive network of smoke and fire detectors had never been tested as required by regulations. **Smoke and fire detectors should be tested as required by legislation.**

Inundation points

8.35 Almost all the cell doors were without inundation points. We were pleased to see that the wing staff had been issued with hammers so that the cell door observation panels could be broken with certainty by any member of staff. Even though hose reels were not fitted with inundation nozzles they could be used for the purpose with some effect. **Inundation points should be fitted to all cell doors.**

8.36 **The hose reel nozzles should be fitted with quick release connections to enable rapid changeover.**

Good points

- the quality of the records kept
- the time allowed for the Fire Officer duties
- the Fire Risk Assessment form used by the Fire Officer.

Health and Safety

8.37 Health and Safety matters were generally in good order under the control of a full time Health and Safety Officer. There were a number of items needing attention but they were all of a relatively minor nature or relatively simple to rectify

Policy/Statement of Arrangements

8.38 There was a workable Policy/Statement of Arrangements which could be improved in a number of respects to the benefit of the prison. Useful documents had been obtained from other prisons but adaptation had not been completed, leaving the prison remained exposed to some degree. **The rewriting of the Policy/Statements should be completed promptly.**

Safety Audits

8.39 About 80% of the Safety Audits required by regulation had been completed during the past year. **Safety Audits should be completed to programme.**

Health and Safety Committee meetings

8.40 The minutes of the Health and Safety Committee were in the form of an action plan. Whilst this was effective in respect of progressing Health and Safety matters, it did not record information to be passed to and available for committee members, such as the number and type of accidents reported in the prison since the last meeting. **Minutes should include information required by committee members.**

Cleanliness

8.41 The prison accommodation was generally to an acceptable standard except for the Segregation Unit. We were told that the Unit had been deep cleaned to a

satisfactory standard only a week before, but at the time of the Inspection it was dirty and did not begin to approach the standards expected. **The Segregation Unit should be kept clean.**

Cleaners

8.42 We were unable to find any records of training for wing cleaners as the F2055C forms were not available in the wings, although they were used elsewhere in the prison. Enquiries revealed no method for ensuring that training was given and that it was recorded. **There should be a structured method for ensuring that all prisoner cleaners receive appropriate training, and the training should be recorded using the F2055C forms.**

Facilities for disabled persons

8.43 There was some isolated provision for disabled persons but it was quite uncoordinated. **A survey should be made of the needs of disabled persons throughout the prison, and facilities provided.**

Radiation protection

8.44 No Local Rules were displayed in the dental room. Local Rules for operation of the medical apparatus and in addition the rules for the dental equipment, were displayed in the X-ray room; neither were dated. **Local Rules should be dated and displayed by the relevant machine.**

Flammable liquids

8.45 Both the furniture shop and the VT cleaners shop were storing flammable liquids in unsuitable steel cabinets. **Purpose designed "Flammables" should be used.**

CHAPTER NINE

RESETTLEMENT

Management

9.01 A number of activities which contributed to resettlement took place in Whitemoor, but no overall Resettlement strategy based on a systematic analysis of the resettlement needs of the population. Both the Probation and Psychology departments were very active and committed, but they operated in isolation and there appeared to be no forum which would allow for their activities to be co-ordinated and linked with the Sentence Planning system. The latter was well managed and had the potential to support the work of both departments in a more coherent way. There were plans to introduce a Throughcare/Resettlement strategy, supported by clearly defined aims and objectives, a multi-disciplinary staff group and regular meetings. **These should be expedited without delay and include senior management ownership and accountability.**

Provisions for Life Sentenced Prisoners

9.02 133 life sentenced prisoners were being held at Whitemoor at the time of the inspection 83 of whom were also Category A prisoners. A Senior Officer (SO) worked full-time as the Lifer Liaison Officer (LLO) and the Governor with responsibility for Sentence Management had portfolio responsibility for lifers. There was no discrete lifer unit and lifer prisoners were located on all residential areas.

9.03 We were told that 151 members of staff had undertaken 'lifer' training and that approximately 124 were Prison Officers. It was of some concern therefore that we found that not all lifer prisoners had Personal Officers who had undertaken lifer training (see Personal Officers). We asked what specific provisions were provided for lifer prisoners and were told that there were none. However, most prisoners were serving long sentences and in that context their needs did not differ greatly from those of life sentenced prisoners. *Prisoners were able to purchase a wide range of goods from the prison shop and sufficient facilities were provided on the residential units to*

enabled them to freeze, refrigerate and store perishable items and to prepare their own meals; this was an example of good practice.

9.04 We spoke with a group of 17 lifers at the start of the inspection who were generally happy with their treatment. A number of minor concerns that were raised were passed on for the Governor's attention. However, some major concerns that were raised were not. These related to a perceived lack of opportunity to attend offending behaviour programmes and the lack of progression or recategorisation achieved by lifer prisoners at Whitemoor. The provision of offending behaviour programmes is discussed in more detail in the section of this report entitled Prisoner Programmes.

9.05 In relation to the lack of progression or recategorisation the LLO explained that prisoners at Whitemoor often found themselves in a "vicious circle" in that those who were assessed as likely to benefit from offending behaviour programmes were unable to attend them because they were not provided at the establishment and establishments that did offer suitable courses invariably required a lower category prisoner. Whitemoor prisoners were unable to be recategorised because they had not done the programme. **This incongruity should be addressed.**

9.06 We examined a sample of lifer files, Life Sentence Plans and Summary Dossiers. Generally these were kept to a high standard with appropriate information filed in an orderly manner. However, a number of the Summary Dossiers we examined had documents missing such as antecedents and pre-sentence reports. The LLO said that this often made it difficult for staff in undertaking risk assessments for the purpose of F75 reports. **The LLO should liaise with Lifer Management Unit to ensure that all Summary dossiers are complete.**

9.07 *The LLO provided a clinic one day a week which involved him being available on the wing to deal with ad-hoc concerns from prisoners; this was an example of good practice.* We did not observe this during the inspection but lifer prisoners with whom we spoke said that they had good access to the LLO. *The LLO had also produced an*

information sheet for lifer prisoners which he intended to produce monthly. Only one had been produced at the time of the inspection but it was a quality bit of work that should be continued.

9.08 Lifer groups had recently been suspended because of a lack of staff. It was hoped that they would recommence in September but this had not occurred. **Managers responsible for staff detail should ensure that the lifer group is part of the profiled work and that staff are made available.**

9.09 It is particularly important that those lifers serving whole life tariffs, or who remain high-risk and for whom release is not a realistic prospect, are able to believe that the authorities recognise their plight and take some responsibility for providing them with a healthy prison environment which recognises their particular needs. It is to the credit of the Psychology and Probation departments that staff have taken an interest in these groups of prisoners by supporting them individually, or in the case of the Probation department, in providing groups for Cat A lifers for whom there is otherwise no official provision. Their experience suggests that these prisoners would like to be able to earn some form of senior prisoner status within which they can take on trusted and worthwhile jobs within the prison, or carry out charity work which will allow them to make some sort of reparation for their offences. The Prison Service at the present time provides no direction for the management of these particular groups of prisoners. **We recommend to the Lifer Management Unit that they consult with the Psychology and Probation staff at Whitemoor with a view to developing national guidance on regimes for exceptionally long term lifers including whole tariff lifers and high risk lifers who are unlikely to achieve release.**

Assessing Offending Behaviour

9.10 The Dispersal Induction Assessment package had recently been re-introduced following its suspension when it could no longer be sustained by a depleted Psychology staff. It had been introduced initially in 1996 as a Psychology department initiative and without additional resources being made available. The new package was less complex and was the responsibility of sentence management staff to implement and co-ordinate. It included the new Offender Assessment System (OAS), which was completed by Officers, a personality disorder screen and self-harm

assessment and a final report provided by a Psychologist. It remained to be seen whether this assessment process, previously seen as the responsibility of the Psychology department, would be owned by sentence management staff.

9.11 The advantages of such a thorough assessment are that it forms the basis for sentence planning, and it has the potential to build into a risk and needs analysis of the Whitemoor population. There are few effective offending behaviour interventions for a high risk population at the present time, and careful assessment of the level of risk is necessary to ensure that prisoners are not exposed to non-effective interventions which hold out false hope that risk is thereby reduced. It can also contribute to a needs assessment of the whole population, identifying the likely numbers who stand to benefit from accredited programmes, and those who might benefit from close management within the 'Progressive Care Facility' (PCF), or from further assessment on 'Red Spur' as Dangerous and Severely Personality Disordered (DSPD). Currently, such initiatives have been made available on the assumption that there are those in the population who will benefit, but there is some confusion about the actual value of accredited and non-accredited programmes, and the relative roles of the PCF and Red Spur for the Whitemoor population. **It is recommended that the results of DIA assessment are used as the basis of individual sentence plans, and that this data is aggregated to provide a needs assessment and inform a resettlement strategy for the new Throughcare/Resettlement Policy Committee.**

Prisoner Programmes

Accredited Programmes

9.12 At the time of our inspection, Whitemoor offered the accredited Enhanced Thinking Skills programme (ETS), but no longer ran the core Sex Offender Treatment Programme (SOTP). The numbers qualifying for ETS were relatively low due to it not being appropriate for organised high-risk offenders, the population turning over slowly and one wing having been decanted. The ETS target had been reduced from 120 to 55 completions in the current year (although they were expecting to reach 63), and included approximately 3,300 extra assessment hours in the form of a full PCL-R assessment as part of the national Psychopathy project. This was all entirely appropriate in the circumstances, although the longer Reasoning and Rehabilitation

programme would provide a higher 'dosage' of treatment and might be worth introducing in the future within the new resettlement strategy. It is also likely that a needs analysis would identify a need for both the CALM and CSCP programmes for tackling angry and violent offending respectively.

9.13 It is not considered appropriate to re-start the core SOTP in isolation, given the highly deviant nature of the sex offending associated with a dispersal population. The core programme is not in itself sufficient without follow up work by means of the extended programme or additional behaviour modification. However, given that this prison does have Penile Plethysmography (PPG) equipment, and expertise in its use, and is undertaking to provide specialised assessment for DSPD (see later), PPG assessment should be provided as part of this process. **Prisoners identified as suitable for sex offender treatment should then be transferred to another dispersal prison specialising in this work**. Whitemoor might provide pre-treatment motivational preparation in terms of ETS, or groupwork within the intervention strategy to follow on from DSPD assessment within Red Spur (see later).

Non-accredited Programmes

9.14 Several non-accredited groups were taking place at the time of our inspection. These were, a drug importers course for foreign nationals, a drug awareness course, a 'drinksense' course, anger management, and a Youth Awareness project. There had also been a very creditable initiative taken by one Probation Officer in undertaking the 'From Murmur to Murder' programme for racially motivated offenders on a one to one with a lifer convicted of two racially motivated murders. We would lke to stress the value of this work, although these programmes cannot be relied upon in themselves to reduce re-offending, they achieve several things. Firstly, they can be catalyst for change, or they can consolidate change which has occurred with personal maturity. They can also develop material which may be incorporated into accredited programmes in due course. They also engage prisoners who are not eligible for accredited programmes and who would otherwise be overlooked. Lastly, they contribute to a healthy prison environment and have the value of easing relationships between prisoners and staff and contributing to improved perspective taking and dynamic security. The cautionary note is that staff should not make the assumption

that completion of such programmes in itself necessarily reduces the risk of re-offending.

9.15 At the time of our inspection, it was not possible to see the Youth Awareness project in action. This allows juveniles at risk of offending into the prison with their social workers to meet with selected prisoners from the enhanced blue spur of B wing to be told by prisoners about the realities of prison life, with a view to dissuading them from a life of crime. It was an established project, known to the Magistrates in the area, who could specify it as part of a community sentence. **We urge the prison and local authority to evaluate its effectiveness by retrospectively following up the young people who have taken part in the past.** There is some evidence that such programmes can have a paradoxical effect, as the senior prisoners to whom the young people are exposed are usually those whose physical and mental fitness are well preserved and who appear as strong male role models to young males who often do not have such models in their lives. **This project should be evaluated.**

Public Protection and Pre-release

9.16 There was a clear appreciation on the part of Probation staff that there was a strong public protection element to their work with a dispersal population. Two thirds of the 90 Schedule 1 offenders were subject to restrictions on child visitors, and an efficient scheme for liaison with Social Services and the Police was co-ordinated by the Senior Probation Officer. Figures supplied by the Probation department indicated that 29% of the 50 or so prisoners released each year were released as Category A prisoners. For all prisoners released from Whitemoor there was a formal pre-release strategy to identify each prisoner twelve months in advance and develop a release plan with a multi-agency public protection meeting in each case four months before release. Although liaising with other departments was formally part of this strategy, Psychologists said they were rarely consulted. Psychologists can provide formal risk assessments specifying the nature and level of risk which can contribute to risk management strategies and build over the course of the year into a profile of the risk and needs of this population being released from Whitemoor. **We recommend that the strategy includes such a request in all cases.**

9.17 There was also scope for the Pre-release strategy to involve greater prisoner centred preparation. Even though many of these cases were unlikely to be granted home leave because of the level of risk they presented, there was scope for, at the least, escorted absences, given that many of these men would have been in prison for long periods of time and become out of touch with the pace and complexity of life outside. **We recommend to the Director General that consideration is given to the escorted temporary release of high risk long serving prisoners who are too risky to be granted home leave, but who still require some sort of phased return to the community.**

Sentence Management

9.18 An active and efficient Sentence Management unit was under a Governor IV, with a Principal Officer, two Senior Officers and several Officers and Discipline Clerks who took responsibility for sentence management for lifers and determinate prisoners, parole, the new dispersal induction assessment and programme management for ETS. An impressive database held sentence management information, including comments from Personal Officers from bi-monthly sentence plan reviews. All Personal Officers were required to carry out these reviews and record comments which were subsequently made available within sentence plan dossiers for annual reviews. The system ensured between 80% and 100% compliance by Personal Officers by actively chasing contributions. Annual DCR and lifer boards took place on the wings where the wing 'admin' Senior Officer was provided with a completed sentence plan dossier compiled by Sentence Planning clerks in advance of the review. This system also ensured that residential staff were connected with the sentence planning process and that sentence plans were live documents holding up to date information and able to inform decisions about individual prisoners. The same system provided regular print outs of the top 25% of targets set in sentence plans and provided staff with a good sense of how sentence planning worked across the establishment to provide prisoners with positive goals.

9.19 The management of sentence planning provided an excellent potential infrastructure for co-ordinating the inputs of different departments engaged in the resettlement process. However, neither Psychologists nor Probation staff contributed to sentence planning or review. The only input from either of these departments being

F75 reports for lifers and Cat A reports. The sentence management system was therefore not truly multi-disciplinary and was not informed by the specialist skills of these two disciplines. **The sentence management system should be built upon professional assessments of risk and need and provide a framework for integrating the work of the specialists with personal officers and other sentence planning staff. This should be addressed by the new Throughcare/Resettlement committee.**

Dangerous and Severe Personality Disorder (DSPD)

9.20 This prison had been selected to operate as a pilot site for the assessment of DSPD in offenders, alongside Rampton Special Hospital. It was to the credit of managers and staff that they had an understanding of the needs of these offenders and were in a position to bid for funding to develop work in this area at the time that the government drafted its paper outlining a possible framework for their identification and management.

9.21 Previous to the identification of Red Spur as the national DSPD pilot, a Progressive Care Facility (PCF) had been created incorporating the Segregation Unit, hospital and a high support unit (E wing) which were located alongside one another. This allowed for an individualised approach to those unable to manage themselves on normal location and who either sought isolation or who were placed in isolation because of their disruptive behaviour. This approach sought to understand the individual's needs and to encourage appropriate behaviours and put in place supports which would allow a return to normal location, thereby preventing such cases being long term incumbents of segregation units.

9.22 The management of the hospital had recently been separated from the joint management of E wing and the Segregation Unit. At the time of our inspection, the concept had drifted from the original approach for a combination of reasons. Firstly the staff had not received sufficient training in personality disorder to understand how this manifested and how it should be managed. Secondly they were not profiled to have the necessary time to spend engaging with prisoners as individuals. The routines, particularly of the Segregation Unit where prisoners had to be exercised, allowed to shower and prepare for adjudication separately did not allow for a full

regime to be run on E wing. Thirdly there was not sufficient mental health input from staff with mental health training. There was some input from Psychologists and Probation staff, but this happened in the margins and was not integrated into the regime of the wing. Without proper clinical governance and sufficient trained staff, the facility was in danger of being run to meet the needs of staff rather than prisoners, with those whose problems manifested in challenging and disruptive behaviour being unlocked less frequently than those who were more inadequate and withdrawn.

9.23 The prisoners in the Segregation Unit and E wing were in effect DSPD prisoners, that is, those with disordered personalities which manifested in disruptive or disturbed behaviour, although they were not labelled as such. This initiative, begun in November 1998, had been somewhat overtaken by the subsequent identification of Red Spur on D wing as the location for the new national DSPD pilot for serious offenders with personality problems. These prisoners overlapped considerably with those already being managed within the PCF, and indeed the first cohort included several prisoners drawn from E wing. This development required a strategic re-think of the roles of the two facilities with respect to one another, a re-think which had not taken place by the time of our inspection, and which was hampered by the fact that the two units were supported by two different funding streams. There was scope for preparatory screening and motivational work to take place on E wing, and for this wing to receive prisoners who withdraw voluntarily from Red Spur, or who are withdrawn for risk management purposes, or who have completed the assessment period but are suitable to be returned directly to normal location. Ideally, the staff for the two wings should be interchangeable, so that the expertise from Red Spur can be brought into the PCF. **We recommend that the strategic roles of the PCF and Red Spur within Whitemoor are re-examined.**

D wing, Red Spur

9.24 This had been open for 10 weeks at the time of our inspection, following several months of planning, and the first group of 12 prisoners were coming to the end of their twelve week assessment period. The project was funded and overseen from the Home Office which also took responsibility for its evaluation. The whole period was divided into three/four week stages, with the intention of starting a new group of twelve prisoners every four weeks. Participation was voluntary on the part of prisoners and could be withdrawn at any point.

9.25 The programme was divided between assessment and small group work which provided an introduction to and assessment of prisoners' likely response to group interventions. Structured and guided association was available in the evenings in which staff interacted with the prisoners. The first stage involved accredited education courses in the morning covering Healthy Living and Working with Others, and clinical assessment groups in the afternoon provided mainly by Psychologists and covering topics to do with personal and social development and emotion management. The second stage moved into individualised clinical assessment alongside a programme of wing based creative work. The third stage continued clinical assessment, in which feedback was provided to individual prisoners and interest groups were begun in creative and expressive activities.

9.26 There were 24 allocated Prison Officers, three Senior Officers and a Principal Officer shared with the rest of D wing. Discipline staff had been trained in understanding personality disorder, Senior Officers were also trained in providing supervision and the basic grade staff in supervision awareness. A Registered Mental Nurse and a Consultant Psychiatrist had been seconded from Rampton until the end of the year 2000. It was not yet clear how the necessary clinical governance was to be continued after that point. Psychology input was provided by a Senior, a Higher and a Psychological Assistant.

9.27 It was planned to follow up the assessment process by intervention, for which funds were available from April 2001. It was not clear yet what interventions would be provided as this would be informed by the results of the assessment, and the hiatus which would be created once the assessment was complete was a source of concern.

It was recognised that the process of assessment would unmask treatment needs and raise expectations which could not be met immediately, and that this might require some form of "supportive holding" for some in the interim.

9.28 The first group had not completed the whole programme at the time of our inspection, so it was impossible to judge how it would be received and what the problems would be. It seems very ambitious to propose to assess in such depth what would amount to approximately 144 prisoners per year, especially as each prisoner will take the equivalent of one week of a Psychologist's time to administer and write up the assessment battery. Resources also have to be found to develop and ultimately deliver interventions for a proportion of those assessed. It seems inevitable that the current target will need to be reduced to be sustainable. It is also important that proper clinical governance is sustained. Without this the unit will come to be managed solely by uniformed staff and lose its multi-disciplinary character and clinical purpose. **Some form of mental health input should continue to be provided, including input from a nurse manager into the management team and ongoing psychiatric assessment alongside psychological assessment.**

Personal Officer Scheme

9.29 The Personal officer scheme was not consistently applied across the prison. Each wing, seemingly, operated it's own scheme. Whilst most of the components of all the different Personal Officer Schemes were essentially the same, examples of good practice were not shared.

9.30 *In particular the Personal Officer scheme on B wing was a model of best practice.* A computer programme had been developed by a member of staff to input all new prisoners assigning them to Personal Officers. *The programme produced an 'introduction sheet' which required Personal Officers to sign that they had introduced themselves to prisoners and prisoners to sign confirming that their Personal Officers had introduced themselves; this was an example of good practice that should be extended throughout the prison. The programme was also able to produce a print out of all prisoners and their Personal Officer and highlight lifer prisoners ensuing that they were assigned to a lifer trained Personal Officer.*

9.31 The assignment of lifer trained Personal Officers to lifer prisoners elsewhere in the establishment was patchy. Unit managers said that they attempted to give lifer prisoners lifer trained Personal Officers but accepted that this was not always the case. **Life sentence prisoners should always be given Personal Officers who has undertaken lifer training.**

9.32 Common to all the schemes was the routine checking by unit managers of entries made in history sheets by Personal Officers that defined the nature and level of the contact they had had with prisoner in their charge. *Each week managers selected a random sample of history sheets and checked entries. Where no entries were found Personal Officers were required to explain why. This was an example of good practice.*

9.33 We examined a sample of history sheets and found the entries made in these to be of a high standard. *Staff should be commended for the quality of their work as Personal Officers.*

9.34 *The questionnaire undertaken by inspectors prior to the inspection visit found that 89% of prisoners knew their Personal Officers and 45% said that their Personal Officers would seek them out once or more in an average week to see how they were getting on. This was an example of good practice.*

CHAPTER TEN

RECOMMENDATIONS AND EXAMPLES OF GOOD PRACTICE

To the Secretary of State

10.01 Prisoners should not be released into the community from Whitemoor and other high security prisons without any experience of lower security conditions to lessen their institutional dependency, prepare them for life outside and thereby reduce the risk to the public. (5.35)

To the Director General

10.02 Consideration should be given to the escorted temporary release of high risk long serving prisoners who are too risky to be granted home leave, but who still require some sort of phased return to the community. (9.17)

10.03 Many Category C prisons were reluctant to take prisoners straight from Whitemoor. Such national issues should be looked at by the Prison Service Headquarters Population Management Unit. (5.34)

10.04 Whitemoor should address the needs of ageing prisoners and find ways of allowing prisoners with mobility problems to live on normal location. (3.05)

10.05 A review of the role of voluntary testing in prisons in general and Whitemoor in particular should be undertaken. (4.18)

10.06 Accumulated visits should be facilitated for all prisoners in prisons near to their homes at six monthly intervals. (5.30)

10.07 Prisoners not of Category A status, should be reviewed for recategorisation at least every 12 months. (5.32)

10.08 A procedure, similar to that used for high-risk Category A prisoners, should be introduced for all prisoners subject to the Protection from Harassment Act as a matter of urgency. (7.44)

10.09 The Lifer Management Unit should consult with the Psychology and Probation staff at Whitemoor with a view to developing national guidance on regimes for exceptionally long term lifers including whole tariff lifers and high-risk lifers who are unlikely to achieve release. (9.09)

To the Director of the High Security Estate

10.10 There should be consistency across the dispersal estate in terms of property allowed in possession. (2.15)

Special Secure Unit

10.11 (Not for publication)

10.12 Prisoners could not move from the establishment because they had not completed the required offending behaviour work, however the required offending behaviour work could not be carried out at Whitemoor. This anomaly needs to be addressed. (5.36)

10.13 A greater range of offending behaviour courses should be available to vulnerable prisoners. (5.52)

10.14 Admissions to healthcare should be restricted to the number that can be safely nursed there in light of the staff available. (6.06)

10.15 A quality assurance plan for the prison including clinical governance issues with annual objectives and an annual report on the progress made should be developed in conjunction with local NHS quality assurance work. (6.15)

10.16 Prisoners identified as suitable for sex offender treatment should then be transferred to another dispersal prison specialising in this work. (9.13)

To the Governor

Reception

10.17 A separate room should be identified for the use of healthcare staff in Reception so that they can see all new receptions in private. (2.05)

10.18 Local information should be given to prisoners in Reception to help them cope with the first 24 hours of custody. (2.06)

Discharges

10.19 The need for double cuffing should be on the basis of individual risk assessment by the discharging Principal Officer. (2.18)

First Night

10.20 Prisoners should be issued with an initial induction pack. (2.19)

10.21 Phonecards should be included in the initial reception packs issued to prisoners. (2.20)

10.22 The wing manager should interview all new receptions separately and in private during their first night. (2.21)

Induction

10.23 Prisoners should receive and be helped to understand detailed information on prison life through a comprehensive, multidisciplinary, induction programme. (2.28)

10.24 Separate arrangements should be made for prisoners who cannot access the normal induction programme. (2.29)

Legal Aid

10.25 Arrangements should be made for legal services staff to undertake the new Legal Services course as a matter of urgency. (2.33)

10.26 The Legal Services information booklet should be made available in other languages. (2.35)

Residential Accommodation

10.27 The auditable cell call system should be used properly as a management tool to check that cell bells are being responded to promptly in all areas. (3.03)

10.28 The offensive displays policy should be relaunched. (3.06)

10.29 The cleanliness of the SSU should be improved. All units should aim to achieve the level of cleanliness seen in B wing. (3.09)

10.30 Showers should be equipped with shower mats, and somewhere to hang dressing gowns/towels when prisoners are in the shower. (3.11)

10.31 All ground floor shower rooms should be re-floored where necessary so that water can properly drain out of these areas. (3.12)

10.32 The prison should ensure that all prisoners are given proper training before they are allowed to use the mini gym facilities on the wings. (3.14)

10.33 Prisoners' in-cell sanitary arrangements should be effectively screened. (3.16)

Clothing and Possessions

10.34 The rules about clothing should be properly and consistently applied across the population. (3.20)

10.35 Mattresses and bedding in the Segregation Unit should be replaced when they become worn or stained. (3.21)

Hygiene

10.36 Colour coded equipment should be used properly as per the system laid down. (3.27)

Anti-Bullying Strategy

10.37 Programmes to support victims and confront bullies should be developed as a matter of urgency. (4.03)

10.38 All staff should receive formal training in respect of Anti-Intimidation procedures. (4.04)

Substance Use

10.39 The strategy should be developed to include an action plan. (4.07)

10.40 An appropriate intervention for those prisoners who were still using drugs and those who would not fit the criteria for the Rehabilitation Programme should be developed. (4.24)

10.41 Physical Education Instructors need further training in order to offer appropriate health promotion. (4.29)

10.42 Further development of the Importers Course to include work on victim awareness is recommended. (4.33)

Equal Opportunities

10.43 Prisoners should be issued with condoms both within the establishment and on discharge. (4.49)

10.44 The profile of equal opportunities and other issues of diversity need to be improved at Whitemoor. (4.50)

Race Relations

10.45 A prisoner representative for D wing should be appointed, as should prisoner representatives from the Healthcare Centre and E wing or the Segregation Unit. (4.51)

10.46 The establishment should continue its efforts to recruit members of outside organisations to attend the Race Relations Management Team meetings. (4.58)

10.47 The profile of the Race Relations Liaison Officer, his Deputies and the prisoner representatives should be raised. (4.59)

10.48 Ethnic monitoring figures should be more comprehensively presented using percentages to highlight any disproportional figures and setting ranges where there are very small numbers involved. (4.65)

Foreign Nationals

10.49 The establishment should reinstate the provision of a five minute phone call in lieu of visits per month funded from the General Purpose Fund for Foreign Nationals. (4.78)

10.50 Foreign Nationals should become a standing item on the Race Relations Management Team meeting. (4.83)

Suicide Prevention

10.51 The Listeners' representative should present their statistics preserving anonymity. (4.97)

10.52 Care should be given to identifying appropriate rooms on each house block that neither stigmatise the individual in distress nor place the Listener at risk. (4.101)

Applications

10.53 A system of recording applications should be introduced which allows for an audit trail to ensure that applications are dealt with at the lowest possible level in the chain and outcomes of action taken are recorded. (4.107)

10.54 Boxes should be made available for prisoners to post applications directly to the Board of Visitors. (4.108)

Request and Complaints

10.55 The Head of Custody Office should ensure that wing logbooks record the correct dates and that prisoners actually receive answers to their request and complaints on the dates recorded. (4.109)

10.56 The Head of Custody Office should ensure that every form issued is followed up and either completed or returned signed by the prisoner stating that he wishes to withdraw the application. (4.111)

Good Order

10.57 In every case a manager should assess the risk of a prisoner resisting the order to be located in the Segregation Unit, before there is any contact between the prisoner and the control and restraint team. (5.06)

10.58 In every case a risk assessment as to the need for handcuffs should be made by the manager concerned who should then record in detail the reasons behind the judgement. (5.06)

10.59 Segregation Unit staff should not carry out removals, but should receive the prisoner once he enters the unit. (5.06)

Segregation Unit

10.60 Some cells we saw were in need of refurbishment and/or redecoration. (5.09)

10.61 There should be a review of facilities in all cells in the Segregation Unit. (5.09)

10.62 Prisoners in the Segregation Unit should routinely have the opportunity for a daily shower. (5.11)

Vulnerable Prisoners

10.63 The conversion of a workshop into an education centre for vulnerable prisoners should be completed as soon as possible. (5.46)

Healthcare

Staffing

10.64 A skills audit should be conducted alongside the assessment of the needs of healthcare patients with a view to having the appropriate skill mix to meet the needs of prisoners in Whitemoor. (6.09)

Continued Professional Development

10.65 All staff whether doctors, nurses or non-nurse trained healthcare officers should have a training plan aimed at enhancing their skills to meet the needs of patients. (6.14)

Needs assessment and commissioning healthcare

10.66 Once the needs analysis has been completed joint working should continue and be further developed to make sure that in addition to clinical services the educational and training needs of healthcare staff are taken into account when the Health Authority negotiates the contract with local NHS education providers. (6.17)

Services to patients

10.67 The treatment room should be upgraded to meet modern standards. (6.19)

10.68 Taps that do not offer ligature points should be fitted. (6.20)

10.69 Sluice and bathroom should be separated. (6.21)

10.70 Therapeutic activity tailored to the needs and capabilities of individual patients should be available every day. (6.24)

10.71 The operation of this nurse prescribing group protocol should be evaluated and any necessary change to the contents of the list made. (6.27)

10.72 F213s should be audited regularly and unusual findings further explored. (6.28)

Pharmacy

10.73 A maximum/minimum thermometer should be obtained and the range of temperatures should be monitored and recorded on a daily basis. The fridge should be defrosted at regular intervals. (6.32)

10.74 The reference sources available to the healthcare staff were out of date. Current editions should be made available and kept updated in the future. (6.34)

10.75 The treatment rooms must be cleaned and decorated, contain sinks with hot and cold running water and fridges with maximum minimum thermometers. (6.35)

10.76 All medicines should be stored in locked cupboards and the trolley should be replaced. The boxes that can be locked must be kept locked. (6.35)

10.77 Patient returned medicines must never be reused. (6.38)

10.78 The technician or healthcare staff should supply, in emergencies, the stock bottle bearing all the details and a system should be in place, for example dual labelling, so that the pharmacist can be sent the second label for her to be reassured the correct medication has been handed out. (6.39)

10.79 A written In-Possession Policy should be drawn up. (6.40)

10.80 A formal protocol for special sick should be drawn up by the Medical Officer. (6.41)

10.81 A notice should be displayed at the treatment room to ensure that prisoners are aware of the availability of the relevant leaflet for them to consult where a leaflet is not able to be supplied directly to them. (6.42)

10.82 The pharmacist should be involved in the development and drawing up of the much needed policies to improve the pharmaceutical service to prisoners. (6.46)

Dental Care

10.83 A value for money exercise should be undertaken to ascertain the effectiveness of the contract. (6.49)

10.84 Emergency drugs and a positive pressure oxygen cylinder need to be provided in the surgery. (6.54)

10.85 Provision of further electrical sockets would aid cross infection procedures. (6.57)

Education

10.86 A part-time integrated programme that uses the advantages of a stable population in a long stay establishment should not be missed. (7.02)

10.87 The evening education programme should be restored. (7.05)

Physical Education

10.88 There should be monitoring of attendance at PE activities to ensure fair opportunities for all prisoners. (7.19)

10.89 There should be a greater range of structured classes. (7.20)

10.90 Opportunities leading to qualifications in PE activities should be provided. (7.21)

Employment

10.91 Prisoner pay for education should be reviewed and brought into line with other activities such as the Wing Orderlies. (7.26)

10.92 Prisoners should receive basic training in health and hygiene and kinetic lifting etc during the Induction programme. (7.28)

10.93 A waiting list should be kept for prisoners wanting a higher paid job if they are prepared to accept other work in the interim. (7.29)

Training Provision

10.94 The wearing of overalls should be introduced in all departments. (7.34)

10.95 The training unit should explore the possibility of introducing the Intermediate Construction Certificate (ICC) qualification. (7.35)

10.96 Formal links between education and training should be established in order to disseminate information. (7.36)

10.97 Learning and assignment packs should be provided to prisoners to enable them to acquire underpinning knowledge when workshops are closed. (7.37)

Letters and Telephone

10.98 Staff should not routinely read all prisoners' mail. (7.38)

10.99 Privacy hoods to card telephones should be replaced. (7.41)

Visits

10.100 Additional rooms should be made available for professional visits. (7.45)

10.101 The number of visits should be standardised across the whole prison. (7.48)

10.102 A new, more suitable, wheelchair should be purchased for the use of visitors. (7.50)

Catering

10.103 Food hygiene training should be provided for all staff and prisoners who prepare, or serve, food. (8.02)

10.104 The prison should review the dietary status of all prisoners and ensure that the kitchens supply appropriate alternatives to fried potatoes. (8.03)

10.105 The practice of holding cooked food in heated trolleys for up to three hours prior to service is unacceptable. The prison should immediately review this practice and considerably reduce the time between cooking and serving food. (8.04)

Prison Shop (Canteen)

10.106 The Governor grade with responsibility for the prison shop should investigates the significance of claims made by prisoners and satisfy himself of the validity of Sutcliffe Catering's stated intention to repay the money. (8.09)

10.107 It should be explained to prisoners, as it was to inspectors how transactions for goods are made to avoid any further misunderstanding. (8.10)

10.108 Minutes should be taken of meetings and posted on all residential units so that prisoners have access to information first hand. (8.11)

10.109 All the prices charged on the canteen list should be examined and revised so that none are priced above RRP. (8.12)

Maintenance of the Establishment

10.110 Vehicle access should be provided to all the building elevations. (8.15)

10.111 The small repair system should be made to work effectively. (8.17)

10.112 Remedial work should be undertaken promptly to secure the bricks in the lintel facings. (8.19)

10.113 The incoming work store should have mechanical air extraction and be fitted with smoke and fire detectors. (8.23)

10.114 The Arts and Crafts workshop should be completed promptly and brought into use. (8.25)

10.115 Ventilation grilles should be checked as part of the daily cell inspection by wing staff, and the grilles kept clear of obstruction. (8.27)

Fire precautions

10.116 Fire Awareness training for all staff should be brought back on programme. (8.31)

10.117 SDBA training should be brought back on programme. (8.32)

10.118 All departments should have at least one evacuation drill each year, some of which should take place while the prison is in patrol state. (8.33)

10.119 Smoke and fire detectors should be tested as required by legislation. (8.34)

10.120 Inundation points should be fitted to all cell doors. (8.35)

10.121 The hose reel nozzles should be fitted with quick release connections to enable rapid changeover. (8.36)

Health and Safety

10.122 The rewriting of the Policy/Statements should be completed promptly. (8.38)

10.123 Safety Audits should be completed to programme. (8.39)

10.124 There should be a structured method for ensuring that all prisoner cleaners receive appropriate training, and the training should be recorded using the F2055C forms. (8.42)

10.125 A survey should be made of the needs of disabled persons throughout the prison, and facilities provided. (8.43)

Provisions for Life Sentenced Prisoners

10.126 The LLO should liaise with Lifer Management Unit to ensure that all Summary dossiers are complete. (9.06)

10.127 Managers responsible for staff detail should ensure that the lifer group is part of the profiled work and that staff are made available. (9.08)

Assessing Offending Behaviour

10.128 Results of DIA assessment should be used as the basis of individual sentence plans, and this data should be aggregated to provide a needs assessment and inform a resettlement strategy for the new Throughcare/Resettlement Policy Committee. (9.11)

Prisoner Programmes

10.129 The prison and local authority should evaluate the effectiveness of the Youth Awareness Project. (9.15)

Public Protection and Pre-release

10.130 Psychologists should contribute to risk management strategies and the risk and needs of this population being released from Whitemoor. (9.16)

Personal Officer Scheme

10.131 Life sentence prisoners should always be given Personal Officers who have undertaken lifer training. (9.31)

EXAMPLES OF GOOD PRACTICE

Reception

10.132 All electrical equipment was PAC tested by Works Department staff and, once checked, sealed with individually numbered property seals. This was good practice and helpful as part of the anti-bullying strategy in place in the prison. (2.11)

10.133 We were pleased to discover that Reception staff issued prisoners with plastic containers to put the contents of any confiscated glass containers into. This was an example of good practice. (2.16)

10.134 All new receptions had a new property card filled out for them when their property was checked. This was good practice as was the photocopying of property cards on a prisoner's discharge from the establishment as this helped staff deal with any future property queries that might arrive for them to deal with. (2.17)

Legal Aid

10.135 The legal services staff were on a separate attendance pattern, from other Prison Officers, which enabled legal services to be available during the main day Monday to Friday: this was an example of good practice. (2.34)

10.136 New prisoners were also given a booklet relating to legal services had been produced by Legal Services staff; this was good practice. (2.35)

10.137 Legal Services Officers were based in the Library and were well resourced including their own computer. Legal reference books were available including a copy of Archibald's on CD Rom. Generally the provision of legal services was well organised and staff with whom we spoke appeared dedicated and enthusiastic about their work. (2.38)

Clothing and Possessions

10.138 Initial bed packs and toiletry/catering packs were given to prisoners on their first night and prisoners were usually given a new pillow and new mattress on their arrival to the establishment. This was extremely good practice which was financially possible because of the length of time that prisoners stayed at Whitemoor. (3.21)

10.139 Kit was marked with prisoner unique numbers so that if a prison kit was laundered it could be returned to the correct person. This was also good practice and meant that prisoners could hold on to well fitting items of prison kit that also prevented undue waste. (3.22)

Hygiene

10.140 We were particularly impressed to find out about the weekly descaling of toilets that took place, carried out by the Cleaning Officer and a cleaning orderly. This was an example of good practice. (3.27)

Anti-Bullying Strategy

10.141 An Anti-Intimidation Committee, which included members of the Senior Management Team, met bi-monthly to examine all reported incidents of bullying/intimidation or violence; this was an example of good practice. (4.01)

10.142 The co-ordinator was able to correlate a high number of incidents with a period when a high number of prisoners had been received from a particular establishment; this was an example of good practice. (4.05)

10.143 Generally were impressed with the procedures for Anti-Intimidation at Whitemoor. They had been well thought out and the co-ordinator was enthusiastic and knowledgeable about the subject. (4.06)

Substance Use

10.144 A needs analysis of substance use amongst its prisoners. This was to inform the development of the proposed Directorate of High Security Substance Abuse Rehabilitation programme. (4.09)

10.145 The detoxification provision with its partnership approach was good practice. (8.14)

10.146 Management of HIV+ prisoners appeared to work well as internal confidentiality was maintained and access to outside services facilitated. (4.15)

10.147 Where prisoners were actively working on their drug problem, the MDT Award Guidelines for Adjudicating Governors suggested the use of suspended awards. (4.36)

Race Relations

10.148 We were pleased to find out that the establishment had hosted a One World Week in 1999. (4.64)

Foreign Nationals

10.149 The Foreign Nationals Group at Whitemoor was an example of good practice and to be commended. (4.75)

Suicide Prevention

10.150 The meetings considered ongoing agenda items such as training and all serious incidents in depth with a report on each new prisoner who had a F2052SH opened that month. This was good practice and made senior staff aware of the amount of distress in the prison. (4.92)

10.151 A daily briefing note, which included the name, location and place of work, was presented to the Governor 4 who was responsible for policy. All closed F2052SHs were brought to the Chairman of the Suicide Awareness Management Team and were audited to improve the quality of the entries. This was good practice. (4.93)

10.152 A monthly newsletter for This was used to reinforce the principles of suicide awareness and to keep staff up to date on changing policy e.g. The Human Rights Act and how it affected prisoners. Guidelines had been produced on how to complete F2052SHs. This was good practice. (4.105)

Request and Complaints

10.153 Prisoners were allowed to have up to four 'live' forms in-possession at any one time. (4.109)

10.154 All replies to request and complaints were typed to ensure that prisoners could read them. We were told that this did not delay replies. This was an example of good practice. (4.110)

Good Order

10.155 It was encouraging to find a management team that was genuinely interested in analysing and then developing the essential constituents of productive staff/prisoner relationships. (5.05)

Violent Incidents

10.156 This reflected a reduction in the level of assaults on officers and other prisoners. (5.07)

Segregation Unit

10.157 We were impressed by the fact that Segregation Unit staff encouraged wing personal officers and other to visit prisoners during their time in the unit. (5.13)

10.158 We were also impressed with the policy and practice of E wing. This was imaginative, courageous and in the best interests of the difficult to manage prisoners who were held there and for the good order of the prison. The idea was to attempt to help prisoners emerge from their patterns of unacceptable behaviour by giving them individual attention and as much trust as possible. (5.14)

Incentives and Earned Privileges Scheme (IEP)

10.159 All prisoners being received at the prison started on, at least, the standard level. Even where prisoners had been on a basic regime level at their previous establishment. (5.39)

Healthcare

Staffing

10.160 At night there were always at least two people on duty, one of who was always a qualified nurse. This is good practice and should be continued. (6.05)

10.161 We were pleased to hear that negotiations had taken place which lead to a joint 'nurse bank' with the local acute trust. This is good practice and when established should be extended to the local community health services. (6.08)

Services to patients

10.162 We were exceptionally pleased to find that in-room TV was available to all standard and enhanced regime patients; something that we have not found in other prisons. This is good practice. (6.18)

Pharmacy

10.163 Internal and external products were separated. Patient specific items were separated from stock items. (6.36)

Employment

10.164 Prisoners who were sacked from the job were permitted to apply for new employment immediately; this was good practice. (7.27)

Training Provisions

10.165 Instructors provided additional training and used their industrial experience to provide an extended training programme, allowing prisoners to gain skills exceeding the requirements of the basic qualification. This is good practice. (7.31)

10.166 In some cases, particularly in painting and decorating and furniture production, some examples of exceptionally high quality work in completed practical tasks were seen. (7.33)

Letters and Telephone

10.167 Foreign National prisoners were given an airmail letter; this was good practice. (7.39)

10.168 The telephone in the Segregation Unit was housed within its own kiosk; this was excellent and, finance permitting, this arrangement should be extended to all telephones in the establishment. (7.41)

Visits

10.169 There was a full-time voluntary crèche worker arranged through the Probation Department; this was an example of good practice. There were also volunteers from the WRVS (Women's Royal Voluntary Service) who provided a shop. (7.46)

10.170 The visit's SO was keen to inform us of the children's party he had arranged for Christmas. Sponsorship had been gained from local business's to provide presents and a Father Christmas and other entertainment was to be provided. (7.49)

Religious Activities

10.171 The Muslim prisoners had their own room for worship which was not used by other religious denominations. All of the pictures in the room were related to their own faith and the notice board was for their exclusive use. This was good practice. Compasses were available for prisoners who were not able to attend prayer sessions so that they could pray in their cells, as on some occasions there had been a shortage of space. (7.55)

Prison Shop (Canteen)

10.172 Some 500 items were available on the canteen list; this was impressive and the most comprehensive list of products available from any prison shop inspectors have found. (8.06)

10.173 Thursdays were used for bagging up or putting in boxes items from the special lists and time permitting, prisoners (rotated by wing spurs) would be allowed to use the prison shop again; this was good practice. (8.07)

Provisions for Life Sentenced Prisoners

10.174 Prisoners were able to purchase a wide range of goods from the prison shop and sufficient facilities were provided on the residential units to enabled them to freeze, refrigerate and store perishable items and to prepare their own meals; this was an example of good practice. (9.03)

10.175 The LLO provided a clinic one day a week which involved him being available on the wing to deal with ad-hoc concerns from prisoners; this was an example of good practice. (9.07)

10.176 The LLO had also produced an information sheet for lifer prisoners which he intended to produce monthly. (9.07)

Personal Officer Scheme

10.177 In particular the Personal Officer scheme on B wing was a model of best practice. (9.30)

10.178 The programme produced an 'introduction sheet' which required Personal Officers to sign that they had introduced themselves to prisoners and prisoners to sign confirming that their Personal Officers had introduced themselves; this was an example of good practice that should be extended throughout the prison. The programme was also able to produce a print out of all prisoners and their Personal Officer and highlight lifer prisoners ensuing that they were assigned to a lifer trained Personal Officer. (9.30)

10.179 Each week managers selected a random sample of history sheets and checked entries. Where no entries were found personal Officers were required to explain why. This was an example of good practice. (9.32)

10.180 Staff should be commended for the quality of their work as Personal Officers. (9.33)

10.181 The questionnaire undertaken by inspectors prior to the inspection visit found that 89% of prisoners knew their Personal Officers and 45% said that their Personal Officers would seek them out once or more in an average week to see how they were getting on. This was an example of good practice. (9.34)