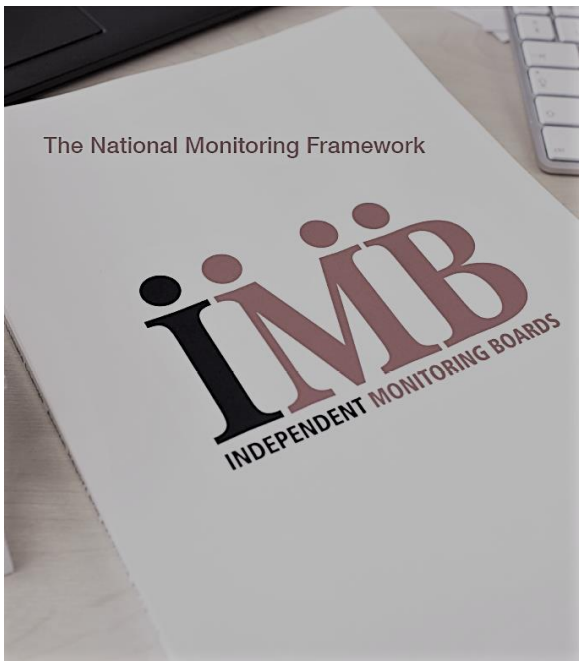
INDEPENDENT MONITORING BOARDS

IMB National Annual Report 2017/18



national preventive mechanism

June 2019

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Introduction

Independent Monitoring Boards are an important part of the independent oversight of prisons and places of immigration detention. Our members are a regular presence in those closed environments, monitoring the treatment and conditions of prisoners and detainees, regularly reporting what they find to those running the establishment, and dealing with queries and concerns from individual prisoners. They are unpaid, but have statutory powers to go everywhere, talk to prisoners and see documents.

Their findings and activities, during the year, are captured in their published annual reports. This national report brings together those findings for the period from late 2017 to 2018. It covers a period when the great majority of prisons were emerging from a significant crisis: the combined impact of serious staffing shortages and an influx of new psychoactive substances, compounded by inadequate maintenance arrangements. It therefore chronicles a system that was overall in slow and sometimes fragile recovery, dealing with the after-effects of that crisis, both for prisons and the treatment and potential rehabilitation of prisoners. It also raises some underlying issues that directly affect prisoners, but which are not under the control of the prison or criminal justice systems: such as the availability of mental health services and post-release support, particularly housing.

In my own visits to prisons, I could not help but be struck by the visible decline in safety, control and the expectations of both prisoners and staff since I last visited them, as Chief Inspector of Prisons, in 2010. It is therefore welcome that additional resources have now been put into prisons, with an influx of staff, but it will take time before prisons can not only stabilise, but progress. There are some promising initiatives under the prison reform programme. They include

- the roll-out of offender management in custody (OMiC)
- the prison estate transformation programme
- lessons learnt from the then Prisons Minister's ten priority prisons project, and responses to the Inspectorate of Prisons' urgent notification process
- revised processes for supporting prisoners at risk of suicide and self-harm
- the new drug strategy
- embedding the CSIP (challenge, support and intervention) process for violence reduction
- new processes and contracts for dealing with prisoners' property.

The report therefore provides a benchmark for the future, to assess the extent and impact of these and other changes. From now on, we will be publishing a digest of IMBs' annual reports every three months, and doing further work with Boards to identify emerging themes and issues and to record progress against the hopes and expectations of the prison reform programme.

Dame Anne Owers. National Chair, Independent Monitoring Boards

Section One: IMB findings

1. Staffing

1.1 Staffing issues dominated annual reports in this period. They affected every kind of prison and every aspect of prison life: from security and safety to healthcare, activities and rehabilitation. During this period, boards were reporting the arrival of new staff, and in most cases an end to the severe regime restrictions which had characterised the previous year. But the impact of staff shortages was far from over. There were still significant difficulties across nearly all kinds of prisons: some were still struggling to deliver acceptable and consistent regimes, and nearly all were expressing concerns about the safety implications of a high proportion of inexperienced young staff, as regimes were gradually being relaxed and prisoners were out of their cells for longer.

1.2 Among local prisons, including those in the high security estate, problems continued well into 2018. The Winchester board was still reporting a restricted regime up to mid-2018, with the majority of prisoners spending up to 23 hours a day in their cells; at Belmarsh there were severe restrictions to the regime impacting on both safety and activity; the Bristol board noted that the regime was able to run on 'green' (normal) for fewer than a third of the days in the year; at Birmingham, prisoners were locked in their cells for up to 20 hours a day; 60% of prisoners in Wandsworth at the beginning of 2018 had no activity, though this had improved by the year end.

1.3 The Woodhill report, issued in mid-2018, encapsulates the concern and frustration this caused, over a significant period:

> 'our serious concerns over staff shortages and restricted regimes, highlighted in the reports of 2014 and 2015, worsened in 2016/17, and continued and deepened during this reporting year [2017-18]. All grades of staff and all areas of the prison were affected. The consequences were chronic and resulted in severe regime restrictions, difficulties developing [staff] ownership on units, inconsistent delivery of services and variable interpretation of rules.'

1.4 The situation in many training prisons was no better. During 2017, the reports of boards at Gartree, Isis and Holme House reflected the impact of staff shortages on their core role and on prisoner well-being. At Isis, the board reported that 'expensively provided facilities are woefully under-used' and prisoners were in their cells for over 14 hours overnight and sometimes for between 25 and 28 hours at the weekend.

1.5 There was some improvement in 2018, but it was slow. The board at The Mount, recovering from an episode of concerted indiscipline, found that at no time up to early 2018 was there a full regime suitable for a category C training prison, and that some prisoners were not even getting time in the fresh air: 'It was the prisoners who suffered most when the prison was in its downward spiral and who have been most affected by its slow recovery'.

1.6 Boards in prisons such as Wayland, Wealstun, Portland and Highpoint continued to report significant difficulties in delivering a consistent regime. As late as September 2018, the Onley board was still reporting shortages and a restricted regime, especially at the weekend:

> *'the prison's wide range of education and training opportunities…. are rendered less effective by staffing shortages which impact on the timely allocation to work/education, an absence of in-cell education opportunities and interruptions to the regime. Greater emphasis needs to be placed on trying to replicate a working day…but the scope for this is very limited due to constant staffing issues.'*

1.7 Women's prisons, too, presented a mixed picture. Some boards noted improvements in regimes and staffing, but at Eastwood Park, even by October 2018, there were still significant concerns, with the prison rarely able to operate at full capacity for a whole day, and the board 'remained concerned that … it is impossible for prison management to maintain the full range of rehabilitative activities [even though] prisoners are spending more of their sentence at Eastwood Park'.

1.8 The high security estate was not immune from these pressures, especially as the heightened security clearance requirements caused significant delays in recruitment. All four Category A prisons holding sentenced men reported staff shortages: at Whitemoor nearly half the scheduled education hours were cancelled, 75% of them due to staff shortages; the Long Lartin board reported that there was too little time out of cell.

1.9 As new staff arrived and regimes relaxed, there were different concerns. Boards reported increased concerns about safety, as prisoners were out of their cells more, but interacting with a high proportion of new and inexperienced staff. Nearly all boards, across all kinds of prisons, commented on staff inexperience and its effects.

1.10 Four boards (Brixton, Winchester, Lincoln and Nottingham) reported that half the staff had less than a year in service; at Woodhill this was 41%; two others (Exeter and Leicester) said that around 50% had been in post less than two years; and at Chelmsford this was 70%. In category C training prisons, there were similar concerns: Guys Marsh and Channings Wood both highlighted concerns about staff inexperience; the Wayland board noted that 45% of staff had less than a year in service; and at Wealstun and Erlestoke 54% and 60% respectively had less than two years' experience. At Swaleside and Gartree, category B training prisons holding long-sentenced higher risk prisoners, there were similar issues. The Gartree board was concerned about a lack of consistency and ownership of wings and areas of the prison; at Swaleside, the board noted that the prison had put in place a 'buddy' system and further training because of staff inexperience and concerns about control and discipline.

1.11 The same issues were reported from prisons holding young adults (aged 18-25). The Swinfen Hall board noted the effect of regime restrictions on activities and access to association, and towards the end of 2018, Deerbolt was still experiencing unplanned closures and regime restrictions. The Feltham board was able to report improvements to the regime by autumn 2018, but expressed concern about the inexperience of staff, many scarcely older than the prisoners they were looking after. At Deerbolt, staff told the board that they felt constantly under pressure; those in support grades were being trained by officers, some of whom had been in post for only a year, while many more senior officers had left.

At Aylesbury, 30% of basic grade officers had less than a year's experience and eight who left during the year had averaged only nine months in service.

1.12 Some boards noted that the overall percentages of new staff underestimated the inexperience of those in prisoner-facing wing roles, as more experienced officers were either pulled into managerial roles or elected for back office, security or reception duties. The Woodhill board, for example, noted that of staff actually on the wings, regularly 60-90% were inexperienced. A number of boards also commented that those managing the new staff were themselves inexperienced in that grade: 60% in Norwich were on temporary promotion.

1.13 Many boards noted the impact on safety and stability in the prison, despite some positive attitudes from the new staff. A few boards were able to report a growing confidence and visibility. But in general boards noted that new staff lacked the confidence to set boundaries or deal with difficult situations: not getting prisoners back into their cells in high risk situations (Bedford), not de-escalating tensions (Peterborough); over-using adjudications rather than using the incentives scheme (Durham and High Down).

> *'Prisoners complain of inconsistent approaches by staff and experienced staff say that appeasement by inexperienced staff makes everyone's job more difficult and less safe. Prisoners expect staff to be able to resolve day to day problems for them … On one occasion, one or our board members was asked by a member of staff who they should contact on behalf of a prisoner' (Nottingham)*

1.14 The result was a continuing fragility and churn in the staff group in many prisons, which struggled to retain both experienced and new staff. Boards at Bristol, Leeds, Winchester and Nottingham local prisons reported attrition rates of between 20% and 40%; the Bullingdon board noted that 50 experienced staff had left during the year, 35 with an average of 9 years' experience and 22 with an average of 14 years. Similarly, in training prisons, many reported the loss of experienced officers (18% at Isis) and the attrition rate of new officer recruits (POELTs); for example, 20 out of 72 left in their first year at Wayland).

1.15 However, some prisons were putting in place positive measures to support new staff: Brixton provided active mentoring and had retained 81 out of 90 of its new entrants by the end of the year; Swaleside had put in place a buddy system for support and continuous training (see above). Other boards, such as at Leicester and Hindley, reported improved support for, and growing confidence of, new officers. Staff training and leadership is one of the focuses of the previous Prisons Minister's ten priority prisons project (see below).

1.16 The staffing shortage not only affected regimes for prisoners, but also reduced or undermined the capacity for positive interactions between staff and prisoners, which are a key part of safety and rehabilitation in prisons. One casualty was the personal officer scheme, designed to link each prisoner with a named member of staff, which was already in decline or fragile in many prisons.

1.17 Under the first phase of the offender management in custody (OMIC) model, a new version of the scheme was being launched during 2018. All prison officers would be trained as 'key workers' and allocated six prisoners with ring-fenced time to spend 45 minutes a week (or the equivalent a fortnight) to engage directly with each prisoner or follow up their progress or concerns. Its introduction has been slower than planned, with some hiccups at the beginning. Guys Marsh was an early adopter of this scheme, and the board reported that

initially there had been ‘a varying degree of knowledge and patchy implementation … amongst wing staff and prisoners’, and staff still ‘need encouragement to engage beyond the needs of their basic duty’ - but that by the end of the year there were encouraging signs of improvement, with a dedicated staff member monitoring the level of key worker engagement. Nevertheless, Boards have been very positive about this initiative and its potential, and look forward to monitoring its impact.

Looking forward

- the number, support and retention of staff
- the impact of the key worker scheme
- lessons learnt from the ten prisons project, and other mentoring processes, to support new staff

2. Drugs

2.1 Boards across all kinds of prisons expressed serious concern throughout this period about the availability of illicit items in prisons: drugs, particularly new psychoactive substances (NPS).

2.2 Drugs in prison not only have a direct impact on health and on prisoners' erratic and sometimes violent behaviour; they also undermine safety and stability by producing an alternative power structure, based on debt, bullying and intimidation of prisoners, their families and sometimes prison staff. This also impacts on already stretched healthcare services: at Humber in 2017, there was an average of ten calls a week to healthcare in relation to NPS, and at Guys Marsh in 2018 356 incidents a year: an average of one a day. The report of the board at Channings Wood was typical:

> *'[the] easy availability [of spice] at HMP Channings Wood is often commented on by prisoners coming from other parts of the estate. Despite numerous preventative strategies – and some significant successes – it has continued to assert an insidious hold over many men, creating a culture of debt, bullying and violence which has on occasion spread to prisoners' families outside.'*

2.3 Boards in both local and training men's prisons reported high levels of positive mandatory drug tests, well over target levels: some local prisons averaged one in five, or even one in three[1], positive tests, though some reported a decline towards the end of the period. There were also reports of tests not being able to be carried out, or followed up in adjudications, because of a lack of staff resource; and in particular a lack of intelligence-led suspicion testing. City centre local prisons faced challenges because of their proximity to urban areas and the number of prisoner movements in and out. Category C training prisons, usually more remote, often had to police huge perimeters, making them a target for organised drug-dealing.

2.4 The Leicester board reported around 30 drug-related incidents a month in the early part of 2018, though this reduced significantly in the latter part of the year. At Haverigg there had been weekly and sometimes daily incidents, with at one point 17 prisoners under the influence of NPS at the same time; in one month at Wayland, 41 prisoners were under the influence of NPS, of whom 26 self-harmed and five had to be taken to hospital. The Guys Marsh board, towards the end of 2018, reported a 'sustained and unacceptably high' use of NPS; on one day, prisoners were 'dropping like flies', with prison and healthcare staff responding to alarms all day. At The Mount, a drug recovery wing had to be shut down because there were too many drugs, and when it moved to another wing, the drugs, bullying and violence moved with it. Drugs were a problem even in the higher security training prisons, with the Swaleside board reporting apparently easy acquisition of drugs, phones and weapons, and Garth and Dovegate a rapid growth in NPS. Even two of the most secure category A prisons, Whitemoor and Long Lartin, noted an increase in NPS and the associated violence.

[1] Of those providing MDT figures, Nottingham reported an average of 33% positive including NPS, Bedford 25%, Bristol 36%, Peterborough 'often' over 20%.

2.5 Boards at women's prisons were also reporting more problems with spice, though not to such a great extent: the high number of those on opiate substitutes, and the trading of medications, was also a concern (see healthcare section)

2.6 The primary focus during this period was on physical security measures to try to reduce supply: scanning or photocopying of mail, increased use of drug dogs, increased searches, barring of windows, netting over exercise yards. The then Prisons Minister's ten priority prisons have been given additional resource, and sometimes new technology and additional staff or dogs, to assist with this. Boards welcomed this as an essential first step, but a number noted that it is necessary also to tackle demand, particularly if drug-using prisoners are to be rehabilitated. They pointed to the importance of dynamic security - the relationships with staff that can both detect and prevent substance abuse - as well as to the link between lengthy lock-up and lack of purposeful activity and the frustration, boredom and depression that create a ready market.

2.7 Open prisons, by definition, cannot rely on physical security to keep out illicit items, and rely more therefore on the incentive of remaining in open conditions. The proportion of positive mandatory drug tests was low, though some boards expressed a growing concern about both drug and alcohol finds. There appeared to be different approaches to prisoners who did test positive. At Thorn Cross, for example, the board reported a 'low tolerance' approach with an immediate return to closed conditions, even before an adjudication had taken place; whereas at Standford Hill and Hatfield, prisoners were referred to drug rehabilitation and support services and given a second chance.

Looking forward

- lessons from the ten priority prisons project
- the new prison drugs strategy, which focuses on restricting supply, reducing demand and building recovery

3. Safety

3.1 Monitoring the safety of prisoners is one of boards' particular responsibilities as part of the UK's National Preventive Mechanism (NPM) under the UN Optional Protocol against Torture. Nearly all boards, across the prison estate, raised heightened concerns about safety in the prison. In general, incidents of violence and self-harm increased, often significantly, throughout 2018. Boards attributed this to a combination of the availability of drugs (and the associated debt and bullying), the inexperience or shortage of staff, and frustration due to inactivity.

3.2 Reported violence increased in every part of the closed prison estate: from local prisons to those with the highest security. Boards in almost all local prisons reported significant rises in violence and assaults by prisoners: doubling in Bedford, Durham, Belmarsh and Wandsworth, and rising for the third year running in Bullingdon. Birmingham 'stabilised' at the high level of 120 assaults a month.

3.3 All but one of the category B training prisons expressed serious concerns about increasing violence, with spikes after the smoking ban. Category C training prisons had similar rises: Portland, recovering from serious disturbances in 2016-17, was still far from stable during 2017-18, with reports of 'fight clubs' and a significant rise in violence-related adjudications. Violence was still increasing, along with drugs, in Channings Wood well into 2018, and also in Guys Marsh (see below).

3.4 Boards in three of the highest security category A prisons noted similar trends, with an increase in violent incidents and bullying in Whitemoor, Wakefield and Long Lartin – though fewer than in other prisons, they had the capacity to be more serious, given the nature of the prisoner population.

3.5 Recorded assaults by prisoners on staff showed a greater increase than prisoner-on-prisoner assaults: but as some boards pointed out, the latter were more likely to be under-recorded for fear of reprisals. The board at Dartmoor, for example, noted that though the recorded number of assaults was very low, the highest number of applications to the board had been around bullying. While dealing with those applications, the board became aware that prisoners were reluctant to report incidents for fear of repercussion. Similarly, the Bristol board was sceptical about the fact that data showed no increase in reported violence, given that there were unexplained injuries and volatility and bullying on the wings. Both boards had concerns about bullying by staff, as well as by prisoners.

3.6 Along with increases in violent behaviour, boards also reported increases in the use of force on prisoners. While this is not surprising, many boards were concerned about the oversight of use of force. A number referred to inconsistent recording, or delays in paperwork. At Exeter, the board reported that no paperwork had yet been submitted in the great majority of incidents, and that officers' statements used similar language: 'I have attended training which has raised my awareness of lawful use of force'. At Guys Marsh, the board noted that the prison itself considered the level of use of force 'unacceptable' and had particular concerns about the use of batons.

3.7 In other prisons, boards reported improvements in monitoring and oversight: at Belmarsh, the number of missing statements had reduced from 500 to 100, and at Wymott use of force had actually decreased, with more emphasis on de-escalation. Boards were also supportive of the use of body worn video, which could both prevent incidents escalating and provide evidence of what had occurred.

3.8 The rise in violence was associated with drugs and drug debts, and the spill-over of gang affiliations into prisons. Boards reported rises and falls associated with the mix of prisoners or the smoking ban (which led to a trade in tobacco and vapes); or indeed a crackdown on drug supply, where the immediate effect was to raise the price and increase indebtedness.

3.9 However, boards also detected other underlying issues. The Gartree board linked increased violence to the restricted regime and the lack of staff time for both violence reduction and interaction with prisoners to build positive relationships. This seemed to be supported by a survey done at Woodhill, after violent incidents more than doubled, which showed that 19 out of 23 violent incidents in one month happened on days when there was no education on offer and activities were reduced. At Eastwood Park women's prison, the board noted that the rise in violence was linked to the return to custody of women who had been recalled.

3.10 A number of boards reported that young adults were disproportionately involved in violence and assaults. In prisons predominantly holding young adults, there were strong links to gang affiliation. The Isis board, recording an increase of 40% in assaults on prisoners and 20% assaults on staff, noted that the nature of the assaults was changing from fights between prisoners to more targeted assaults, often related to drug debt and gangs. Similarly, the Feltham board, reporting towards the end of 2018, noted that 'many prisoner-on-prisoner assaults and multi-prisoner fights are "organised" and happen as a result of gang activity on the outside'. Deerbolt (previously a relatively stable YOI) reported a steady increase in violence towards the end of 2018, as its population had changed and there were more drugs, mobile phones and gang members.

3.11 Some boards reported a gradual decrease in violent incidents towards the end of the reporting year, as more staff arrived and there was a greater focus on proactive interventions with perpetrators -including the CSIP (challenge, support and intervention plan) process - rather than simply removing either the perpetrator or the victim. Sometimes, however, this was short-lived. The Guys Marsh board had welcomed a 'demonstrable drop in violence' towards the end of 2017, but by the time of its next report there had been a 'marked increase', peaking during the second half of 2018, associated with illicit substances, debt and coercion, and often taking place out of sight of CCTV cameras. In a three-month period, there were also four NPS-related deaths in custody in the prison.

3.12 A lack of safety and stability can also lead to increased self-harm. Most boards reported an increase in the number of assessment, care in custody and teamwork (ACCT) documents opened for those at risk of suicide or self-harm during the period. This may be in part a consequence of increased vigilance, following the steep rise in suicides in preceding years. The Nottingham board was concerned that an overly risk-averse approach had resulted in too many ACCTs being opened, making it more difficult properly to identify and support those at serious risk of harm.

3.13 Self-harm in closed women's prisons, particularly those taking women direct from court, continued to be high, with three boards reporting around 1,000 incidents a year, rising to 1,418 in Styal, of which around half involved only six women. At New Hall, the board noted that self-harm tended to coincide with canteen day and when the prison was in patrol state (i.e. women were locked in their cells). Foston Hall, recognising the same phenomenon, had produced information and distraction programmes on in-cell television, with input from mental health. There, prolific self-harmers had weekly sessions with a psychologist and peer-led enrichment activities on the wings, part of a well-regarded and growing peer mentor network. Unusually, the number of ACCTs had declined significantly over the year.

3.14 Self-harm incidents were also significant in many male closed prisons, again often reflecting multiple instances from a number of prisoners. At Forest Bank there had been 969 incidents in the year; there were 790 in Peterborough, 730 in Nottingham, and 4-500 in many other smaller prisons. They were also rising in the high security estate, at Whitemoor, Full Sutton and Garth, where the board reported that there had been a 53% increase in self-harm incidents. In view of the prevalence of self-harm[2], it was worrying that some boards pointed to delays in answering cell call bells, and failures to record or analyse data on this.

3.15 Many boards welcomed the increased staff training in suicide and self-harm, and some reported improvements as a result. However, some also pointed to continuing concerns about the quality and consistency of ACCT documentation, observations and support, and in some cases the lack of involvement by healthcare staff in ACCT reviews, especially given the strong connection between mental health issues and self-harm. IMBs therefore note with interest the current review of ACCT procedures.

3.16 One phenomenon, particularly evident in male training prisons, was for some prisoners to self-isolate, not engaging with the regime or other prisoners for fear of violence or threats. Some prisons were actively working to reduce this, as at Swaleside, but in others it was a continuing issue, and at Channings Wood the board reported that the staff seemed unaware of prisoners who had isolated themselves:

> *'there are regularly large numbers, in excess of 20, of prisoners who are self-isolating …it has proved very hard to obtain details of who they are, where they are and why they are self-isolating …There have been cases where it has been several days before [prison staff have become aware that a prisoner is self-isolating. The IMB finds this extremely worrying'.*

3.17 A number of boards pointed to the connection between self-harm, self-isolation and mental illness and the availability of support or activity. The Deerbolt board, noting an increase in self-isolation among the over-21s, said that this also reflected the lack of appropriate activity and that 'they are very often left for long periods of time without any support or purposeful activity, through no fault of their own.'

[2] MoJ safety in Custody statistics including self-harm publ April 2019 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/797074/safety-custody-bulletin-q4-2018.pdf

3.18 The complex underlying factors behind increases in self-harm, and the importance of staff availability were also brought out in the report of the board at Cardiff prison, where there had been a six-fold increase in self-harm year on year. A survey had been carried out of over half the prisoners who had self-harmed:

> *'the most common reason given were bullying, a desire for vapes and frustration. Of those completing the questionnaire, 47% stated that they should have talked to staff rather than self-harmed.'*

3.19 Similar results came from an exit survey of women in Eastwood Park, who said that contact with staff, particularly one to one, was most likely to make them feel safe.

Looking forward

- the impact of CSIP
- the review of the ACCT process
- the roll-out of new use of force methods, including PAVA spray

4. Segregation

4.1 Monitoring segregation units, the most restrictive form of custody, is one of the most important responsibilities of IMBs, and part of their NPM role. Boards routinely visit segregation units on each visit to the prison, and report on the conditions and treatment of segregated prisoners.

4.2 The Nelson Mandela Rules (the UN Standard Minimum Rules for the Treatment of Prisoners) prohibit 'prolonged solitary confinement'. Solitary confinement is defined as:

> *the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days. (Rule 44)*

The Mandela Rules also provide that:

> *Solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review (Rule 45)*
>
> *The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. (Rule 46)*

4.3 IMBs have a particular role in relation to those prisoners who are segregated because their behaviour is held to be a threat to the prison's good order or discipline (GOOD). This can result in prisoners, including those with mental health conditions or at risk of self-harm, spending lengthy periods in segregation. Their continued segregation is reviewed every 14 days, and after 42 days (six weeks) of segregation, authority has to be sought from a regional prison manager. In addition, segregation units hold prisoners for their 'own protection': unwilling to return to normal location in that prison, sometimes because of accumulated debts, or fear of violence or intimidation.

4.4 It is clear, from IMB reports across all kinds of prisons, that segregation units are being used to contain those with serious mental health or personality disorders, sometimes for very lengthy periods; indeed, the more severe the disorder, the longer the period of solitary confinement. Some of those in segregation exhibit very challenging or violent behaviour. This was particularly the case in the high security estate:

> *'The work of the Unit has followed a now familiar pattern: coping with a population of long-staying men, typically with complex psychological problems or mental health needs, who often come on transfer from other segregation units within the dispersal system and some of whom circulate for years within it' (Long Lartin)*

4.5 This was a persistent theme across prisons of all kinds and functions. As Annex 1 shows, segregation units are dealing with individuals with severe mental health conditions, who need specialist mental health care but who cannot be transferred because of the chronic shortage of suitable accommodation, and who can spend unacceptably long periods in solitary confinement.

'*one man was in the segregation unit for more than nine months…he transferred to a therapeutic environment…[after a longstanding cycle of segregation at a succession of prisons' (*IMB Brixton)

'*one resident with complex needs spent 162 days in the women's [segregation] unit (*IMB Peterborough)

'*almost all of the prisoners held for over 100 days [in segregation] were judged by healthcare to have complex mental health needs and required transfer to a specialist unit. The Board feels it cannot be right to hold prisoners in segregation for over 200 days and that this does not constitute humane and decent treatment (*IMB Lowdham Grange)

'*the process for referral to, and transfer of, a prisoner to a mental health hospital is very lengthy and the outcome…frequently uncertain. As a result, prisoners with significant behavioural or mental health problems remain in the segregation unit for many months' (*IMB Full Sutton)

Even where prisons try to create suitable environments themselves, they often rapidly become 'bed-blocked' due to an inability to transfer prisoners out (see healthcare section).

4.6 In addition, a significant number of those in segregation were suicidal or self-harming, which is unlikely to be improved by being locked up for up to 23 hours. At Wealstun, up to a third of those in the CSU were on an open ACCT, as were one in five of those at Woodhill, and six out of nine of those segregated in Wandsworth at one point during the year. The Erlestoke board reported:

'*Routinely the Care and Separation Unit houses prisoners on an ACCT. During the year there have been occasions where [they] have been confined to the CSU for weeks on end despite the unsuitability of the environment*'

4.7 Annex 1 shows the extent, nature and consequences of these concerns. The information from each board in relation to prisoners segregated in their own prison in fact underestimates the length of time a prisoner may spend in total in segregation, being moved around from one prison to another. One board, Channings Wood, was unable to obtain any data about length of segregation, as detailed statistics had not been kept since 2015.

4.8 One women's prison, Eastwood Park, had resisted having a segregation unit, and kept segregated women on the wings; however, the increase in the number segregated towards the end of 2018 led to a proposal to create a separate Behaviour Management Unit, because of the disruption to the regime for other prisoners on normal wings. The board noted the rise in adjudications, violent incidents and assaults, and was concerned about a lack of planned action to address behavioural issues.

4.9 Boards are entitled to attend the regular Good Order or Discipline (GOOD) reviews and sign the documentation to indicate that they are satisfied that due process has been carried out and the decision is a reasonable one in the circumstances. Some complained that the rescheduling or irregular scheduling of reviews made it difficult for them to attend. A number noted that healthcare staff did not attend, even though their presence is mandatory, and even where prisoners were under the care of the mental health team: this was said to be due to staffing, or even contractual, restrictions (see healthcare section).

4.10 The dilemma, for prisons and for monitoring boards, is that in practice in over-stretched and sometimes unsafe prisons, segregation may be the safest place for a very disturbed, ill or fearful prisoner, and paradoxically one where they get more one to one staff attention than would be the case on normal location. In most cases, boards did sign off continued segregation as the only realistic option in practice, but many did so reluctantly and only because there was no viable alternative within either the prison or the healthcare system. They recorded these concerns in their annual reports, including the deterioration in both physical and mental health and the fact that segregation staff, however willing, were untrained. On some occasions, boards refused to sign: either because no healthcare staff were available, or because in practice the treatment of the prisoner had become inhumane because of their deterioration in long-term segregation.

4.11 Some boards noted the work being done to try to reintegrate prisoners, and commended prisons' attempts to provide alternatives or progression for segregated prisoners. Sometimes, as at Holme House, these attempts were frustrated by staff shortages. Swaleside had recognised, as noted above, that inexperienced staff tended to over-use adjudications and segregation. After a focused effort by one senior manager, who challenged the automatic assumption of segregation at the first hint of trouble, the average number segregated had reduced from 22 to 15 for much of the year. The board also noted that specialist drug recovery wings should reduce the underlying drug/debt issues. The Haverigg board commended the rehabilitative culture and restorative justice initiatives that had impacted on the outcome and perceived fairness of adjudications.

4.12 Various attempts were also being made within and between prisons to work with and move on prisoners with complex needs. The Parc board reported that the prison was developing a new initiative for complex and violent men, with a structured regime in the Credwch unit, which had had some successes. Among some Yorkshire prisons, there was an informal 'virtual segregation' arrangement, whereby they swapped difficult or recalcitrant prisoners. Though the aim was help prisoners make a 'fresh start', the board at one of those prisons, Moorland, expressed concern: 'this may result in some challenging prisoners being moved around the prison system without their complex needs being addressed in a consistent and effective manner.' The Long Lartin board referred to a pilot 'progressive segregation scheme' between three high security prisons, though they noted that it would require expanded psychology resource.

4.13 The great majority of boards commend the staff in segregation units for their professionalism, faced with some extremely challenging behaviour, and regular 'dirty protests'. The one exception was the report of the Dovegate board, referring to allegations of assault by segregation staff, unproven because of lack of evidence, but which led to a significant change in the management and staffing of the unit.

4.14 There were, however, some concerns about inconsistencies in the regimes in segregation units, and the way in which decisions about this were made: for example, whether televisions were allowed, or whether there was in-cell activity or visits from the education department. The High Down board noted that the segregation unit was a 'major area of concern' and that showers and phone calls were available only every other day, while at Belmarsh, the board reported a 'refusal' regime to try to 'persuade' reluctant prisoners to

return to their wings, by restricting access to showers. Other boards noted the impact of redeployment of experienced staff and resulting inconsistency of treatment.

4.15 A number of boards also commented on the poor physical conditions in segregation units, often exacerbated by the maintenance problems referred to later in this report, since cells in the unit were more likely to suffer damage. The Exeter board described the physical state of the unit as 'lamentable'. The Winchester board described it as 'a dungeon…the seven cells are in poor condition, with damp walls and peeling paint. They are uncomfortably hot in summer and cold during the winter. There is little natural light and the artificial light is gloomy'. The Bedford board also described the segregation unit as a 'dungeon' where toilets were regularly blocked, and which should be closed down. At Erlestoke, the board noted that 'water from the two shower rooms continues to leak into the main corridor, the non-slip floor is disappearing … and has been described as a "bacteria breeding ground" ' Many boards complained about heating malfunctions and cold; the Holme House board noted that cell call bells were not working, even though prisoners had known mental health issues.

Photo from IMB Winchester annual report 2017/18: '*The Care and Separation Unit (CSU) is a dungeon….*

4.16 Boards also expressed concern about 'hidden' segregation and the inappropriate location of segregated prisoners. At Haverigg, the segregation unit was also used to house vulnerable prisoners, who were sometimes held alongside those who had bullied them. Some segregated prisoners were held in the first night centre, where their disruptive behaviour could have a damaging effect on newly arrived prisoners; the same was true at Lancaster Farms, and the board were not at first told about this. The Gartree board, among others, noted that in fact a majority of segregated prisoners were often confined to cells on normal wings. Other boards expressed concern about prisoners who were effectively segregated but without the protection of the segregation rules: at Whitemoor one wing was effectively for self-segregating prisoners, who on average were segregated for 134 days.

Looking forward

- continued monitoring of
    - length of time in segregation
    - conditions and treatment
    - alternatives within the prison system and the NHS

5. Accommodation

5.1 IMBs were among the first to raise publicly the failings in the maintenance contracts negotiated for most public sector prisons with Amey and Carillion, which has since collapsed. This exacerbated the problems caused by under-investment in prison maintenance over many years, and the inability to achieve the promised closure of establishments that were no longer fit for purpose.

5.2 The picture painted in nearly all annual reports is extremely depressing, with failures, sometimes compromising health and safety, across all kinds of prison and in all areas. Four boards described conditions as 'squalid'; others as inhumane and unfit for purpose. The Bristol board summarised this:

> *'HMP Bristol remains a run down, unhygienic, dated and shabby environment for prisoners and staff alike and not conducive to promote good behaviour, wellbeing, hope and/or rehabilitation.'*

5.3 Some boards noted a slight improvement in the management of the Amey contract in the north, and some southern boards reported an initial improvement once the Carillion contract was taken over by Government Facility Services Limited (GFSL). However, their hopes often did not materialise, partly because of the huge backlog of unmet need (where sometimes the failure to carry out a small maintenance task had led to major structural problems) and partly because the new contracts became as centralised and bureaucratic as the old ones. Boards described priorities that met national key performance indicators rather than local need (Bristol), 'administrative red tape with many layers of authorisation needed before any repair work can be done' (Erlestoke) and 'labyrinthine' purchasing and commissioning processes. Much work continued to be reactive, rather than preventative.

5.4 Annex B lists the issues that boards raised during the year. They include failings that impacted directly on health and safety: overflowing toilets and urinals, damp, mould and unheated cells, and a sewage pipe uncapped for months. At Wormwood Scrubs, fire inspectors found insufficient fire-fighting equipment and 600 broken emergency lights. They later had to issue an enforcement notice, which was only lifted seven months later. In Exeter prison, prisoners were reduced to using buckets to flush their toilets, as they were blocked and there was waste and excrement on the floor and overflowing urinals. At Lincoln, the health and safety executive is still investigating the origin of a legionella outbreak that left one prisoner dead. Nearly all open prisons reported major problems, with some accommodation that was barely fit for purpose. For example, the Ford board reported:

> *'accommodation remains in a parlous state … there is a lack of funds for infrastructure improvement. When any money becomes available the implementation process is tortuous, resulting in severe delays. Preventive planned maintenance is totally lacking.'*

5.5 Many establishments had essential kitchen equipment unrepaired for many months; the same was true for washing machines and driers, with prisoners in Bristol having to wash their clothes in buckets. Failure to clear gutters of plants and debris for some years led to water seeping into buildings, in one case through light fittings and in another causing a ceiling

collapse. Safety was compromised when outside lights went unrepaired for months, cell bells did not work or broken windows allowed the entry of drugs or even weapons as the board at Pentonville reported.

5.6 Activities and resettlement opportunities were undermined when workshops had to close. The mother and baby unit at Eastwood Park, one of only three in the country, was out of use for over two years because of catastrophic water damage. One prison had 900 outstanding jobs, another over 1300 planned and 1300 preventive jobs.

5.7 There were some innovative attempts to employ and skill prisoners to carry out minor repairs and redecoration. At Dartmoor, the prison was planning to work with GFSL (the government company that replaced Carillion) to fund a prisoner working party to undertake decoration and repairs while gaining qualifications and potential future employment. Other prisons, such as Featherstone and Buckley Hall, had prisoners undertaking painting projects, sometimes alongside the contractor. Given the scale of the problem, the availability of labour and the need for prisoners to develop marketable skills, this suggests the need for a more systematic and proactive approach. One imaginative attempt at self-help In Ford open prison, for a team of staff and prisoners to do routine repairs to floors in showers and urinals, failed because the central organisation could not agree a specification.

5.8 These problems were not nearly so evident or acute in private sector prisons, usually relatively recently built and able to rely on their own or their company's maintenance departments. Birmingham was an exception, and other boards reported some minor issues, but in general they remained clean and well maintained. The board at Parc, for example, found that there was a regular planned maintenance programme, and the accommodation blocks were clean and tidy.

5.9 Sometimes prisons appeared to have drifted into learned helplessness and given up on things that they could in fact control or influence. Many boards reported that wings and outside areas were dirty and rubbish-strewn, which attracted vermin of all kinds. Inside, there were reports of rats, mice and cockroaches and at Pentonville a flea infestation in one of the workshops (the board noted that Rentokil would not attend again until Carillion paid its overdue bills). The board at Highpoint raised cleanliness as an issue on 31 weekly occasions. In its 2018 report, the Guys Marsh board was critical of the variable leadership on wings, where cleaning was not monitored or prisoners challenged, and where food trolleys were left in a 'disgusting state', which the board considered compromised health.

5.10 The Bedford board reported on regular shortages of clothing and basic items, such as toilet rolls, clean sheets and cleaning materials; at Birmingham some newly arrived prisoners were placed in cells with no mattress, no furniture and no television. At Norwich, there was a persistent lack of cleaning materials and poor management of cell equipment, which the board said seemed to come as a surprise to staff and managers. Even though there was furniture and winter clothing in the stores, the board at Portland found that they had not been distributed, and prisoners were storing their clothes on the floor. Prisoners at Kirkham open prison lacked the towels, vests, t-shirts and protective footwear they needed for work. At Whitemoor and Gartree, there were repeated failures to provide bedding and clean clothes.

5.11 There was, however, evidence that increasingly some prisons and governors were gripping the issue, and taking proactive steps to maintain standards of decency and cleanliness. Brixton, Wandsworth, Wymott and Durham, for example, had instituted regular 'decency' or accommodation fabric rounds to ensure that cells and wings were properly equipped and clean. At Cardiff, there was a painting team of prisoners, and a programme of furniture replacement. In Leeds, governors had clinics on the wings and a rolling system of replacing white goods and fitting curtains and toilet screens.

5.12 Boards continued, rightly, to raise the more fundamental and so far intractable issue of two prisoners sharing a cell meant for one, with a toilet, sometimes unscreened, in a cramped space where they also ate their meals. This would not be acceptable in any other publicly owned building. In some cases, as the Pentonville and Nottingham boards pointed out, those cells were so small as to contravene basic international standards for cell space.

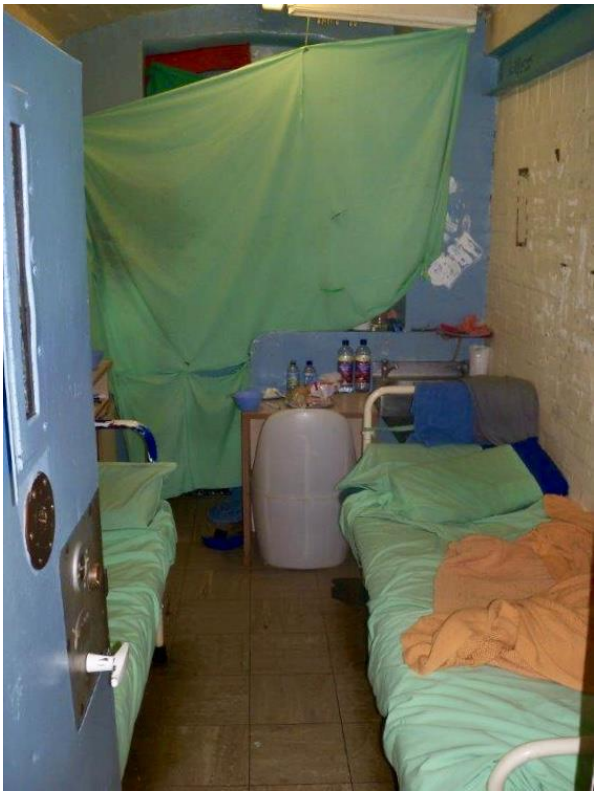

Photo from IMB Winchester annual report 2017/18: '*The standard of accommodation at HMP/YOI Winchester is unacceptable. Conditions are unpleasant and dirty. Some prisoners share cells with a sheet separating their bed from a toilet.'*

5.13 Even worse, 400 prisoners at Coldingley and half those at Long Lartin were in cells without any integral sanitation, and had to use the unreliable 'night sanitation' systems. This could involve lengthy delays in being able to access toilets overnight, with the consequence that prisoners had to use buckets. Boards in those prisons described this as 'inhumane and undignified' and 'degrading and insanitary, even when it works.' Both boards pointed out the particular and potentially discriminatory impact on their older prisoner population, more likely to need toilet facilities overnight.

Looking forward

- prison estates strategy
- re-letting of maintenance contracts
- initiatives within prisons to monitor and act on decency

6. Property

6.1 For far too long, boards have been urging change in the systems and processes that should unite prisoners and their property, yet which signally fail to do so. Nearly every board report reiterated the request that the Prison Service, the Ministry of Justice and/or the Minister take decisive action to deal with this long-running problem.

6.2 Many boards reported that between a fifth and a third of prisoners' applications to them were about lost property, and overall property accounted for 23% of applications to boards. Property went missing either in transit between prisons or within the prison, often when prisoners had moved or been moved from their cell and it had not been secured.

6.3 From the outside, this can seem a relatively minor issue, given the many serious problems referred to elsewhere in this report. But it has a disproportionate effect on prisoners and prisons. It is possible to monetise this impact, in terms of the thousands of pounds in compensation paid to prisoners, as well as the amount of staff time (and IMB and Prison and Probation Ombudsman (PPO) time) chasing property around the system, often in vain. Leyhill open prison noted that it could take six months to try to sort out property for prisoners moved there.

6.4 However, the impact is not just about resources. Some of prisoners' losses are personal and irreplaceable: family photographs, children's drawings, letters from families and lawyers, and other keepsakes. Personal possessions are all that prisoners have that is theirs, and their loss adds to their frustration, isolation and disconnection. The situation is particularly critical for long-sentenced prisoners, who will have accumulated possessions and memorabilia over decades.

6.5 This is a problem which has been going on for decades. As the Bedford board pointed out, however, there are no key performance indicators to help drive improvement. Some of the problem is contractual: the stipulations in the contracts with the private companies that ferry prisoners between and to prisons. The size of the vans mean that all property cannot always travel with prisoners: indeed, the Woodhill board reported that smaller vehicles were being used, which could be driven on a car licence, so that drivers did not need additional medical tests and training.

6.6 As board reports make clear, there are two separate actions needed. The first is to ensure that the escort contract negotiations now under way properly allow for the transport of items, as well as people; and to look for technological solutions, such as bar coding, which are used in almost all other industries where goods have to be moved efficiently from one place to another. The second is to ensure that systems are in place within prisons to log and distribute property and in particular to secure it when prisoners move cells: there is a strong suspicion among prisoners, and some boards, that the loss of property after a prisoner is forcibly removed from a cell is seen as a secondary punishment – and certainly that there is too little positive effort to ensure that this does not happen.

Looking forward

- new prison escort contracts
- effective methods for distributing and securing prisoners' property within prisons

7. Equality and diversity

7.1 The majority of boards reported a reduction in the time and attention given to diversity issues, particularly race and ethnicity, over the year, as resources were diverted to fill gaps elsewhere in the prison caused by staff shortages. This was beginning to improve by the end of the year. Boards also reported a lack of data, or little analysis of it.

7.2 In many prisons, especially when staffing was tight, diversity/equality action team (DEAT/EAT) meetings were cancelled, prisoner forums did not take place regularly and equalities officers (EOs) were redeployed. At Norwich, the EO was able to devote only two hours a week, instead of the profiled 31.75. The Channings Wood report, in August 2018, was typical:

> *'The establishment has an Equality Action Plan, but meetings to monitor its progress have not been regular … The ongoing lack of staff assigned to equalities is of significant concern to the Board. … Forums for each minority group are planned, but sometimes do not take place when officers are not available'.*

Towards the end of the year, as more staff arrived, and in the wake of the Lammy report on race in criminal justice, more resource was being planned or put into equalities work in a number of prisons.

7.3 Some prisons had managed to maintain a focus on equality during this period, in spite of the other pressures. At Leicester, there was an energetic EO, and eight peer representatives who met fortnightly and fed issues into the quarterly EAT meetings. Data was used to compare actual to expected outcomes in areas such as complaints, adjudications, segregation and IEP status. Haverigg had responded to the Lammy report by re-examining its IEP processes. The Swinfen Hall board had carried out its own analysis of disproportionality in adjudications, employment rates and segregation, finding that white prisoners were 22% more likely to be employed, and BAME prisoners were 1.6 times (60%) more likely to face adjudications. At Standford Hill open prison, the board noted that there was under-representation of BAME prisoners on Stage 2 working out (paid work); however, the Ford board reported that, though there was a 45% BAME population and a largely white staff, it was younger white prisoners who were the most likely to be returned to closed conditions.

7.4 Prisons reported varying outcomes of the process by which prisoners could complain of alleged discrimination (the discrimination incident report (DIRF) process). An increase in DIRFs could be a positive sign, as the Wandsworth and Feltham boards reported, as it could indicate more active work and more confidence in the system. Most DIRFs submitted by prisoners related to allegations of racism (79% at Aylesbury, 56% at Coldingley); many took a long time to process, and very few were upheld, sometimes on the grounds that there was 'no evidence'. At Eastwood Park, the board was concerned that DIRFs were not upheld unless there was third party confirmation. The Portland board was concerned about casual racism going unchallenged, and pointed out that an allegation of racist name-calling had not been investigated because it was submitted on an ordinary complaint form, not a DIRF. Only a few prisons (including Isis, Feltham and Stoke Heath) had external scrutiny of their DIRF decisions.

7.5 One issue that emerged in board reports from some open prisons, for example Kirkham and Spring Hill, was that prisoners were inhibited from making complaints about discrimination, and indeed about other issues, because of a fear of reprisals, specifically that they would be transferred back to closed prisons. The Kirkham board suggested a need for a prisoners' charter and more transparency about complaints data and the reasons for transfer.

7.6 In general, there seemed to be a more positive and proactive approach to issues of age and disability, though in practice the layout and age of many prisons made accessibility difficult, particularly if lifts were not properly maintained. A number of prisons, like Lincoln, Dartmoor and Littlehey, reported a shortage of wheelchair-accessible cells, or areas of the prison that were not accessible to mobility-impaired prisoners. There were active 'buddy' or prisoner carer schemes in many prisons with a large proportion of older prisoners, though there was some concern about the process for risk assessing and training them. With the ageing population, some prisons also had dementia trained staff (dementia friends) (see also healthcare section). One prison, Stoke Heath, had identified a group of around 20 disabled prisoners with complex issues who were 'hard to reach' and was attempting to provide a bespoke programme of work and education for them.

7.7 Many prisons had a large number of foreign nationals, and had set up forums for them. Particularly in women's prisons, they could be deported direct from prison, sometimes at very short notice. The support provided in two women's prisons, Eastwood Park and Foston Hall, was very different. At Eastwood Park, the board noted that there was no specialist voluntary organisation to support the 30 foreign national women, and limited use of translation or interpretation services, both due to cost factors. At Foston Hall, there was a full-time foreign national peer adviser, with daily drop-in sessions, a weekly group, and monthly visits from community organisations, particularly for eastern Europeans.

7.8 A number of prisons reported positively on the approach to transgender prisoners, though there could be problems with allocation to a suitable prison. Some prisons, too had set up forums for Gypsies and Travellers, to respond to their specific needs, and reported that this allowed more of these prisoners to self-identify.

Looking forward

- improved data collection and analysis of equalities data, following the Lammy review
- better resourcing for equalities work in general as staff numbers rise.

8. Health and social care

8.1 Boards reported the pressure on prison healthcare, reflecting the level of both physical and mental health need, as well as staff shortages and the impact on prisons of shortfalls in provision outside criminal justice.

8.2 It is well known that overall prisoners' health, both physical and mental, is worse than among the general population. Physical health outcomes are affected by lifestyles, drug and alcohol misuse and disengagement with community healthcare, as well as the complex needs of an ageing prison population. As shown in the section on segregation, prisons, like the rest of the criminal justice system, disproportionately contain individuals with mental health problems, which imprisonment can exacerbate – particularly as prisons, unlike mental hospitals, cannot compulsorily treat patients except in extreme circumstances.

8.3 The transfer of healthcare commissioning to the NHS in England provided a stimulus to both the quality and quantity of healthcare provision, as well as better links to healthcare in the community and to secure hospitals. However, from the beginning the service, particularly mental health in-reach, was over-stretched, and in places it is now clearly creaking at the seams.

8.4 Healthcare services should be 'equivalent' to those in the community. As the Royal College of General Practitioners makes clear, this does not mean 'the same'. Provision needs to reflect the health inequalities referred to above, the duty of care owed to those who are detained, and the fact that prisoners, unlike those in the community, cannot seek alternative help or advice. Some boards did report that access to healthcare was as good as that in the community. However, that was not the case across all prisons, where the shortage of staff and the extent of need resulted in inadequate services, compounded by the effect on wellbeing of long periods spent in cells. The Gartree board summed up the problem:

> *'the current prison regime and health and wellbeing services are not designed or resourced to improve health and wellbeing, tackle health inequalities and other health issues'*

8.5 The Wymott board considered the service was 'woefully short of the duty to provide an equivalent service', with some prisoners spending several days without their medication. Three other boards reported that the regulator, the Care Quality Commission (CQC) had served requirement notices on the prison.

8.6 Many boards reported the effects of staffing shortages, both of uniformed and healthcare staff. Sometimes there were not enough uniformed staff to escort prisoners to appointments, either within the prison or to external hospitals; staff shortages also impacted on the supervision of medication queues. Shortages of nursing staff, particularly mental health nurses, led to long waiting times, over-high caseloads and reliance on expensive agency staff with no continuity of care. At Winchester, a 50% vacancy rate had reduced, but was still 28% by the year end; the Humber board reported that the mental health team had 50% agency staff; at Woodhill there were 35% nursing vacancies.

8.7 These problems were reflected in the high number of prisoners' applications to boards. Healthcare applications came second only to property, representing nearly 14% of all applications, often relating to delays or cancellations in treatment or medication. Pressure on healthcare services also resulted in healthcare staff not playing a full part in ACCT reviews and not always attending segregation reviews, even though their attendance is mandatory.

8.8 Shortages of uniformed prison staff and poor communication also affected the high number of prisoners not attending appointments made for them (DNAs), which were reported by many boards; where prisons were able to devote staff time to following this up, as at Wayland, DNAs reduced considerably.

8.9 Some healthcare provision was, however, rated good by boards, prisoners and sometimes external bodies. Kirkham open prison healthcare team were runners up for best clinical team in secure environments at the Royal College of General Practitioners' health and justice summit, even though they were looking after a high proportion (17%) of older prisoners, some with complex, long-term and multiple health conditions.

8.10 Some differences seemed to reflect different healthcare providers, local pressures or salary levels (particularly in the home counties); and, in some cases, poor management and communication. In some prisons, problems and issues in relation to individual prisoners seemed to fall through the gap between the complementary responsibilities of prison governors and NHS commissioners and providers. Others, however, had developed good and constructive relationships. The Ranby board reported on a 'supportive and effective' relationship between the prison, the health provider and the NHS commissioner, with regular and constructive reviews of the contract; similarly, at Lancaster Farms the governor chaired a quarterly delivery board, with attendance from the commissioner.

8.11 However, the underlying problem was a disconnect between the level of need and the level of provision. The demand for healthcare services, especially mental health, was extremely high in many prisons, and many boards reported that need was increasing beyond current resource. At High Down, there were 120-130 referrals a month to the mental health in-each team; at Wayland the team carried caseloads of 60; at Humber the team was often supporting over 150 patients; other boards noted that there was no mental health cover at evenings or weekends. Waits for talking therapies, such as counselling, were also long in many prisons: at Deerbolt there was a 27-week waiting list for one to one counselling; Aylesbury's 45-bed unit for intensive therapy was over-subscribed, but beds were restricted because of financial constraints.

8.12 In women's prisons the demand was even higher. Boards reported a very high level of need: 95% of the women at Bronzefield were on some form of medication; two-thirds of the women in Peterborough reported mental health problems; at Styal the number of women with complex needs and severe and enduring mental health issues had increased, and around one in six women were actively under mental health treatment. This is also reflected in the high proportion of applications made to boards in women's prisons in relation to healthcare concerns. Unlike in men's prisons, the number of healthcare applications was even higher than those about property (see paragraph 12.5 below)

8.13 The ageing prison population also created pressures in many prisons, particularly those holding sex offenders. Relatively recent relationships with local authorities in England for the provision of social care were working reasonably well in most areas, at least for assessment and the provision of aids. However, the actual provision of support was more problematic. The Stafford board noted that external social care workers only visited between 8am and 7pm, and that in practice their visits lasted only ten minutes. Much of the daily care, for example for bedridden and incontinent prisoners, was therefore provided by untrained staff and prisoner carers. There were some good local initiatives in many of these prisons, such as 'buddy' schemes, with trained prisoner carers, and 'dementia friends.'

8.14 Prisons with a large older population also tended to have a high number of bed-watches and external hospital appointments – 1388 hospital escorts and 102 bed-watches at Whatton, 137 hospital visits per month at Rye Hill and 120 at Littlehey - which depleted staff in the prison still further. End of life care was also an issue. Some reported good provision, but the Stafford board considered that due to the absence of 24/7 nursing care and the high admission criteria of some hospices, some prisoners were being cared for in an inappropriate environment. Boards will be looking with interest at the implementation of the new NHS England end of life policy, 'Dying well in custody', issued in April 2018.

8.15 A great number of boards described lengthy delays in transferring seriously mentally ill prisoners to more appropriate NHS care. In training prisons, without in-patient units, those prisoners were often held in segregation, where their mental health deteriorated, as the Guys Marsh board and many others noted (see Annex A). In local and high security prisons, they tended to revolve between in-patient units (some of which lacked fully trained mental health nurses) and segregation units, creating a high level of disturbance for themselves and staff.

8.16 In Durham prison, the board commented positively on the Integrated Support Unit, a regional initiative for prisoners with serious mental health problems. However, it also noted that many of the prisoners there should have been placed in NHS, not prison, facilities and that there was an increasing problem with 'bed-blocking', with eight referrals to medium secure units but no available beds. The board reported that of the twelve prisoners awaiting mental health transfers, the average wait was 56 days, with the longest 12 months. At Wandsworth, the board considered that the 12-bed in-patient mental health unit was not fit for purpose, with a long waiting list for admission to it and long delays in transferring prisoners out: 55% of the patients in the inpatient unit were transferred, 25% within 14 days, 45% within three months, three within six months and one waited even longer. As a number of boards pointed out, these figures in fact underestimate the delays, as they represent the delay between assessment and transfer, and there may be a considerable delay between referral and assessment.

8.17 The same issues arose in women's prisons that had developed special units for those with complex needs. The unit at Eastwood Park held ten severely disturbed women, with high levels of self-harm and was at times unable to admit all those who needed it. Similarly, at Styal there were concerns about the specialised Dove unit for women with complex needs, some of them waiting for healthcare beds to become available, and being cared for by staff with little formal training.

8.18 Some prisons had, however, developed positive relationships and good processes with external providers: in Leicester the gatekeeping process had improved, and led initially to more rapid transfers, due to liaison between the prison's mental health team and outside commissioners, with a shared tracking sheet that has been adopted by NHS England. Other prisons reported improved transfer times, but subject to limitations of bed space.

8.19 Boards also commended the some of the specialist units for prisoners with personality disorders, both in the male and female estate, including the PIPE units (psychologically informed planned environment), jointly run by prisons and the NHS which aim to provide a progression route for long-stay prisoners and those with personality disorders. In some cases, due to the focused support available, prisoners were able to return to normal location.

Looking forward

- additional funding for mental health services in the community
- implementation of the 2018 National Partnership Agreement for Prison Healthcare in England
- implementation of new end of life pathway from NHS England
- continuing issues in relation to placements of those with serious mental health problems

9. Education, work and purposeful activity

9.1 During the reporting period, boards reported the impact on education, training and activity of issues already referred to: staff shortages and maintenance failings. The former could result in lockdowns or insufficient uniformed staff to escort prisoners to activities; the latter led to workshops or classrooms being unusable for long periods. Boards also raised concerns about the amount and suitability of the activities available, and the processes for allocation and ensuring attendance.

9.2 Access to genuinely purposeful activity is important for two reasons. It can provide skills and experience that help prisoners' reintegration and employability; and it reduces the frustration and negativity that can fuel violence and self-harm. In local prisons, with a transient population and a high level of remands, it is much more difficult to provide enough quality activity; training prisons by definition are meant to be able to purposefully occupy the great majority of their population.

9.3 The first section of this report records the impact on regimes in general of staffing levels. Most boards reported gradual improvements to regimes as staffing levels improved. However, the underlying problem in most local prisons was that there were not enough, or enough suitable, activity places for their populations. Belmarsh had places for only a quarter of prisoners at any one time; 500 men in Birmingham were unallocated to activity; Lewes had 380 spaces, some part-time, for 630 prisoners; the Norwich board reported that on one typical day 259 out of 773 prisoners were not engaged in activity.

9.4 Many boards also commented on the fact that the provision that did exist was under-used, especially in education, where attendance levels were sometimes barely half. Sometimes this was associated with problems in allocation or effective monitoring and encouragement of prisoner attendance; sometimes there were not enough uniformed staff to physically get prisoners to education. At Pentonville, the board reported that attendance had dropped to half, mainly due to lockdowns, but also noted that when there were staff shortages, prisoners were not routinely unlocked for education, but were for the commercially contracted workshops. Boards also, however, pointed out that in some cases the education provision, focusing on numbers and certificates, was not appropriate to a population that was constantly revolving, and men who in many cases associated formal classroom education with past failure.

9.5 When prisons introduced functional skills (literacy and numeracy) in a workshop context, attendance levels and achievements were higher. Parc offered qualifications in all workshops, and had purposeful activity spaces (including wing cleaning) for 80% of its prisoners. Some were less successful: at Liverpool only five of the twelve workshops were functioning properly, and only two provided vocational skills. In a survey of prisoners in the Bedford workshops, many of them carrying out mundane and repetitive work, 71% felt that they were 'doing time', rather than 'using time'.

9.6 Some local prisons, like Bullingdon, Lincoln and Cardiff, focused on roll-on roll-off courses, where both attendance and achievement were much higher. Durham, the pilot for 'reception' prisons, had a much higher proportion of remanded prisoners and a much shorter average stay (three weeks) than had been originally predicted. This made it impossible to

meet the previous targets in the education contract. The department therefore reviewed the curriculum to provide short 'taster' courses where prisoners could acquire a portfolio of achievements short of formal qualifications. This increased take-up even among remand prisoners (who are not obliged to attend).

> '*The Learning Skills team developed an academy model based on employment sectors focusing on motivation and engagement whilst addressing behaviour. Numeracy and literacy are integrated within all activities. There is clear measurable evidence [in portfolios] of prisoners learning skills and personal development achieved through the activities.*'

9.7 Both attendance and completion rates tended to be higher in women's prisons, with attendance and completions up to 90%, even in local prisons. Lack of sufficiently broad provision, and/or staff shortages, tended to be the greatest concerns.

9.8 Training prisons, by definition, should have higher aspirations than local and reception prisons, but many boards in these prisons also reported too little access to purposeful activity. During the early period covered by this report, they were still struggling to recover from the severe regime restrictions of 2017.

9.9 The board at The Mount recorded the activity was still restricted by early 2018, with only 39% of education spaces occupied, and prisoners who should have had 23 hours' activity a week in fact getting only eight. Similarly, at Portland, where an external audit had commended the 'impressive range of employment and training initiatives', the board found this provision was seriously under-used into the early part of 2018, due to 'regime malaise', which could lead to working days of less than four hours and often only 50-60% of prisoners engaged in formal activities.

9.11 At Stocken, not only was there too little meaningful work, but the Board observed prisoners sitting idly in the workshops that were running, noting the need for a joined-up approach and better liaison with external companies. The Erlestoke board reported that, though there was activity available for 80% of prisoners, too much of it was assembly and packing work that offered no skills training.

9.12 There were similar problems in some prisons in the high security estate. The Swaleside board noted that workshop space had not kept pace with the doubling of the prison's population and that the lack of sufficient vocational training was exacerbated by delays in refurbishing a second engineering workshop. At Lowdham Grange, there were too few opportunities for training and the board sometimes found two thirds of prisoners on the wings. The Gartree board did not consider that there was sufficient training to equip prisoners for future employment, made worse by the impact of regime restrictions, which also halved the scheduled education hours at Whitemoor.

9.13 Nevertheless, even during this period of recovery, a number of boards were able to report innovative approaches and close to full employment. The board at Moorland recorded that there had been a needs analysis, work was rarely cancelled, and there was a community engagement officer to promote employability: organising resettlement fairs, employment drop-ins and prisoner information forums. At Ranby, a wide range of qualifications was available; four outside firms were working with prisoners and could offer some employment on release. Oakwood also provided structured pathways, some opportunities for work on

release, and was seeking further employer engagement. At Wealstun, only 50 of the over 800 prisoners on average were unemployed, and there was a strong relationship with local employers and organisations, researching local vacancies to try to ensure that prison work met outside need. Coldingley, which has a history as an 'industrial' prison, continued to have sufficient work and education spaces for all its prisoners, though there were some concerns that contract work was privileged over education and training.

9.14 Boards in training prisons specialising in sex offenders were more positive about the availability and relevance of activities. In general, they reported a range of opportunities and high employment levels; the Stafford board noted both the income generated through contract work that was reinvested in activity provision, and the fact that there were functional skills in all workshops.

9.15 In prisons holding young adults, purposeful activity is particularly essential both in rehabilitation and safety. At Brinsford, the board commented on the young men's reluctance to participate in classroom-based education and the need to provide more vocational training relevant to employment. The Aylesbury board noted that

> '*The total number of sessions provided by the prison is a disappointing 66% of the total number needed for full employment…only 36% of prisoners are in full-time employment. In practice, the number of sessions which actually take place is often considerably less than this*'

Rochester, which had been due to close, had to discontinue some courses because of tutors leaving, which the board considered contributed to the drugs problem. Swinfen Hall had lost 26,000 learning hours between August 2017 and April 2018, with significant regime restrictions. The Deerbolt board, reporting in late 2018, noted both the negative effect of the restricted regime and the positive impact of education being integrated into workshops.

9.16 Some boards queried both the 'official' statistics for attendance at education or training, and its relevance to work opportunities outside. The Wymott board noted that management statistics showed that industry hours had been exceeded, but that the board frequently noted a significant number of prisoners on the wings during the working day.

In one typical week towards the middle of 2018, 462 sessions were missed: 39% because of refusals to attend work and 41% because prisoners were 'not required'; the board also queried whether the work provided was appropriate for employability.

9.17 Board reports from mid-2018 began in general to paint a more positive picture, with increased activity and fewer lockdowns, and at least in theory sufficient activity, either full or part-time, for all prisoners. The board at Featherstone, for example, reported that a new core day had increased potential activity time to 10 hours, with an 85% attendance at education, a 45% increase in certificates obtained and:

> '*a wide range of vocational courses … aligned with opportunities that exist on the outside, i.e. Timpson's, Railtrack, engineering and catering. A potential new working partnership is currently being discussed … to set up the first academy working on commercial tyres which would lead to employment on release.*'

9.18 Other boards in training prisons also reported links with local employers, and new courses and workshops. As reported above, in some prisons the perennial maintenance problems and the need for prisoners to gain employability skills came together in the development of prisoner working parties for general maintenance, with the possibility of gaining qualifications.

9.19 In the women's estate, the board at Foston Hall was enthusiastic about the positive approach to work and training. Training and qualifications were integrated into an increasing number of activities, there were short courses geared to the needs of remand prisoners, and proactive links to employers and employment opportunities. Women were able to work with a commercial organisation to develop proposals for a business enterprise in the prison, which led to one project being adopted and job interviews for all participants. Similarly, at Drake Hall, the board reported a wide range of educational and training opportunities, with 97% of the women in work or education, as well as 23 women working outside the prison on release on temporary licence (ROTL). There were some industry-led activities with opportunities for employment on release: all those who had accepted post-release jobs at Halfords and Greggs were still there, and two had been promoted to management roles.

9.20 At Feltham, there had been some notable improvements in the provision for young adults by the end of the reporting year. Attendance at education had improved from 51% to 71%, due to the greater availability of staff escorts, achievements had also risen and the number of new courses doubled. Workshops were still being cancelled at short notice due to staffing problems, but there were some positive initiatives, including the redecoration of the library and the reinstatement of City and Guilds qualifications.

9.21 There was a mixed picture in open prisons. Some had made impressive efforts to engage local employers and community partnerships, though some found this challenging, given their geographical isolation. The Hatfield board reported on an excellent education provision, providing life skills as well as learning and working closely with partners in the community in a joined-up approach, and that 'a resourcing consultant works "across the gate" and has supported 60 men into employment and a further 10 into ongoing training'.

At East Sutton Park women's prison, the board reported a variety of provision, from short courses for women only staying for a short time, to work-based qualifications. The prison was 'tirelessly involved in finding new placements', and holding regular employment fairs.

Looking forward

- New Futures programme, with links to employers
- new education and employment strategy

10. Preparation for release

10.1 Boards reported that resettlement work was severely affected during this period by a number of factors: the inability of community rehabilitation companies (CRCs) to meet the resettlement needs of short-sentenced and low-risk prisoners; the impact of housing shortages and universal credit; the effects of staff shortages on prisons' offender management units; and the inability to allocate prisoners to appropriate prisons. There were also continuing concerns about those still serving indeterminate sentences for public protection (IPP).

10.2 The definition of preparation for release will differ in different kinds of prison: for prisons holding long-term prisoners in the high security estate, it will consist of courses and programmes to allow prisoners to be re-categorised and move through their sentence, for training prisons it will include achieving qualifications and work experience, while for local prisons it will principally consist of the practical steps that short-sentenced prisoners will need to return to the community. Some prisons have a specific resettlement role, to develop or strengthen links with families and community services.

10.3 Boards in local prisons repeatedly commented on the limited service offered by the CRC, the lack of coordination with probation and prison staff and the consequences for successful resettlement. Initial assessments were often not followed through until the mandatory 12 weeks before release (if then) by which it was often too late to organise post-release support and particularly accommodation. Many teams were under-resourced: the Wealstun board reported that the resettlement team had been understaffed every time the board visited and many prisoners were therefore released without the necessary support. There were some exceptions: the Leicester and Berwyn boards recorded active work and effective communication with the CRC.

10.4 At Eastwood Park women's prison, the board referred to the overall inadequacy of the resettlement service, with insufficiently resourced or experienced CRC staff and poor communication between the CRC, the National Probation Service and the prison's offender management and resettlement services. Conversely, they considered that the good work being done to work with women with substance use problems and to link them to post-release services in the community was undermined by cuts to those community services. Drake Hall (a women's training prison) had a more successful relationship with the CRC, and no backlogs in OASys or sentence plans.

10.5 Boards will monitor with interest the proposed changes and additional investment announced by the Secretary of State in May 2019.

10.6 Finding housing for released prisoners was a major concern among many boards, particularly those in the south and west. Many men's prisons recorded around a third of prisoners leaving without settled accommodation (NFA), and some boards had concerns about the 'settled' nature of some that was recorded. Some prisons had even higher NFA figures of up to 40%; others slightly lower, at 20-25%. In some parts of England – especially in the north and midlands – many boards reported a better picture, with up to 90% recorded as leaving to settled accommodation. Nearly all women's local prisons reported concerns

about accommodation on release: 40-50% of those leaving Bronzefield had nowhere to live, as did around 30% of those leaving Eastwood Park and Peterborough.

10.7 In Wales, the Swansea board considered that fewer than half of the prisoners had their accommodation resolved before release. When the Cardiff board did its own survey of prisoners being released on one day, only 13 out of 25 had somewhere to sleep that night, and in general only around half of those released had any accommodation, some of it very temporary such as 'sofa surfing' with friends. The board raised this with the Welsh Government.

10.8 There were particular problems for 18 to 21-year-olds, most of whom up to the end of 2018 were not entitled to housing benefit. While the Feltham board reported that all young adults left with somewhere to stay, only half of this was permanent accommodation, with the rest being hostel or approved accommodation, often arranged only one or two days before release. Deerbolt, holding young men from all over the country, was able to provide assessments and referrals, but the local CRC inevitably lacked knowledge of the local circumstances and links in their home area.

10.9 Without settled accommodation, it is very likely that prisoners will reoffend; indeed, the Bristol and Cardiff boards reported hearing that some men reoffended simply in order to get a roof over their heads. The reporting period did not cover the new responsibilities to liaise with local authorities in England in relation to potential homelessness under the Homeless Reduction Act, which only came into effect in October 2018. Though this requires prisons and CRCs to notify local authorities of anyone at risk of homelessness, it does not give those local authorities a duty to house them. At Brixton, designated as a resettlement prison, where a third of prisoners were released to no, or very temporary, accommodation, the board noted:

> *'Accommodation on release is a vital factor in reducing reoffending. The Board welcomes the provisions of the Homelessness Reduction Act; but where there is a shortage of affordable housing, as in London, local authorities may be unable to meet the duty without housing men out of area, potentially violating their licence conditions.'*

10.10 Statistics on future employment, education or training are less reliable, but where boards were able to obtain them, in most cases fewer than a third of released prisoners had any form of employment or training to go to on release. Many boards expressed great concern about the impact of the universal credit arrangements on released prisoners: as the Eastwood Park board reported

> *'following the introduction of universal credit, the opportunity to apply for benefits prior to release was removed. In effect this meant that prisoners had to survive for at least five weeks on their discharge grant of £47. This must undermine the woman's ability to remain crime-free. In addition, those who had been recalled received no grant upon release.'*

10.11 These continuing issues underline the impact on many prisoners of short sentences and short recalls to prison, which disrupt whatever social and economic stability they may have had, and increase their social exclusion and the likelihood of reoffending.

10.12 A number of boards reported greater emphasis on family ties, including family days and parenting courses, as a result of the 2017 Farmer review, which stressed their importance. At Foston Hall women's prison, there was the first 'family bonding unit' in a local prison, where prisoners could spend a whole day with their families, carrying out normal activities, overseen by a family engagement worker

10.13 During the year, the Skills Funding Agency's contract between prisons and the National Careers Service, to provide through the gate assistance with employment, came to an end. Many boards expressed great concern about this, and the apparent lack of any plans for an immediate alternative. The Belmarsh board was typical, referring to the 'excellent' service that had been offered and a potential ten-month gap in provision. At Channings Wood, the board said that the role of the NCS 'in matching jobs within the prison, careers and training guidance for release has not been taken on by anyone with the knowledge and experience that they brought'.

10.14 Boards both in local and training prisons also repeatedly pointed to the impact of staff shortages and redeployment on the ability to plan prisoners' sentences and placements properly. In local prisons, this often meant that the initial assessment (OASys) was not done, or only partially done, before prisoners were moved to a training prison. Caseloads of 120-130 for each offender manager/supervisor were reported at High Down in 2017, due to redeployment or shortage of staff; at Bullingdon the backlog had doubled to 330 by mid-2018; other local prisons were unable to hold resettlement boards. There were some improvements towards the end of the period, with the board at Wandsworth noting that the increase in staffing had led to a measurable decrease in the OASys backlog.

10.15 These backlogs then transferred, with the prisoners, to training prisons, which were not resourced to carry out OASys assessments. At The Mount, two-thirds of prisoners arrived without an OASys; as did half of those at Onley and Hindley. This led to backlogs: 120 at Channings Wood; 150 at Wayland, with over 200 prisoners having no OASys; nearly 25% of prisoners at Oakwood had no OASys, partly because of difficulties in obtaining information from the National Probation Service.

10.16 The problem was compounded in the early part of the period by the regular redeployment of staff in offender management units to fill in for staff shortages in the rest of the prison. This directly affected the ability to plan prisoners' sentences, to re-categorise them, and to offer home detention curfew or release on temporary licence. By the end of the period, in some prisons, offender management time was being ring-fenced and backlogs were starting to reduce, sometimes with the help of significant amounts of overtime. By the end of 2018, the Guys Marsh board was reporting significant improvement, with more probation officers, a dedicated governor, and a reduction in OASys and sentence planning backlogs.

10.17 Once prisoners did have a sentence plan and an appropriate categorisation, they often faced a different problem: that the prison estate as a whole is not configured so that prisoners can always be allocated to the right prison to meet their plans and needs. Many boards reported significant bottlenecks, with category B and C prisoners awaiting transfer from local to training prisons, and prisoners who were suitable for open prisons (category D) being unable to transfer there. At Brinsford, the board reported that frustrated young adults

staying too long, because of the inability to transfer to a category B training prison, could end up in segregation. At Wymott, prisoners could wait over seven months for a transfer to an open prison, including a significant number of those serving life and indeterminate sentences. A number of boards pointed not just to the unavailability of space in receiving prisons, but also to the unavailability of transport to get prisoners there, as priority was given to courts, paroles and hospital transfers.

10.18 A further problem was that not all category C training prisons were designated and resourced as resettlement prisons. The aim was that prisoners should be transferred towards the end of sentence to a prison with a resettlement capability, nearer their home. In principle, this is clearly a good idea: 80% of the prisoners in Wayland (Norfolk) were not from East Anglia and only 25% of Portland's prisoners were from the local area. In practice, however, such transfers were difficult to achieve because of the pressure of population. Dartmoor, one of the most remote prisons, had no dedicated resettlement resource and yet released over 220 prisoners a year. Wymott and Stocken, also not resettlement prisons, nevertheless released 300 and 129 prisoners respectively a year.

10.19 The same pressures meant that some prisoners were released directly even from higher security category B prisons: Swaleside released 77 prisoners, without having any consistent or reliable resettlement service; at Lowdham Grange the board reported 25 direct releases. Young adults could face the same problem, waiting up to 18 or 20 weeks at Swinfen Hall for transfer to resettlement or open prisons, or at Deerbolt being released directly, often far from home.

10.20 Boards in dedicated sex offender prisons reported even greater difficulties, both in moving between category B and C prisons, and particularly in the shortage of open prison spaces. They also noted an increase in direct releases, especially from category C prisons. Around 20 prisoners a month were released directly from Whatton, sometimes only obtaining an address on the afternoon before release; 73% of Stafford's prisoners were released directly, as were around 400 during the year from Littlehey. While these prisoners are subject to multi-agency public protection arrangements (MAPPA), they will have had no opportunity to be tested in open conditions before release.

10.21 Boards continued to express concerns about the number of prisoners with indeterminate sentences for public protection (IPPs) held long beyond tariff (the minimum period set by the court). At Gartree, 86% of those with IPPs were over tariff and of those two-thirds had initial tariffs of less than four years. One had been given a 10-month tariff when he was 18, 11 years ago. The board noted that these prisoners were twice as likely to self-harm as other prisoners, and considered that most IPP prisoners had significantly deteriorated since the end of their original tariff. At Coldingley, at the beginning of the year, there were 36 IPP prisoners who between them had served 277 years beyond tariff, and a year later there were still 23, with 160 years post-tariff. Bronzefield held six women five years over tariff, one of whom was over nine years over, which the board considered was physically and mentally detrimental.

10.22 The board at Warren Hill, however, reported some very impressive work being done with IPP and life sentenced prisoners who were long past tariff, or who had previously failed in open conditions. During the year, 79 of the 130 who had Parole Board hearings were released on licence, and a further 26 were moved to an open prison. The prison's record in

working with these men, and achieving successful progression to release or open prisons, has also been praised in a recent report from the Cambridge Institute of Criminology, and deserves replicating. However, both the board and the Cambridge study noted that the prison's good work could be undone by a lack of support afterwards, in the community, which is essential given the length of time those prisoners have served and the uncertainty they have experienced. This resulted in men being recalled after release.

> *'Warren Hill deals with a particularly complex and challenging population who have often struggled in other environments and there are indications that the care and supervision they have received in the prison needs to be better matched when they move on to serve the non-custodial part of their sentence … 26 men who had been released were recalled to prison before the end of the year, in most cases not having committed a further offence but for failing to comply with a condition of their licence … men released after a long period of incarceration face sudden and major challenges especially if they have not had the opportunity of Release on Temporary Licence (ROTL) to provide a more staged release and reintegration process .. Warren Hill has not been allowed by the Ministry of Justice to offer ROTL … [and] urges the Minister to reconsider this.'*

10.23 Open prisons were better able to manage the transition between prison and the community. They had hundreds of prisoners working outside the prison on ROTL in voluntary or paid work, with very few failures. Kirklevington issued 3,000 ROTLs a month and Hatfield 2200, both with rare breaches; North Sea Camp averaged 1100 a month, with a 98% success rate; Prescoed had granted 22,679 during the year with only 11 failures. Boards reported that very few prisoners left without accommodation, as well as a high proportion leaving for paid work or further training: 475 from Standford Hill went on to paid work, and fewer than ten percent reoffended within three years; 70% from Ford left to further education or work over a seven-month period; 71% from Springhill had some form of employment on release.

10.24 In the women's estate, Drake Hall had an open unit that replicated conditions in the community, with 25 women regularly working outside the prison, and had granted 4700 ROTLs, with no failures. The board was, however, disappointed at the low take-up of on-site family accommodation. At East Sutton Park, there were excellent links with employers and a wide range of opportunities for women to work outside the prison; however, only 21% left to full-time employment and 29% to part-time work, self-employment or further education. The board recorded two factors affected this: many of those leaving without employment had been at the prison for too short a time to benefit from outside work, and over one in five had given up work because they could only afford the rent for supported housing by becoming eligible for housing benefit. The board was particularly critical of the fact that flats, refurbished at a cost of a quarter of a million pounds, to provide semi-independent living as a bridge between prison and the community, were standing unused because of lack of funding for staff.

Looking forward

- Review of probation services and CRCs
- Prison estates transformation strategy to increase training and open places
- Placing of Prison Offender Managers (POMs) in prisons under Phase 2 OMIC

Section Two: The IMB year

11. Governance

11.1 This year, we have put in place the new governance structure agreed by Ministers, to strengthen the independence and effectiveness of the IMBs. This consists of

- a National Chair, responsible for leading the work of the IMBs, chairing the Management Board, task managing the Head of Secretariat and acting as the principal national media spokesperson and national liaison with Ministers, the Department, Parliament, HMPPS and partner organisations.
- a Management Board, responsible for developing and agreeing national strategies and policies, and the processes and systems that underpin the work of IMBs, and for setting and monitoring an annual business plan.
- Regional Representatives, who provide advice and support to Chairs and IMBs within their region (or in the case of the IDE, the immigration estate) to help them fulfil their statutory responsibilities

11.2 Following the appointment of the National Chair, we held five regional forums in spring 2018 to discuss the detail and priorities for the new structure. During the summer and autumn, there was an open recruitment process within the IMB structure for members of the Management Board and for the Regional Representatives. One external Management Board member with finance and audit responsibility has been recruited, and recruitment for a second external member is ongoing.

11.3 The Management Board met formally for the first time in November 2018. It identified seven priority areas of work: training and development; recruitment and retention; knowledge and information management; reviewing conduct and performance codes and processes; reviewing the National Monitoring Framework and annual report template; conducting a skills audit of members; organising a national conference.

11.4 The conference was held in February 2019, and work is progressing in all the other areas. The Management Board will agree and publish a business plan for 2019/20. This will include the workstreams above as well as policy and communications work, to ensure that the impact of IMBs is maximised and their findings fed into policy development within the Prison Service and the Ministry of Justice.

11.5 The new Regional Representatives took up their roles in November 2018, and have been visiting and liaising with IMBs in the prison regions and the immigration detention estate, as well as chairing regional meetings. A joint meeting with the Management Board was held in February, and further joint meetings are planned. They will be working closely with the Management Board on aspects of the business plan.

11.6 We have written to Ministers to ask for statutory underpinning for this new structure, which is necessary in order to create a national, independent arms-length body (ALB), able to recruit staff and with clear accountability.

12. The work of IMBs

12.1 There are currently 1,381 IMB members. Recruitment is an ongoing process, as members retire at the end of their tenure or resign. During the year, 319 new members were appointed and 269 resigned; this involved holding 117 recruitment campaigns, with over 700 applicants for these roles. The national training team provides training for new members, board leaders, and board development officers, supported by an e-learning package, which was revised during the year: eleven national courses were held during 2018-19 and in addition members of the team provided bespoke training to boards and areas.

12.2 During 2018/19, board members carried out 51,284 prison and 2,508 immigration detention visits. In addition, prison boards deal with around 30,000 individual applications from prisoners each year (see Annex C and 12.5 below), and boards in the immigration detention estate receive around 1500 applications. This volume of work, carried out by unpaid public appointees, was supported by just 15 posts in the IMB Secretariat, and a total budget of £1.64m.

12.3 These are very slender resources to assist with recruitment, provide the support and advice that unpaid board members should expect, and ensure that their findings can be of maximum benefit to Ministers and the prison and immigration detention services. We have commissioned an organisational development review, to look at resources in the light of the risks and needs of IMBs and the services they monitor.

12.4 The findings of the annual reports of boards in adult (over-18) prisons are summarised in the previous section of this Annual Report; the findings of under-18 and immigration detention boards will be published later this year. During 2019/20, we will publish quarterly digests of the findings of IMB reports, to highlight emerging themes and issues. The Head of Policy and Communications is also looking at other ways of maximising impact, such as thematic reviews.

12.5 During their visits, boards take applications from prisoners and detainees, in relation to their own individual concerns, which they then raise with the establishment itself. Across all prisons, the highest proportion of applications (23%) related to prisoners' property, followed by 13.5% about healthcare and 11.5% about sentence management. In women's prisons, however, there were slightly more applications relating to healthcare than those about property (390:373); and women's prisons also generated the highest number of applications per prisoner. In young offender institutions, which generate fewer complaints overall, staff and prisoner concerns, including bullying, were the second highest category of applications after property.

12.6 The IMBs are part of the UK's National Preventive Mechanism (NPM), set up under the Optional Protocol to the UN Convention against Torture, and we meet regularly with other member organisations. An IMB member sits on the NPM sub-group on children and young people. This year we contributed to the NPM's annual report, and also to its submission to the UN Committee against Torture. We also briefed members of the Council of Europe's Committee on the Prevention of Torture during their visit to the UK in May 2019.

12.7 The IMBs also provided written evidence to two Justice Committee inquiries, into prison maintenance and the prison population; and gave both written and oral evidence to the Joint Parliamentary Committee on Human Rights' inquiry into immigration detention. IMBs in the immigration detention estate are also providing evidence to the Chief Inspector of Borders and Immigration's first annual review of adults at risk.

12.8 We have Protocols with Her Majesty's Chief Inspector of Prisons and with the Prisons and Probation Ombudsman, and have regular meetings to share information and discuss matters of common concern.

12.9 We regularly meet with officials from the Ministry of Justice (MoJ), HM Prisons and Probation Service (HMPPS), and Home Office Detention and Escorting Services to share information and raise issues emerging from IMBs' work. We have concluded a Protocol with the MoJ, which has been presented to the Justice Committee; and are reviewing our service level agreements with Home Office Detention and Escorting Services and HMPPS.

12.10 During 2018, the IMBs were asked by the Office of the Deputy Governor of the Cayman Islands to advise on an independent board to monitor detention on the islands. The national chair and a member of the IMBs' national training team provided information, carried out an exploratory visit and produced a report for the Deputy Governor's office. Two members of the national training team then provided training to the recently appointed monitoring team, and the Cayman board chair attended our board leaders' course. This work was funded by the government of the Cayman Islands.

Annex A: Segregation units: issues and concerns

Local prisons

Altcourse	'a small number of prisoners with complex mental health and behavioural issues are held in the CSU for significant periods of time…[they] are challenging and volatile and cause a disproportionate amount of disruption'
Brixton	'one man was in the segregation unit for more than nine months…he transferred to a therapeutic environment…[after] a longstanding cycle of segregation at a succession of prisons'
Belmarsh	'several prisoners have spent extended periods in the unit, one for over 240 days…often prisoners are swapped between prisons.'
Birmingham	'during the year there have been three men held in the unit for more than 84 days, with two men held more than 120 days…[this was] the safest place to hold these men.'
Bullingdon	'26 prisoners spent more than 42 days in the SSCU and one prisoner was there for 14 months'
Exeter	'a number of prisoners stayed in the segregation unit longer than 15 days. Often these individuals had severe mental health problems.'
Norwich	'one prisoner was in the unit for ten months…the other remains in the unit from his reception [6 months]. The Board feels most strongly that HMP Norwich has tried but received no support in transferring these prisoners to more appropriate establishments…and that this is completely unacceptable.'
Wandsworth	'ten prisoners spent 42 days or longer within the Unit, and three prisoners stayed for more than 84 days. Prisoners on ACCTs were vulnerable…and placing them in the Segregation Unit could make them feel more vulnerable…On one occasion during the reporting year six out of nine prisoners in the Segregation Unit were on an ACCT.'
Durham	'there is an increase in prisoners being held for more than the initial 42 days…One prisoner, who has resided in SACU [for seven months] has caused significant operational/staffing issues due to violent behaviour and threats to staff and as a result frequently has been subject to a 5 man unlock and use of cuffs, resulting in a strain on resource.'
Lewes	'there has been a sharp increase in the number of prisoners on open ACCTs being held in the Segregation Unit, from 6.3%…to…16.5%...The transfer to other establishments including secure mental health units has been particularly difficult due to the lack of space within the prison system and mental health secure units.'
Winchester	'prisoners (including some who are on an ACCT) may be held in the CSU for up to 90 days.' [the board having described it as a 'bleak and oppressive dungeon' not fit for purpose]

Lincoln 'there have been a number of very difficult to manage prisoners who had been located in segregation beyond 42 days and the establishment finds it very difficult to transfer out this type of prisoner' [though there were no lengthy stays during the last three months of the reporting period]

Nottingham 'staff have dealt with numerous prisoners who suffer from severe mental health problems and/or personality disorders which often manifest themselves in challenging behaviour….Prisoners do still come to the unit from mental health hospital environments…Scheduled transfers to specialist institutions following assessment are subject to the same pressure on resources and the rest of the community and it is concerning that prisoners often wait quite long periods for transfer to a more appropriate environment.'

Belmarsh 'several prisoners have spent extended periods in the unit, one for over 240 days…often prisoners are swapped between prisons, so the unit population remains high.'

Woodhill 'the average number of men in segregation on an ACCT was 22%. The Board remained concerned with the lack of 'ownership' in managing long-stay segregated prisoners and the inexcusably protracted decision-making process.'

Women's prisons

Bronzefield 'there is one long-term prisoner with complex needs who has resided on the unit for several years. She refuses to leave the unit'.

New Hall 'the past year has seen a small number of women staying on the unit for very considerable lengths of time.'

Styal 'five women have spent between 31 and 42 days on the unit…a sixth woman arrived {five months ago]…The Unit is not ideal for anyone to spend more than a few days…Where women have stayed, this is because their behaviour has been such that moving [to a wing] is not an option.'

Peterborough 'one resident with complex needs spent 162 days in the women's [segregation] unit.'

Foston Hall 'there is currently no data available on the percentage of prisoners in the CSU with diagnosed mental ill health, however the IMB has observed a significant number of prisoners with serious mental health problems.'

Drake Hall 'for the first time…there have been two 'long stays' in the unit…There have also been a number of women on ACCT documents (26 during this reporting year).

Male category C training/resettlement prisons

Berwyn 'there are individual cases, usually with a high mental health content, that take an enormous amount of time and application to resolve, for example a young man, who arrived at Berwyn having committed a criminal offence while homeless, has eventually been housed in a local mental health facility – not easily and not quickly.'

Coldingley 'Nine prisoners have been held for 42 days or more at a stretch in CSU (one for 93 days, another for 82 days)…The answer seems to be a continual transfer from one prison to another to ensure their protection. This is unsatisfactory, expensive and disruptive.'

Erlestoke 'the IMB is particularly concerned about the 50+ [segregated prisoners] who were on ACCTs, many with mental health issues and some perpetual self-harmers.'

Wealstun 'once prisoners have been in the seg for over 42 days…they are put on the virtual seg moves, which means they usually get transferred to a local prison…A significant number of prisoners in the seg (sometimes a third) have an open ACCT.'

Ranby 'a number of prisoners have been held in segregation…due to exceptional circumstances with their mental health…These prisoners are on open ACCTs…There have been occasions where prisoners are held here for long periods of time due to lack of facilities elsewhere. The Board repeats its belief that prisoners are sometimes not transferred to secure hospitals within an appropriate time frame…During the year there have been 68 prisoners held in the unit for over a month.'

Portland 'the unit continues to house prisoners for months at a time who cannot or will not be relocated onto normal location…Some are suffering from severe and enduring mental health problems and cannot cope on a main location in prison but are not considered sufficiently 'treatable' or mentally ill to be allocated a hospital bed.'

The Mount 'prisoners with mental health issues are difficult to manage on the wings meaning that they have to be transferred to the less appropriate environment of the CSU…Delays in finding more suitable facilities for them in the NHS…frequently lead to extended stays in the CSU.'

Lancaster Farms 'a significant proportion of prisoners (at least 33%) continue to be held for lengthy periods in the CSU for their own protection (now termed self-isolation)…Some prisoners on ACCTs are held on the CSU (IMB analysis…suggests about 15%)

Lindholme 'we had a concern at the length of time some prisoners remained in the unit. It was not unusual for there to be three or four prisoners at any one time being held there for more than 42 days. [many were seeking transfers out]

Northumberland 'a persistent minority (typically two or three) [are] on ACCTs….data is not currently available…The Board was particularly unhappy about the length of one prisoner's stay in CSU – over five months – which it considered to be excessive. The prisoner…had complex mental health needs…the wider HMPPS and NHS system failed a troubled individual who needed specialist care.'

Guys Marsh 'the Board noted that [the CSU] continued to be used for extremely difficult or mentally ill prisoners…which resulted in a number of 42-day rule extensions being required.'

Onley 'one prisoner [was] in the CSU for a long time (2-3 months) before they were transferred because they were sectioned to a mental health hospital.'

Lowdham Grange 'the Board has concerns at the length of time some of the prisoners are held in segregation whilst transfers or alternative provision is secured for them…Almost all of the prisoners held for over 100 days during the reporting period were judged by Healthcare to have complex mental health needs and required transfer to a specialist unit. The Board feels it cannot be right to hold prisoners in segregation for over 200 days and that this does not constitute humane and decent treatment.'

High Security category A prisons

Whitemoor 'high proportions of men were segregated in excess of 42 and 180 days. On 28 May 2018, the five longest-term residents had been there for between 184 and 362 days.

Wakefield 'some of the prisoners in the unit present with severe mental health problems…It is particularly difficult finding beds for these prisoners in secure mental health hospitals.'

Long Lartin '[the unit holds] a population of long-staying men, typically with complex psychological problems or mental health needs, who often come on transfer from other segregation units within the dispersal system – and some of whom circulate for years within it…the Board once again expresses concern that men have been segregated while subject to open ACCT documents, although the numbers have remained small.'

Full Sutton 'stays remain long...quarter 1 data for 2017/18 recorded an average length of stay on the Full Sutton segregation unit of 43 days (6 weeks) where the range was from 1 day to 399 days. The figures exclude days spent in segregation units prior to the transfer to Full Sutton...The process for referral to, and transfer of, a prisoner to a mental health hospital or other special unit is very lengthy and the outcome of the referral is frequently uncertain. As a result, prisoners with significant behavioural or mental health problems remain in the segregation unit for many months.'

Gartree 'there continue to be men [with mental health needs] kept in the SPU or segregated for many months.'

Sex offender prisons

Rye Hill 'the Board is concerned about the lengthy segregation (257 and 323 days) of two prisoners with complex needs, and considers that the CSU is not the most appropriate place for the long-term accommodation of these prisoners.'

Littlehey 'a small number of the prisoners were exhibiting mental health issues and presented a significant challenge to the [staff and mental health team]

Isle of Wight '20 prisoners spent more than a month in segregation with 18 exceeding the 42-day period.'

Young adult prisons

Aylesbury 'a prisoner can spend up to three months in the segregation unit awaiting transfer to another prison…it is much longer that is appropriate for this age group and raises significant concerns for their mental and physical wellbeing.'

Brinsford 'referrals to secure hospitals have been compounded by varying opinions, which contributed to delays [and] a cycle of alternating between healthcare and the CSU…On [other] occasions, residents have spent a prolonged period of time in the CSU and this cannot be positive for their emotional or mental wellbeing.'

Annex B

Maintenance problems, 2017-18

Bedford	'the environment of the segregation unit is simply appalling. It is a dungeon. The toilets frequently block, there has been a consistent infestation of cockroaches and…a plague of rats.' In the prison as a whole, 'ill-fitting and broken windows are the norm', washing and drying machines were out of use for several months; there were heating and hot water failures.
Bristol	facilities 'shocking and unfit for purpose'; toilets and showers poor and often not working; flooring in some areas past repair; washing machines out of action on two wings for five for months and prisoners washing their clothes in buckets.
Bullingdon	backlog of maintenance problems left over from Carillion; but new washing machines and dryers now provided
Chelmsford	'significant delays to repairs after transfer to GFSL; works under-resourced and unable to provide adequate maintenance; defective or unavailable kitchen equipment
Wormwood Scrubs	Backlog of 2000 tasks post-Carillion; environment 'unacceptably poor in many residential areas': rat infestations; some unheated cells with broken windows; lifts out of use; half the prison unheated for six weeks due to boiler problems; electricity and cell bell failures in one wing; enforcement notice issued by fire inspectors, due to insufficient fire-fighting equipment and 600 broken emergency lights.
Exeter	toilet doors missing on one wing: some toilets not flushing, with waste and excrement on the floor; urinals blocked and overflowing when flushed so that prisoners were using buckets to flush toilets. Funding provided had still not resulted in any repairs seven months later.
Hull	'poor overall performance of Amey'; showers on old wings not fit for purpose, but slow improvement by the end of the year
Leeds	works taking too long, but small in-house team doing some repairs, and privacy screens being fitted
Leicester	routine repairs slow, with rising backlog of work; complex subcontracting arrangements and delays which 'threaten the safety and decency of the establishment'; three out of five ovens and a food mixer not working; some refurbishment and painting/decorating carried out

Liverpool	backlog of 2000 works requests; many cells unacceptable with no electrics, blocked toilets, no running water, broken windows; 'environmentally unhealthy conditions' for prisoners and staff; many cell bells not working; kitchens without essential equipment
Norwich	'diminishing standards of maintenance and deteriorating conditions' under Carillion; slight improvement since; mould growing on one wing because of an overflow pipe not fixed for many weeks; water was dripping through the ceiling around light fittings in two cells; washers and driers constantly breaking down and taking weeks or months to repair; some showers and window grilles mouldy, with fear of chest infections; one sewage pipe uncapped for months; kitchen equipment breakdown.
Durham	programme of improvement e.g. privacy screens, but poor ventilation in many cells, and some still with no toilet screens
Lewes	issues with vermin and ventilation of showers; kitchen equipment not repaired sufficiently quickly
Winchester	standard of accommodation 'unacceptable'; some cells have only a sheet separating the toilet; cells regularly out of use; showers and phones frequently out of order; hot water erratic; two showers replaced in the previous year at cost of £150k and already floors cracked, fans ineffective and water repellent membrane failed
Lincoln	legionella infection being investigated by Health and Safety Executive (one prisoner died) [the board has recorded some improvements since], lack of resolution of repair s and maintenance results in 'unacceptable living and working conditions'; some heating failures; welded windows making cells in one wing too hot; long delays repairing kitchen equipment and washing machines
Pentonville	old windows insecure and compromise safety (knife and drugs entry – reported since 2016); vermin; plumbing 'overloaded'; showers routinely not working properly and some 'stinking'; backed up toilets; none of phones in first night centre working, 37/90 phones in rest of prison out of order; ovens, Bratt pans, cooking kettles broken
Cardiff	heating turned off in one landing throughout winter as pipes were so hot they burnt prisoners; no heating in four workshops in winter; showers on two wings regularly failing; some phones out of use for months; however, painting teams and new furniture made improvements
Haverigg	holes in walls and roofs; floors damaged; showers in poor condition; frequent heating breakdown in several units and in kitchen in winter; laundry failings so some prisoners had no kit changes for two weeks
Channings Wood	floors lifting through damp; showers unhygienic; rooms out of action due to broken windows or leaking roofs; Leaking roofs and unsafe

	electrics; failure to unblock gutters with plant growth led to water penetration; 'red' rating for kitchens fabric and structure – issues dating back to 2016; kitchen equipment continually breaking down; issues with heating, plumbing, floors and showers, with repairs said to take from six months to two years
Buckley Hall	'little evidence of any planned maintenance', rather than a reactive approach; problems with heating, showers and windows taking too long to resolve
Coldingley	night sanitation system in older wings 'inhumane and undignified'; communal showers, washrooms and toilets 'at best completely unacceptable and at worst unfit for human use': many toilets with no seat, showers with no doors, mould on walls, plumbing failures; often toilets and sluices blocked, and smell of urine permeates.
Erlestoke	Under Carillion, cracked and broken windows not fixed for several months; one unit with no hot water for months as boiler broken; amputee unable to get to exercise yard for months as no ramp, though materials were on site. New company 'bogged down in administrative red tape with many layers of authorisation needed before any repair work can be done'
Wayland	50 cells out of action; in old wings leaking roofs; in new wings leaking showers and heating and ventilation problems; kitchen floor repaired many times but still problems
Wealstun	'additional resources required'; delays in equipment replacement; lack of ownership of jobs once on the system and poor communication re progress; standard of some work 'unacceptable'; kitchen floor awaiting repair for over a year
Wymott	electrical supply overloaded; half of showers either out of use or inadequately screened; stair lift out of action in older prisoner wing; kitchen needs total refurbishment; regular equipment failures; weeks for maintenance response; lights on exercise yard out for five months; render missing on one wing so letting water in (reported 18 months previously); failure to finish shower repairs so water seepage
Stocken	'significant reduction in quality, cost and speed of maintenance' under Amey contract; delays to mend showers and shower room flooring; leaks in workshop
Ranby	poor response to repairs; washers and dryers breaking down and slow to install and repair; some workshop machinery out of action for two years
Portland	many cells 'insanitary, in a very poor state of repair and demoralising for prisoners and staff'; delays in essential works with security implications – including cameras and fire prevention; cell windows

	unable to close, inadequate heating and draughts; sink holes due to rat infestation; flooding in some wings
Isis	problems with maintenance and repair of kitchen equipment; defective windows, floor covering defects causing safety hazards; no proper privacy screens for toilets
Highpoint	900 outstanding jobs including repairs to electrical equipment, plumbing, CCTV, hot water and heating in one healthcare facility
Guys Marsh	Board raised maintenance issues 22 times in 2017; some refurbishment ongoing during 2018, but still sustained periods of lack of heating in one workshop and hot water on wings; poor conditions in showers ('squalid'), leaks and blockages in water system.
Whitemoor	no significant improvement with GFSL: showers in poor condition; damaged windows in segregation unit; broken kitchen equipment
Long Lartin	'poor performance of Amey…essential repairs are outstanding in every residential area'; no running water and sanitation in oldest wings; some showers and toilets in poor state; poor standard of repairs, with long waits, wrong materials used, or lack of parts – 'every part of the prison has its own tale of woe'
Swaleside	'appalling condition of showers on most of the wings', with promised work not taking place, and external health and safety inspection reporting they were the 'worst seen in any prison in the country'; some improvement in general repairs under GFSL
Gartree	delays in repairing kitchen equipment, with confusion as to responsibility for repair and replacement (but some refurbishment elsewhere)
Woodhill	'total failure of works contract' which continued under GFSL; at one time 50% perimeter lights not working though this was reported weekly; many cells out of action
Manchester	length of time for repairs and maintenance impacting on conditions; at one point 26 cells out of use; sustained periods of no heating or hot water for showers on wings; broken tiles and windows
Deerbolt	cell windows damaged (funding secured but no progress and issues re drugs getting in); new lockers not installed; hope for better cooperation with Amey in future
Aylesbury	*'*poor maintenance and degradation of the structure and fabric'; low priority for ordinary maintenance; poor state of floors in wings and cells creating trip and hygiene hazards; contract disputes delaying shower repairs; temporary boilers often themselves needing replacement; faulty kitchen equipment; failure to maintain gutters and drains

Rochester	'deteriorating and dilapidated state of many buildings'; many cells need floor replacement; ventilation, heating and water problems across units; delays repairing showers and toilets; one prisoner stated: 'It is easier to buy drugs in Rochester than to get your clothes dry'; some improvements more recently with speedier repairs
Stoke Heath	delays in repairs to three workshops and inability to start work in fourth until drains provided
Feltham	years of inadequate maintenance, with works team trying to catch up – 7,000 basic maintenance jobs reported and addressed January to November 2018: still leaking roofs in residential units and workshops; two cells mouldy walls and ceilings; ventilation and condensation problems, leading to extremes of temperature and damp; some showers not operating for months; broken washers and dryers
Styal	'lack of maintenance is leading to longer term problems with buildings': 42 projects were approved in year, only 21 completed or in train; widespread damp; first night centre unusable on wet days for many months; gutters flooding and uncleaned so damp entered walls and floors are lifting; bathroom ceiling collapsed in one house due to leak; some windows rotted through; issues with some showers and toilet doors
Eastwood Park	meagre maintenance: buildings getting worse; water damage reported for two years; rotting wood; mother and baby unit had catastrophic water damage and was closed from May 2016 to August 2018; privacy issues re toilets and showers
Foston Hall	concerns about length of time for building and maintenance by Amey e.g. classroom out of action for eight months because of leak in ceiling and delays to opening recycling building
Drake Hall	two dilapidated houses not replaced as promised this year: 'the units are damp, mouldy and not fit for human habitation'
Whatton	Amey maintenance team 'understaffed and sometimes struggle to keep up with routine maintenance'
Littlehey	'lack of long term investment and the facilities management contract has caused the prison to operate below acceptable standards of decency at times', 1,385 outstanding reactive maintenance and 1,303 planned jobs at one point; some showers out of action for two years; some boilers out of action for eight months; intermittent hot water and heating, including closure of workshops and classrooms
Ford	money for refurbishment held up in 'labyrinth of contracts and specifications'; poor management of contract by GFSL; unacceptable delays even for emergency repairs and no preventive maintenance; nine months to repair one lift; budget agreed for self-help shower/urinal/flooring refurbishment programme using staff and

	prisoners but no action to agree specification; frequent breakdown of kitchen equipment and washers;
Leyhill	frequent delays but smoother recently; protracted delays including kitchen floor repairs which became significant health and safety issue; repeated faults in electrical equipment in kitchens, with need to use paper plates for several weeks
Kirkham	heating and hot water problems; 'firefighting rather than proactive maintenance'; regular problems with showers, toilets, heating and water
North Sea Camp	kitchen equipment maintenance delays; one in three washing machines out of order with MOJ and Amey disputing responsibility
Thorn Cross	delays in regular maintenance and essential repairs, especially in laundry
Hatfield	refurbishment of showers and toilets; some improvements in Amey response times
Spring Hill	poor conditions on many of the huts: mould in shower areas, lack of shower heads, unsafe electrical work; some units 'barely fit for purpose and require substantial investment'; some initial improvement in repairs with GFSL, previously serious delays e.g. re mice infestation; 50 gym sessions cancelled over three months due to heating failure; faulty kitchen equipment, including plate wash so 56k disposable plates used

Annex C

Applications to IMBs

Application areas: summary

Applications concerning **Property (H1, H2, and H3)** received the highest level of applications across the prison estate by a significant margin. **23.1%** of all applications fell within this category.

Applications concerning **Health (G)**, which includes social care, physical and mental health received the second most applications with **13.1%**.

Applications concerning **Sentence Management (I)** received **11.8%** of all applications, making it the third highest category. **Staff and Prisoner concerns including bullying (J)** received the fourth highest share of complaints, with **10.7%. Letters/Finance and visits (E1, E2)** came in fifth, with **10.5%**.

Key	
A	Accommodation including laundry, clothing, ablutions
B	Discipline including adjudications, IEP, sanctions
C	Equality
D	Purposeful Activity including education, work, training, library, regime, time out of cell
E1	Letters, visits, phones, public protection restrictions
E2	Finance including pay, private monies, spends
F	Food and kitchens
G	Health including physical, mental, social care
H1	Property within this establishment
H2	Property during transfer or in another establishment or location
H3	Canteen, facility list, catalogue(s)
I	Sentence management including HDC, ROTL, parole, release dates, re-categorisation
J	Staff/prisoner concerns including bullying
K	Transfers
L	Miscellaneous
X	Confidential

Source: Ministry of Justice Prison Scrutiny Intelligence team

About Independent Monitoring Boards

Members of an IMB are from the local community, appointed by the Secretary of State for Justice under the Prison Act 1952. Each IMB has a duty to satisfy itself as to the humane and just treatment of those held in custody within its establishment and (for prisons and YOIs) the range and adequacy of the programmes preparing them for release; to inform promptly the Secretary of State, or any official to whom s/he has delegated authority as it judges appropriate, any concern it has; to report annually to the Secretary of State on how well the establishment has met the standards and requirements placed on it and what impact these have on those in its custody.

To enable the Board to carry out these duties effectively, its members have right of access to every prisoner or detainee, every part of the establishment and all its records (except for personal medical records).

Interested in becoming an IMB member?

IMB members are independent, unpaid and work an average of 3-4 visits per month. Their role is to monitor the day-to-day life in their local prison or immigration removal centre and ensure that proper standards of care and decency are maintained.

A typical monitoring visit, for example, might include time spent in the kitchens, workshops, accommodation blocks, recreation areas, healthcare centre and chaplaincy. For more information and for details about how to apply, visit **www.imb.org.uk**