



# **Annual Report of the Independent Monitoring Board at HMP Stafford**

**For reporting year  
1 May 2022 – 30 April 2023**

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## Introductory sections 1 - 3

### 1. Statutory role of the IMB

The Prison Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State from members of the community in which the prison is situated.

Under the National Monitoring Framework agreed with ministers, the Board is required to

- satisfy itself as to the humane and just treatment of those held in custody within its prison and the range and adequacy of the programmes preparing them for release
- inform promptly the Secretary of State, or any official to whom authority has been delegated as it judges appropriate, any concern it has
- report annually to the Secretary of State on how well the prison 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 and every part of the prison and also to the prison's records.

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty designed to strengthen protection for people deprived of their liberty. The protocol recognises that such people are particularly vulnerable and aims to prevent their ill-treatment through establishing a system of visits or inspections to all places of detention. OPCAT requires that states designate a National Preventive Mechanism to carry out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations for the prevention of ill-treatment. The IMB is part of the United Kingdom's National Preventive Mechanism.

### 2. Description of the establishment

Located at the edge of Stafford town centre, HMP Stafford during the period of this report

- was one of the oldest fully operational prisons in England and included several Grade II listed buildings
- was a category (cat) C training prison
- was for people (men) convicted of sexual offences
- had a certified operational capacity of 753 prisoners\*

[\* Figures included in this report were local management information. They reflected the prison's position at the time of reporting but may be subject to change following further validation. Therefore, they may not always tally with official statistics later published by the Ministry of Justice.]

The prison included seven residential wings with most cells accommodating two prisoners. Each wing had in-cell sanitation and a shower block. Except for four cells in B wing, in-cell showers were only available in the newest wing (G). One wing (D)

was used for induction, to accommodate the healthcare centre and the Support and Separation Unit (SSU). G wing also accommodated the new Special Care Unit (SCU) used to house prisoners who required specialist 24-hour medical care.

The outside environment was exceptionally clean and tidy, supporting exercise yards, an Astroturf pitch, many flower beds, a Railtrack teaching area, beehives, and a small paddock that hosted two pygmy goats. Outside areas were further enhanced through murals painted by the prisoners.

Brookside Cabin and garden provided a separate area for older prisoners (Senior Support Group – SSG), enabling indoor and outdoor activities, as well as facilities for relaxation and socialising.

Significant workshop space was provided for employment.

Fulford's Bistro, which provided catering for staff and visitors, was managed by prisoners, and enabled them to gain catering qualifications.

Unity 7 supplied refreshments for prisoners, Barista training courses, a charity shop and meeting place for clubs, including chess. In the process, this enabled many prisoners, who had no experience of them, to become familiar with cashless payment systems.

Within the establishment many voluntary organisations supported the prisoners, including Samaritans (support and training for Listeners), Barnardo's/PACT (Visitors' Centre), Lincolnshire Action Trust (resettlement), the Shannon Trust reading plan "Turning Pages" and Chaplaincy volunteers.

### **3. Key points**

As per previous reports, HMP Stafford is recognised as being a very safe establishment, where the prisoners are fairly and humanely treated and their health and wellbeing needs met. Importantly the previously reported critical issues regarding medicines management, after so many years, have been addressed.

The greatest impact on the "normal" running of the prison that resulted in lost activities (e.g., Video Visits) and wing closures was staff shortages, caused by a mixture of

- staff illness
- bed watches
- unscheduled (i.e., emergency) hospital visits
- detached duty directives

It is understood and appreciated that the staffing resource of HMP Stafford was much better than many other prisons, which explained the requirement placed on it to provide staff for detached duty. However, from a prisoners' perspective there was little understanding and empathy when they were locked in their cells for issues at prisons far removed from them and for reasons not of their doing.

Credit must be given to the staff on duty at such times as they managed prisoners' frustration extremely well such that there were no significant disturbances as a

result, as monitored by the IMB directly and through the Apps\* submitted by prisoners.

[\* An App (Application) is a form prisoners submit to formally draw attention to a particular concern or complaint they may have. The Board also accepted verbal Apps under some circumstances.]

In March 2023, the Board undertook a thorough monitoring exercise into the state of the roadways within the prison, with the following objective:

“To undertake a review of the roadways/walkways that are used by prisoners, with special regard to those in wheelchairs or who require some form of physical aid to walk e.g., walking stick.”

The full report is contained in Annex B, the conclusion of which was as follows:

“The conclusion of the Board, and that of all we spoke to, staff, contractors, and prisoners, is that it is amazing there has not been many serious injuries to prisoners/staff by now as a result of the dangers posed by the roadways/walkways and that it is only a question of time before this does happen.

It is totally accepted that the resolution of the issue is not cheap and may not be able to be done in one go. However, set against potential litigation and compensation cost, and in particular the potential health hazards posed, then the situation can no longer go unattended and should be addressed as a matter of importance and urgency.”



As demonstrated through the images contained within the report, as exemplified above (an area used by wheelchairs), this situation cannot continue and must be rectified before serious injuries take place.

Furthermore, it must be noted that the state of these roadways has been reported on within the prison for 18 years but to no avail. As described by one member of the

prison staff “a fire engine may get down to the workshops but is unlikely to be able to return.”

Although categorised as a training prison and not resourced for resettlement, HMP Stafford continued to discharge direct to the community. The number so discharged in the reporting period was 111.

## Evidence sections 4 – 7

### 4. Safety

Safer custody data sets and prisoner feedback confirm the findings of previous years, namely that when compared to other similar establishments, HMP Stafford remains a low risk, safe prison. There were two significant security concerns during the reporting period

3. the number of gates/doors found unlocked across the prison, due to staff not checking them properly
4. the percentage of staff wearing body worn cameras

both of which have been/are being addressed.

#### 4.1 Reception and induction

Induction was observed to be well managed and delivered with many positive, and no adverse comments from prisoners to the Board.

#### 4.2 Suicide and self-harm, deaths in custody

Category	Total	Monthly Average	Trend
Self-harm	99	8	↓
ACCTs*	150	13	→
Adjudications	450	38	↑
Deaths in custody	12	1	↑
Violent incidents	24	2	→
Use of force	81	7	↑

[\* ACCTs – Assessment, Care in Custody, Teamwork – documentation/planner for those at risk]

Incidents of self-harm were down from 116 in 2021/2022 to 99 in 2022/2023 with cutting remaining the most common form.

Adjudications were up from 288 in 2021/2022 to 450 in 2022/2023, a 56.3% increase. These were mainly as a result of increased cell searches and emphasis on security.

With having on site, the Special Care Unit (SCU), that had, as its core, the delivery of palliative care, deaths in custody were expected to increase, especially when coupled with the elderly population of the prison and the existing level of morbidity.

What was not expected was the impact of these deaths in terms of the increase in administrative workload, such as Prison and Probation Ombudsman (PPO) reports/investigations and Coroners' inquests, on those responsible for reporting on these deaths, especially healthcare administration/management and the Safer Custody team. (See Annex C - Death in custody impact).

Sadly, in August 2022, the prison experienced its first self-inflicted death for a long time. The prisoner concerned was on an IPP (Imprisonment for Public Protection) sentence. Therefore, the question must be raised as to whether the Justice Select Committee and subsequent Ministerial response at that time, into the appropriateness of such a sentence, and the impact it can have in removing any form of hope from a prisoner, played a part in his death.

As much as possible access to the Samaritans phone was unlimited and there was good access to the Listeners group. During the early part of the report period lockdowns made it difficult for Listeners to move about the prison as freely as they needed to and should, but this was recognised and addressed by the Safer Custody team.

#### 4.3 Violence and violence reduction, self-isolation

During the period of the report, levels of violence at HMP Stafford remained low when compared to similar establishments. There were 24 documented assaults and only eight of these involved officers, supporting the conclusion that HMP Stafford remained a safe prison for both prisoners and staff.

#### 4.4 Use of force

Use of Force had increased from 66 in 2021/2022 to 81 in 2022/2023. As per adjudications this was reported as being somewhat due to the changing dynamics of the prison. That is the increase in prisoners, who due to the change in the manner by which the prison service handled recently convicted prisoners, were arriving at HMP Stafford as their first prison or much earlier in their sentence.

#### 4.5 Preventing illicit items

HMP Stafford previously had the reputation of being a prison with a very low-level drug problem, for which the table below again provides evidence for. However, it must be noted that the number of positive tests represent an increase over previous years.

Mandatory Drug Testing Annual Report May 2022 - April 2023													
	Random	Risk	Suspicion	Frequent	Reception	Total Samples taken	Refusals	Diluted samples	Terminated due to time	Positive tests returned	Consistent with Medication	Problem reports from lab	Weekend testing
<b>TOTAL</b>	387	41	43	2	31	504	6	0	10	79	38	8	141

Of the 504 samples taken, 79 (15.7%) were positive but, of these, 38 were consistent with the medication the prisoner was on, so leaving, at worst, a final figure of 41 positives (8%).

In December 2022, it was decided to convert B wing to an “Incentivised Substance Free Living Unit”. The aim of this unit was to support a decent, healthy, and safe environment for the whole community and to increase motivation to remain drug free whilst in custody. Initial feedback was that this is working very well.

## **5. Fair and humane treatment**

### **5.1 Accommodation, clothing, food**

The establishment as a whole was kept remarkably clean, tidy, and looking fresh, which for a building of its age was testimony to the hard work of all involved.

Shower refurbishment, coupled with the legionella outbreak that continued for all of 2022, negatively impacted most prisoners at different times.

It was encouraging to note that, at the time of writing this report, the installation of in-cell phones had commenced and was anticipated to be complete before year end. Less encouraging was the return of legionella and the need to reintroduce mobile shower units as a result.

Clothing availability for prisoners was enhanced by the re-introduction of the charity shop located within Unity 7, which, in the process, generated significant donations for the charity.

Food, as in previous reports, was praised by the prisoners and the extra menus made available at times of religious festivals, and for those on special diets, was appreciated by the vast majority.

### **5.2 Segregation**

The Separation and Segregation Unit (SSU) consisted of four cells, three normal and one special cell (only used in exceptional circumstances typically for the safety of the prisoner and/or staff).

Over the 12-month reporting period 30 prisoners in total were held in the SSU. It was rare for all the normal cells to be occupied at the same time and there were often periods when no prisoners were resident there.

There were no prisoners in the SSU for more than 42 days. Those that required segregation, but could not be held in the SSU, were, typically, held in cellular confinement (CC) in appropriate cells on the residential wings.

Board members were routinely notified when a prisoner was taken to the SSU or placed in CC and the prisoner was contacted/visited where possible.

There were 16 Rule 45 reviews during the reporting period.

It was important to note that as soon as a prisoner was relocated to the SSU the following steps were put into action, as appropriate for each prisoner

- reintegration plans were started in conjunction with residential staff



- Key worker and Prison Offender Manager (POM) visits were increased
- prisoners still attended programmes and continued to work with education and/or Inclusion where possible
- Challenge, Support, and Intervention Plan (CSIP) referrals were instigated if they had not been already
- there was collaborative working across all areas to reduce the time spent in segregation and to reduce the risk of the prisoner returning

### 5.3 Staff and prisoner relationships, key workers

Shortage of staff, illness, bed-watches, hospital transfers, detached duties and regime lockdowns all stretched the relationship between staff and prisoners, especially when wings had to be shut at short notice, often due to a medical emergency hospital transfer.

Key worker sessions were very much the focus of the Senior Leadership Team (SLT) who strived to ensure they were delivered whenever possible and by Q1 2023 were starting to get much better results. An example of their encouragement was provided by the Governor in the prison “Jail Jottings” of 5 February, as quoted below:

“Some positive news now. Our Keywork passed **40%** this week for the first time in years! You managed to deliver a rate of **41.78%**! This means that we are moving towards almost half of our prisoners received a session of keywork this week.”

### 5.4 Equality and diversity (prisoners and staff)

A significant event of 2023 was the opening of a dedicated ED&I (Equality, Diversity, and Inclusion) hub, supported by highly experienced officers and staffed by the representatives from each diversity strand (e.g., disability). Many events have taken place during the reporting period such as the LGBT+ celebrations and awareness during February, community coffee mornings, Gender meetings, Menopause Support Group, much work with the Zahid Mubarek Trust (who aimed to ensure fair and humane treatment and conditions in prisons), Foreign National immigration surgery, as well as forums for each section.

#### Prisoner data:

<b>PRISONER PROFILE (PERIOD JAN – MAR 2023)</b>		
	<b>Numbers</b>	<b>% of Population</b>
Total Prison Population	743	100%
IPPs	32	4.3
Lifers	30	4.0
Transgender	6	0.8

<b>INCENTIVES SCHEME STATUS (ROLL = 748)</b>				
Enhanced	418	55.8		
Standard	329	44.0		
Basic	1	0.1		
<b>ETHNICITY (ROLL = 748)</b>				
White	662	88.5		
Asian	43	5.7		
Black	31	4.1		
Mixed	9	1.2		
Other	1	0.1		
Not stated	2	0.3		
<b>AGE PROFILE (ROLL = 751)</b>				
18 years to 21	1	0.1		
21 years to 29 years	74	9.8		
30 years to 39 years	191	25.4		
40 years to 49 years	139	18.5		
50 years to 59 years	144	19.2	46.1%	26.9%
60 years to 69 years	126	16.8		
70 years plus	76	10.1		

- no year-on-year significant differences in the incentives or ethnicity profile of the prison
- no significant change in the age profile overall when compared to last year, despite the feeling by all that the population was moving to a much younger one

#### Staff data:

	<b>MARCH 2023</b>	
<b>Age Range</b>	<b>Number</b>	<b>%</b>
18-20	4	1.2
21-30	57	16.6
31-40	73	21.3
41-50	47	13.7
51-60	117	34.1
61+	45	13.1
<b>TOTAL</b>	<b>343</b>	<b>100.00</b>

- 64% were male, 36% were female
- 13 more staff in total when compared to the same period last year
- no significant change in age distribution profile, perhaps with the exception of 18-20 where there was only one last year and a slightly lower proportion of 61+ (45 vs 52)

## Discrimination Incident Report Forms (DIRFs)

		LAST YEAR	THIS YEAR	DELTA
CLASSIFICATION	CRITERIA	TOTAL	TOTAL	
DIRFs	Submitted	30	52	+22
	Prisoner vs Prisoner	12	24	+12
	Prisoner vs Staff	13	25	+12
	Prisoner vs Prison	3	3	0
	Staff vs Prisoner	1	0	-1
	Staff vs Prison	1	0	-1
STATE	Proven	12	19	+7
	Unproven	17	29	+12
	No outcome (withdrawn by complainant)	1	4	+3
	Pending	0	0	0
STRAND	Gypsy, Roma, and Travellers	1	1	0
	Gender Re-assignment	1	11	+10
	Foreign Nationals	0	0	0
	Disability	5	10	+5
	Race	9	16	+7
	Religion	2	3	+1
	Sexual Orientation	11	12	+1
	Age	0	0	0

A 73.3% rise in the number of DIRFs submitted, with a similar rate proven (40% vs 36.5%) for this reporting period when compared with last year. Though a disconcerting rise in the absolute number of DIRFs this was felt by the Board to be more as a result of increased awareness of their existence rather than any underlying problems within the prison as these issues were not replicated within the IMB Apps.

One DIRF from the period of this report is still under discussion as it involved a breach of the Data Protection Act and a report to the Information Commissioner's Office (ICO).

### 5.5 Faith and pastoral support

With Covid-19 behind them the Chaplaincy were able to deliver virtually all of their planned events and facilitated the return of the Prison Visitors, a service that was reported to the Board to be much appreciated by the prisoners.

As a Board we were conscious of their workload, especially the impact again of the number of deaths in custody.

As in previous years all celebrations that required, or could be enhanced by, a special meal/menu were supported by the catering department, to the appreciation of both staff and prisoners, as reported in Prisoner Council meetings.

## **5.6 Incentives schemes**

Lammy Review meetings took place throughout the period of the report, remembering that the recommendation of the initial Lammy review was as follows:

- Chapter 5 PRISONS – Recommendation 24:

To increase the fairness and effectiveness of the Incentives Policy (IP) system, each prison Governor should ensure that there is a forum in their institution for both Officers & Prisoners to review the fairness & effectiveness of their regime. Those from Ethnic Minority backgrounds & White Prisoners should be represented in this forum. Governors should make the ultimate decisions in this area.

Following the meeting in March 2023 a new draft IP was issued for consideration, ready to be enacted at the next meeting. Importantly, although many of the elements of this new policy were part of the national agenda the focus was that it be key worker driven.

## **5.7 Complaints**

During the reporting period there were 1161 complaints, which included Comp1 (initial complaint), Comp1a (appeal to the response provided against the initial complaint) and Comp2 (confidential complaint). This was marginally less than the number (1164) of complaints in the previous year.

Of the 1161 complaints, 267 were upheld by the establishment (23%).

The main areas of complaint related to wing or cell issues, which amounted to 186 complaints, representing 16% of the total.

Once again, the Board wished to acknowledge the efforts of the staff in ensuring that an effective system for tracking complaints was in place. The Board often needed to review specific complaints and the details of these were provided swiftly. This enabled the Board to communicate with the prisoner more promptly and thoroughly and the Board were satisfied that, of the responses to the complaints reviewed, they were answered in a polite and timely manner. The Board was aware, however, that the responses were not always to the satisfaction of the prisoner making the complaint.

## **5.8 Property**

Property issues around transfers was not a major problem, generating only five IMB Apps during the reporting period, a significant improvement over previous years.

More of a concern was property within the prison, where issues typically arose from transfer prisoners over one prison's interpretation of what a prisoner was allowed in their cell compared to another.

Changes during the year in the way catalogue orders were allowed and handled initially caused the prisoners much concern. However, as a result of these changes, the significant reduction in the number of parcels received by Reception meant that they were able to process them much more efficiently to the benefit of all. The main

issue that caused (and still causes) the biggest upset is the number of “out of stock” catalogue items, which can add considerably to the ordering process and time for all involved.

## 6. Health and wellbeing

### 6.1 Healthcare general

Compared to previous years it was encouraging to note how few healthcare issues were raised with the IMB. The care delivered was often praised and certainly on a par with what could be expected within the community.

### 6.2 Physical and mental healthcare

The number of concerns raised by prisoners fell dramatically, once the medicines management issues were improved, as can be seen from the table below and by April 2023 the results were extremely positive.

Concerns and Complaints Trends 2022 - 2023												
	05 22	06 22	07 22	08 22	09 22	10 22	11 22	12 22	01 23	02 23	03 23	04 23
Appointment / Referral Time /Waiting Times	21	25	16	17	8	11	7	13	9	3	5	2
GP Decision Conflicts	3	0	1	0	0	5	4	0	0	0	4	3
Staff Attitude	6	8	8	8	8	3	4	5	1	3	1	0
Late Medication	1	1	2	0	5	0	1	2	3	4	5	3
Missing Medication	5	4	2	3	5	2	2	3	2	0	0	0
Medication Conflicts	0	0	0	0	2	0	0	1	4	4	1	0
Confidentiality	0	0	1	2	1	0	0	0	0	0	1	0
Medical Records	0	0	0	0	0	0	0	0	3	0	2	1
Smoking Cessation	0	0	1	0	1	2	0	2	0	0	0	0
Dental	0	0	2	0	0	0	1	0	1	3	8	2
Physio	0	0	1	0	1	3	2	1	0	0	1	0
Optician	0	0	0	0	1	1	0	2	1	1	1	0
Podiatry	0	0	0	0	0	0	0	0	1	3	1	0
Global Diagnostics	0	0	0	0	0	1	0	0	0	0	0	0
Mental Health	4	5	4	1	0	2	3	0	0	2	0	0
Clinical Care	0	2	0	1	4	3	3	3	1	0	0	0
Process Failure	2	4	2	2	3	3	5	5	2	0	3	1
Communication Information	3	1	2	7	5	0	3	0	8	1	2	0
Other	0	0	0	0	0	0	0	0	0	2	1	0
<b>TOTALS</b>	<b>45</b>	<b>50</b>	<b>42</b>	<b>41</b>	<b>44</b>	<b>36</b>	<b>35</b>	<b>37</b>	<b>36</b>	<b>26</b>	<b>36</b>	<b>12</b>

During the year, the introduction of “good practice” initiatives by medical staff was not always appreciated by prisoners. This applied specifically to medicine reviews,

where the number of items prescribed to a prisoner were reduced, especially when these were deemed to be inappropriate pain relief drugs.

### **6.3 Social care**

Sadly, due to a healthcare directive, we are no longer allowed access to the meetings that take place with social care staff and so cannot make valid comment regarding delivery of the service. On a positive note, we have not received any Apps that suggest the service is not being delivered as it should.

### **6.4 Time out of cell, regime**

Other than the impact of repeated Covid-19 and legionella outbreaks, and staff illness in general (which mirrored that of the wider community), the greatest impact on the “normal” running of the prison that resulted in lost activities (e.g., Video Visits) and wing closures was staff shortages, caused by a mix of

- bed watches
- unscheduled i.e., emergency hospital visits
- detached duty directives

It is understood and appreciated that the staffing resource of HMP Stafford was much better than many other prisons and hence the requirement/directive placed on it to provide staff for duty in other prisons (detached duty). However, from prisoners’ perspective there was little understanding and empathy when they were locked in their cells for issues at prison’s far removed from them and for reasons not of their doing.

Credit must be given to the staff on duty who managed prisoners’ frustration extremely well, such that there no significant disturbances as a result, as monitored by the IMB directly and through the IMB Apps submitted by prisoners.

### **6.5 Soft skills**

In addition to multiple clubs and competitions, further opportunities for prisoners included working together to produce William Shakespeare’s play The Tempest.

During the reporting period much work was carried out, mainly by prisoners but also many staff, to develop a new prisoner led in-house magazine called “Inspire”. This was defined as “A rehabilitative culture publication” that set out to define, describe and advertise all that has happened, and is about to happen, regarding rehabilitative culture within the prison. The first edition of this publication was printed at the time of this report’s creation and was seen as a triumph for all involved in its production.

## **7. Progression and resettlement**

### **7.1 Education, library**

As in previous years the Learning and Skills Manager demonstrated very clear leadership and set high expectations for all those within her team and for the prisoners.

A comprehensive assessment system was in place to support the prisoners throughout their educational and vocational journey with personal development plans created and delivered to the learners.

The QIG (Quality Improvement Group) met every two months to monitor the provision of education and skills. A QIP (Quality Improvement Plan) was produced and used to monitor the development of the targets set and reviewed by the Regional Head of Learning Skills.

The rate of prisoner activity fell dramatically during the Covid-19 outbreaks but improved quickly thereafter, to a very positive figure. For the period January – March 2023 inclusive the attendance statistics were:

<b>% of capacity used</b>	<b>Education</b>	<b>Industries</b>	<b>Other*</b>
<b>AM</b>	88.2%	89.5%	89.8%
<b>PM</b>	86.5%	86.8%	88.1%

[\* **Other** – mentors, “Reps” (such as Healthcare), Active Permits, etc.]

Only 69 (9%) prisoners were unemployed, which included those aged over 65 who decided not to engage in any activity and those who were unemployable for any other reason e.g., recently arrived and not yet assessed.

These figures display how well managed the prisoners were in terms of educational and vocational activities.

Acorn, replaced during the year by Prospects Training, delivered employability programmes and career development, with the result that most of the educationally active prisoners held their own Records of Achievement file. A document that contained all the qualifications and courses they attended, which was used as part of their CV when leaving the prison and looking for employment.

NOVUS was the main education provider and delivered a wide range of courses to prisoners. These courses were designed to lead towards national qualifications and allow access to the Open University. The outcomes and achievements for prisoners undertaking these courses was very commendable and regular feedback from the course participants showed positive comments about the courses they undertook in relation to content, interest, and achievement.

Library services were reduced due to staffing vacancies and this had a detrimental effect on their ability to offer their normal comprehensive support and extended opening hours to prisoners. The library staff still offered much for the prisoners including inductions, Storybook Dads sessions for prisoners to record stories for their children, and general opening hours for access to books, CDs, and audio books. The library was well supported by the prisoners and attendance was usually high.

## **7.2 Vocational training, work**

Vocational training was an integral part of the prisoners’ journey, with many skills being offered to them.

7 out of the 8 workshops were utilised to deliver the contracts in place.

RESTART- (Reintegrating Environment Striving to Achieve Results Together) was one example of excellent practice.



This project was set up within workshop 6 by an instructor and prison officer and ran alongside the normal routine of the workshop. They established a need for those prisoners who were 'hard to reach' and aimed to improve their functional skills and those of

relationship development and trust. Prisoners for the project were selected by a multi-disciplinary prison team.

The Board commends this initiative as it has observed the tremendously positive impact it has had. Over the last 12 months, 20 prisoners, who displayed very challenging behaviours or had substance misuse or other disadvantages, have made remarkable progress towards total reintegration within the prison regime.

### **7.3 Offender management, progression**

With programme delivery being dependent upon either small group, or one-to-one work, then, during the various Covid-19 outbreaks it naturally had to cease. Encouragingly, by the end of Q1 2023 the programmes management team were almost completely back on track following all of the issues and waiting lists created by the pandemic. During March, the targets for 2023/2024 were set at delivering the following type and numbers of programmes

- Horizon - 90 starts 81 completions
- Kaizen - 16 starts, 14 completions
- Healthy Sex Programme (HSP) - 10 starts, 10 completions

which represents a significant increase over previous years.

### **7.4 Family contact**

During the year, the management of the visits centre transferred from Barnardo's to that of the charity PACT (Prison Advice and Care Trust). Throughout the many years that Barnardo's managed the contract there had been nothing but praise for the service it delivered by both visitors/families and prison staff. Unfortunately, the same level of service had not been delivered during the first months of the new contract and it was hoped that this was quickly resolved due to the stress it placed on everyone when not working as it should.

Physical changes within the Visits Hall had facilitated much better family contact. Examples being the creation of new Video Visits (what were Purple Visits previously) rooms and opening of the refreshment area.

### **7.5 Resettlement planning**

Although not resourced as a resettlement prison, HMP Stafford continued to discharge direct to the community. The number discharged in the reporting period



was 111 (compared with 166 in the previous year). During the last reporting year, HMP Stafford was re-designated as a training prison which had resulted in a reduction of 33% in the numbers resettled direct.

### ***Accommodation and Transfers***

The Board were pleased to note that all, except four, prisoners released during the reporting period had accommodation on release.

Of those not accommodated on the day of release, three were sentence expired discharges, one of whom declined support, one was advised to present as homeless to the local housing authority (LHA) and one was assessed as non-priority homeless by the LHA but declined the offer of hostel accommodation. The other prisoner discharged without accommodation was deported.

### ***Finance, Benefit & Debt***

17 successful bank account applications were made. A representative of Jobcentre Plus (JCP) visited the prison once a week and held walk-in sessions.

### ***Proof of ID/National Insurance (NI) Numbers***

As in previous years, prisoners were screened at induction and when they were in their resettlement window to ensure they knew their NI numbers and had proof of identity. Prisoners were also supported when they applied for a driving licence. Photographic proof of ID letters to prisoners were supplied to those discharged without any proof of ID.

### ***Will Writing Service***

The list of participating solicitors had been disseminated to wing information desks and prisoners were expected to contact their chosen solicitor direct.

## 8. The work of the IMB

Recruitment and retention of Board members remained the major issues experienced during the 12 months of this report, which was not made any easier as a result of the delays and frustrations created by the vetting process/software/organisation.

### Board statistics

Recommended complement of Board members	14
Number of Board members at the start of the reporting period	6
Number of Board members at the end of the reporting period	9
Total number of visits to the establishment	245

N.B. "Total number of visits to the establishment" listed above cannot, and must not, be construed as a proxy for the amount of time each Board member spent on prison matters, as this figure excluded the many hours at home making phone calls, attending to emails, responding to data requests, dealing with Apps, etc. This number of visits only directly reflected and related to the amount of expenses paid to Board members.

### Applications to the IMB (including via the 0800 telephone line)

Code	Subject	Reporting year	
		Previous	Current
A	Accommodation, including laundry, clothing, ablutions	9 (4.8%)	4 (1.9%)
B	Discipline, including adjudications, incentives schemes, sanctions	5 (2.7%)	7 (3.3%)
C	Equality	4 (2.1%)	1 (0.5%)
D	Purposeful activity, including education, work, training, library, regime, time out of cell	5 (2.7%)	20 (9.5%)
E1	Letters, visits, telephones, public protection restrictions	5 (2.7%)	20 (9.5%)
E2	Finance, including pay, private monies, spends	3 (1.6%)	9 (4.3%)
F	Food and kitchens	1 (0.5%)	7 (3.3%)
G	Health, including physical, mental, social care	<b>72 (38.3%)</b>	<b>34 (16.2%)</b>
H1	Property within this establishment	19 (10.1%)	25 (11.9%)
H2	Property during transfer or in another establishment or location	13 (6.9%)	5 (2.4%)
H3	Canteen, facility list, catalogue(s)	3 (1.6%)	13 (6.2%)
I	Sentence management, including HDC, release on temporary licence, parole, release dates, recategorisation	12 (6.4%)	12 (5.7%)
J	Staff/prisoner concerns, including bullying	16 (8.5%)	25 (11.9%)
K	Transfers	2 (1.6%)	3 (1.4%)
L	Miscellaneous, including complaints system	19 (10.1%)	25 (11.9%)
Total number of applications		<b>188 (100%)</b>	<b>210(100%)</b>

- an 11.7% increase in the number of Apps year on year from 188 - 210
- Apps relating to healthcare remain the highest number overall at 34 but this represents a 52.7% reduction compared to the previous period
- miscellaneous, property and staff/prisoner issues were equal second in terms of number, with all but property typically being related to the regime
- only six (2.8%) Apps were submitted by phone (0800 number) with three of these from one prisoner
- the average response time to an App was 7.3 days. However, this figure was inflated by the number of Apps that took over 20 days, and one that took 75 days, to resolve
- 187 (89%) Apps received a written response, 34 (16.2%) a verbal response. Of the 210 Apps, 14 (6.7%) received both a verbal and written response
- the highest number of Apps submitted by a single prisoner was 14 (6.7% of the total)

#### **Annex A – List of service providers**

- Physical health and social care provider - Practice Plus Group (PPG)
- Mental health provider - Practice Plus Group: subcontracted to Inclusion and MPFT (Midlands Partnership NHS Foundation Trust) that together form an integrated mental health and substance misuse service
- Education services - Novus and Acorn/Prospects Training
- Library services - Staffordshire County Council
- Escort contractor - GEOAmey
- Canteen\* - DHL
- Facilities management - Amey plc
- Visits management – Barnardo's/PACT

[\* Canteen – the equivalent of an external shop that exists outside of the prison, that prisoners can order from once a week for items such as toiletries]

## **Annex B - HMP Stafford IMB report on the state of the roadways/walkways used by prisoners, March 2023**

**OBJECTIVE:** To undertake a review of the roadways/walkways that are used by prisoners, with special regard to those in wheelchairs or require some form of physical aid to walk e.g., walking stick.

**BACKGROUND:** The Board have reported in numerous Rota Reports the deteriorating state of the roadways/walkways used by prisoners to gain access to the residential wings, workshops, Visit Centre, healthcare facilities and other general access areas. Having seen an elderly prisoner almost toppled out of his wheelchair as a result of it becoming stuck in a rut, it is felt by the Board that the state of the roadways/walkways is now so poor in certain areas as to constitute a major Health and Safety issue. This is compounded by the unusually high percentage of elderly and infirm prisoners within HMP Stafford who have need for physical aids to help them walk around the site.

The images that follow do not do justice to the poor state of affairs as it is difficult to capture the magnitude of a 3D problem in 2D. They also do not reflect the length of time some of these issues have existed. For example, one of the Amey contractors, who has worked at the prison for 18 years, explained that he has constantly raised the issue of the roadway in front of Workshop 1/2 for the period of his tenure but to no avail.

This report will form the basis of the Health and Safety section of the HMP Stafford IMB Annual Report 2022/23.

**AREA IN FRONT OF THE CRESCENT:** The images show how the area is criss-crossed by repairs to the tarmac as a result of trenches dug for issues such as drainage investigations. The result is not just sunken tarmac, that fills with water, which in winter freezes and becomes extremely dangerous but also raised and sunken iron works creating trip hazards.

Many of these areas, as well as having to be traversed by wheelchairs, are also the routes for the kitchen trollies and delivery truck food crates.



*View from The Crescent back towards D wing. Main thoroughfare from Visits.*

View alongside the face of The Crescent down E wing, which is the route for the kitchen trolleys, the main access to both E and F wings for wheelchair users and the exercise area for both wings. Note the sunken areas that contains pooled water, one of which is highlighted within the image.



This picture is taken further along the face of E wing, closer to the kitchens and the exceptionally poor state of the roadway can be clearly seen, with trips hazards, ruts, and iron works at different levels.



One particularly bad example of the danger (as follows in the next image) is at the gate to the exercise area, where the tarmac is missing, the area is



sunken and the iron work exposed. It is through this gate that kitchen trollies and wheelchairs must come and where the food lorries discharge their crates, which are 2m tall.



## FROM THE CRESCENT TO WORKSHOP 7

Images that clearly show:

- The poor state of the roadway in front of the kitchen. N.B. Distribution lorries have to unload their crates (2m tall) at the gate and move them over the very uneven surface to the kitchen stores





- Ramp entrance to Education, which is not functional as wheelchairs get stuck in the area where the water pools causing the occupant to be thrown forward and potentially out of their wheelchair



- Uneven tarmac and ironworks, especially on the main route outside Brookside Cabin, the location for the Senior Support Group (SSG) of retired prisoners, many of which have mobility issues. This area includes outside of the library where the drain is below the level of the pathway



## IN FRONT OF WORKSHOP 1/2

Possibly the most dangerous area to walk on with regard to the main thoroughways. Access to the workshops (other than Workshop 7) is via this point.

As you walk across this “zebra crossing” the drainage covers (circled) move. They are uneven, pose a major trip hazard and a hence form a serious Health and Safety issue.





The entrance to Workshops 1 and 2 is the gated green door on the left. There is not sufficient space on the painted “designated walkway” for prisoners as they exit the workshops and hence spill out across the road on to the unstable/dangerous drainage covers.





## IN FRONT OF A WING



Sunken drain repairs form the major hazard as they are so close to the main walkway and are extremely easy to “go over” on.



## WINGS A, B, C MAIN ENTRANCE

The pooling of the water shows the issues and hence dangers.







## IN FRONT OF CAMELOT

Many risks based on raised, sunken iron works, uneven tarmac.





**CONCLUSION:** The conclusion of the Board, and that of all we spoke to, staff, contractors, and prisoners, is that it is amazing there has not been many serious injuries to prisoners/staff by now as a result of the dangers posed by the roadways/walkways and that it is only a question of time before this does happen.

It is totally accepted that the resolution of the issue is not cheap and may not be able to be done in one go. However, set against potential litigation and compensation costs and in particular the potential health hazards posed, then the situation can no longer go unattended and should be addressed as a matter of importance and urgency.

## **Annex C - Death in custody impact**

It is important to remember that every death in custody, and especially the journey to death, had an impact on the following individuals/departments, often requiring them to deliver over and above the normal expectations

- Prisoners
  - Cell mate - often their carer
  - Listeners
  - Impact of the journey to death on other prisoners especially where the quality of life deteriorated dramatically in the final months, but the prisoner had to be managed on the wing
  - Impact as a result of staff involved in bed watches on prison life - wing closures, reduced regime, etc.
  - Impact on other prisoners of the death, especially those on ACCTs
- Prison staff
  - Impact on staff of the death - especially those attending at the time of death
  - Impact of the journey to death on staff especially where the quality of life deteriorated dramatically in the final months but the prisoner had to be managed on the wing
  - Healthcare in the ongoing management of the individual - could be a number of years, so relationship built
  - Safer Custody – ACCTs/social care/death in custody reports
  - Family Liaison Officer(s) - appointed closer to death
  - Prison Offender Manager (POM)
  - Staff involved in bed watches - 2 persons up to 3 shifts per day
  - Impact as a result of staff involved in bed watches on prison life - wing closures, reduced regime etc.
  - Chaplaincy - directly with the prisoner concerned, their family and also the impact of their death on others
  - Administrators of the death - especially healthcare/SLT - e.g., responses to PPO investigation, Coroner etc
- Family
  - Pre and post death, especially visiting whilst in the last stages of life
- External agencies
  - Samaritans
  - IMB
  - Police - required if DiC within the prison
  - Prison Staff Care groups e.g., PAM Assist (leading employee assistance programme)
  - PPO investigation
  - Coroner and Inquest
  - Press

Now multiply this impact by an average of one death in custody per month (sometimes two in one week), remembering that the dilution effect of a death in a community (e.g., village) does not apply within the walls of an institution.





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