Independent Monitoring Boards

The impact of a crumbling prison estate on prisoners

A thematic monitoring report

November 2024

national preventive mechanism

Introduction from the National Chair

The findings of IMBs across England and Wales paint a stark picture of the human cost of the crumbling prison estate. Prisoners routinely live in conditions that can only be described as appalling. Flooded corridors, cramped filthy cells, leaks of raw sewage, and rat and insect infestations in kitchens, showers and on wings – these are the environments in which prisoners are expected to be reformed and rehabilitated. And prisoners face these conditions in all areas, whether they are working, eating, sleeping or receiving medical care.

Decades of underinvestment in the fabric of the prison estate has eaten away at the infrastructure and equipment of prisons, stripping away much of the estate's resilience. The line between inadequately maintained buildings and buildings which are simply not fit for purpose is sometimes blurred; older buildings are of course more difficult to maintain and present more trenchant issues, but when the Prison Service makes the decision to keep them in use it also makes the commitment to maintain the buildings to a decent standard, however difficult or costly that may be.

With so few prison places in decent condition, the system is stretched each time a new problem unfolds. When prison spaces are taken out of action, as we have seen with the temporary closure of HMP Dartmoor due to dangerous radon levels, the Prison Service is barely able to cope, spawning new problems in the process.

The problem, however, is not only lack of funding, but the inefficient spend of what little money there is. IMBs have seen huge investments in repairs and new facilities, which have later been found unfit for purpose, or simply sit unused. Governors have far too little autonomy to arrange the most cost-effective and speedy solutions for the prisons they run and often feel hamstrung by purchasing systems and other obstacles. Members have reported time and time again that bureaucracy and red tape prevails over prisoner wellbeing and common sense.

This report highlights the consequences of underinvestment and sticking-plaster solutions. It should serve as a warning against continuing down these paths. Furthermore, as the prison population continues to age, what is required to deliver decent standards of care will only increase. IMBs already regularly report failings in these areas, with physically disabled prisoners struggling to access healthcare, purposeful activity and visits. The insufficient consideration given to disabled prisoners is readily apparent: lifts out of service for months or years, wheelchair users held in inaccessible cells, and serious shortfalls in fire safety arrangements, all of which are unacceptable. Clear standards of accessibility must be set and adhered to.

None of these issues are new to the prison sector. Prisoners have been enduring worsening conditions for years, if not decades. Many local IMBs report that prisoners are so accustomed to appalling conditions that they lack motivation to submit complaints, telling members there is no point because 'it's just prison'.

This resignation should be seen for what it is – an indictment of years of underfunding, mismanagement and neglect of the prison estate. It must not be used as an excuse for complacency. IMBs play a vital role, reporting what they see on a day-to-day basis against the standards to which the Prison Service should be held.

Elisabeth Davies **November 2024**

IMB National Chair

About IMBs and this report

Independent Monitoring Boards (IMBs) monitor and report on the conditions and treatment of those detained in every prison in England and Wales, as well as every immigration detention facility across the UK.

This report provides an overview of the impact of aging buildings and delayed maintenance and repairs on men and women in adult prisons and children and young people in young offender institutions (YOIs).

It is based on:

- A survey completed by 86 IMBs (79% response rate) over a five-week period in mid-2024.
- Findings from IMBs' most recent annual reports.

Key findings

- Delayed maintenance and repairs had serious safety implications at many prisons. Faulty windows and grills increased the risk of illicit items being smuggled into the prison, unsafe building design and faulty fire alarms increased the risk of fire and fire-related injury, and environmental hazards such as flooding, unsuitable walkways and sewage leaks posed considerable health and safety challenges.

- Heating, ventilation issues and flooding led to uncomfortable, at times intolerable, living environments for prisoners. Those who shared small cells with unscreened toilets, or who were without in-cell sanitation, faced indecent and often inhumane conditions.

- Vital laundry and kitchen equipment frequently broke down, and repairs and replacements took far too long to source. Stop-gap measures were inefficient and expensive, and prisoners sometimes went without hot food or clean clothes and bedding as a result.

- Vermin and waste mismanagement led to extremely unhygienic, and occasionally dangerous, conditions for prisoners.

- At many prisons, prisoners with physical disabilities faced obstacles to participating in every aspect of prison life, with lifts frequently inoperable and individuals held in cells unsuitable for their needs.

- There was little accountability when maintenance providers' performance fell short, and Governors felt they did not have enough autonomy. On-site maintenance teams and prisoner working teams were reported on much more positively than external contractors.

- Even in instances where there is a clear commitment from His Majesty's Prison and Probation Service (HMPPS) to upgrade the physical estate, it takes far too long – sometimes years – for these improvements to be completed. Timescales are either not adhered to, or not provided at all.

IMB findings

1. Physical decency and cleanliness

1.1 Heating and ventilation

Malfunctioning heating systems and faulty or inadequate ventilation often led to intolerably hot or cold temperatures for prisoners; over 50% of survey respondents named heating or ventilation issues as one of their primary concerns. Heating systems frequently broke down, leaving prisoners without heat or hot water, and ventilation systems were often unfit for purpose. At Gartree, heating failures were so persistent that in January 2024 the Board escalated its concerns to the Minister.

A common theme was failures in temperature control. Prisons grappled with systems that either turned on or off according to a schedule, with no scope for staff to adjust according to temperature fluctuations, or that turned on and off as a result of a malfunction. Styal IMB noted the toll that hot conditions could take on perimenopausal women.

These issues were compounded by the poor state of cell windows in many prisons. Many Boards reported windows that could not be either opened or closed, exposing prisoners to stifling conditions in the summer and cold and damp in the winter. At Birmingham prisoners with asthma complained that the permanently open windows were causing their symptoms to worsen.

At Huntercombe, a mass protest occurred during a period of extremely hot weather in 2021. Eighty men refused to return to their cells, stating that the heat in the cells was unbearable and the windows would not open.

1.2 Flooding, leaks, damp

Flooding and leaks were among the most frequently reported concerns. Several Boards reported hallways and corridors regularly dotted with buckets to catch water dripping through ceilings, which could cause trip hazards, and unexpected leaks or overturned buckets created the risk of slipping and injury. Serious leaks could result in areas of a prison being taken out of action, particularly workshops. At Bedford, the care and separation unit (CSU), which holds some of the most vulnerable men in the prison, was situated underground. As well as being a generally unpleasant subterranean environment unconducive to rehabilitation, it habitually flooded in rainy conditions. Similarly, the leaking roof of the CSU at Feltham B resulted in buckets being used to catch water contaminated with ferrous oxide, which could easily be knocked over when officers escorted men to cells under restraint.

In 2024, Wayland IMB escalated concerns about water penetration in consultancy rooms and the pharmacy, which risked preventing the healthcare provider from delivering its contract. Thankfully, the Board's escalation led to immediate emergency repairs being carried out. Similarly, Huntercombe IMB considered part of the healthcare facility unfit for purpose due to water ingress and a vermin infestation.

Boards reported that workshops were one of the areas most commonly taken out of use due to fabric issues, which not only reduced the number of activity places but also affected the predictability of the regime. The most common problems were leaks and cold temperatures – at Littlehey conditions were so poor at times that workshop instructors refused to work. Prisoners could have their work session cancelled at the last minute due to inclement weather, such as rain coming through the ceiling of a workshop with a leaking roof.

1.3 Vermin

The presence of vermin was an acute issue across the estate. IMBs described cockroach infestations, biting flies infesting showers, dead rodents rotting on the wings and cells taken out of use due to bedbugs, which could be disruptive when a prison was at full capacity. Rats were a particularly common issue, with Board members reporting unacceptable conditions in kitchens and on wings. At Hollesley Bay, a prisoner was bitten by a rat while sorting through rubbish.

Rat infestation in the Pentonville kitchen

The IMB first observed evidence of rats in the kitchen at Pentonville in July 2023. The issue was not dealt with by the prison despite the immediate risks to food safety, and an HMPPS report produced in the autumn of 2023 highlighting the same. The Board consistently raised concerns about the unhygienic state of the kitchen to prison management in its weekly monitoring reports and during monthly Board meetings.

In March and April 2024 Board members observed large numbers of rat droppings under numerous pieces of kitchen equipment and chewed and spat out ceiling insulation in light fittings above open broilers of food and food workstations. As no effective action was being taken by the prison or GFSL, the IMB contacted the HMPPS Area Executive Director for the South and the London Prison Group Director on 4 April, requesting that the situation be reported to Islington Council's Environmental Health Service by the end of the following day. As no such report was notified to the Board, the Board itself made contact with Islington Council on 8 April and also wrote a letter outlining events to the then Prisons Minister.

The kitchen was closed on 10 April, ahead of a planned visit by Islington Council Environmental Health the following day. There was no apparent local or national contingency plan for the kitchen closure. Prisoners were served sandwiches and pasties for multiple meals, and even freeze-dried army grade rations one evening (at a reported cost of over £9000), before the prison was able to serve limited options from two temporary portacabin kitchens. The main kitchen remained closed for over three months before reopening on 19 July 2024.

1.4 Cleanliness

In addition to the ingress of dirty water caused by leaks, broken flooring and crumbling walls made it impossible to keep areas of some prisons in good condition. Prisons such as Long Lartin had inaccessible 'dark side' areas that collected debris and waste thrown by prisoners, which could not be reached by the cleaning crew, further exacerbating the risk of vermin. At Swinfen Hall the Board had serious concerns about fly infestations in the rubbish bins, and at Bullingdon prisoners were bitten by venomous false widow spiders, which the Board attributed to a lack of thorough cleaning.[1]

1.5 Living conditions

While IMBs' concerns about cell-sharing mainly fall outside the scope of this report, it is important to acknowledge the profound effect that the doubling-up of cells intended for one prisoner has had on decency. Many of these cells are simply not large enough to accommodate two prisoners and do not contain the furniture that each cell should have as a minimum; Boards described prisoners eating meals while sitting on toilets in the absence of anywhere else to sit, and belongings stacked up in tall piles due to the lack of cupboard space. These conditions must also be viewed in the context of the poor regime delivery across most of the prison estate, particularly in reception prisons and those with high levels of violence and self-harm, where prisoners can spend the majority of their day locked in these cramped cells.

In some cells, the effect of the urgency with which they have had to be doubled up to expand capacity was evident. Where cells were poorly fitted out, this could lead to accessibility or safety concerns – for example, at Wayland bunk bed ladders were unusable for most prisoners (and indeed often used as shelves), with prisoners instead using unsafe methods of access, such as standing on chairs to get in and out of the top bunks. It was common for Boards to report that toilets were insufficiently screened, or not screened at all, which seriously impacted on the dignity of those sharing cells. Where prisoners also ate meals in their cells, these conditions were unsanitary.

A particularly severe decency issue is the lack of in-cell sanitation in many cells across the closed estate, where occupants often still have to 'slop out' at night. There were serious hygiene issues as a result; at Long Lartin prisoners did not have anything with which to wash their hands except bottled water. At Coldingley, 180 cells were without in-cell sanitation, with the situation expected to persist until at least summer 2025. The night sanitation system was antiquated and inefficient, with men using chamber pots or ad-hoc materials such as empty packaging and plastic bottles as a result. Coldingley IMB described the resulting conditions as inhumane and unfit for the 21st century. As sluices were often blocked, men responded by disposing of human waste in rubbish and recycling bins, which were later sorted by hand by prisoner teams.

In some cases, sanitary issues became so acute that they posed clear threats to health and safety. At Coldingley suspected raw sewage leaked through several ceilings, and at Spring Hill raw sewage was seen pooling at the base of pod accommodation. Four Boards reported the discovery of legionella in showers.

2. Maintenance and repairs

2.1 Alarm systems and evacuation procedures

Fire safety was an acute, recurring concern of IMBs. Given that prisons and other secure custodial settings have the highest fire risk of all Crown Premises, this is highly worrying.[2] HMPPS has acknowledged this issue; in 2022 HMPPS told MPs that almost half of prisoners were being held in cells that did not meet the current fire safety standards. Despite assurances that 'good progress' was being made on fire safety, the pace of these works does not appear to have matched the rising threat of prison fires – the number of cell fires increased by 62% from 2022 to 2023.[3]

IMBs' concerns centred around:

- Faulty alarm systems, which were reported by many Boards. The most common issue was false alarms, causing regime disruption and potential distress to those who find evacuating more challenging; at Haverigg, where a high proportion of the population are elderly, such false alarms were a regular occurrence. Some Boards feared that these false alarms could lead to complacency and less prompt staff responses in the event of a genuine fire. At Cookham Wood, the IMB reported that faults in the fire alarm system were so frequent that staff had stopped reporting them.'. Similarly, Haverigg IMB reported an incident where an officer asked a prisoner why he had failed to evacuate during a (false) fire alarm; he explained that the alarms had gone off so frequently that he had misunderstood their purpose, believing they were intended to call for staff help. In some prisons there were considerable failures in the alert systems in place; at Downview, there was a period of time when the communications team was not alerted when fire alarms went off in several wings, resulting in landing staff having to notify them by phone.
- Poor preparation for evacuation procedures. While personal emergency evacuation plans were generally in place for those who needed them, Lancaster Farms IMB reported delays in plans being completed. Stafford IMB reported particularly severe concerns in this area; a member of prison staff commented that 'a fire engine may get down to the workshops but is unlikely to be able to return.'
- Three Boards highlighted specific serious concerns about prison fires:
    - At Dartmoor, in April 2024 there was an incident in which the Fire Brigade could not gain access to respond to a small cell fire, as the main gate could not be opened. Had the fire been serious, this could have been catastrophic. The IMB is concerned that subsequent communication between the prison and the service provider has not been sufficient to ensure lessons have been learned to reduce risk in future, as each gave different reasons for the failure of the gate to open.
    - At Wayland in 2022, a serious cell fire set in a barricade made by a prisoner resulted in life-threatening injuries, as the barricade did not give way when door-jacks were used against it. The Board identified that only 12 of the 500 cells in newly built accommodation were

equipped with anti-barricade doors. While the prison has committed to replacing these doors, no firm timeframe has been set and as of 2024 the majority of doors continue to be in the old inward-opening style.

- Eastwood Park lacks in-cell fire detection on some residential units, with some house blocks relying on battery-operated smoke detectors outside cell doors. Following a fire-related death in December 2022, a review has been carried out by the Prison Service's fire team and the Prison Service is still in the process of implementing their recommendations. As of July 2024, the residence where the death occurred still did not have in-cell fire detection, with installation planned for later in the year.

2.2 Cell windows

Replacement windows often took far too long to be installed, even when safety concerns were urgent. At several prisons, such as Long Lartin and The Mount, broken or outdated windows made it easier for drones to deliver items such as drugs and weapons to the prison. In 2016, a Pentonville prisoner was killed with a weapon believed to have been smuggled in through a window, and two prisoners escaped through their cell window shortly afterwards. The subsequent urgent investigation recommended 800 insecure windows and security grilles be replaced as a priority – but eight years later, this is yet to be completed.

2.3 Kitchen and servery equipment

A prominent concern across the estate was the frequent breakdown of kitchen equipment, which could take a considerable amount of time to repair. In the meantime, workarounds could be expensive (as at Whitemoor, where the breakdown of equipment necessitated the purchase of frozen vegetables as they could no longer be prepped in-house), or considerably limit the range of food available (as at Bullingdon, where fried food could no longer be provided as a consequence of breakdowns).

Food hygiene concerns were also common; at Chelmsford, for example, a significant proportion of the servery equipment on one wing could not reach adequately hot temperatures. In an environment where food is a central part of prisoners' daily lives, these issues could have considerable impact on wellbeing. At Pentonville, following the rat infestation in the kitchens, more prisoners took to cooking food in their cells even after the kitchen infestation had been resolved, having lost faith in hygiene standards surrounding food preparation.

2.4 Laundry facilities

Many Boards reported that laundry equipment frequently broke down and took an extremely long time to be repaired. This could lead to laundry being outsourced increasing the likelihood of clothing being lost. Long Lartin also reported that the laundry workshop was shut down, with the loss of prisoner jobs as a result. At some prisons there were unacceptable delays in providing clean kit (clothing, bed linen and towels) – at Chelmsford men waited up to six weeks for a kit change, and some men

told Boards that they were fearful of bullying or assault by other prisoners due to their body odour from being unable to change clothes.

Boards reported that prisoners routinely resorted to washing clothes in their sinks, having no other options available. This resulted in clothes being hung over railings, by cell windows and sometimes on clothes horses, which, as Dartmoor IMB noted, constituted a fire hazard.

3. Accessibility

Physically disabled prisoners were frequently held in locations where they could not move around the prison freely, or at all. Boards across the estate reported on habitually broken lifts and a shortage of accessible cells. The lack of step-free access pushed some prisoners with mobility issues into taking risks in order to simply move around the prison. Concerning reports included prisoners who struggled to use the stairs, with the Board at Pentonville observing a prisoner with one leg hopping up a flight of stairs. The IMB at Stafford, which houses a predominantly elderly population who are more likely to have lower levels of mobility, conducted a thorough review into the suitability of walkways for wheelchairs, including discussions with prisoners, staff and contractors. It found that the majority of walkways were notably unsafe and concluded that the risk of serious accident was high: 'The conclusion of the Board, and that of all we spoke to, is… that it is only a question of time before this does happen.'

Some prisons, such as North Sea Camp, were able to deliver good levels of purposeful activity to prisoners with mobility issues by situating classrooms and workshops on ground floors and making good use of ramps. At prisons such as Lancaster Farms and Wymott, however, disabled prisoners, particularly wheelchair users, found it difficult to access work or education. These access issues also extended to visits in some prisons, with broken lifts and stairlifts making it difficult or impossible for prisoners to attend social (in-person) visits with their loved ones. At Birmingham, the lift to the visits' hall was out of order for six weeks; one man told the Board that he had been unable to see his family for the entirety of this period.

For prisoners with mobility issues, access to healthcare both within and outside the prison could be difficult or impossible. Frequently out of order lifts and chairlifts caused delays and complications accessing healthcare appointments, as prisoners had to wait for assistance or take long, circuitous routes to healthcare facilities. In some cases, however, these prisoners were unable to attend appointments at all – at Pentonville some wheelchair users were unable to attend outside hospital appointments due to broken lifts, and at High Down prisoners requiring step-free access were left unable to visit practitioners who required fixed equipment, such as the dentist and optician.

Medication access was also frequently problematic for prisoners with mobility issues. Some prisoners struggled to reach pharmacies due to a lack of step-free access – at Downview a prisoner with mobility issues was forced to use the stairs for this reason while waiting many months for repairs to the lift – and others had to wait for medication to be delivered to them, causing considerable anxiety. Pharmacy hatches were often difficult for prisoners with mobility issues to access due to their height.

4. Obstacles to progress

4.1 Funding

Boards across the estate commented on the lack of funding available for necessary maintenance and repairs. The long-term underinvestment in the fabric of the prison estate was widely acknowledged, and Boards had particular concerns about 'sticking plaster' solutions which were usually more expensive in the long run. For example, Ford IMB highlighted the fact that the restrictive purchasing system had led to the purchase of domestic washing machines rather than the necessary industrial-standard machines, which of course soon broke down.

Another widespread concern was the chronic underinvestment in accessibility for physically disabled prisoners, particularly egregious in light of the ageing prison population and the projected increase in the number of prisoners with physical disabilities. Several Boards highlighted that the strategy for ageing prisoners, though promised for several years, has yet to materialise due to a lack of funding allocated by the Prison Service.

4.2 Management and accountability

IMBs' perception of maintenance providers' performance was generally, though not universally, poor. When providers failed to establish a regular physical presence, the scale of the problems increased. Most IMBs considered prison staff to be 'genuinely doing their best', and the work of on-site maintenance teams compared favourably to work done by external providers. Although several IMBs described on-site teams as responsive and efficient, where workers had to be brought in from outside the prison (for example, to repair certain equipment), Boards almost always reported negatively on this.

In contrast, the most common example of good practice provided by Boards was the use of prisoner teams to repair and maintain the environment they lived in, which had the added benefit of providing purposeful activity and, potentially, vocational training. At Bullingdon, there were two decency teams in place, each comprising one officer and four prisoners; this was well-received, with minor maintenance issues being solved quickly. At the time of the IMB's survey response there were no cells out of action with maintenance issues.

While some issues could be primarily or solely attributed to funding issues, Boards also reported significant errors resulting in substantial wasted investment:

- Bedford faced consistent issues with broken laundry equipment which took a long time to be repaired or replaced. In one incident, the contractors replaced the wrong machines.
- At Lincoln, a malfunctioning walk-in fridge was damaged beyond repair by the maintenance provider Amey, necessitating the order of a replacement.
- In June 2023, an oil leak was reported between two wings at Erlestoke. The maintenance provider GFSL reported that 100 litres of oil had leaked in the first 24 hours since it was discovered, and advised MoJ Property Services to

purchase a new oil tank. It was subsequently discovered that one of the pipes had not been properly capped and no oil had leaked.

IMBs frequently found that improvement works or repairs were delayed due to disagreements over responsibility and cost, resulting in the buck being passed between different functions, such as the provider and the prison, or the provider and the subcontractor.

IMBs across the estate felt that Governors did not have enough control over the work being carried out within their prisons, and that mechanisms to hold providers to account if they failed to fulfil their contract were inadequate.

There were some indications that maintenance and repairs were carried out more effectively at private prisons. IMBs at private prisons reported significantly more positively regarding maintenance issues. At Ashfield, for example, the contractor Serco carried out extensive works ahead of the elapse of its contract with the Prison Service, in accordance with a clause in the contract stating that any buildings and facilities that were worn or in disrepair must be restored to the state in which they were at the start of the original contract. Ashfield IMB further commented that maintenance had been carried out efficiently on an ongoing basis by the in-house maintenance team, which they attributed to the prison being privately-run. At Dovegate, work was carried out across all areas of the prison to bring it up to standard ahead of a contract review. Oakwood IMB noted that the prison had not experienced any serious incidents relating to maintenance issues and that because Oakwood is a private prison, repairs to cells had to be carried out quickly.

4.3 Delays

In some instances, such as the Pentonville window safety issue mentioned in section 2.2, works promised and planned by HMPPS took an inexplicably long time to deliver, with enormous costs to safety and decency, and poor financial implications. At Wandsworth, a new multi-million-pound healthcare centre had still not been opened over two years after its planned opening date, depriving prisoners of the benefits of these facilities and making poor use of capital investment.

Radon gas at HMP Dartmoor

On 21 March 2024, the Chair of IMB Dartmoor wrote to the Director General of HMPPS to raise concerns about the detection of radon gas within the prison. Specifically, the Board were alarmed that despite radon monitoring taking place in 2020, it was not until 2022 that mitigations were put in place to protect prisoners. The IMB questioned whether prisoners had been exposed to significant safety risks in the interim periods.

[1] HMP Bullingdon, however, attribute this to renovation work being carried out in the loft space above the wing which disturbed these spiders, pushing them into the cells below.
[2] Crown Premises Fire Safety Inspectorate Annual Report 2021/22, published December 2023.
[3] Based on data provided by Prisons Minister Edward Argar in his written response to a parliamentary question, 10 May 2024.