



**Isle of Man  
Government**

*Reiltys Ellan Vannin*

# **Response to the Inspection of the Isle of Man Prison by His Majesty's Chief Inspector of Prisons**

**June 2023**

---



# Contents

---

<b>Minister's Foreword</b>	<b>3</b>
<b>Background</b>	<b>4</b>
<b>Inspection &amp; Reporting process</b>	<b>4</b>
<b>Department Commentary</b>	<b>5</b>
<b>Annex A: Action Plan - Priority concerns</b>	<b>6</b>
<b>Annex B: Action Plan - Key concerns</b>	<b>8</b>

# Minister's Foreword



**Hon. Jane Poole-Wilson, MHK**  
**MINISTER FOR JUSTICE AND HOME AFFAIRS**

The Department agreed with His Majesty's Inspectorate of Prisons in March 2022 that the Isle of Man Prison would be inspected as part of its 2023 inspection programme.

The standard inspection framework was used, as set out in the Report, which has now been published. The report highlights 14 concerns, 6 of these being priority concerns.

Alongside HMI's report the Department has produced this document to provide commentary on the report and to outline the action plan for each of the priority and key concerns detailed in the report. This document provides background detail to the commissioning of the inspection of the Prison by HMI, the inspection itself and the reporting process. It also provides updates on work since the inspection took place. Annex A provides the action plan for the priority concerns. Annex B provides the action plan for the key concerns.

The Department is committed to ensuring that our services are efficient and effective and independent inspections play an important role in meeting that objective. However, the cost of inspections is considerable and Government needs to ensure it obtains best value for money in conducting future inspections that provide independent and timely feedback founded in robust understanding of the context of a small jurisdiction such as the Isle of Man. Therefore, the Department will continue to work with the Prison, relevant agencies in the UK, and other similar jurisdictions to look at mutual peer review processes where appropriate.

The Department has, however, requested that HMI return in 2024 to assess progress on the matters raised by this inspection. Separately the Department has sought a review by the Prisons Ombudsman in England and Wales into the recent deaths in custody which remain subject to the Coronal process, in order to identify any further areas for improvement.

I am grateful to the Prison Governor, and all Officers involved, for their time and support during this inspection.

# Background

His Majesty's Inspectorate of Prisons (HMI) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, court custody and military detention.

In England and Wales, prisons are inspected at least once every five years, although most establishments are inspected every two to three years. The vast majority of inspections are full and unannounced, assessing progress made since previous inspections and undertaking in-depth analysis.

As the Isle of Man is an independent jurisdiction, His Majesty's Inspectors are invited to inspect the Island's Prison on an announced basis, with any formal recommendations made thereafter being reviewed by the Department in order to compile a response/action plan on how to address and resolve, where appropriate.

All HMI reports prepared on Island services are published. Previous HMI reports on the Isle of Man Prison service are available online [here](#).

The United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment was extended to the Isle of Man in 1992. The Optional Protocol to this Convention, commonly known as 'OPCAT', was extended to the Island in 2014. As part of the Island's commitment to OPCAT, it must ensure that all places of detention are regularly visited by independent bodies to ensure that prisoners are not subject to abuse, torture or ill-treatment. This independent inspection complements the ongoing work of the Independent Monitoring Board in the Isle of Man.

## Inspection & Reporting process

The latest inspection of the Isle of Man Prison conducted by HMI took place from Monday 6th March 2023 until Thursday 9th March 2023.

The Department were provided with an initial de-brief report in March 2023 and a final draft for comment on factual inaccuracies, or contextual issues, on 12 May 2023. Further evidence was provided at this stage in respect of some of the areas inspected.

The final report will be independently published by HMI on 26 June 2023.

The inspection by HMI and their final report cost just over £39,000 and the Department is grateful to HMI for agreeing to a cost recovery model which meant that the Department only paid the costs incurred by HMI.

# Department commentary

The Department welcomes the report from HMI as part of ongoing efforts by the Prison and Probation Service to improve the services provided to the people of the Isle of Man in order to contribute towards having the safest and most secure small Island community.

The Prison and Probation Services have been undergoing significant change in recent years in terms of staffing, structure and governance with significant progress made in these areas and in the culture improvement. This report provides a welcome overview of progress in those areas and helps to reaffirm or steer where further work is required.

The report provides ratings for outcomes for prisoners in four key areas compared to the last inspection in 2011. Of those key areas, the Department recognises that the rating for safety has decreased (and action to address this is underway), while respect has continued at a reasonably good rating, purposeful activity remains at the same rating (with improvement required). The Department is pleased that ratings for Rehabilitation and release planning have improved, while recognising that further improvement is required and underway.

The Department commends the Prison for areas where the report reflects high performance compared to elsewhere, such as the positive relationships between staff and prisoners, as well as other notable practices, including support to young people transferring from secure care into the adult prison.

The Department recognises the concerns raised around governance, particularly in relation to data collection, reporting and training. The Department will work with the Prison in order to support, as required, and oversee improvements in this area, which are already underway.

The Department will also support the Prison to continue its work with colleagues across Government to introduce the required improvements identified in relation to the provision of healthcare and education.

The Department welcomes recent initiatives introduced and being planned by the Prison that are already contributing towards achieving the improvements outlined in this report. These new initiatives include, but are not limited to, a new Life Minus Violence intensive course (12 month programme for serious violent offenders that will complete its first cohort this summer), introduction of forensic psychologists, new programmes for general offenders due to start this summer, a Group Intervention Programme for Compassion Focussed Therapy and Substance Abuse programme (in planning). The introduction of these interventions and utilisation of specialist staff are designed to better address offending behaviour and are expected to significantly contribute towards improvement in ratings of rehabilitation and release planning and improve the safety of our Island in the long-term.

The Department is grateful to the Prison and colleagues across Government for preparing the action plan included in this report (Annexes A and B) in response to the report and will support delivery against it as required.

The Department is committed to ensuring that this action plan is delivered and will do so through existing, and improving, governance and reporting frameworks for the Prison and Probation Service.

## Annex A

# Action Plan - Priority concerns

Ref	Priority concern	Action	Responsible owner	Delivery Date
1	Governance and oversight of many critically important areas of accountability – for example, use of force, segregation and safeguarding – were weak. The collection, monitoring and analysis of data was very limited, if it occurred at all. There were few forums to provide proper oversight, and arrangements to support accountability were virtually non-existent.	<ul style="list-style-type: none"> <li>• Creation of Compliance and Audit Team to oversee governance across Prison and Probation</li> <li>• Daily quality assurance checks of Folder 5/Assessment, Care in Custody and Teamwork (ACCT) documents.</li> <li>• Use of Force - introduction of risk assessment and new documentation to staff</li> <li>• Segregation - Quality Assurance checks to be carried out by the Close Supervision Unit (CSU) managers, including data</li> <li>• Electronic adjudication paperwork to be implemented</li> <li>• Create safeguarding link for prison and probation and healthcare</li> <li>• DHA to develop improved quarterly monitoring and performance framework.</li> </ul>	<ul style="list-style-type: none"> <li>• Director of Operations &amp; Governance, Probation</li> <li>• Principal Officer Residential, Prison</li> <li>• Principal Officer Operations, Prison</li> <li>• Principal Officer Residential, Prison</li> <li>• Principal Officer Residential, Prison</li> <li>• Prison Healthcare Manager, Manx Care &amp; Head of Community Rehabilitation, Probation</li> <li>• Deputy Chief Officer, DHA</li> </ul>	<ul style="list-style-type: none"> <li>• Sept 2023</li> <li>• July 2023 (F5)/Sep 2023 (ACCT)</li> <li>• Dec 2023</li> <li>• Dec 2023</li> <li>• Sep 2023</li> <li>• Sep 2023</li> <li>• March 2024</li> </ul>
2	The treatment of prisoners at risk of suicide and self-harm was inadequate. Interventions or responses were often disproportionate and too often lacked sufficient focus on care for individuals or their well-being. For example, the use of segregation, and especially special unfurnished cells, was inappropriate for people in crisis.	<ul style="list-style-type: none"> <li>• Quality Assurance checks to be carried out on current safeguarding measures (Folder 5)</li> <li>• Project underway to introduce ACCT Version 6</li> <li>• Introduction of safe cells on the Induction unit as an option for prisoners who are at risk and require further support to keep them safe.</li> </ul>	<ul style="list-style-type: none"> <li>• Principal Officer Residential, Prison</li> <li>• Principal Officer Residential, Prison</li> <li>• Deputy Governor, Prison</li> </ul>	<ul style="list-style-type: none"> <li>• Dec 2023</li> <li>• Dec 2023</li> <li>• Oct 2023</li> </ul>

Ref	Priority concern	Action	Responsible owner	Delivery Date
3	The clinical governance of health services was weak in some areas of service delivery. Staff support and development, clinical audit and information management were undeveloped, leading to gaps in the provision of primary care for long-term conditions and mental health.	<ul style="list-style-type: none"> <li>Review the mechanism for Manx Care Board to hold Manx Care to account for standard of clinical practice</li> <li>Complete various improvements: <ul style="list-style-type: none"> <li>stabilise &amp; improve staffing levels</li> <li>more directly define required standard of care</li> <li>deliver &amp; assure delivery of required standard of care</li> <li>increase clinical audit &amp; supervision</li> <li>improve &amp; continue to monitor mandatory training compliance &amp; strengthen role-specific training</li> <li>Ensure any electronic patient record specification meets the requirements for prison healthcare</li> </ul> </li> <li>Ensure appropriate oversight of clinical governance by Department of Health and Social Care (DHSC)</li> </ul>	<ul style="list-style-type: none"> <li>General Manager, Primary &amp; Community Care, Manx Care</li> <li>Associate Director of Nursing, Primary &amp; Community Care, Manx Care</li> <li>Deputy Chief Officer, DHA</li> </ul>	<ul style="list-style-type: none"> <li>Sept 2023</li> <li>Dec 2023</li> <li>Ongoing to Dec 2023</li> </ul>
4	The prison's regime and, in particular, the education, work and training on offer, did not sufficiently prepare prisoners for employment after release. In education, there were not enough practical courses, and none of the prison jobs offered training, realistic work conditions or accreditation of skills.	<ul style="list-style-type: none"> <li>Review of education offering to include practical and accredited programs</li> <li>Implementation of improved regime</li> <li>Enable engagement from Department of Education, Sport and Culture (DESC) to support review and improvement of education offering</li> <li>Review of work opportunities and programmes for prisoners</li> <li>Implementation of Revised Work Programme</li> </ul>	<ul style="list-style-type: none"> <li>Education Manager, DESC</li> <li>Education Manager, DESC &amp; Education Liaison Officers, Prison (to be identified)</li> <li>Deputy Chief Officer, DHA</li> <li>Head of Community Rehabilitation, Probation</li> <li>Principal Officer Resettlement, Prison</li> </ul>	<ul style="list-style-type: none"> <li>Sept 2023</li> <li>During 2024</li> <li>Ongoing to Dec 2024</li> <li>June 2024</li> <li>Sept 2024</li> </ul>
5	Public protection arrangements were not robust. The assessment and management of the risk of serious harm to others were poor. Often, neither risk management plans nor information about offending behaviour were on record to support safe management of individuals in custody or after release.	<ul style="list-style-type: none"> <li>Review of public protection arrangements completed. Introduction and training to take place in Summer 2023.</li> <li>Domestic violence offending procedures, assessments and intervention training will take place in late 2023.</li> <li>A risk of serious harm policy to be written and implemented.</li> </ul>	<ul style="list-style-type: none"> <li>Head of Community Rehabilitation, Probation</li> <li>Head of Community Rehabilitation, Probation</li> <li>Head of Community Rehabilitation, Probation</li> </ul>	<ul style="list-style-type: none"> <li>Dec 2023</li> <li>Dec 2023</li> <li>Dec 2023</li> </ul>
6	The lack of offence-focused interventions meant that most prisoners were released without addressing their offending behaviour or risk of harm to others. This included some serving long sentences for serious offences.	<ul style="list-style-type: none"> <li>Further development and implementation of forensic pathways based on individual needs assessments.</li> </ul>	<ul style="list-style-type: none"> <li>Head of Community Rehabilitation, Probation</li> </ul>	<ul style="list-style-type: none"> <li>June 2024</li> </ul>

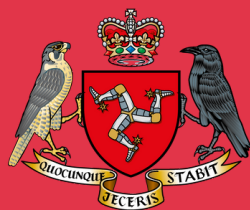
## Annex B

# Action Plan - Key concerns

Ref	Key concern	Action	Responsible owner	Delivery Date
7	Newly arrived male prisoners were held in conditions that were unnecessarily intrusive and restrictive. Regardless of risk, prisoners were subject to 30-minute observation in cells, with constant video monitoring for the first 24 hours. They were also kept locked up excessively in their early days at the prison.	<ul style="list-style-type: none"><li>• Induction policy to be written and implemented.</li><li>• First night risk assessment using a multi-disciplinary approach to be introduced.</li></ul>	<ul style="list-style-type: none"><li>• Principal Officer Residential, Prison</li><li>• Principal Officer Residential, Prison</li></ul>	<ul style="list-style-type: none"><li>• Mar 2024</li><li>• Sept 2023</li></ul>
8	There were insufficient safeguards to protect the well-being of prisoners placed in segregation. Documentation to authorise and account for segregation was not always completed by managers of health care staff, and oversight of extreme measures such as special accommodation was especially poor.	<ul style="list-style-type: none"><li>• Review and refine recently updated CSU Plan</li></ul>	<ul style="list-style-type: none"><li>• Principal Officer Residential, Prison</li></ul>	<ul style="list-style-type: none"><li>• Sept 2023</li></ul>
9	Many security procedures were disproportionate to the risk posed and were needlessly restrictive. For example, frequent strip-searching of some prisoners was unjustified and excessive, and certain items were banned for reasons not based on any sensible analysis of risk.	<ul style="list-style-type: none"><li>• Monthly security team meetings to discuss risk</li><li>• Security specific training to be arranged for and completed by all members of the security department</li><li>• Quarterly departmental meetings to share information regarding identified risks</li><li>• Effective means of data analysis is being explored</li><li>• Review of policies across prison and probation</li></ul>	<ul style="list-style-type: none"><li>• Principal Officer Operations, Prison</li><li>• Principal Officer Operations, Prison</li><li>• Principal Officer Operations, Prison</li><li>• Principal Officer Operations, Prison</li><li>• Deputy Governor, Prison</li></ul>	<ul style="list-style-type: none"><li>• July 2023</li><li>• Aug 2024</li><li>• Sept 2023</li><li>• Dec 2023</li><li>• June 2024</li></ul>



Ref	Key concern	Action	Responsible owner	Delivery Date
10	The prison needed to do much more to promote equality and diversity. There was a lack of adequate oversight or consultation, and hardly any effort to affirm and support minority groups.	<ul style="list-style-type: none"> <li>• Introduction of Equality and Diversity Team</li> <li>• Equality and diversity policy to be written and implemented</li> </ul>	<ul style="list-style-type: none"> <li>• Deputy Governor, Prison</li> <li>• Deputy Governor, Prison</li> </ul>	<ul style="list-style-type: none"> <li>• Dec 2023</li> <li>• June 2024</li> </ul>
11	The professional oversight and management of medicines optimisation and pharmacy services were inadequate.	<ul style="list-style-type: none"> <li>• Recruitment for pharmacist by Manx Care to manage the pharmacy provision</li> <li>• Ensure appropriate oversight of pharmacy services by DHSC</li> </ul>	<ul style="list-style-type: none"> <li>• Prison Healthcare Manager, Manx Care</li> <li>• Deputy Chief Officer, DHA</li> </ul>	<ul style="list-style-type: none"> <li>• Sep 2023</li> <li>• Jan 2024</li> </ul>
12	Most prisoners spent very little time in the education, work or activity placement to which they had been allocated. Many prisoners whom the prison considered to be employed full-time were actually occupied for only 13.5 hours per week.	<ul style="list-style-type: none"> <li>• Recruitment planned for a new Resettlement Principal Officer to co-ordinate improved work and education placements.</li> </ul>	<ul style="list-style-type: none"> <li>• Head of Community Rehabilitation, Probation</li> </ul>	<ul style="list-style-type: none"> <li>• Sep 2024</li> </ul>
13	Not all prisoners were assessed for literacy and numeracy on arrival. Managers did not have sufficient information on the educational needs of the population on which to base curriculum plans.	<ul style="list-style-type: none"> <li>• As part of the new induction policy, assessments will be carried out on all new receptions.</li> <li>• Identification of education programmes to address literacy and numeracy needs</li> </ul>	<ul style="list-style-type: none"> <li>• Education Manager, DESC</li> <li>• Education Manager, DESC</li> </ul>	<ul style="list-style-type: none"> <li>• Mar 2024</li> <li>• Mar 2024</li> </ul>
14	Much more needed to be done to promote and strengthen family ties. Visits were well run, but there were too few initiatives to encourage family contact, or for example, parenting skills.	<ul style="list-style-type: none"> <li>• Review for support and opportunities for prisoners and their families</li> <li>• Implementation of Family Programme</li> </ul>	<ul style="list-style-type: none"> <li>• Principal Officer Operations &amp; Principal Officer Resettlement (to be appointed), Prison</li> <li>• Principal Officer Operations &amp; Principal Officer Resettlement (to be appointed), Prison</li> </ul>	<ul style="list-style-type: none"> <li>• Dec 2023</li> <li>• During 2024</li> </ul>



# Isle of Man Government

*Reiltys Ellan Vannin*