Report on a scrutiny visit to

HMP Whatton

by HM Chief Inspector of Prisons

18 and 25–26 August 2020

Any enquiries regarding this publication should be sent to us at the address below or:
hmiprisons.enquiries@hmiprisons.gsi.gov.uk

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Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England

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Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Aerosol generating procedures (AGPs)
Certain medical and patient care activities that can result in the release of airborne particles (aerosols), and a risk of airborne-transmission of infections that are usually only spread by droplet transmission.

Assessment, care in custody and teamwork (ACCT)
Case management for prisoners at risk of suicide or self-harm.

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Challenge, support and intervention plan (CSIP)
Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

Community rehabilitation company (CRC)
Since May 2015, rehabilitation services, both in custody and after release, have been organised through CRCs, which are responsible for work with medium- and low-risk offenders. The National Probation Service (NPS) has maintained responsibility for high- and very high-risk offenders. Following a change in policy, all offender management will be brought under the NPS by spring 2021.

Early release on compassionate grounds
Determinate-sentenced prisoners may be considered for early compassionate release for medical reasons or in tragic family circumstances. Life or indeterminate sentence prisoners are only eligible to be considered for compassionate release in medical circumstances.

Email a prisoner
A scheme that allows families and friends of prisoners to send emails into the prison.

End of custody temporary release scheme
A national scheme through which risk-assessed prisoners, who are within two months of their release date, can be temporarily released from custody. See:
https://www.gov.uk/government/publications/covid-19-prison-releases

Exceptional delivery model (EDM)
A suite of EDMs have been published to guide prisons through the construction of local regime recovery management plans (RRMPs). An EDM is a guide containing the principles that must be incorporated into a local plan for each element of regime delivery.

HMPPS
Her Majesty's Prison and Probation Service.

Kaizen programme
An accredited offender behaviour programme for adult males who have been convicted of violent or sexual offences, and who are assessed as high or very high risk.

Key worker scheme
The key worker scheme operates across the closed male estate, with prison officers managing around five to six offenders on a one-to-one basis.

Overcrowding draft
Prisoners transferred by directive of HMPPS to ease overcrowding in other establishments.

Personal protective equipment (PPE)
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

Prison offender managers (POMs)
Introduced along with core offender management as part of the Offender Management in Custody (OMiC) model.

Reverse cohort unit (RCU)
Unit where newly-arrived prisoners are held in quarantine for 14 days.

Safer Living Foundation
A charity established in partnership between HMP Whatton and Nottingham Trent University with several projects in the East Midlands, including within Whatton.

Shielding
Those who have health conditions that make them vulnerable to infection are held for at least 12 weeks in a shielding unit.

Short scrutiny visit (SSV)
A type of HM Inspectorate of Prisons (HMI Prisons) visit in which up to three similar establishments (for example, young offender institutions or local prisons) are visited. The aim of these visits was not to report on how an establishment met HMI Prisons' *Expectations*, as in a regular full inspection, but to give a snapshot of how it was responding to the COVID-19 pandemic and to share any notable positive practice found.

Social care advocates (SCA)
Peer supporters.

Social care package
A level of personal care to address needs identified following a social needs assessment under taken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc, but not medical care).

Social/physical distancing
The practice of staying two metres apart from other individuals, recommended by Public Health England as a measure to reduce the transmission of COVID-19.

Introduction

HMP Whatton is a category C training prison in Nottinghamshire and at the time of our visit held about 770 convicted male prisoners. Whatton fulfils a national function providing services to address the offending behaviour of prisoners convicted of sexual offences. The vast majority of prisoners held are serving long sentences of over four years, including some 45% serving indeterminate or life sentences.

In the five months leading up to this visit, Whatton had been operating a restricted regime that had been imposed nationally in response to the COVID-19 pandemic. At the very start of the pandemic, one prisoner had died in hospital from a COVID-19-related illness and a few staff members had been symptomatic, but there had been no further cases in the prison since then. Clear communication to staff and prisoners and the implementation of appropriate measures to reduce the spread of infection had helped to keep the prison safe.

During the restricted regime, levels of violence had reduced and the use of force remained low. However, self-harm was higher than before the restrictions were imposed. While this could be partially attributed to a small number of prolific individuals, the problem was clearly wider spread.

In our survey, almost one in four prisoners reported feeling unsafe. The uncertainty created by the restricted regime and threat of a dangerous virus no doubt fed those negative perceptions. We were concerned that some of the systems in place to identify vulnerable prisoners, such as first night safety interviews and good quality key work, were not sufficiently robust, and there was no formal system to identify those who were isolating themselves from staff and peers. During a normal regime at Whatton these prisoners would possibly stand out, but at a time when prisoners spent most of their day locked up there was an increased risk that some vulnerable prisoners could be overlooked.

Staff-prisoner relationships remained positive, and although time out of cell was restricted, staff were approachable and friendly when prisoners were unlocked. Managers had taken a reasonable decision to focus what limited time for key work was available on the prisoners with the greatest need, such as those who were being supported by assessment, care in custody and teamwork (ACCT) case management. However, other one-to-one opportunities with prison offender managers (POMs) or other specialist staff were limited, providing a possible explanation for our survey findings, which although positive about relationships with staff, indicated the quality of contact needed to be better.

The mental health team and the 'intellectual and developmental disabilities' service continued to provide good support for those with the most acute need, and the social care support was a real strength. However, there were some risks in the management of medicines that required review.

The prison had maintained several important strategic meetings, including one covering equality and diversity. Good support for prisoners from the LGBT community and older prisoners had continued through the restricted regime, but many black prisoners felt that they were treated differently and as a result had a more negative experience than their white counterparts. We strongly urge the prison to explore and understand these perceptions, and to take action to address the issues identified.

Prisoners at Whatton felt the weight of the restrictions heavily because before lockdown most of them had benefited from plenty of time out of cell and reliable access to programmes, education and work. At the time of our visit, most prisoners were locked up for around 22 hours a day, which was clearly taking its toll on many of those we spoke to. The prison had retained work for around a third of the population, which was commendable and gave these prisoners more time out of their cells.

Managers believed they could deliver more but the need to comply rigidly to the national framework for recovery (https://www.gov.uk/government/publications/covid-19-national-framework-for-prison-

regimes-and-services) had affected the scope of what the prison could offer, and the pace at which it could be delivered, in several areas. This was clearly a source of frustration for managers and prisoners, who felt their ability to be innovative and creative had been severely curtailed.

Prisoners had transferred to Whatton from all over the country to complete offending behaviour programmes to reduce their risk and progress through their sentence. Much of this crucial work had stopped during the restricted regime and some prisoners reported feeling stuck.

The prison had maintained some useful one-to-one offending behaviour work and had well-developed plans to restart small-scale groupwork. However, it was clear that it would take some time before it could address the growing backlog of cases, and some prisoners would be released without addressing some risky behaviours. Additionally, despite local efforts, too many prisoners were released without sustainable accommodation, which undermined the otherwise good public protection work.

In conclusion, managers and staff at Whatton were keeping prisoners relatively safe and motivated during challenging times. The pace of change was being directed nationally and was slower than the prison was capable of. Managers and staff were anxious about the impact on prisoners of long-term restrictions in a prison that had previously provided a full and rehabilitative regime.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons
September 2020

Fact page

Task of the establishment
HMP Whatton is an adult male category C training prison holding exclusively people convicted of sex offences.

Certified normal accommodation and operational capacity (see Glossary of terms)
Prisoners held at the time of this visit: 777
Baseline certified normal capacity: 841
In-use certified normal capacity: 775
Operational capacity: 841

Prison status (public or private) and key providers
Public

Physical health provider: Care UK
Mental health provider: Care UK
Substance use treatment provider: Care UK
Prison education framework provider: PeoplePlus
Community rehabilitation company (CRC): Derbyshire, Leicestershire, Nottinghamshire and Rutland (DLNR)
Escort contractor: GEOAmey

Prison group
East Midlands

Brief history
HMP Whatton was built in 1966 as a detention centre for boys. It became a young offender institution in 1989 and re-roled in 1990 as an adult male category C training prison. During the 1990s, it developed as a prison for people convicted of sex offences. Its population more than doubled in early 2006 with the building of eight new units. The prison remains exclusively for prisoners convicted of sex offences.

Short description of residential units

A1–8	Newer residential wings with modern cells. The care and separation (segregation) unit is attached to A3.
B1 and B2	The original accommodation, mostly former dormitories with cubicles.
B3 landing	35 cells
C1–3	Modular units: C2 is low security, C3 is doubled accommodation.

Palliative care unit

Name of governor and date in post
Dr Lynn Saunders OBE, 2008

Independent Monitoring Board chair
Colin Braziel

Date of last inspection
August 2016

About this visit and report

A1 Her Majesty's Inspectorate of Prisons (HMI Prisons) 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, police and court custody and military detention.

A2 All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

A3 During a standard, full inspection HMI Prisons reports against *Expectations*, the independent criteria against which we inspect outcomes for those detained. Inspection teams of up to 12 people are usually in establishments across two weeks, speaking to prisoners and staff, observing prison life and examining a large amount of documentation and evidence. The COVID-19 pandemic means that it is not currently possible to carry out inspections in the same way, both for health and safety reasons and because it would not be reasonable to expect places of detention to facilitate a full inspection, or to be assessed against our full set of *Expectations*, at this time.

A4 HMI Prisons has therefore developed a COVID-19 methodology to enable it to carry out its ongoing, statutory duty to report on treatment and conditions in detention during the current challenging circumstances presented by COVID-19. The methodology has been developed together with health and safety guidance and in line with the principle of 'do no harm'. The methodology consists of three strands: analysis of laws, policies and practice introduced in places of detention in response to COVID-19 and their impact on treatment and conditions; seeking, collating and analysing information about treatment and conditions in places of detention to assess risks and identify potential problems in individual establishments or developing across establishment types; and undertaking scrutiny visits to establishments based on risk.

A5 HMI Prisons first developed a 'short scrutiny visit' (SSV) model in April 2020 which involved two to three inspectors spending a single day in establishments. It was designed to minimise the burdens of inspection at a time of unprecedented operational challenge, and focused on a small number of issues which were essential to the safety, care and basic rights of those detained in the current circumstances. For more on our short scrutiny visits, see our website: http://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/short-scrutiny-visits/.

A6 As restrictions in the community are eased, and establishments become more stable, we have expanded the breadth and depth of scrutiny through longer 'scrutiny visits' (SVs) which focus on individual establishments, as detailed here. The SV approach used in this report is designed for a prison system that is on the journey to recovery from the challenges of the COVID-19 pandemic, but recognises that it is not yet the right time to reintroduce full inspections. SVs provide transparency about the recovery from COVID-19 in places of detention and ensure that lessons can be learned quickly.

A7 SVs critically assess the pace at which individual prisons re-establish constructive rehabilitative regimes. They examine the necessity and proportionality of measures taken in

response to COVID-19, and the impact they are having on the treatment of and conditions for prisoners during the recovery phase. SVs look at key areas based on a selection of our existing *Expectations*, which were chosen following a further human rights scoping exercise and consultation.

A8 Each SV report includes an introduction, which will provide an overall narrative judgement about the progress towards recovery. The report includes a small number of key concerns and recommendations, and notable positive practice is reported when found. Reports include an assessment of progress made against recommendations at a previous SV, but there is no assessment of progress against recommendations made at a previous full inspection. Our main findings will be set out under each of our four healthy prison assessments.

A9 SVs are carried out over two weeks, but will entail only three days on site. For more information about the methodology for our scrutiny visits, including which *Expectations* will be considered, see our website: http://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/

Summary of key findings

Key concerns and recommendations

S1 Key concerns and recommendations identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.

S2 During this visit we identified some areas of key concern and have made a small number of key recommendations for the prison to address.

S3 **Key concern:** The national HMPPS framework for recovery and the exceptional delivery models (EDMs) dictated what the prison could deliver. There were numerous examples, including time out of cell and access to activity, where managers wanted, and indicated that they were able, to deliver more but were not authorised to do so. This was despite there being no recorded cases of COVID-19 since April.

Key recommendation: The national recovery framework should set out minimum standards but give governors the autonomy to deliver a fuller regime at a faster pace if they judge it safe to do so. (To HMPPS)

S4 **Key concern:** Current restrictions and prolonged periods locked up increased the risk of vulnerable prisoners becoming isolated. There was no formal system to identify and support vulnerable prisoners who were withdrawing from staff and peers, which increased their risk of psychological deterioration.

Key recommendation: The prison should introduce robust measures to identify vulnerable prisoners and social isolators to ensure that these prisoners receive appropriate supervision and support. (To the governor).

S5 **Key concern:** Prisoners from a black or minority ethnic background, predominantly black prisoners, reported worse outcomes than white prisoners in some important areas.

Key recommendation: Managers should actively seek to understand and address the negative experiences of black prisoners. (To the governor)

S6 **Key concern:** The lack of accommodation for prisoners on their release was a growing problem, with reduced availability in the approved premises needed for many of those released from Whatton. Thirteen prisoners had been released without accommodation since April, and in some cases their first-night release address was a hotel. The offender management unit and community rehabilitation company staff worked hard to support community offender managers in finding housing wherever possible, but outcomes were not improving and the reasons for this were not confined to the impact of COVID-19.

Key recommendation: HMPPS should work with government to ensure that there is sufficient appropriate accommodation, especially in approved premises, for released prisoners who need such accommodation for reasons of public protection and their own safe resettlement. (To HMPPS)

Notable positive practice

S7 We define notable positive practice as innovative practice or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

S8 Inspectors found the following examples of notable positive practice during this visit.

- The unit for older prisoners and those needing social care had maintained very good support during the restricted regime, with carers based on the unit and appropriate input from the health team. An occupational therapist provided mobility and equipment assessments, promoting a rehabilitative approach to care. The team, together with peer supporters (social care advocates, SCAs) created a positive environment which enabled prisoners to do as much for themselves as possible (see paragraph 2.24).

- The mental health team and intellectual and developmental disabilities (IDD) service continued to provide good care to patients on their caseload and were responsive to urgent referrals. Although groupwork had been suspended, individual therapy and a range of distraction packs and anxiety management resources were provided (see paragraph 2.25).

- The Acorn project was a relatively recent initiative doing rigorous therapeutic work with some prisoners who had problematic personality traits causing a risk of harm, as part of the offender personality disorder pathway. This work was carried out within a clinical structure supported by NHS governance and supervision, and was a promising approach to work with a group of 30 prisoners who showed challenging behaviours (see paragraph 4.11).

- Two of the Safer Living Foundation's projects – circles of support and accountability in the local counties, and the in-prison volunteer support and mentoring service – were doing valuable work to prepare and support prisoners up to and following release. The support and mentoring service in the prison targeted some prisoners with the most pressing needs (such as over-55s, and those with intellectual and developmental disabilities), and had continued to work through in-cell packs during the COVID-19 period (see paragraph 4.16).

Section 1. Safety

In this section, we report mainly on leadership and management; arrival and early days; managing prisoner behaviour; and support for the most vulnerable prisoners, including those at risk of self-harm.

Leadership and management

1.1 The senior management team had focused their attention appropriately on measures to manage the risks associated with the COVID-19 virus. The prison was carrying out the national directives issued by HM Prison and Probation Service (HMPPS) on how to contain and prevent the spread of the virus, and cohort arrangements for prisoners were in place. There had been clear communication to staff and prisoners about the pandemic and associated risks, with information communicated to staff in notices and regular verbal briefings. Prisoners were informed by notices, the WayOut TV channel and verbally by staff and peer workers. Despite the older age profile and vulnerability of the population at Whatton, there had been very few cases of COVID-19 among prisoners or staff.

1.2 The need for social distancing was re-enforced but remained problematic in practice as some corridors and office spaces made this virtually impossible at all times. There had been attempts to supervise distancing in areas such as meal service and domestic visits, but in other settings prisoners and staff worked and associated in close proximity.

1.3 The restrictions on prisoner activity and movement had been relaxed in recent weeks, which allowed a little more time out of cell, but most prisoners were still locked up for 22 hours a day. The prison had made good efforts to mitigate the restrictions, and several work areas remained open. However, the national framework of exceptional delivery models (EDMs – see Glossary of terms) by and large dictated what the prison could deliver. There were many instances where managers could and wanted to deliver more but were not authorised to do so (see key concern and recommendation S3). There were also a few cases where the prison was not delivering the full extent of activity the EDMs allowed.

1.4 Our staff survey highlighted some concerns from staff and suggested that morale had declined during the pandemic. It was clear that some felt demotivated by their inability to continue the valuable rehabilitative work they had prided themselves on before the restrictions were imposed.

Arrival and early days

1.5 The number of prisoners transferring into the prison had reduced since the commencement of restrictions but Whatton continued to receive small numbers regularly. They arrived into a clean reception area with adequate space to social distance. Reception processes were efficient and prisoners were positive about their experience on arrival.

1.6 New arrivals were separated from the rest of the population for 14 days in the designated reverse cohort unit (RCU – see Glossary of terms). The single accommodation cells were clean, and new arrivals were offered a shower and telephone call on their first night.

1.7 A private room was available on the wing to complete a first night safety interview, which was important in identifying any risks or vulnerability presented by a new arrival. However,

we found that some prisoners had not received this interview until the day after they had arrived (see paragraph 1.23).

1.8 Under the EDM for 'early days' new arrivals could formally meet a prison Listener (prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners). However, local managers had not adopted this process, which was another missed opportunity to identify vulnerability in the critical first days in the prison.

1.9 At the time of our visit, the RCU operated up to five different regimes to accommodate groups who had arrived at different times. Each group had to quarantine together for 14 days. During that time there was no enhanced support or regular and meaningful welfare checks by staff to ensure that new arrivals were coping well (see paragraph 1.23). We noted that one prisoner had arrived by himself and therefore spent his 14 days in quarantine on his own. This was offset to some extent by the support and advice provided by peer workers on the unit. All prisoners on the RCU could shower, exercise and make a telephone call daily.

1.10 Formal face-to-face induction to the prison had ceased when restrictions were initially imposed. New arrivals were given a laminated induction booklet in their cell, although this covered the previous regime rather than the restricted regime in place. Peer support on the RCU was very good. The prison had very recently reintroduced manual handling training sessions on the sports field, which qualified new prisoners to apply for a wider range of work opportunities. Education assessments had also just recommenced.

Managing behaviour

1.11 In our survey, almost a quarter of prisoners said they felt unsafe; 34% reported victimisation or bullying from other prisoners and 37% reported victimisation by staff. The usual indicators of safety (see below) did not explain why these figures were relatively high, and it was difficult for us to draw conclusions during a short visit. We urge the prison to explore these perceptions further to understand and address any issues.

1.12 Levels of violence against staff and prisoners remained low and had reduced further during the restricted regime. Drug misuse was low and had further reduced, although there had been some recent finds of fermenting liquid used to brew illicit alcohol. Local security intelligence reports submitted by staff had reduced by half since the implementation of restrictions. The security department was proactive, and there was a good focus on the risks of prisoners accruing debt during the restricted regime.

1.13 Incidents of use of force were low. There had been a spike in April with 17 incidents, although most involved the use of guiding holds or were necessary to prevent self-harm. The prison had retained use of force meetings by telephone conference calls to oversee this critical area, and documentation was mostly up to date.

1.14 It was disappointing that the reward scheme had been suspended. The prison was potentially missing the opportunity to motivate the few prisoners who were less invested in the community and to reward those who clearly went the extra mile. This was particularly important given the value of some of the incentives available to enhanced prisoners – such as an increased allowance to spend in the prison shop – that were currently out of reach to some who merited them.

1.15 The segregation unit was clean. Staff were friendly and approachable, and prisoners were generally positive about their treatment on the unit. TVs were not routinely issued to segregated prisoners, although following risk assessment one prisoner had been approved to

have one. Radios and distraction packs were available in all cells, and prisoners had access to the showers, telephones and exercise every day.

1.16 The number of adjudications had reduced since the restrictions had begun. The adjudication room was large enough to allow for social distancing and hearings continued as normal. The exception to this was prisoners who were shielding; their hearings were adjourned to a later date. Due to the pandemic, the independent adjudicator was not visiting the prison. Instead, the governor reviewed the relevant hearings, and consulted with adjudicating governors to assess which ones could be heard and dealt with locally. Regular quality assurance of the disciplinary process had been sustained during lockdown.

Support for the most vulnerable, including those at risk of self-harm

1.17 Prisoners who were considered clinically at risk were advised, verbally and in writing, of the importance of shielding on one of two designated units. Initially, 52 prisoners had been identified for shielding. Ten prisoners declined the opportunity to shield and were required to sign a disclaimer; they were, however, still supported by health care staff. Following a recent review of arrangements, the number of prisoners shielding had reduced to just four at the time of our visit (see paragraph 2.20).

1.18 There had been three deaths of prisoners during the restricted regime, two of which occurred outside at hospital. Both cases had been investigated by the Prisons and Probation Ombudsman (PPO) and were expected to lead to natural cause verdicts. One of the prisoners died of a COVID-19-related illness believed to have been contracted while in hospital.

1.19 The number of self-harm incidents had increased significantly in February and remained high following lockdown. The prison managed some prisoners with complex cases who repeatedly self-harmed, accounting for over a quarter of all incidents. Prisoners who had recently self-harmed reported feeling very frustrated with the prolonged restricted regime.

1.20 Monthly safeguarding and safer custody meetings had continued, and a range of useful data was collated and analysed. Incidents of serious self-harm and near-miss investigations had also been completed and learning was identified.

1.21 Prisoners at risk of suicide or self-harm on assessment, care in custody and teamwork (ACCT) case management received valuable additional support from cross-deployed programmes staff, regular visits from the chaplaincy and, more recently, key worker sessions (see paragraph 2.3). The formal Listener scheme was still functioning. Meetings took place in association rooms to allow for social distancing, and a comfortable crisis suite was also available.

1.22 In our survey, 45% of prisoners who had been on ACCT said they had felt cared for by staff. The ACCT documentation we reviewed was completed reasonably but some care map actions lacked detail, and records did not reflect some of the meaningful interactions that took place.

1.23 Although prisoners in our survey was broadly positive about relationships with staff (see paragraph 2.1), only 31% said that a member of staff had asked how they were getting on in the last week. Staff were focused and active in monitoring some of the most vulnerable prisoners once they had been identified, However, missed first night safety interviews, limited key work, and less time out of cell to observe prisoner behaviour and build relationships affected staff's ability to identify vulnerability. There was no formal process to

identify prisoners who were withdrawing from their social contact with staff and peers. During a normal regime at Whatton, these prisoners would possibly stand out, but at a time when prisoners spent most of their day locked up there was an increased risk that some vulnerable prisoners could slip through the net. Staff were busy ensuring that the regime ran smoothly, and they were generally friendly and approachable, but there was a lack of regular and meaningful welfare checks on prisoners to identify and address any psychological deterioration (see key concern and recommendation S4).

Section 2. Respect

In this section, we report mainly on staff-prisoner relationships; living conditions; complaints, legal services, prisoner consultation, food and canteen; equality, diversity and faith; and health care.

Staff-prisoner relationships

2.1 Staff-prisoner relationships continued to be good. In our survey, 85% of respondents said that there was a member of staff they could turn to if they had a problem, and 82% said that staff treated them with respect. This was supported in most of our conversations with prisoners, and by our observations of a friendly and approachable staff group.

2.2 Despite this, the quality of relationships between staff and prisoners was affected by the restricted regime and reduced time out of cell, which had only recently been increased to around two hours a day (see paragraph 3.1). In our survey, only 31% of prisoners said a member of staff had spoken to them in the last week to ask how they were getting on (see paragraph 1.23).

2.3 Key worker sessions had stopped in March but were reintroduced on a small scale in June. Sessions were limited to prisoners identified as the most vulnerable, such as those who were shielding or subject to at-risk case management. Given the available staffing, this was a reasonable approach but it did not take account of other prisoners who were struggling during the prolonged restrictions. We were not assured that all systems were sufficiently robust to identify all potentially vulnerable prisoners (see paragraph 1.23 and key concern and recommendation S4). Records of key work in prisoners' electronic case notes were of reasonable quality but demonstrated inconsistency, for example, prisoners were not always seen by the same member of staff. Recent quality assurance checks by managers were leading to improvement in this area.

2.4 In our staff survey, 71% said the prison was supporting them well during the COVID-19 crisis but 40% said that morale had declined. Staff of all grades attributed this to weariness and frustrations associated with the prolonged restrictions. Many felt demotivated because the restrictions affected the level of care they could offer and quality of work they could deliver. Some of the important rehabilitative work that characterised Whatton was not considered to be essential within the criteria of the national framework and had halted during the lockdown.

Living conditions

2.5 The external environment was pleasant with well-maintained gardens, which had a positive effect on well-being. Cells on A and C wings were of a good size but those on B1 and B2 remained unacceptably small, overcrowded and cramped, with a toilet positioned close to the bed without any privacy screening. Despite this, all cells were adequately maintained, well kept and adequately furnished (see Appendix II: Photographs).

2.6 Almost all prisoners in our survey (97%) said that they could shower daily. Some cells in the newer accommodation across A wings had integral showers, which prisoners greatly appreciated. Showers in other areas were clean, although those on B1 and 2 lacked sufficient privacy.

2.7 There was a good standard of cleanliness in wings and communal areas, and most prisoners were given enough time to clean their cells and could access cleaning materials daily. In our survey, 90% of prisoners said they had they had sufficient clean clothing each week and 92% that they had clean sheets weekly; most prisoners could use wing washing machines and the prison made effective use of its in-house industrial laundry. However, there was no hand sanitiser at the entrances to wings.

Complaints, legal services, prisoner consultation and food and shop

2.8 While there had been a slight reduction in complaints between January and June 2020 compared with the same period in 2019, the number submitted had remained high and higher than similar prisons. In our survey, only 54% of prisoners said it was easy to make a complaint and prisoners spoke of delays in receiving a response. We saw several wing complaint boxes without complaint forms, which meant that prisoners would have to request one from staff or a prisoner information desk (PID) peer worker.

2.9 Managers had continued to analyse complaints monthly to identify trends. A range of data was made available to senior managers and other key forums, such as the equality action team, but actions to address identified issues were not clear. The prisoner complaints forum had very recently been reinstated to help address poor prisoner perceptions of the system.

2.10 The Independent Monitoring Board (IMB) had recently resumed its visits to the prison. It had continued to receive complaints throughout the restricted regime and had participated in daily operational meetings via telephone conference calls.

2.11 Formal prisoner consultation had stopped in March although the prison had recently reintroduced the rehabilitative culture committee, which facilitated discussion on several key topics. The meeting had met twice since July and was led by the deputy governor who ensured that the key messages from the meeting were communicated throughout the prison.

2.12 Menu choices had been reduced from five to three options at each meal time to allow for social distancing in the kitchen. Despite the reduction, all dietary needs were met. Lunch consisted of soup and a sandwich, with a hot meal provided for dinner. Most prisoners told us that the food was reasonably good. Meals were also supplemented by additional weekly snack bags, although some prisoners thought these were high in sugar and lacked healthy alternatives. Other than a shortage of some items at the start of restrictions, the prison shop service had remained largely unaffected.

Equality, diversity and faith

2.13 It was positive that the Whatton equality action team (WEAT) meetings had continued since March, albeit without some key staff representatives and no prisoner representation. The WEAT was chaired by the deputy governor and analysed a range of useful data and information. However, the equality action plan and records of meetings indicated that updates were not always provided when requested, and some identified issues had been allowed to drift.

2.14 There had been no formal support groups or consultative forums for protected groups since March. Members of the equality team were frequently redeployed to other duties, which affected the individual support they could provide. The consultation that had taken place before March was not led at a senior level to ensure it was focused and meaningful, and

there was little evidence that issues raised were followed up. Consultation with black and minority ethnic prisoners was a clear example of this, with no evidence that issues raised in October 2019 had been followed up.

2.15 Around 12% of the population were from a black or minority ethnic background. In our survey, fewer of these prisoners than white prisoners, 54% against 87%, felt that they had been treated with respect by most staff, and more said they had been victimised by staff. Many black prisoners spoke to us openly about issues that ranged from inequality of access to key jobs, such as those in the staff canteen, to unfairness in the awards received at disciplinary hearings. We received similar negative feedback from black prisoners at the last full inspection. Senior managers needed to do some in-depth targeted work to understand and address this important issue, perhaps through consultation led by independent external black and minority ethnic organisations (see key concern and recommendation S5).

2.16 The prison had continued to provide limited but valuable support for some protected groups, including LGBT and older prisoners. Support from prisoners in the role of social care advocate (SCA – see Glossary of terms) remained an impressive feature of care for this vulnerable group (see paragraph 2.24).

2.17 The chaplaincy had provided pastoral support to prisoners and continued their statutory duties throughout the restrictions. This included meeting new arrivals and visiting segregated prisoners. The team provided valuable one-to-one support, and had facilitated the use of computer tablets to enable prisoners' virtual attendance at funerals. However, the pace of work to reinstate group activity and corporate worship during the recovery phase was slow, and the prison had not been very ambitious in its plans to deliver these, which were now permitted under recent HM Prison and Probation Service (HMPPS) exceptional delivery models. Limited plans to facilitate small group activity of no more than five prisoners had no confirmed start date at the time of our visit (see key concern and recommendation S3).

Health care

2.18 There was evidence of effective partnership working between the health team, the prison, Public Health England (PHE) and NHS England in managing the risks around COVID-19. Before the prison service went into a restricted regime, the health team had identified a few prisoners with potential COVID-19 symptoms and took prompt action to isolate them, in consultation with PHE and the prison. There had been one positive case of COVID-19 in April, when a prisoner in an outside hospital for other reasons then tested positive for COVID-19 and died in hospital. There had been no further positive cases since then.

2.19 The change of health provider to Care UK Ltd in April 2020 initially brought some challenges, including establishing new medicine suppliers and difficulties in obtaining personal protective equipment (PPE – see Glossary of terms), but staff had contingency plans to ensure that patient outcomes were not affected until processes became established. These included having additional medication in stock to pre-empt any gaps in supply, and borrowing PPE from the prison until a supply chain was established. All health staff had received face mask fit testing, and their emergency equipment was updated with additional PPE.

2.20 Following national guidance, the GP and senior clinicians identified 52 patients who met the shielding criteria, who were encouraged to move to the identified shielding wings. Ten patients chose not to move or to shield and signed a disclaimer to this effect. As national guidance changed, staff saw those shielding to explore their options, and most decided not to continue to shield.

2.21 New arrivals received an initial health screening and were told that they would need to isolate for 14 days on the reverse cohort unit. They received a second health screen following this period. The intellectual and developmental disabilities (IDD) service also completed a learning disability screening questionnaire with all prisoners.

2.22 Despite some absences, a resilient and caring health care team, who knew their patients well, had maintained strong clinical leadership and adequate staffing throughout the restrictions. Essential services had also continued throughout, with primary care nurse triage and access to a GP. Other services, such as the optician and podiatrist, had recently restarted with clinics running to address the lengthy waiting lists.

2.23 External hospital appointments, where not cancelled by the hospital, continued to be facilitated, including urgent and emergency appointments. More routine appointments were now being offered.

2.24 A good standard of social care had been maintained, particularly on A8 wing, with regular carers and an occupational therapist providing mobility and equipment assessments, which promoted a rehabilitative approach to care. The prisoner social care advocates (SCAs) were an asset providing valuable support and enabling their peers to do as much for themselves as possible. Initially, due to visit restrictions, social care assessments were completed by the advanced social work practitioner over the telephone, but face-to-face assessments had recently resumed. The social worker liaised with the parole board and local authorities to continue social care on release.

2.25 During the restrictions, the skilled multidisciplinary mental health team and IDD service - which included access to a psychiatrist, psychologist, mental health nurses and a learning disability nurse - continued to provide good care to patients on their caseload. They responded promptly to all routine and urgent referrals, and attended assessment, care in custody and teamwork (ACCT) reviews. While groupwork had been suspended, individual therapy continued, including the IDD psychologist who worked with compassion-focused therapy group members individually. A range of material available covered mindfulness, specific COVID-19 anxiety management information in an easy-read format, and in-cell distraction activity resources.

2.26 Seven prisoners were on reducing or maintenance doses of methadone, the only opiate-substitution treatment available, and received regular clinical reviews. Psychosocial groups had been cancelled but psychosocial support had been maintained by the substance use practitioner, who continued to see prisoners on his caseload and provided work booklets. Harm minimisation and relapse prevention work was undertaken in advance of prisoners' release.

2.27 Medication continued to be delivered to the cell door as from March. While this was completed as safely as possible in most cases, there remained potential risks for errors, it took a long time and was not best practice. The controlled drugs gabapentin (an antiepileptic) and pregabalin (an anticonvulsant) were also given weekly in-possession, which was against national guidance and increased the risk of diversion and misuse. A risk-assessed protocol to return to prisoners collecting controlled drugs from the medications distribution hatch was still not in place, despite the prison's positive record on COVID-19. These practices needed to be revised to ensure that patients received their medication in the safest way adhering to professional and good practice standards.

2.28 Time for Teeth Ltd provided dental services, and emergency dental care had been available since the start of the pandemic. Regular risk-assessed dental clinics had been running for several weeks, prioritising treatment on clinical need. Equipment and essential checks had been maintained, and a new dental chair had been installed in February. Appropriate PPE was available. The dentists had been offering aerosol-generating procedures (see Glossary of

terms) in line with community practices, but this had been stopped nationally by the Prison Officers' Association, causing waiting lists to rise.

2.29 The health department had maintained pre-release assessment and discharge planning, and, where needed, was supplying 28 days' medication instead of seven days due to the potential difficulty in getting this in the community.

Section 3. Purposeful activity

In this section we report mainly on time out of cell; access to the open air; provision of activities; participation in education; and access to library resources and physical exercise.

3.1 A severely restricted regime was in place, although it was consistent and most prisoners had at least two hours a day out of cell, including 60 minutes in the open air. This was better than we have seen at some other prisons during the pandemic. New arrivals in the reverse cohort unit (RCU – see Glossary of terms) and those who were shielding were not disadvantaged and received a comparable regime to prisoners on other units. Around a third of the population were still engaged in some essential work and could be out of cell for up to five hours a day.

3.2 Key activity areas included several industrial workshops that were supplying essential items, such as laundry and prison shop groceries, to other prisons, and manufacturing hospital scrubs for the NHS. These workshops had continued to operate with a reduced prisoner capacity throughout lockdown. Senior managers had implemented a rota shift system in early March to ensure that output could be safely maintained. Although prisoners could not attend all their activities, they were paid for those to which they were allocated to help them avoid debt.

3.3 Prisoners were given an in-cell activity pack, containing crosswords and puzzles, to relieve the anxiety and boredom of being locked in cell for 22 hours every day. However, in our survey, only 37% of prisoners who been given a pack said they had found them useful. The number of TV channels available to prisoners remained limited, whereas other prisons we visited during this period had increased the number of TV channels for prisoners. There were attempts to improve in-cell activity with some basic educational material and other creative activities, such as needlework. Self-help guidance and information about local support was provided through the prison's WayOut TV channel. However, none of this compensated for the loss of purposeful activity in workshop or education facilities.

3.4 Some prisoners had been given education packs but found it demotivating that their completed work had not been marked. During our visit less than half the teaching staff were on site, and there was no one-to-one or group education. Despite adequate facilities to accommodate socially distanced classroom activity, this had not been approved centrally, and many prisoners remained locked up instead of progressing their education.

3.5 Even though the prison had had no cases of COVID-19 since April, HM Prison and Probation Service (HMPPS) guidance restricted its ability to open the library or gym in a safe manner, and both had remained closed for five months. An outreach service provided a regular exchange of books in all areas. The PE department ran weekly sessions on the sports field for all prisoners on a rota basis. PE staff had also been instrumental in reintroducing manual handling training to support the allocation process for new arrivals. However, managers were frustrated by the lack of progress in returning to some level of normal activity.

Section 4. Rehabilitation and release planning

In this section, we report mainly on contact with children and families; sentence progression and risk management; and release planning.

Contact with children and families

4.1 Measures to help prisoners maintain contact with their families during the COVID-19 period had made slower progress than in many establishments. The management of risks associated with a population of prisoners convicted of sexual offences had been a factor in the delay. Social visits had only just been reintroduced the week before our visit. Despite this, arrangements to reduce the number of visits from 30 to 10 at a time were proportionate, preserving as much as possible of the normal visits experience by minimising the visual impact of precautionary measures. The visits centre, staffed by the charity PACT (Prison Advice and Care Trust), was now operating for all social visits sessions.

4.2 Facilities for video visits had been tested and were in place but had not yet been introduced; these were planned to begin by the end of August. Conference-call legal visits tool place one day a week, but the recovery plan for legal visits had not yet been finalised. It was hard to understand why legal visits could not have commenced earlier.

4.3 The extra weekly telephone credit which had been made available nationally helped prisoners to stay in contact with their friends and family. In our survey, 91% of prisoners said they could use the telephone very day, but there were no telephones in cells and some prisoners felt that there was not fair or adequate access to them, especially on B wing. Few prisoners had benefited from the multiple mobile phones provided during the pandemic due to the prison's narrow interpretation of the national guidance on their use. An important exception to this was the case of a prisoner receiving palliative care who was able to stay in contact with his family. The 'email a prisoner' scheme (see Glossary of terms) was in operation, but prisoners could not send replies, as they could in other prisons.

Sentence progression and risk management

4.4 Even though the establishment was strongly focused on and resourced for interventions, in our survey almost a third of prisoners did not know what their custody plan objectives or targets were. Of the 70% who did know their objectives or targets, only 41% said that staff were helping them to achieve them. It was unclear how much of this negative feedback was due to the restricted contact and limited services available during the pandemic.

4.5 There was a full team of prison offender managers (POMs) and the offender management department had not been seriously affected by absences during the pandemic. The POMs were non-operational staff, which meant they had not been cross-deployed to other duties. Probation staff had returned to work in the prison at the earliest opportunity. Nevertheless, for a long period almost all interaction with prisoners had been through written communication only. Socially distanced face-to-face interviews with prisoners had been reintroduced only six weeks previously.

4.6 Preparation for parole hearings, of which there were between 15 and 20 a month, had been prioritised; hearings were carried out by telephone. There had been a reasonably smooth

transition between the stages of the national framework in the offender management unit (OMU) as some aspects of the transition had been anticipated and implemented early. For example, face-to-face but socially distanced meetings between POMs and individual prisoners had already been taking place, and probation staff had continued to work in the prison in the later stage.

4.7 OASys (offender assessment system) assessments had continued through the COVID-19 period. The backlog at the time of our visit was 40, representing approximately 5% of those eligible. Much of this backlog was due to prisoners who had recently arrived with no OASys assessment, having not long been sentenced. Most prisoners currently arriving at Whatton were on overcrowding drafts from local prisons, rather than on progressive moves to complete the offending behaviour programmes offered at the prison.

4.8 Recategorisation processes were being kept up to date. There were 46 category D prisoners in the establishment, of whom about half had been returned from open conditions and had work to do before they could return. Moves to open prisons, other than HMP Haverigg, had been very difficult during lockdown; HMP North Sea Camp had recently offered spaces to enable Whatton prisoners to progress.

4.9 The interdepartmental risk management meeting (IRMT) and all public protection work had continued throughout the restricted regime. Multi-agency public protection arrangements (MAPPA) had also continued, including written pre-release reports and telephone attendance at MAPPA meetings. The monitoring of mail and telephone calls continued daily, with 108 prisoners currently on telephone monitoring. The IRMT reviewed child contact restrictions.

4.10 Programme staff had delivered one-to-one work to support some prisoners whose programme had been interrupted by the restrictions, in particular the 30 who had been in the middle of the intensive Kaizen programme (see Glossary of terms). Permission for the resumption of one-to-one work in Kaizen had been given nationally in July, and a new model for programmes in groups of two or three had also been approved. Staff were selecting and preparing for these groups, with commencement due shortly after our visit. There was also a plan for staff to deliver one-to-one interventions, in PPE (personal protective equipment – see Glossary of terms), to those who were shielding.

4.11 The Acorn project was a relatively recent initiative, which was doing rigorous therapeutic work with some prisoners who had problematic personality traits causing a risk of harm; this was part of the offender personality disorder pathway. This work was carried out within a clinical structure supported by NHS governance and supervision. It was a promising approach to work with a group of 30 prisoners who showed challenging behaviours.

Release planning

4.12 Since March, prisoner contact with the community rehabilitation company (CRC) had been limited to written rather than in-person transactions. In our survey, only 40% of prisoners expecting to be released in the next three months said that there was anybody helping them to prepare for this. CRC staff had, however, been in the establishment through most of the COVID-19 period, and their relocation to the OMU office had improved coordinated working in release planning. No prisoners had been released under the COVID-19 early release scheme.

4.13 Finding accommodation on release was an increasing problem. The supply of approved premises places had reduced considerably during COVID-19, and there was sometimes a gap of up to three months between the parole board directing release, and the availability of a place. The CRC worked with every prisoner to seek housing, in close cooperation with

OMU staff. However, of the 80 prisoners released since April, at least 13 had been released without permanent or settled accommodation (see key concern and recommendation S6).

4.14 During our visit, the OMU was notified on the day before one prisoner's release that he would be staying at a hotel, and would have to find himself accommodation as soon as possible thereafter. We were told that this prisoner was a registered sex offender, and that there were risks in relation to children. The community offender manager, who held the formal responsibility for arrangements on release, had acknowledged that this was 'not ideal'. The CRC said that such a release would not be recorded by them as 'no fixed accommodation', which was concerning and distorted the statistics on prisoners released to unsustainable accommodation.

4.15 Prisoners being released were given useful information packs explaining the current state of COVID-19 precautions in the community, including places where local restrictions applied. Some prisoners were released to approved premises in Leicester, and they were given a detailed leaflet with advice on living in the city, especially during the additional lockdown there. The pack also contained details of Rehability UK and Turning Point services.

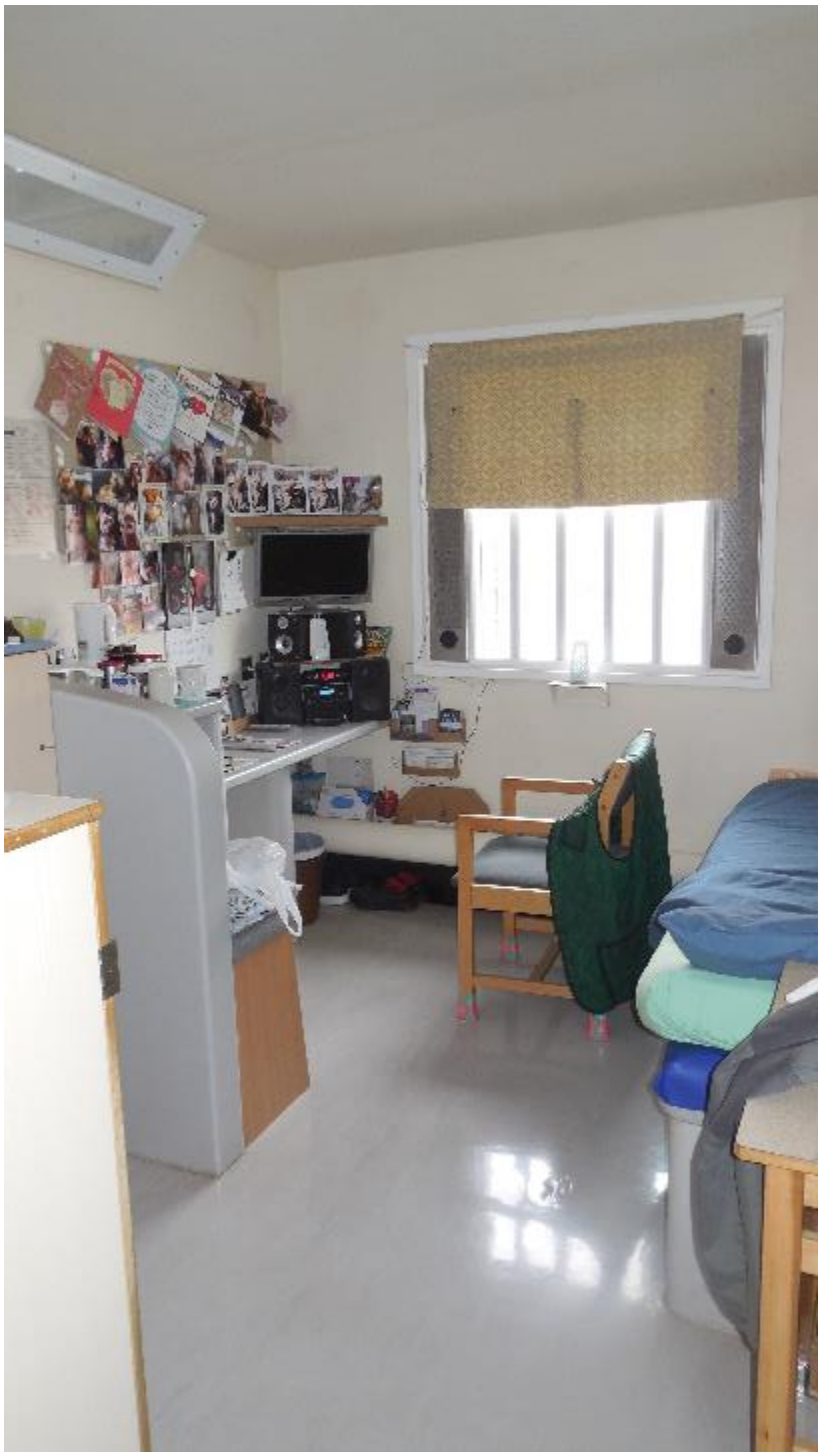
4.16 Two of the Safer Living Foundation's projects – circles of support and accountability in the local counties, and the in-prison volunteer support and mentoring service – were doing valuable work to prepare prisoners for and support them after release. The support and mentoring service in the prison was supporting some of those with the most pressing needs (such as over-55s, and those with intellectual and developmental disabilities), and had continued to work through in-cell packs during the COVID-19 period.

Section 5. Appendices

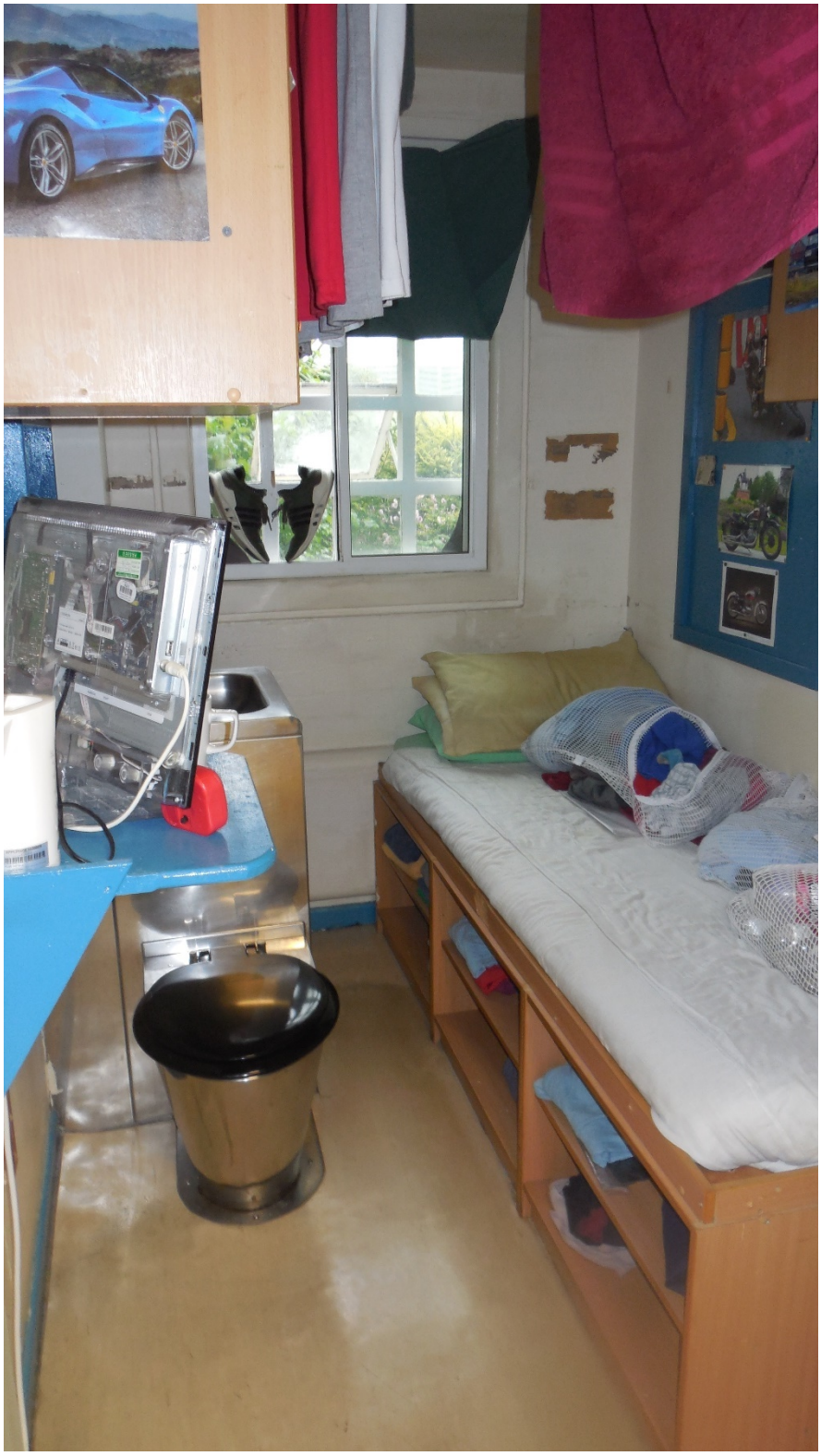
Appendix I: Scrutiny visit team

Deborah Butler	Team leader
Ian Dickens	Inspector
Natalie Heeks	Inspector
Martin Kettle	Inspector
Maureen Jamieson	Health care inspector

Appendix II: Photographs



A wing cell



B wing cell

Section 6. Further resources

Some further resources that should be read alongside this report have been published with it on the HMI Prisons website. For this report, these are:

Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of the scrutiny visit, the results of which contribute to our evidence base for the visit. A document with information about the methodology, the survey and the results, and comparisons between the results for different groups are published alongside the report on our website.

Staff survey methodology and results

A survey of staff is carried out at the start of every scrutiny visit, the results of which contribute to the evidence base for the visit. A document with information about the methodology, the survey and the results are published alongside the report on our website.