Report on an unannounced inspection of

# HMP Wandsworth

by HM Chief Inspector of Prisons

22 April – 2 May 2024

# Contents

# Introduction

Built 170 years ago, Wandsworth prison in south London has come to epitomise the decaying inner city Victorian institution, symbolic of the problems that characterise what is worst about the English prison system. An overcrowded reception prison with a significant turnover of population, at the time of the inspection it held over 1,500 men. Of these, half were on remand and nearly half were foreign nationals, with the level of need perhaps best evidenced in the near 500 individuals requiring some form of mental health referral each month.

The findings of our inspection led me to write, in accordance with the protocol I have with the Ministry of Justice, to the Secretary of State invoking the Urgent Notification (UN) process on 8 May 2024. In that letter, and in the inspection debriefing paper that accompanied it, I set out my concerns about the jail. Under the protocol, the Secretary of State commits to respond publicly to the UN within 28 days, explaining how outcomes for those detained will be improved. The publication of that response was quite understandably delayed owing to purdah with respect to the recent (2024) general election.

At the time of our inspection, Wandsworth was a prison still reeling from a very high-profile escape that occurred in late 2023. Our findings suggest that security remained a significant concern, although failings were evident in almost all aspects of the prison's operation, a fact reflected in our healthy prison test scores which were poor for safety, respect and purposeful activity and not sufficiently good in preparation for release.

We found chaos on the wings, and staff across most units were unable to confirm where all their prisoners were during the working day. There was, for example, no reliable roll check that could assure leaders that all prisoners were accounted for. Given the recent escape, and the amount of input from the prison service, it was unfathomable that leaders had not focussed their attention on this area. There had been 10 self-inflicted deaths since the last inspection, seven of which had occurred in the last 12 months. The rate of self-harm was high and rising, and yet around 40% of emergency cell bells were not answered within five minutes.

Overall rates of violence, including serious assaults, had increased since the last inspection and were higher than most similar prisons. In our survey, 69% of prisoners said they had felt unsafe at Wandsworth. Over half (51%) of prisoners surveyed said it was easy to get illicit drugs and the smell of cannabis was everywhere. Although leaders had identified this issue as presenting the highest level of security risk, they had suspended drug testing between August 2023 and January 2024. In the most recent confirmed random drug test results (February 2024), 44% of prisoners tested positive.

Wandsworth has a transient population and was badly overcrowded with very poor living conditions. Cells were cramped and ill-equipped, and the prison was still too dirty. The fabric of the buildings and facilities including showers and heating still needed significant investment to bring them up to a decent standard. In our survey only 41% of prisoners said that staff treated them with respect, significantly lower than in comparable prisons. Very limited time out of

cell, absent staff, and a failure to deliver any key work reduced the opportunity to develop meaningful relationships on wings.

A lack of work and education spaces and poor use of those that were available meant there was very little purposeful activity. Most prisoners were unemployed and spent over 22 hours a day locked up. Prisoners had no idea when or if they would be unlocked each day or whether they would get access to fresh air. Life on residential units was unpredictable and confusing for staff and prisoners alike.

Consistent failures to enable access to healthcare services due to prison staff absences resulted in important assessment and treatment interventions being curtailed. Clinic non-attendance rates were high at around 24%. The costly new health centre that was supposed to open in the summer of 2022 was still unused.

Despite a full complement of officers, sickness, restricted duties, and training commitments meant that over a third could not be deployed to operational duties each day; this led to curtailed regimes, cross-deployment, and burnt-out staff. Inexperience across every grade of operational staff was preventing them from bringing about much needed change. Staff were not wilfully neglectful, they simply did not understand their role and they lacked direction, training, and consistent support from leaders.

The poor outcomes we found at Wandsworth stemmed from poor leadership at every level of the prison, from HMPPS and the Ministry of Justice, leading to systemic and cultural failures that have led to this shocking set of outcomes. There was a degree of despondency amongst prisoners that I have not come across in my time as Chief Inspector. Many well-meaning and hard-working leaders and staff persevered at Wandsworth, but they were often fighting against a tide of cross-cutting, intractable problems that require comprehensive, long-term solutions. For this troubled prison to begin to recover, Wandsworth needs permanent experienced leaders at all levels who are invested in the long-term future of the prison to improve security, safety and guide their less experienced colleagues.

**Charlie Taylor**
HM Chief Inspector of Prisons
May 2024

# What needs to improve at HMP Wandsworth

During this inspection we identified 15 key concerns, of which seven should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

## Priority concerns

1. **Inexperience across every grade of operational staff made it difficult to bring about much-needed change or sustain any progress.** Most leaders were temporarily promoted, and new staff were learning from inexperienced frontline managers. Senior leaders were not visible on the wings.

2. **Rates of self-inflicted deaths and self-harm were high and rising**. Oversight did not identify or fully address the drivers of self-harm. Despite seven self-inflicted deaths in the last year, the death in custody action plan had not been reviewed to make sure that all actions were addressed promptly.

3. **Levels of violence, particularly against staff, were high.** Leaders had not taken effective action to address the causes of violence. They had not set and enforced high standards and there was nothing in place that meaningfully incentivised good behaviour.

4. **The availability and use of illicit drugs were widespread and presented a significant risk to stability and safety.** Leaders had not allocated sufficient resource to drug testing, or addressed the main issues that fuelled the demand for drugs: poor living conditions, a lack of purposeful activity and ineffective staff-prisoner relationships.

5. **Time out of cell was poor and unpredictable.** Most prisoners were locked up for over 22 hours a day. Prisoners often missed important appointments and were unable to collect critical medication, which posed serious potential risks to health. Prisoners struggled to complete basic tasks, shower and exercise in the short time they were unlocked.

6. **There were not enough purposeful activity spaces to occupy prisoners and help them to develop new skills and knowledge.**

7. **Prisoners' attendance at the activities offered was far too low.** Prisoner pay did not incentivise engagement in education and too many activities lacked relevance to prisoners' needs.

## Key concerns

8. **Staff-prisoner relationships were distant and ineffective.** The lack of any key work hindered opportunities to develop more productive relationships. Staff absences and inexperience meant that prisoners struggled to get even basic requests dealt with.

9. **The condition of cells and prison facilities was poor.** Most cells had missing items or damaged furniture and fittings. Many cells and communal areas were dirty and dilapidated. Showers were in poor condition and there were frequent problems with heating and hot water.

10. **Processes designed to help prisoners resolve problems, manage their daily life and contribute to the prison community were not operating effectively.** There were, for example, significant weaknesses in the complaints, applications and consultation processes.

11. **The provision for foreign national prisoners, who made up around half the population, was too limited.** There were too few spaces in English for speakers of other languages classes, professional interpreting services and translated materials were not used routinely and the reducing reoffending strategy did not seek to meet the needs of these prisoners.

12. **The prison's quality improvement group for education, skills and work, and its associated quality improvement planning, did not have sufficient involvement from senior leaders in the prison.** This prevented the group from functioning effectively as a key driver for change and improvement.

13. **There was a substantial backlog of uncompleted personal learning plans because too few information, advice and guidance sessions took place during the education, skills and work induction.** This meant that staff had poor records of prisoners' starting points, career aims or support needs in and outside of custody.

14. **The quality of teaching and learning in education and prison workshops required improvement.**

15. **Resettlement and pre-release support for unsentenced prisoners was poor**. This was despite remand and unsentenced prisoners making up more than half the population.

# About HMP Wandsworth

**Task of the prison**
HMP Wandsworth is a local category B reception and resettlement prison for men.

**Certified normal accommodation and operational capacity (see Glossary) as reported by the prison during the inspection**
Prisoners held at the time of inspection: 1,521
Baseline certified normal capacity: 979
In-use certified normal capacity: 964
Operational capacity:1,538

**Population of the prison**
- An average of 6,056 new prisoners were received each year (around 505 per month).
- 51% of prisoners were on remand.
- 46% were foreign national prisoners.
- 36% of prisoners were from a black and minority ethnic background.
- An average of 260 prisoners were released into the community each month.
- 295 prisoners were receiving support for substance misuse.
- An average of 476 prisoners were referred for mental health assessment each month.

**Prison status (public or private) and key providers**
Public

Physical health provider: Oxleas NHS Foundation Trust
Mental health provider: Oxleas NHS Foundation Trust
Substance use treatment provider: Change Grow Live
Dental health provider: Prisoner Centred Dental Care
Prison education framework provider: Novus
Escort contractor: Serco

**Prison group/Department**
London

**Prison Group Director**
Ian Blakeman

**Brief history**
Built 170 years ago, Wandsworth is a large Victorian prison serving the courts of south-west London.

**Short description of residential units**
**Heathfield unit**
A and B wings – general population
C wing – general population; vulnerable prisoners
D wing – drug recovery unit
E wing – first night and induction unit

**Trinity unit**
G, H and K wings – general population and workers (incorporating the incentivised substance-free living unit on K wing)
**Addison and Jones units** – health care inpatient units

**Name of governor and date in post**
Katie Price, July 2022

**Changes of governor since the last inspection**
Graham Barrett, October 2019

**Independent Monitoring Board chair**
Matthew Andrews

**Date of last inspection**
13 and 20–24 September 2021

# Section 1 Summary of key findings

## Outcomes for prisoners

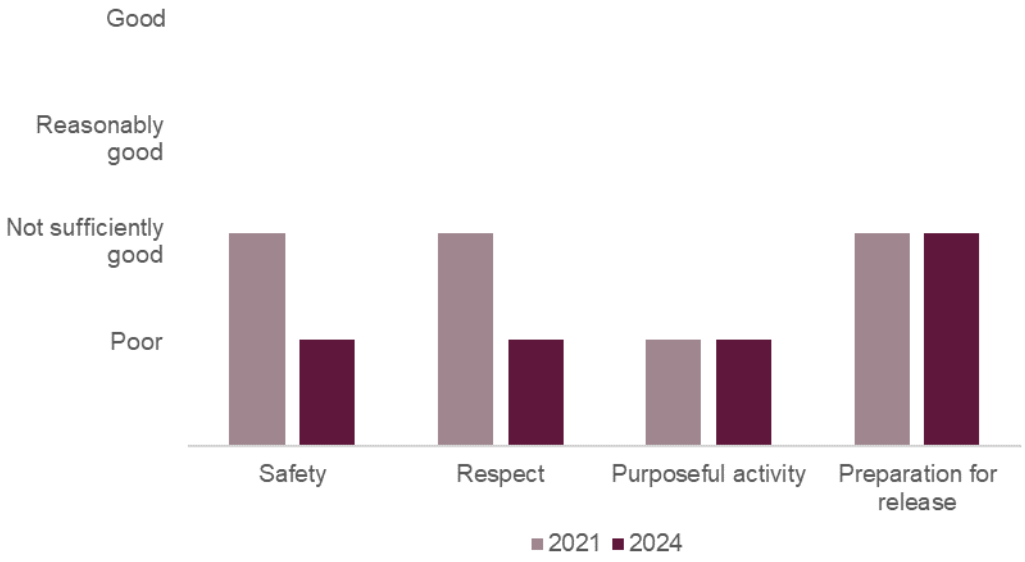
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and preparation for release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of HMP Wandsworth, we found that outcomes for prisoners were:

- poor for safety
- poor for respect
- poor for purposeful activity
- not sufficiently good for preparation for release.

1.3 We last inspected HMP Wandsworth in 2021. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

**Figure 1: HMP Wandsworth healthy prison outcomes 2021 and 2024**




## Progress on key concerns and recommendations from the full inspection

1.4 At our last inspection, in 2021, we made 29 recommendations, nine of which were about areas of key concern. The prison fully accepted 22 of the recommendations and partially (or subject to resources) accepted seven.

1.5 At this inspection, we found that one of the nine key concerns identified had been achieved, one had been partially achieved and seven had not been achieved. None of the three recommendations made in the area of safety had been achieved. One of the four recommendations in the area of respect had been achieved, one partially achieved and two not achieved, and neither of the recommendations made in the areas of purposeful activity and rehabilitation and release planning had been achieved. For a full list of the progress against the recommendations, please see Section 7.

## Notable positive practice

1.6 We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for prisoners, and/or particularly original or creative approaches to problem solving.

1.7 Inspectors found four examples of notable positive practice during this inspection, which other prisons may be able to learn from or replicate. Unless otherwise specified, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other establishments. They show some of the ways our expectations might be met but are by no means the only way.

| Examples of notable positive practice | | |
|---|---|---|
| a) | Patients prescribed opiate substitution therapy were identified using their fingerprints, which minimised the risk of administering the medication to the wrong patient. | See paragraph 4.70 |
| b) | Alcoholics Anonymous provided a service specifically for Polish speakers which enabled this group of clients to access support in maintaining recovery which was otherwise unavailable. | See paragraph 4.71 |
| c) | Connecting Communities (CC; see Glossary) practitioners based in the prison provided a good 'through the gate' service, ensuring that prisoners linked with addictions and housing teams in the community, reducing the likelihood of harm. | See paragraph 4.72 |
| d) | A local solicitor delivered a monthly legal clinic providing advice and guidance to prisoners with family court applications free of charge. | See paragraph 6.7 |

# Section 2 Leadership

**Leaders provide the direction, encouragement and resources to enable good outcomes for prisoners.** (For definition of leaders, see Glossary.)

2.1 Good leadership helps to drive improvement and should result in better outcomes for prisoners. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 The pace of change and improvement since the last inspection had been too slow, and in critical areas outcomes for prisoners were worse. A high-profile escape from the prison in September 2023 had led to huge implications for the prison and properly brought an intense level of scrutiny from ministers and HM Prison and Probation Service (HMPPS) leaders. We were told that this had consumed most of the governor's time and focus and was given as the reason why progress had stalled in many key areas.

2.3 Inexperience and inconsistency characterised much of the culture at the establishment. Most leaders were temporarily promoted, and new staff were learning from inexperienced frontline managers. The working culture was not supportive and there was little team ethos across functions. Senior leaders were not visible around the jail.

2.4 Relationships between staff and prisoners were distant and ineffective. Leaders had not set high standards of behaviour on residential units or provided any meaningful incentives to motivate prisoners to behave and engage; this had led to a cycle of disruptive behaviour, violence, self-harm and drug misuse.

2.5 Leaders in the jail and the prison service had not done enough to improve the living and working environment at the establishment, which was dilapidated and overcrowded.

2.6 Despite being identified by leaders as one of their top priorities, there was no purposeful regime to speak of, and most prisoners were unemployed; they had no idea when or if they would be unlocked each day. Another leadership priority to reduce violence was unlikely to succeed while basic procedures to maintain order and control were not followed, staff could not account for the whereabouts of their prisoners, and life on the residential units was chaotic and confusing for staff and prisoners alike.

2.7 Despite a full complement of officers, sickness, restricted duties and training commitments meant that over a third were not available to deploy to operational duties each day. This had led to curtailed regimes, cross-deployment and burnt-out staff. National leaders had commissioned a deep dive into the reasons for poor retention, which

highlighted a lack of visible leadership and poor culture, something which we also observed during the inspection.

2.8 Since the escape, HMPPS had invested almost £900,000 in additional resources in safety and security. Despite this, leaders had not got the basics of security right and poorly led staff could not account for the whereabouts of their prisoners during the day. An action plan created after the last escape in 2019 had not been completed.

2.9 Many well-meaning and hard-working leaders and partners persevered, trying to unpick and address the myriad of problems within their functions; their resilience was impressive, but they were often fighting against a tide of cross-cutting, intractable issues.

2.10 There were pockets of good work and some emerging plans that had the potential to have an impact if HMPPS could create some stability in leadership roles. Local leaders had recently started an academy to develop skills in frontline leadership and invested in additional new colleague mentors. Staff lacked direction, training and consistent support from leaders at all levels.

2.11 The issues we found had to stem from poor leadership at every level, all the way up to HMPPS and the Ministry of Justice, who were presiding over systemic and cultural failure that had led to a shocking decline in outcomes.

# Section 3 Safety

**Prisoners, particularly the most vulnerable, are held safely.**

## Early days in custody

Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

3.1 Reception processes were slow. In our survey, only 13% of respondents said that they had spent less than two hours in reception, and just 56% that they had been treated well during the process. These figures were notably lower than at the time of the previous inspection and when compared with similar prisons.

3.2 This deterioration was unsurprising, given the large daily throughput of prisoners coming in and out of the establishment. With an average of 130 new prisoners each week, the strain on admission procedures was immense, leading to delays and inefficiencies at every stages. Many prisoners spent four to five hours in reception before being assigned to their cells, a process described by prisoners as frustrating and exhausting. Some new prisoners had not been located in cells until 2am.

3.3 Prisoners who arrived in crisis did not have access to a Listener (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) while in reception. It could take some time before they received food and a drink, and they were unable to shower, despite many spending hours in court, a prison van and then a cramped holding cell. They had a private consultation with a nurse and underwent a first-night interview before being placed in the induction unit (E wing).

3.4 There were long delays in creating a telephone PIN number so that prisoners could contact family and friends, and many had to wait several days, and often weeks (see paragraph 6.4). Despite acknowledging the issue, prison leaders had yet to implement a solution. Prisoners were issued with one full set of clothing, including one set of underwear, and this had to last them until the next clothing exchange on their wing, which could be a week later.

3.5 In our survey, only 23% of respondents said that their cell had been clean when they arrived and on their first night at the prison. We found dirty cells, with heavy graffiti, broken windows, damaged flooring, missing furniture and blocked toilets. Poorly maintained sinks leaked into the cells below, and in one case into the office of a supervising

officer. Prisoners on the induction wing spent 23 hour a day locked up in these conditions.

**Damaged first night cell**

3.6 During the inspection, prisoners on E wing had not had a shower for five days because there was no hot water, a situation that prison leaders were unaware of until we brought it to their attention. The shower facilities were dirty and in disrepair, further diminishing living conditions.


**E wing showers**

3.7 Improvements had been made to the induction process, including the introduction of an informative video and a well-designed information booklet. None of these resources were accessible to non-English speakers, even though they made up a relatively large proportion of the population. The absence of a clear timetable for induction left many prisoners confused and disorientated during their initial days in the prison.

## Promoting positive behaviour

Expected outcomes: Prisoners live in a safe, well ordered and motivational environment where their positive behaviour is promoted and rewarded. Unacceptable conduct is dealt with in an objective, fair, proportionate and consistent manner.

### Encouraging positive behaviour

3.8 Levels of violence, including serious assaults, had increased since the last inspection and were now higher than at most similar prisons. While it was encouraging that despite this there had been some recent reduction in the last 12 months, the establishment still had the fourth highest assault rate against staff amongst all adult male prisons in the country. During this period, there had been 524 violent incidents, which, even with population changes, equated to a 50% increase in the rate of violence against staff since the last inspection.

3.9 Prisoners' concerns about violence were reflected in our survey; 69% of respondents said that they had felt unsafe at some point during their stay at the establishment, and a third currently felt unsafe.

3.10 Leaders had identified the reduction of violence as a key priority in their self-assessment report. The functional lead responsible for safety had introduced a violence and conflict resolution strategy in autumn 2023. The strategy was evidence based and made good use of key data from incidents to enable staff and prisoners to better understand the contributors to violence. For example, data indicated that violence was often perpetrated between younger prisoners and linked to wider community gang issues. The strategy also recognised the links between violence and the poor regime and living conditions (see sections on living conditions and time out of cell).

3.11 Work strands identified from the strategy were tracked in a safety action plan that was reviewed regularly. Many of the identified actions were relatively low level and would be considered as routine business in other prisons (such as completing welfare checks on prisoners in crisis). Although these actions provided a sensible foundation for the safety team to begin to drive improvement, fundamental change would only be achieved when leaders had a firmer grip on some of the bigger issues that contributed to violence and perceptions of safety.

3.12 The response to violence included the use of the HM Prison and Probation Service (HMPPS) challenge, support and intervention plan (CSIP; see Glossary) model to help manage violent prisoners. However, the process from referral to action took too long, and too many plans to address and change behaviour were limited in scope and lacked creativity. More positively, we observed some very good support from individual custodial managers (CMs), especially during reviews for prisoners on a CSIP. One proactive CM, for example, had organised a weekly group with these prisoners, setting them tasks that were designed to help them reflect on and learn from their behaviour. This positive work was an example of what could be achieved with clearer direction from senior leaders.

3.13 The safety team conducted welfare checks on prisoners who were particularly vulnerable. There were approximately 400 such checks each month; this number had substantially increased, and the quality improved, following the introduction of the violence and conflict resolution strategy. Safety leaders had appointed several prisoner conflict resolution peer mentors, but their work was poorly promoted and supported by residential staff. These representatives were enthusiastic about what they could contribute, but few staff outside the safety function understood the role and they were rarely unlocked to carry out their work.

3.14 Several external partners had recently joined forces with safety leaders to reduce violence and support the prisoners involved. For example, 'Unlock my Life', a third-sector organisation, had been attending since February 2024 to train prisoners as mental health ambassadors. There were also credible plans for the Mayor's Office for Police and Crime to

offer a two-year support programme that aimed to reduce violence at the prison and provide support to prisoners on release.

3.15 Prisoners at risk of or involved in violence were discussed at the weekly safety intervention meeting. The purpose of the monthly safety meeting was to review trends in data to inform future strategy. However, attendance at this important meeting was sometimes poor and the absence of key leaders made it less effective than it should be.

3.16 There was no cohesive vision or effective strategy to manage behaviour or motivate prisoners to engage with their sentence. Leaders and staff did not set or enforce high standards of behaviour for prisoners, and there were no meaningful rewards to incentivise them. The only exception to this was for the nine prisoners being supported by the substance misuse support team on the incentivised substance-free living (ISFL) unit, who had better time out of cell, recreation equipment and some limited self-cook equipment. However, the ISFL unit was in a dark subterranean area underneath Trinity unit, where the smell of dead rodents was repugnant.

3.17 Prisoners' perceptions of the local incentives scheme were poor and only 10% of respondents to our survey said that the culture within the prison encouraged prisoners to behave well. A lack of purposeful activity, poor living conditions, widespread drug misuse and distant relationships with staff left prisoners feeling neglected, demotivated and despondent.

### Adjudications

3.18 Leaders had improved oversight of the adjudication process and there were now monthly governance meetings that reviewed data relating to disciplinary hearings and the use of segregation. The deputy governor also provided regular quality assurance of completed hearings and highlighted learning points.

3.19 Local data showed that around a quarter of disciplinary hearings were not proceeded with each month, including for acts of serious violence, often because of delays in the process or reporting officers failing to attend the hearing. While the improved governance had identified this, actions to address it were yet to be implemented fully. This weakened the impact of adjudications as a deterrent to poor behaviour.

3.20 There were just over 600 outstanding hearings at the time of the inspection, around half of which were for serious charges that had been referred to the police. Leaders had very recently appointed a member of staff as the 'crime in prisons' lead, who acted as the single point of contact for the police when a crime was committed in the prison.

### Use of force

3.21 The use of force had increased since the previous inspection and the rate was now among the highest when compared with similar prisons.

Despite this concerning rise, leaders were not adequately focused on measures to reduce use of force.

3.22 Data from the HMPPS use of force reporting tool indicated that there had been 2,013 control and restraint incidents in the previous 12 months. PAVA (see Glossary) had been drawn 19 times and used on seven occasions, and batons had been drawn 43 times and used on 10 of these. It was concerning that prison leaders could not confirm the accuracy of these data; their local use of force data log did not correlate with the figures they had reported through the incident reporting system which informed the use of force reporting tool.

3.23 There was an up-to-date and relevant strategy to reduce the use of force. Monthly meetings aimed to review data to inform an action plan to reduce the use of force. However, attendance by key leaders, including the governor and deputy governor, was infrequent, which limited its effectiveness. Although some relevant data were reviewed at the meeting, participants did not break down the underlying reasons for prisoner non-compliance (the primary trigger for use of force, according to prison data). This represented a missed opportunity to identify appropriate actions and direct targeted interventions.

3.24 Most incidents were captured on body-worn cameras, and documentation submitted by officers to justify the use of force was almost up to date. However, not all staff consistently activated their cameras, and the quality of reports we reviewed was too varied.

3.25 There was insufficient scrutiny of documentation and footage of the use of force. Senior leaders only reviewed high-level incidents such as those involving the use of batons and PAVA. They did not review enough unplanned incidents which meant that some of our concerns about the use of force had not been identified and acted on.

3.26 In our review of body-worn camera footage, we observed several incidents that could have been avoided through better de-escalation. We also observed that some nurses had not always been within close enough proximity to monitor the prisoner's well-being during the use of restraint. In a few cases, staff had used unauthorised techniques to gain the prisoner's compliance, and only about a third of staff were up to date in their control and restraint training.

3.27 Use of force debriefs with prisoners who had been restrained were superficial and gained little information from the prisoner's perspective. This again was a missed opportunity to learn from incidents and minimise reoccurrence.

3.28 Unfurnished ('special') accommodation had been used five times in the last 12 months, all for incidents involving two prisoners. There were inconsistencies in the documentation, and the prisoner was not always removed from this accommodation at the earliest opportunity.

## Segregation

3.29 The segregation unit was undergoing refurbishment at the time of the inspection, but even some of the refurbished cells remained in poor condition. The communal areas on the unit were generally clean, but the yard was as austere, bare and dirty, as at the time of the previous inspection; security fencing was still strewn with prisoner clothing and bed sheets.


**Segregation yard in 2021 (left) and 2024**

3.30 The regime for segregated prisoners was extremely limited. They received just 30 minutes out of cell each day to exercise and use the telephone, shower and electronic kiosk (see paragraph 4.23). Some prisoners told us that, before the inspection, the regime often consisted of 'one of three', where they had to choose between a shower, telephone call or exercise. We also found evidence of unofficial punishments, where some staff had further restricted prisoners' access to an already poor regime without appropriate authority.

3.31 Apart from some very complex cases, most prisoner stays in the segregation unit were relatively short. Leaders had worked hard to improve plans to reintegrate prisoners back to the main residential units. Plans were communicated well to prisoners, and we saw examples of effective reintegration.

3.32 Monthly governance meetings reviewed segregation data. The head of function had identified the areas that needed improvement (see above), but progress was very limited.

## Security

Expected outcomes: Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance misuse and effective drug supply reduction measures are in place.

3.33 Following a high-profile escape from the prison in September 2023, HMPPS had invested significant resources to address some serious security concerns at the prison. The findings from an independent investigation into the escape were yet to be made public because of ongoing criminal proceedings.

3.34 Before the escape, security procedures had been neglected for a considerable time. For example, all prisons are required to have a local security strategy which clearly sets out to staff the security arrangements for the prison. Key elements of this strategy at Wandsworth had not been reviewed for over 10 years. Similarly, an action plan from a similar escape from the prison in 2019 had not been adequately implemented or reviewed.

3.35 Unsurprisingly, the escape brought with it an intense level of scrutiny from HMPPS and government ministers, including an investigation and full audit of security procedures. This had led to over 100 actions for the prison, but progress to implement them had been very slow. There had been five security managers in the 18 months before the inspection, which contributed to a lack of consistency and decisive action in this area. Senior leaders from the long-term and high security estate had provided support to the prison security team to develop strategies to improve procedures and build experience. However, these strategies were yet to be agreed and implemented by local senior leaders.

3.36 There were significant weaknesses in many aspects of procedural and dynamic security which had an impact on outcomes for prisoners. Staff were inexperienced and lacked confidence in the application of basic tasks, such as maintaining a 'running roll' (head count) of prisoners on their residential units. During the inspection, staff were unable to confirm how many prisoners were off their units and how many were locked up, and we could not be confident that all prisoners were accounted for during the working day. Leaders had communicated the importance of maintaining a correct roll, but staff were not adequately trained and there was a lack of consistent visible leadership on the wings to reinforce basic procedures (see also paragraph 5.2).

3.37 The number of appropriately trained intelligence analysts had been increased to address the backlog of intelligence reports, and new intelligence was triaged to enable managers to respond in priority order. However, some intelligence reports were poorly written and contained insufficient detail, which hindered the work of the security

team. Most of the key security threats identified in the local tactical assessment (LTA – see glossary) were not being addressed to make the prison safe.

3.38 Many of these concerns were reflected in a recent HMPPS security audit, which resulted in the lowest grade, 'unsatisfactory'. The current head of function with responsibility for security had been in post since December 2023 and had a clear vision of what was needed to address the concerns identified, but the pace of improvement was slow.

3.39 There was evidence of some good partnership work with HMPPS regional search teams and the local police to address threats to security. There were on-site officers from the London Prison Intelligence Unit, who provided valuable support, while 'Operation Sceptre', led by the Metropolitan Police, united police and prison staff in a coordinated effort to tackle serious violence, including knife crime, at the prison.

3.40 Despite no longer holding prisoners charged with offences relating to terrorism, the prison still benefited from an on-site counterterrorism unit. The experienced local corruption prevention manager managed the risk to the prison's security from staff involved in criminality or breaching professional standards. This individual also provided effective support to the head of function to address wider security risks.

3.41 In our survey, 51% of respondents said that it was easy to get illicit drugs at the prison. The prison's strategy to reduce the supply of, and demand for, drugs was failing; important actions had not been addressed and although we were told that regular drug strategy meetings took place, there were no records of meetings to show any progress made. The drug strategy did not make the link between illicit drug use and poor conditions within the prison or take learning from Prisons and Probation Ombudsman reports following self-inflicted deaths that were connected to illicit drug use.

3.42 The prison had identified the supply of illicit items as presenting the highest level of security risk ('critical') since May 2023. Despite this, leaders had suspended drug testing between August 2023 and January 2024. Throughout the inspection, we found evidence of widespread drug misuse, with many prisoners appearing to be under the influence of illicit substances. The smell of cannabis was everywhere throughout residential areas.

## Safeguarding

Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

### Suicide and self-harm prevention

3.43 There had been 10 self-inflicted deaths since the last inspection, seven of which had occurred in the last 12 months. Coroner's inquests for these deaths had not yet started, although some were scheduled in the coming weeks.

3.44 Early learning reviews from the self-inflicted deaths had been completed and there was a death in custody action plan. However, several actions had not been completed or reviewed and senior leaders did not have sufficient oversight of the plan to prioritise and address the outstanding actions.

3.45 The level of self-harm was slightly lower than in comparable prisons, but it was high and increasing. Leaders were unable to explain the continuous rise in self-harm and self-inflicted deaths, although poor conditions and ineffective relationships between staff and prisoners (see section on staff-prisoner relationships) clearly inhibited the development of a safe culture of care and well-being.

3.46 During the inspection, we found prisoners who were clearly in distress without an appropriate level of support. Staff were oblivious to a prisoner in crisis who had self-harmed in his cell until inspectors brought it to their attention.

3.47 The monthly safety meeting reviewed appropriate data on self-harm, but it was poorly attended by senior leaders, despite safety being identified as one of the governor's key priorities (see section on encouraging positive behaviour). Therefore, there was an insufficient drive to improve safety and reduce self-harm.

3.48 There were 64 prisoners being supported by the assessment, care in custody and teamwork (ACCT) case management process for prisoners at risk of suicide or self-harm. In our survey, only 37% of those who had been on an ACCT said that they had felt cared for. Many of those we spoke to said that ACCT reviews were superficial and rarely helped them to resolve their problems.

3.49 There were weaknesses in the ACCT process. Reviews were sometimes missed and did not always identify the prisoner's issues, and records showed that even when risks were identified, they were not acted on. In addition, reviews took place in wing offices, which were noisy and lacked privacy. Care maps were often blank or contained limited information to help staff support prisoners.

3.50 Many prisoners on an ACCT told us that a lack of contact with family was the key driver for their low mood. This was exacerbated by delays in processes to approve telephone PIN numbers, preventing prisoners from speaking to family and friends (see paragraphs 3.4 and 6.4).

3.51 There were two prisoners on constant supervision during the inspection, both of whom were locked in cells that were dirty and lacked privacy screening around the toilet. The doors were kept shut, with staff conducting their observations through a plastic screen. These prisoners had limited interaction with staff or other prisoners, and there was little effort to engage them in an activity. Staff knew little about either of them, and handovers from one member of staff to the next at shift change was superficial and not useful in keeping the prisoner safe. It was evident that constant supervision did little to improve prisoner's mood or well-being.

3.52 There was a Listeners scheme. Listeners we spoke to said that they rarely left their own wings, despite a rota that was prison-wide, and leaders did not monitor if Listeners were able to support prisoners in crisis during the night state. The Listeners suites were rarely used.

**Listeners suite**

**Protection of adults at risk (see Glossary)**

3.53 Anyone concerned about the safety of a prisoner could use either a ‘concern email address’ or telephone number that was advertised on the prison website. Both were active and worked well when tested. The adult safeguarding lead at the prison was the head of safety, but this was not widely advertised and few staff we spoke to were aware of how to make a safeguarding referral. Leaders told us that they regularly attended the local adult safeguarding board meetings, but despite a number of requests, they were unable to provide records to support this.

# Section 4 Respect

**Prisoners are treated with respect for their human dignity.**

## Staff-prisoner relationships

Expected outcomes: Prisoners are treated with respect by staff throughout their time in custody and are encouraged to take responsibility for their own actions and decisions.

4.1 In our survey, fewer respondents than at similar prisons said that staff treated them with respect (41% versus 69%), and that there were staff they could turn to if they had a problem (47% versus 71%).

4.2 Relationships between staff and prisoners were generally distant and ineffective. While we did observe instances of staff attempting to engage positively with prisoners, most interactions were abrupt and transactional. This was made worse by daily routines that meant that prisoners were rarely out of their cells (see section on time out of cell), where there was a lack of key work (see Glossary) and staff absences reduced officers' time and opportunities for conversation with prisoners.

4.3 Key work at the prison had halted entirely since the last inspection. In our survey, just 23% of respondents said that a member of staff had talked to them about how they were getting on in the past week, again evidencing a lack of regular, positive engagement.

4.4 Prisoners frequently told us that they struggled to have their requests dealt with by wing staff. Many staff were inexperienced and some lacked confidence in challenging low-level poor behaviour, such as vaping on the landings and blocking observation panels. Line managers at all levels were also inexperienced and while we observed some frontline leaders giving guidance to staff, too often they were not visible on the landings and officers were left to manage challenging situations without sufficient support. Our staff survey indicated that morale was low, and officers told us that they felt unsupported by prison leaders. Several new staff told us they had joined the Prison Service to make a difference by helping the prisoners in their care, but they felt jaded and despondent about the reality of working at Wandsworth.

4.5 The prison had a range of peer workers supporting different functions, but the quality of their contribution was inconsistent because oversight by managers varied greatly. Some peer workers were well supported, but too often peer work was poorly promoted and staff did not understand its importance. We found peer workers who were not unlocked to perform their duties, including some who had not received any guidance on what they were supposed to do.

## Daily life

Expected outcomes: Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

### Living conditions

4.6 The population had expanded to over 1,500 prisoners, up from 1,364 at the time of the previous inspection. It remained one of the most crowded prisons in the country, with around 80% of prisoners sharing cramped cells designed for one.

4.7 Living conditions were poor. While there had been some minor improvements to the tidiness of communal and outdoor areas, wings remained dirty, and some outdoor areas were strewn with litter. Prisoners continued to throw rubbish and food waste from their cell windows, contributing to the prison's vermin issues.

**Litter thrown from cells**


**Wing flooring damage (left) and broken landing window pane**

4.8 Most cells were missing items or had damaged furniture. Broken windows and leaking fixtures were common, much of the flooring was damaged and some observation panels had been smashed. Many cells had no effective screening around toilets, even though they held two prisoners together, often for over 22 hours a day. Issues with heating and hot water were also common, with several outages across the prison during the inspection. At the time of the inspection, the prison had over 900 outstanding jobs in its facilities log, reflecting the scale of the challenge.


**Cell interior (left) and cell with damaged flooring**


**Damaged and blocked observation panel (left) and cell with broken window**

**Damaged bed**

**Wing exterior with multiple broken windows (left) and leaking cell sink**

4.9 The introduction of a dedicated senior manager responsible for decency was a positive step, and monthly checks meant that missing or damaged items were now being identified and logged. Senior managers were also conducting weekly cell decency checks to support this, as well as meeting the Government Facilities Services Limited on-site team regularly to discuss outstanding repairs. However, too many issues still went unreported and staff and managers on the wings did not ensure that standards were being maintained from day to day.

4.10 Showers across the prison were in a poor state and lacked privacy, and some should have been decommissioned entirely. Some units had showers with standing water, leaking sinks and badly damaged cubicles. Others continued to have inadequate shower facilities for the number of prisoners they held; for example, on G wing, around 140 prisoners were sharing just six cubicles. In our survey, only 21% of respondents said that they could shower daily, which was far less than at the time of the previous inspection (41%), or in comparable prisons (75%).

**G wing shower (top) and damaged shower cubicles on Heathfield unit**

4.11 Prisoners expressed frustration with laundry services, and only 39% in our survey said that they had enough clean clothing that fitted them. Wings did not have laundry facilities because there was a large on-site communal laundry, but prisoners were often reluctant to use this for fear of items going missing. Some told us that they had resorted to washing clothes in their cell sinks.

4.12 Vermin such as pigeons, rats and mice continued to be a problem at the prison. However, a recent period of intensive work with an outside

pest control provider had led to some improvement. We found rodent faeces and urine across residential units, although prisoners and staff told us that sightings of rats and mice were now less common because of the prison's recent efforts.

**Dead rat**

4.13 Over the last year, around 40% of cell call bells had not been responded to for more than five minutes, despite the high level of self-harm and self-inflicted deaths (see paragraph 3.45). During the inspection, wings often had multiple active cell call bells going unanswered, and in our survey only 10% of respondents said that their cell call bell was normally answered within five minutes. Cell call bell response time data were monitored daily and we saw some recent examples of leaders challenging late responses, but this had not yet driven significant improvement.


**Wing panel showing active cell call bells**

## Residential services

4.14 In our survey, only 24% of respondents said that the food at the prison was good, a large decline from the figure we found at the time of the last inspection (54%). Prisoners received one hot meal per day, in the evening, along with a cold lunch meal and a small breakfast pack. In our survey, 15% of respondents said that they got enough to eat most of the time, which was worse than the 33% comparator. Some lunch options were meagre, although the hot meals appeared more substantial.


**Lunch**

4.15 Prisoners could leave their cell to collect the hot meal from the servery, but their cold lunch meal was delivered to their cell door, which reduced their time out of cell (see Glossary and section on time out of cell). There were no communal eating facilities, and almost all prisoners ate in cramped cells beside their toilets. Apart from on the incentivised substance-free living (ISFL) unit, there were no self-catering facilities.

4.16 Serveries on the wings were not supervised effectively. Servery workers did not always follow basic food hygiene practices, such as checking the temperature of the food or wearing appropriate personal protective equipment, and some serveries had no hand soap.

**Servery**

4.17 We found serveries with broken hot plates, which meant that they were serving lukewarm or cold food. Cleanliness was inconsistent; some serveries were dirty and in one hot plate we saw what appeared to be mouse faeces.

**Hot plate with suspected mouse droppings**

4.18 The main kitchen was well ordered and tidy. It was staffed by a team of prisoner orderlies who had received food safety training, and the prison had recently brought in a provider offering level 2 and 3 catering accreditations. The kitchen maintained a good record of individuals on special diets, to provide them with appropriate meals.

4.19 The prison shop operated under the national contract with DHL, offering a reasonable range of goods, including fresh fruit. Although orders were delivered weekly, the shop was not operating effectively. Numerous prisoners raised concerns about items missing from their deliveries and long delays, of weeks or even months, before receiving refunds.

4.20 Despite the shop being one of the most common sources of complaints in the prison over the past year, there was no data collection or analysis to understand underlying issues or monitor progress. We were concerned that the prison had no action plan to address this problem.

**Prisoner consultation, applications and redress**

4.21 In the absence of effective support from staff to resolve issues informally (see also paragraph 4.4), prisoners had to rely on the formal processes in place to make requests, raise complaints and influence change. However, our survey indicated a lack of confidence in applications, complaints and consultation processes.

4.22 Prisoner council meetings took place monthly and recordings of the full meetings were broadcast on the prison radio. Despite this, few prisoners were aware of these consultation arrangements, or of any changes that had taken place as a result. Outcomes of the meetings were not summarised and translated, and there was no clear communication about outcomes – for example, in 'You said, we did' posters.

4.23 Prisoners' perceptions of the applications process were worse than at the time of the previous inspection. The often limited time that prisoners spent out of their cells hindered their ability to access the electronic wing kiosks to make their requests for help or to get things done. Too many kiosks were broken, which meant that prisoners had to spend the short time they had out of cell in queues. Monitoring data showed that most applications were responded to on time but did not reflect the fact that prisoners' issues had often not been fully resolved.

4.24 Prisoners' complaints had been poorly managed. Delays in the initial logging of submitted complaints meant that they had waited longer for responses, although focused effort had led to some recent improvement. The quality of investigations and responses in the sample of complaints that we reviewed was mostly adequate and there were some examples of remedial actions taken and apologies offered. However, there was no quality assurance of replies or monitoring of trends so that leaders could remedy the main reasons for complaint.

4.25 The prison had good private legal visit and video-link facilities. At the previous inspection, the work of the bail information officer had been highlighted as notable positive practice, but this support was no longer available to the large number of remand prisoners. The main library had a good stock of current legal, prison and immigration information. Prisoners could also use library computers to work on their individual cases, although their access to the library was often limited (see section on time out of cell). The security department managed the temporary issue of secure laptop computers to enable prisoners to work on their legal cases in their cells.

4.26 In our survey and during the inspection, prisoners reported that their legal mail was being opened before they received it. We were also told about delays in receiving important, time-critical information from legal representatives, both of which needed attention from leaders.

## Fair treatment and inclusion

Expected outcomes: There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics (see Glossary), or those who may be at risk of discrimination or unequal treatment, are recognised and addressed. Prisoners are able to practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

4.27 The prison held a very diverse population but work to promote fair treatment and inclusion had not been sufficiently prioritised and support for prisoners with protected characteristics was underdeveloped.

4.28 The two-person equality team was committed and visible around the prison and was soon to be augmented by a prison officer equality worker. Senior leadership team members were the allocated leads for each of the protected characteristic groups, but consultation to understand prisoners' experiences had been infrequent for many of the groups. There had been a greater emphasis on engagement in recent times, but it was too early to see any positive impact on prisoners. The involvement of community organisations in some of the forums for prisoners who had previously been in local authority care was an example of positive practice.

4.29 It was positive that prisoner representatives, overseen by the equality team, took part in the two-monthly prisoner-focused equality meeting. However, the meeting had not been used effectively to drive improvement and senior leadership team members had not attended regularly. Notes of the meetings indicated a consistent delay in completing identified actions agreed at the meeting.

4.30 Poor recording of race, disability, nationality and sexual orientation undermined leaders' efforts to use data to identify disproportionate outcomes in the areas they were responsible for. Where

disproportionate outcomes were identified, the subsequent investigation was not carried out promptly. For example, an action to investigate overuse of the lowest incentive level (basic) and warnings given to young, black and Muslim prisoners was still outstanding several months after it was discussed at an equality meeting.

4.31 Discrimination incident reporting forms (DIRFs) were available on the wings, and 50 had been submitted by prisoners in the previous 12 months. In many cases, there had been a delay in responding to DIRFs. Investigations involved discussion with the prisoner who raised the DIRF, but in some cases there had been limited enquiry. The governor reviewed all DIRFs, and the Zahid Mubarek Trust provided external scrutiny.

4.32 Around half the population were foreign nationals. Catch 22 (see Glossary) was commissioned to provide a support service. Its staff saw prisoners on induction, offered some one-to-one support, held groups on a different wing each week and oversaw the work of prisoner foreign national representatives. Relevant stakeholders took part in a monthly foreign nationals oversight meeting.

4.33 The Home Office had based a team of immigration officers in the prison who aimed to see newly sentenced foreign national prisoners within 28 days. The team was not fully staffed, so were unable to hold wing surgeries, but they were available in legal visits on Friday mornings for those who could get there. The number of prisoners held beyond their sentence expiry date for immigration reasons (IS91s) had reduced since the previous inspection, with 16 at the time of this inspection. Notification of the decision to detain was still being made close to release dates in some cases. Bail for Immigration Detainees, a non-profit organisation in London, provided in-person advice to IS91 detainees and those applying for immigration bail.

4.34 Other weaknesses in the support provided to foreign national prisoners included the popular English for speakers of other languages classes which was limited to 36 places with long waiting lists (see also paragraph 5.14). Those living on the vulnerable prisoner wing did not have any access to this support.

4.35 Professional telephone interpreting and translated materials were not routinely used to make sure that prisoners who did not speak English had the same access to services and support as English speakers. Staff who were bi- or multilingual provided some support, which was appreciated by prisoners, but they were not always available, so prisoners relied heavily on their peers to help them. Leaders had plans with Prison Advice and Care Trust to introduce sessions for prisoners where they could spend time with others from their national group for mutual support.

4.36 Foreign national prisoners we spoke to were unaware of their entitlement to request a free five-minute overseas telephone call each month if they had not had a visit. Only prisoners held for immigration reasons received £5 telephone credit weekly.

4.37 It was encouraging that the recently introduced foreign nationals strategy had a realistic action plan to address some of the identified weaknesses in the current provision.

4.38 The prison was not designed to accommodate an ageing population or prisoners with mobility difficulties. Prison leaders were working to improve the identification of prisoners with disabilities and to make practical adaptations where they could. For those who had identified needs, provision included a small number of adapted cells, personal emergency evacuation plans (PEEPs), neurodivergent passports, support from equality peer representatives and, if needed, social care support. Some PEEPs were unhelpful as they lacked detail, and some night staff did not know where to find them. This was addressed when we raised it with leaders.

4.39 Retired prisoners were not unlocked with working prisoners during the core day and there was no specific activity provision for older prisoners – unlike young adults, who at least could attend dedicated gym sessions.

4.40 A newly appointed neurodiversity manager had focused on raising awareness of these conditions with staff. They had introduced monthly neurodiversity sessions in the library and some prisoners had been issued with individual passports, which consisted of a plan with actions for staff to support them during their time at the establishment. Neurodiversity week had been observed with a mask decorating project and there were advanced plans to introduce a self-regulation group intervention for neurodivergent prisoners.

4.41 Around a third of prisoners were from a black and minority ethnic background. In our survey, more prisoners from this background than others said that they had been bullied or victimised by staff (62% versus 39%). This was not highlighted as an issue by prisoners we spoke to during the inspection, although some disproportionality had been identified in prison data, which should prompt leaders to take more decisive action in this area. The staff profile was much more diverse than at many other prisons, which was encouraging.

**Faith and religion**

4.42 The multi-faith chaplaincy was well integrated into prison life and provided valued support to prisoners, from arrival until departure. Prisoners had the opportunity to worship and attend groups with others of their faith, but some had to miss their daily social and domestic period to do so (see section on time out of cell), which was inappropriate. The main chapel was still closed for repair, and while the mosque and multi-faith room on Heathfield unit were reasonable, the facility for worship on Trinity unit remained uninspiring.

4.43 Chaplains met new arrivals promptly, visited prisoners in the segregation and health care units daily and checked on prisoners being managed on assessment, care in custody and teamwork (ACCT) documents at least weekly. Suitable bereavement support was offered.

One of the team jointly delivered parenting courses with an external voluntary organisation.

## Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

4.44 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found no breaches of the relevant regulations.

### Strategy, clinical governance and partnerships

4.45 Oxleas NHS Foundation Trust was the prime provider of health care services. Relationships with the prison were generally positive and the head of health care was a member of the senior leadership team. However, prison-wide staffing problems frustrated efforts to deliver some vital health care services to prisoners. Appointments were cancelled too often and an inability for the regime to accommodate access to clinics, and even to critical medicines, presented a major risk. Clinical governance arrangements ensured the close monitoring of clinical activity, audit was used to good effect and risks were well understood, although the local delivery board met too infrequently to pursue service improvements.

4.46 Leadership of the health care team provided a clear drive and energy, and most staff we spoke to felt well supported. There was evidence of shared learning by health care staff following significant incidents, including deaths in custody, which incorporated concerns raised by the coroner. There was limited opportunity for consultation with patients, but their views were sought, and individual complaints were managed well. The sample of responses we scrutinised demonstrated that the specific concerns aired were being addressed, although greater face-to-face resolution should have been adopted and the process would have benefited from enhanced oversight from senior managers.

4.47 There was a permanent nursing presence on site and there were few staffing vacancies, with successful retention being an indicator of a positive culture within the health care team. Compliance rates for mandatory training were appropriate and there were opportunities for professional development. Most staff received regular supervision and good communication channels were established with the team. The clinical records we sampled mostly captured the care provided, and the contacts we observed with patients were professional and respectful. The ‘Task’ system for overseeing appointment requests and managing waiting lists needed additional scrutiny to make sure that patient lists were reviewed regularly, and access prioritised appropriately.

4.48 The health care department and treatment rooms on the wings were ageing and most of the latter could not comply with infection prevention standards. It was incomprehensible that the new health care facility, which apparently had been built some time ago, had not yet opened. It was anticipated that this would open in the next few months.

4.49 There was a robust system to ensure a prompt response to medical emergencies. Registered nurses were trained to intermediate life support levels and allocated as part of the daily roster arrangements. Emergency equipment was located strategically and checked regularly. We saw some examples of patients needing urgent or emergency care which had been responded to promptly, with good clinical decision making.

**Promoting health and well-being**

4.50 Although there was no clear whole-prison health promotion strategy, the team worked hard to ensure appropriate access to health education, information, screening and immunisation support. An advanced nurse practitioner oversaw arrangements and planned to implement a regular calendar of events that mirrored national priorities. Given the frequent changes in the population, it was difficult to establish a community of trained peer supporters to nurture local initiatives.

4.51 Age-appropriate screening and standard vaccinations were promoted, particularly at the secondary screening for new arrivals. Sexual health services and barrier protection were available and smoking cessation support could be provided if needed. There were good arrangements for an outbreak of a communicable disease.

**Primary care and inpatient services**

4.52 Nursing staff screened new arrivals in dedicated rooms in reception which were private and had handwashing facilities. The GP and nurse-led clinics were available from Monday to Saturday, with emergency nurse cover at the weekend and overnight. The service employed both advanced nurse practitioners and wing nurses, who ran triage clinics, reception and secondary health screens, and administered medication.

4.53 Patient applications were processed and triaged, and prisoners were seen promptly by the relevant clinical professional. There had been a high vacancy rate within primary care, which was now largely resolved. Patients generally had good access to most support, although a few patients waited too long to see the GP. Access was significantly hindered by the poor prison regime (see section on time out of cell) and availability of officers, which meant that appointments were often cancelled. Data indicated an approximately 24% non-attendance rate for all clinics across the last six months.

4.54 Patients with a long-term condition were identified and reviews took place, and although care plans were not always completed, there was a good level of detail documented in the patient notes. There was a

range of visiting practitioners and allied health care professionals, including a physiotherapist, optician and podiatrist. The waiting list for the optician, who visited once a week, was too long, with 95 people waiting at the time of the inspection.

4.55 Outpatient appointments and emergency visits to a local hospital were often cancelled by the prison at short notice because of officer staffing shortages, although sometimes the hospital cancelled appointments or prisoners refused to attend.

4.56 Primary care nurses identified patients due for release or transfer and aimed to see them all before discharge. However, health care staff were not always kept informed of court dates, and many prisoners did not return from court. Staff saw all complex patients, those attending court and those with an unexpected release before they left the prison.

4.57 The physical environment of the two inpatient facilities remained extremely limited and still included accessible ligature points. The six-bedded inpatient unit for patients with physical health needs had a clear admissions policy, but the unit was not fully suitable for patients; only three cells were in a fit state to be used and they did not meet infection prevention and control standards because of the age and condition of the building. Despite this, the unit was well run, and patients received good care. The staff worked closely with a local hospice and had been commended for their care provision. The mental health inpatient unit was supporting nine prisoners at the time of the inspection. Most prison staff were knowledgeable and supportive of these patients' needs, and despite the limitations of the environment and regime constraints, individual care plans were clear and regular multidisciplinary levels of therapeutic support were provided.

**Social care**

4.58 There were 17 patients in receipt of a social care package (see Glossary), which ranged from simply supplying equipment to the delivery of personal care several times per day.

4.59 Change Grow Live (CGL) was subcontracted to provide social care, and the local authority conducted assessments, although these took far longer than the agreed target of 10 days. Some patients waited several months for assessments to be conducted, which was unacceptable. However, patients' needs were met by the health care provider until an assessment had been undertaken.

4.60 CGL met local authority staff regularly to discuss patients' needs, as well as the delays in providing the assessments. Prisoners generally spoke positively about the care they received and said that staff were kind and caring. However, because of a shortage of trained social care providers in CGL, some personal care provision had not taken place for one prisoner on several occasions. We spoke to the provider, and this was resolved promptly.

4.61 Several prisoners who had been designated as in need of medical support to shower were not always accommodated when scheduled because of officer staff shortages. Equipment and support aids were provided to those who needed them. However, there were delays from the local authority in providing equipment and undertaking repairs. Social care patients could access advocacy services provided by POhWER (see Glossary).

**Mental health**

4.62 Oxleas provided mental health services, and there had been a high level of investment since the last inspection. The team was well led and made up of a range of skilled clinicians, from a variety of professional groups which included therapists, psychologists, mental health nurses, occupational therapists, psychiatrists and a learning disability nurse. This multidisciplinary team was therefore able to offer a full range of interventions in supporting prisoners with mild to moderate problems through to major ill-health and complex needs.

4.63 There was a clear pathway to access the available services. Prisoners were screened on admission and supported by an early days in custody team, which flagged up any immediate need and risk. The duty nurse system made sure that acute need was considered daily, including those subject to ACCT case management, although the service was not available at weekends. Prisoners could make a referral directly through the wing kiosks, with officers and other health care professionals contacting the duty team to make referrals. All patients were triaged to establish if an immediate response was needed, and routine referrals were seen within a week. A weekly, recorded, multidisciplinary review meeting, chaired by the psychiatrist, enabled cases to be assessed and risk to be escalated appropriately.

4.64 The team was supporting around 80 patients at the time of the inspection, including 15 with a severe and enduring mental illness. Patients could be seen in the health care department, but many individual contacts were delivered on the wings, with group work facilitated at a dedicated hub. The clinical records we sampled showed regular contacts and clear care planning. The biggest challenge facing the service was the restrictions faced through regime pressures. Periodically, clinics did not run as staff did not unlock prisoners or facilitate their attendance. There was also little space to deliver interventions and complete contacts on the wings. Despite these constraints, waiting times were short and the team worked flexibly to access patients.

4.65 Psychiatry input was available from Monday to Friday, enabling cases to be prioritised, medicines to be initiated and prescribing to be reviewed. Frequently, prisoners were identified as needing an assessment under the Mental Health Act. The mental health inpatient unit was able to support patients reasonably well before any potential transfer to hospital. A transfer coordinator was assigned specifically to oversee the referral and transfer system and although there were some long delays in transfers – mostly for those needing highly specialised

beds – the process was well managed and most waits were relatively short.

4.66 There was a strong emphasis on identifying prisoners with a potential need for ongoing support on release from prison, with evidence of effective liaison with community services.

**Support and treatment for prisoners with addictions and those who misuse substances**

4.67 The prison drugs strategy was ably supported by CGL and Oxleas, and their recovery and clinical teams were well led, suitably trained and accessed regular supervision.

4.68 First night screening and urgent prescribing were followed by detailed assessment on day two, to identify needs. In April 2024, 40 prisoners had required alcohol detoxification, which was provided safely.

4.69 Approximately 300 prisoners were receiving CGL support to manage addictions. An extensive range of therapeutic options was on offer. These included one-to-one and group approaches, including educational, psychological and lifestyle components. Care planning was individualised, although there were waiting lists for some therapies, which suggested that demand was greater than capacity. CGL supported prisoners on the ISFL unit and provided pop-up groups on other wings on contemporary topics such as cannabis and 'spice' (see Glossary).

4.70 Opiate substitution therapy (OST) had improved since the previous inspection and was evidence based. It was being provided by Oxleas to 98 prisoners at the time of the inspection. There was now fingerprint identification of patients receiving OST, which minimised the risk of giving the medication to the wrong patient, and the administration of buprenorphine (an opiate substitution medication) under the tongue or by monthly injection was an additional clinical option. Officer supervision of medicine queues was inconsistent (see below), and not all prisoners received OST at their allotted time.

4.71 All nine substance use peer worker roles were vacant, so local peer support was unavailable, although a new CGL coordinator had begun the recruitment process. Vital visiting mutual aid groups, such as Alcoholics Anonymous (AA), Cocaine Anonymous and Narcotics Anonymous, were available to those in recovery. One AA group was available in the Polish language, which enabled this sub-population to access support in maintaining recovery that was otherwise unavailable.

4.72 Connecting Communities (CC; see Glossary) practitioners, employed by CGL, and family workers supported these prisoners in preparing for release by maintaining family ties and coordinating discharge with the prison. CC workers worked 'through the gate' and in the community to make sure that clients linked with addictions and housing teams, reducing the likelihood of harm. Clients were given harm minimisation

advice and naloxone (an opiate reversal agent) training and supplies, as needed.

**Medicines optimisation and pharmacy services**

4.73 Medicines were supplied by an in-house pharmacy in a timely manner. Not-in-possession medicines were supplied on a named-patient basis, with appropriate labelling and a dispensing audit trail. Previous staffing difficulties were now resolved, with experienced and competent staff in the pharmacy.

4.74 Medicines were administered by pharmacy technicians and nurses from the wings three times a day, with some provision for the supply of night-time medicines when needed. Some medicine hatches opened directly onto the wings and inconsistent officer supervision meant that patient confidentiality was not maintained and increased the likelihood of diversion. Furthermore, prisoners were not always released from their cells for the administration of critical medicines. Although such incidents were identified and reported, and an escalation policy had been introduced, far too often important medicines were either delayed or omitted entirely, which was a major risk to patient safety.

4.75 Most cells did not have lockable storage facilities for in-possession (IP) medicines, which increased the risk of diversion, although cell checks took place. A large number of patients had not received an IP risk assessment because of staff shortages. This had reduced IP use to 47% of prisoners in receipt of a prescription, which further increased pressures during medicine administration. The pharmacy team now reviewed all patients in reception and was working through the backlog of those without a risk assessment.

4.76 Prescribing and administration were recorded on SystmOne (the electronic clinical record). Pharmacists clinically assessed all medicines, and went to the wings to speak to patients with particularly complex concerns. A pharmacist had also just restarted medicine reviews on targeted patients. Medicines for minor ailments, without the need to see a doctor, were available, along with an appropriate range of patient group directions (which enable nurses to supply and administer prescription-only medicine).

4.77 The pharmacy was well organised, with good medicines management on the wings and adequate provision for the supply of medicines out of hours. Prisoners who were released following court attendance were encouraged to return to the prison to get their medicines or an FP10 prescription, but this did not always happen.

4.78 Written procedures and protocols were appropriate. Errors and incidents were recorded on Datix (the electronic incident reporting system). There were well-attended monthly medicines and therapeutics meetings. The prescribing of abusable and high-cost medicines was monitored and managed. There was higher than expected prescribing of mirtazapine (an antidepressant), but the pharmacy was aware that this was an issue and was currently carrying out an audit.

### Dental services and oral health

4.79 The dental service was commissioned to provide 10 sessions per week. The waiting time for a routine appointment was, on average, seven weeks, which was reasonable. The health care and dental teams triaged patients and offered pain relief and/or antibiotics, if needed, for those waiting for an appointment. The dental nurse provided advice on teeth and gum care, and an oral dental surgeon held appointments at least once a month.

4.80 The care records we reviewed showed that the treatment provided was well documented and that patients had been informed of possible treatment options. The use of X-rays and their clinical justification were documented and supported by recent audits.

4.81 The dental surgery was compact but functional, and all equipment was in good working order and well maintained, with routine servicing taking place. There was an enhanced air purification system. Decontamination procedures were followed and infection control standards were generally met, although the building needed refurbishment. The new health care building (see above) included a dental suite. The dental surgery held copies of up-to-date policies and procedures, and supervision and training records.

# Section 5 Purposeful activity

**Prisoners are able and expected to engage in activity that is likely to benefit them.**

## Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary) and are encouraged to engage in recreational and social activities which support their well-being and promote effective rehabilitation.

5.1 Time out of cell was poor. In our survey, 74% of respondents said that they usually spent less than two hours out of their cells each day from Monday to Friday, which was worse than the already inadequate 56% seen in comparable prisons. Time out of cell at the weekends was often even worse.

5.2 During two random roll checks, we were unable to assess how many prisoners were locked up, on the wing, or off the wing in an activity because staff were unable to provide any accurate figures. There was no consistency or clarity in what should have been a basic procedure to account for prisoners at all times (see also paragraph 3.36). This had a knock-on effect across the prison as roll checks, regularly taking over 45 minutes to complete, delayed prisoners getting to work and education, and led to missed appointments and cancelled time out of cell.

5.3 These delays, coupled with regular staff absences, meant that life on the residential units could be chaotic and unpredictable for staff and prisoners. Only 51% of respondents to our survey knew the unlock and lock-up times, and just 18% of these said that these times were usually kept to.

5.4 At the time of the inspection, at least two-thirds of prisoners were unemployed. The published regime scheduled these prisoners only two hours out of their cells each day, but in reality they received even less than that. Many, including those in work, told us that they struggled to do everything they needed to in the limited time available to them; prisoners competed to use limited facilities, such as electronic kiosks and showers.

5.5 In our survey, just 8% of respondents said that they could complete domestic tasks on five days in a normal week, with 11% saying the same for association and 5% for outside exercise. Most exercise yards had some fitness equipment available, but outdoor exercise sessions were subject to regular cancellations. Apart from on the ISFL and health care units, there was no recreational equipment, such as pool tables, and limited enrichment activities were available.

**Exercise yard**

5.6 The prison had two libraries, the smaller of which was temporarily closed at the time of the inspection. The main library was a large, welcoming and well-ordered space, but it was seriously underused. Prisoners were rarely able to visit because of a lack of available staff to escort and supervise them, and in the previous three months just 10 of 108 planned sessions in the library had taken place. Available data indicated that footfall was very low, with the most recent month showing fewer than 100 visitors each week, on average.


**The library**

5.7 There was a reasonable supply of English language books and an excellent supply of legal reference texts, although, given the large population of foreign national prisoners, the stock of texts in other languages was too limited.

5.8 Although access was poor, the library was conducting outreach through a team of dedicated orderlies, delivering books and DVDs to prisoners. It was also offering some activities to prisoners who were able to attend, such as film screenings, author visits and book clubs. There were book trollies of varying size and quality available on the wings.


**Wing book trolley**

5.9 There were two gyms, a sports hall and an artificial grass sports area, with a combined capacity for around 290 prisoners each day. The PE programme offered most prisoners access to a single session a week, with additional sessions sometimes available in the evenings and at weekends to those on the enhanced incentives level and the ISFL unit.

**Gym (left) and sports hall**

**Artificial grass sports area**

5.10 The gym team offered remedial sessions, CrossFit (see Glossary) and weekly football, and around 850 sessions were used each week. However, the latest analysis we were shown indicated that only around 17% of prisoners were using the gym, indicating that a small number of prisoners had disproportionate access.

5.11 The gym offered first-aid as an accredited qualification and was about to start providing levels 1 and 2 gym instructor courses, as well as a 'twinning' programme with Queens Park Rangers Football Club.

## Education, skills and work activities

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the areas of concern, provided in the summary section of this report, this constitutes

Ofsted's assessment of what the establishment does well and what it needs to do better.

5.12 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness: Inadequate

Quality of education: Requires improvement

Behaviour and attitudes: Inadequate

Personal development: Inadequate

Leadership and management: Inadequate

5.13 Prison leaders recognised that the education, skills and work (ESW) provision was poor and were working hard to improve it. However, as most of their improvement actions were either very recent or yet to be implemented, the impact of these actions was slight. Leaders had not been able to tackle most of the recommendations from the previous inspection successfully.

5.14 Leaders faced major challenges. By their own estimation, between 60% and 70% of prisoners in the prison were unemployed. More precise data were not available. There were only sufficient full-time and part-time activity spaces for around half the prison population. These spaces were not all fully utilised, and activities rarely ran at capacity. The waiting lists on some courses were extremely long, notably for the small number of courses in English for speakers of other languages (ESOL), which the very large number of foreign nationals in Wandsworth were desperate to access. Waiting lists were also long for art, cookery, English, mathematics and dry lining. Prisoners often waited up to six months to be allocated a space on the course of their choice. Too many gave up waiting and opted for a job in one of the prison industry workshops instead. Since the start of this year, around a quarter of prisoners had elected not to attend the education induction sessions they had been invited to following their arrival at the prison.

5.15 Historically and currently, too few of the small number of prisoners who were allocated to education sessions attended them. Delays in moving prisoners from the wings to activities due to lengthy roll checks (see also paragraphs 3.36 and 5.2) meant that ESW sessions frequently started late. This dramatically reduced prisoners' time in learning.

5.16 The curriculums offered were neither sufficiently ambitious, offered at a high enough level nor relevant for the majority of prisoners. Current courses included English and mathematics, along with catering, food hygiene, and health and safety. However, almost all of the vocational learning, such as construction and barbering, had ceased. There was very little provision for vulnerable prisoners beyond art, mathematics and a radio course. Leaders recognised that a training needs analysis (TNA) produced in autumn last year was now out of date and of no use as the foundation for future curriculum planning. A new TNA was being

developed but was in its infancy. Leaders had, however, started changing the curriculums by introducing unit-based courses such as speaking and listening, reading and writing. These were more likely to be completed in the short time that most prisoners spent at the prison. Instructors in industries structured practical curriculums well to develop prisoners' technical skills, knowledge and understanding over time, alongside employability skills such as teamwork, following instructions and developing vocational skills.

5.17 Wing staff were not consistently good advocates for ESW, and too many were not encouraging prisoners into purposeful activity during the core day. The pay that prisoners received for education sessions was too low and did not provide sufficient incentive for prisoners to sign up for academic courses.

5.18 Leaders were switching some of the full-time provision in industries to part-time within two weeks of the inspection, but this was creating only a modest increase in activity places. The number of qualifications available in industries was about to rise a little with the imminent launch of a course in the textiles workshop. Leaders had not determined exactly when any further qualifications would be offered. Leaders were focusing on engaging what they identified as priority groups for ESW, such as foreign nationals, remand and younger prisoners, but this strategy was at an early stage of implementation. Only a very small minority of prisoners were following Open University or distance learning courses and they were the only prisoners using the virtual campus (see Glossary).

5.19 Leaders' most recent evaluation of the strengths and weaknesses of the provision focused too much on describing laudable educational aspirations and values, but not on overcoming the barriers to achieving them. However, the many weaknesses identified were honestly and correctly reported, and far outweighed the strengths. Leaders used quality improvement plans effectively for well-considered change and improvement actions, but they were not widely known by all managers. The prison's quality improvement group met monthly, but as senior managers were not routinely involved in the meetings, the group's profile and influence in improving the ESW provision in the prison were low.

5.20 Leaders had not implemented the reading strategy well enough. They encouraged reading during the core working day, and reading-related events, such as poetry readings, were popular. However, the numerous trained Shannon Trust (see Glossary) mentors based on the wings were not being unlocked at times best suited for learning sessions. Consequently, the substantial number of prisoners signed up to learn English had had no, or extremely few, face-to-face learning sessions with mentors. As a result, these men could not use any service in the prison on their own which involved reading or the use of English.

5.21 The quality of education and vocational training provided by Novus required improvement. For example, it was too often the case that lessons started very late due to delays in staff getting prisoners to their

learning sessions. Despite this, teachers in education sessions, particularly in ESOL and English courses, frequently did not adjust the lesson content accordingly by teaching only the main elements of prisoners' planned learning. They crammed too much into the little time they had with prisoners in the session, and consequently prisoners' learning was impaired.

5.22 Teachers did not routinely make their explanations of lesson topics or activities clear enough for prisoners or consistently link previous learning to any new topics being introduced. Too often, teachers posed prisoners questions but simply gave the answers themselves. Managers in the education department had accurately identified areas for improvement around teaching and had arranged relevant training. However, in subjects such as mathematics, catering, coding, food safety and radio, most teachers were already using effective teaching and assessment methods successfully, such as repetition and recapping, which helped prisoners consolidate their learning.

5.23 Most teachers used the results of initial assessment well to ensure prisoners were on the appropriate course and level for them. They used an appropriate diagnostic tool to identify if prisoners had additional learning needs and then provided a good range of practical support, such as coloured overlays. Most teachers and instructors gave prisoners effective and developmental feedback on their work. This motivated prisoners and encouraged them to develop their skills further.

5.24 The majority of teachers had suitable professional experience and qualifications in the subject they taught. Most instructors in industries used their experience well to teach and train prisoners. As a result, most prisoners gained theoretical and practical industry skills valued by employers.

5.25 Prisoners' achievements on accredited education courses had improved since the previous year and were high on many of them. Most prisoners on catering, dry lining, food safety, Construction Skills Certification Scheme (CSCS) card, biohazard and Railtrack courses achieved the related qualifications. Prisoners took justifiable pride in their work in art sessions, for example. Most of those in learning had a strong sense of achievement.

5.26 Prisoners had a very low appreciation of, and consequently low participation in, ESW. Their attitudes to learning were poor. Prisoners' behaviour in education sessions frequently did not meet the standards expected by teachers. In ESOL lessons, classes were too often interrupted by excessive noise levels, which disrupted learning. On average, only around half of prisoners attended their education sessions, and consequently could not develop positive attitudes to learning skills and gaining knowledge over time. Prisoners' behaviour and attendance were better in workshops, which helped foster a calm and purposeful environment. As a result, the majority of these prisoners worked effectively and supported each other to develop useful skills and knowledge over time. Instructors in industries did not use the

'progress in work' booklets well enough to monitor and record prisoners' development of industrial skills.

5.27 In workshop sessions, most prisoners were provided with equipment such as gloves and protective clothing in order to undertake their work safely. There were too few hard hats available for the number of prisoners in outside work parties. Some prisoners threw liquids and pieces of furniture through cell windows at prisoners involved in outside yard cleaning, which was a significant health and safety concern. Inside the classrooms and workshops, prisoners felt safe, and showed respect to their tutors and peers.

5.28 Far too many prisoners had not had timely or sufficient information, advice and guidance during their education induction to identify their starting points, career aims and support needs in and outside of custody. Consequently, the majority did not have a personal learning plan (PLP) and the backlog of PLPs was extremely high.

5.29 Leaders and managers arranged enrichment activities such as guest speakers, arts, yoga, book clubs and chess sessions, but too many prisoners were not aware of them. Leaders did not ensure prisoners developed their understanding of the dangers and risks relating to radicalisation and extremism. Staff did not promote the benefits of healthy lifestyles consistently well. Prisoners' understanding of community values and how they applied to their own and others' lives was inconsistent.

5.30 Leaders had developed productive partnerships with external and specialist organisations, such as StandOut (see paragraph 6.30 and Glossary), Shannon Trust and Catch 22 (see Glossary). These provided useful support services specific to prisoners' needs, not least Catch 22's support work with foreign nationals.

5.31 A small staff team provided useful support for the minority of prisoners close to release – for example, to create CVs and disclosure statements, which prisoners valued. The team had developed some productive partnerships with a range of organisations to help prisoners after release with accommodation and training, such as Price Waterhouse Coopers, the Salvation Army and St Mungo's.

# Section 6 Preparation for release

**Preparation for release is understood as a core function of the prison. Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.**

## Children and families and contact with the outside world

Expected outcomes: The prison understands the importance of family ties to resettlement and reducing the risk of reoffending. The prison promotes and supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 The capacity for in-person social visits had increased since the previous inspection and these were now available during the mornings and afternoons, six days a week. Sentenced prisoners could have two one-hour social visits a month, and remanded prisoners at least three a week. Take-up had improved and at the time of the inspection, up to 70% of the population had received at least one visit.

6.2 In our survey, only 15% of respondents said that their visits started or finished on time, and during the inspection we saw evidence to support this view. Visits were often delayed because of daily roll checks not being completed in time or accurately (see also paragraphs 3.36 and 5.2).

6.3 The walkway to the visits hall was filled with child-friendly murals, which softened the environment, but the play area for younger children had been out of commission for a long period. The refreshments available to visitors were restricted to cold drinks and a limited supply of snacks such as chocolate and crisps.


**Artwork along the walkway to the visits hall**

6.4 As a result of long-standing and substantial staff shortfalls, there were extensive delays in processes to approve telephone PIN numbers and visitors for new arrivals (see also paragraph 3.4). This meant that many prisoners waited several weeks before they could connect with their families. Once numbers had been approved, prisoners were allowed to use their in-cell telephones 24 hours a day, if they had credit. They could also send and receive correspondence via the 'email a prisoner' scheme.

6.5 Secure social video calling (see Glossary) continued to be well used. All prisoners could have two social video calls a month, which could be made in private as each of the four rooms now accommodated a laptop computer.

6.6 Prison Advice and Care Trust (PACT) worked collaboratively with the prison to provide a compassionate family service. It provided good support and information to visitors, and the visitors centre was a welcoming environment.

6.7 Family engagement officers supported prisoners on a range of matters involving family contact, such as helping foreign national prisoners to establish a connection with their families, arranging DNA tests and making family court applications to initiate or reinstate contact with children. The PACT team had also arranged with a local solicitor to hold a monthly legal clinic, free of charge, that provided support and guidance to prisoners going through family courts. This was a well-attended and well-received clinic.

6.8 A range of creative and inclusive family days (see Glossary) were held throughout the year, with a range of activities involving staff and

prisoners. There were also credible plans to provide events for prisoners who did not receive visits.

## Reducing reoffending

Expected outcomes: Prisoners are helped to change behaviours that contribute to offending. Staff help prisoners to demonstrate their progress.

6.9 As a result of the nature of the population at the establishment, staff were dealing with a high turnover of prisoners and some complex cases. Over half of prisoners were remanded to custody, 10% were convicted but unsentenced and a further 6% had been recalled to custody. Approximately half the total unsentenced population and over 10% of the sentenced population remained at Wandsworth for three months or less.

6.10 Leaders had conducted a needs analysis of the population and devised a basic strategy to reduce reoffending. The core function of assessing and planning for newly sentenced prisoners was achieved, but there was too little in place to meet the needs of the large number of remanded and foreign national prisoners.

6.11 Substantial staff shortages in the offender management unit (OMU) had had an impact on stability within the department. There had been long-term vacancies for prison- and probation-employed prison offender managers (POMs) and a manager, and there were two newly appointed managers.

6.12 This developing management team had slowly begun to raise the quality of some of the work done by POMs, particularly through regular professional supervision provided by the probation manager. The cross-deployment of POMs to other areas of the prison, which had been an issue at the time of the previous inspection, had been resolved, and there had been a recent fall in caseload numbers to around 30, which was reasonable.

6.13 The OMU team was split between two locations, with the probation managers and probation-employed POMs located in a separate building to the main OMU, which housed case administration and all the prison-employed POMs. This did not encourage the joint working approaches we have seen in other prisons.

6.14 While we often find a difference in the approach taken by prison- and probation-employed POMs, the distinction at Wandsworth was particularly clear. Prison-employed POMs were very task driven, but beyond the demands of OMU processes, they had little contact with prisoners. This contact was dictated by key points in a prisoner's sentence, such as parole hearings, offender assessment system (OASys) reviews or recategorisation reviews. However, many of the prisoners we met could not name their POM and few described regular contact. By contrast, the probation-employed POMs were more proactive in the way they managed the group of cases they held.

6.15 In our survey, few sentenced respondents (26%) were aware of having a sentence plan. Of these, most (77%) knew their targets, but few (40%) said that staff were supporting them to achieve them. This was echoed by prisoners we spoke to, who had a limited understanding of their own sentence plan targets.

6.16 Both probation- and prison-employed POMs were making good efforts to assess prisoners' level of risk and generate sentence plans, and backlogs were minimal. Most prisoners had an OASys assessment less than a year old and their sentence plans generally addressed the relevant areas, with understandable and achievable targets.

6.17 Progress against sentence plan targets was variable. In the sample of cases we reviewed, targets related to offending behaviour work were rarely achieved. Other targets, such as engagement with mental health and drug support, provided better outcomes for prisoners.

6.18 The amount of one-to-one work which both probation- and prison-employed POMs were carrying out with their prisoners was minimal, and much less than we often see.

6.19 Key work (see Glossary and paragraph 4.3) was virtually non-existent and so did not support offender management.

6.20 Eighteen prisoners were serving indeterminate sentences and there was good oversight of this cohort by a dedicated officer, supported by a manager. Activities included an effective consultation forum and dedicated family days (see Glossary).

6.21 Home detention curfew (HDC) processes were difficult to manage. Most prisoners were released after their eligibility date, often for reasons beyond the control of the prison – for example, prisoners sentenced with very little time left before their HDC release date, or because a community offender manager had not been allocated. In these cases, the prison was proactive in progressing the applications, where possible.

6.22 The end-of-custody supervised licence early release process was also having a huge impact on resources. Leaders had allocated a dedicated hub manager to review all eligible prisoners, but they had to work long hours to keep on top of the demands of this task. The hub manager often had to chase the community probation office for the information necessary to complete risk assessments to confirm release, and on occasion the head of offender management delivery had to intervene. There were instances where prisoners were released late because of this. The scheme undermined the preparation of effective, practical and safe release planning work as the arrangements often resulted in very rushed and last-minute preparation.

6.23 Most of the prisoners we spoke to were negative about their own progress and the lack of rehabilitation at the establishment. In our survey, only 35% said that their experience at the prison had made

them less likely to reoffend in the future, a finding that was far worse than in similar prisons.

## Public protection

Expected outcomes: Prisoners' risk of serious harm to others is managed effectively. Prisoners are helped to reduce high risk of harm behaviours.

6.24 Public protection procedures to safeguard children and protect other potential victims had deteriorated substantially since the last inspection. Only four prisoners had been identified as needing telephone and mail monitoring, and even this was not taking place consistently. On occasions where calls were monitored, intelligence obtained was not acted on or shared with the relevant agencies.

6.25 Twenty-nine prisoners had been identified as persons posing a risk to children. Guidelines for these prisoners state that contact decisions should be reviewed at least annually, or earlier if there is reason to believe that circumstances have changed, resulting in either an increase or decrease in risk. However, oversight of this group was poor and reviews had not been taking place.

6.26 The inter-departmental risk management (IDRM) meeting aimed to provide good oversight of release planning for prisoners known to present a high risk of harm and those subject to multi-agency public protection arrangements (MAPPA; see Glossary). We were told that IDRM meetings were held monthly and were multidisciplinary, and while we believed this to be the case, there were no appropriately detailed records of such meetings. An action tracker was completed, but was not consistently followed up, and it was difficult to track the work done in preparation for the release of high-risk prisoners.

6.27 MAPPA management levels were generally confirmed before release, but the quality of written contributions for MAPPA meetings was inconsistent. Both prison- and probation-employed POMs attended MAPPA meetings for level 2 and 3 cases.

## Interventions and support

Expected outcomes: Prisoners are able to access support and interventions designed to reduce reoffending and promote effective resettlement.

6.28 As the establishment was a reception prison, it did not include a function to deliver accredited offender behaviour programmes as these would be delivered to prisoners further into their sentence.

6.29 Many of the needs of the large numbers of remanded and unsentenced prisoners (see paragraph 6.9) were not being met. Until very recently, the prison had been a pilot for an effective remand support service which helped prisoners with employment and accommodation on

release and provided support with finance and debt. The team had offered targeted support to the remand population and generated good outcomes. Unfortunately, and despite the need for it, the team was disbanded in March 2024 because of a lack of funding.

6.30 Some work was being done to address the needs of the sentenced population, including one-to-one work delivered by the psychology team. Prison to PhD (see Glossary) delivered an intervention to 18–35-year-olds involved in gang-related crime, with the intention of building and supporting healthier relationships. StandOut (see Glossary) delivered group-work programmes on goal setting, internal controls and improving employability prospects with CV writing and interview techniques.

6.31 The prison provided a very limited range of in-cell work packs – for example, on victim awareness and drugs – but there was rarely any input from staff on the completion of these, to help embed any learning. On a few occasions, probation-employed POMs had delivered a reducing reoffending engagement workbook.

6.32 Prisoners could open bank accounts through the resettlement team. The Department for Work and Pensions delivered a basic provision on benefit claims, and education, skills and work leads helped prisoners to obtain birth certificates, but there was no formal finance or debt support.

## Returning to the community

Expected outcomes: Prisoners' specific reintegration needs are met through good multi-agency working to maximise the likelihood of successful resettlement on release.

6.33 With an average of 260 releases each month, the demand for resettlement help was high. A small pre-release team, consisting of only two people, was allocated to this work for low- and medium-risk (sentenced) prisoners up to a maximum of 12 weeks before their release.

6.34 While some good support was also provided by external agencies such as Nacro and St Mungo's, only one or two staff were provided by each agency, so prisoners needs were not always met.

6.35 Only 11% of the prisoners leaving the establishment in the last 12 months had been released into settled and sustainable accommodation (see Glossary).

6.36 Practical arrangements for the day of release were very basic. Prisoners were often delayed on the day of departure – sometimes because of incidents in the prison, but more often as a result of delays with the roll check (see also paragraphs 3.36 and 5.2). Vulnerable prisoners leaving the prison were not always supported to reach either their allocated accommodation or probation appointment.

# Section 7 Progress on recommendations from the last full inspection

## Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison.

## Safety

### Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2021, outcomes for prisoners were not sufficiently good against this healthy prison test.

#### Key recommendations

Prison leaders need to develop longer term plans for improving the prison against their priorities. The governor and his team should introduce robust governance arrangements to give them assurance that plans are being followed, that work is taking place on time, that there are clear lines of accountability, that progress is monitored and that there is a process for reviewing plans.
**Not achieved**

There should be a prison-wide approach to reducing violence and making prisoners feels safe. This should include setting targets for set periods, monitoring progress and reviewing, and where necessary, amending plans.
**Not achieved**

Leaders should make sure that body-worn cameras are switched on at the beginning of any incident. There should be regular and effective senior management scrutiny and oversight of the use of force, including deployment of batons and PAVA, to make sure that force used is always justified and proportionate.
**Not achieved**

#### Recommendations

All new arrivals should be offered a shower.
**Not achieved**

Searching procedures should be proportionate to the risk posed and not applied automatically.
**Partially achieved**

There should be a wide range of incentives to encourage prisoners' positive behaviour and effective systems to address poor behaviour.
**Not achieved**

Managerial oversight of disciplinary procedures should make sure that all hearings are held fairly and completed within a reasonable time.
**Not achieved**

There should be meaningful reintegration planning for prisoners held in the segregation unit, which should address the reasons for the behaviour that has led to their segregation.
**Achieved**

Assessment, care in custody and teamwork (ACCT) documentation across the prison should be maintained to a sufficient standard to assist the provision of support to prisoners in crisis.
**Not achieved**

## Respect

**Prisoners are treated with respect for their human dignity.**

At the last inspection, in 2021, outcomes for prisoners were not sufficiently good against this healthy prison test.

**Key recommendations**

All living conditions, including the inpatient unit and Trinity unit, should be improved to safe and decent standards.
**Not achieved**

Foreign national prisoners and detainees should have their cases reviewed promptly and have timely access to information, help and face-to-face support.
**Not achieved**

The prison should work with the local delivery board, in conjunction with NHS England and Improvement, to make sure there are sufficient staff to meet the needs of patients with mental health problems safely.
**Achieved**

The prison should work with the local delivery board, in conjunction with NHS England and Improvement, to make sure that patients requiring a transfer under the Mental Health Act are transferred expeditiously and within the current transfer guidelines.
**Partially achieved**

**Recommendations**

Prison leaders should continue to develop the key work strategy to make sure that each prisoner has regular and high-quality contact with a named key worker.
**Not achieved**

All prisoners should have access to basic items, including weekly provision of clean bedding, clothes and cleaning materials.
**Not achieved**

Lunch should be served no earlier than 12 noon and dinner no earlier than 5pm.
**Not achieved**

Professional telephone interpreting should be used to communicate with prisoners who do not speak English when confidentiality or accuracy is required.
**Not achieved**

There should be a time limit on immigration detention.
**Not achieved**

The prison should work with the partnership board to reduce non-attendance rates for both internal and external appointments to optimise use of clinical time, reduce waiting times and improve outcomes for patients.
**Not achieved**

There should be effective release planning to make sure prisoners have adequate information and medicines for continuity in their health care on release or transfer.
**Achieved**

Medication should be administered in line with professional standards by consistently checking patient identity.
**Achieved**

Officers should manage medication queues to maintain patient confidentiality, enable supervised consumption of medicines and prevent any diversion.
**Not achieved**

## Purposeful activity

**Prisoners are able, and expected, to engage in activity that is likely to benefit them.**

At the last inspection, in 2021, outcomes for prisoners were poor against this healthy prison test.

### Key recommendations

Time out of cell should be improved, including a daily regime that provides at least an hour in the open air for all and access to work, PE, the library, education, training or other constructive activities.
**Not achieved**

### Recommendations

Leaders should ensure that they fully use all activity spaces, so that a high proportion of prisoners participate in purposeful activity.
**Not achieved**

Leaders should ensure that staff understand the prior knowledge of English and mathematics that prisoners have, so that they can place them on to suitable courses.
**Not achieved**

Leaders should introduce accredited qualifications in a wider variety of subjects, so that prisoners gain qualifications that will help them in their future careers or with further study.
**Partially achieved**

## Rehabilitation and release planning

**Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.**

At the last inspection, in 2021, outcomes for prisoners were not sufficiently good against this healthy prison test.

### Key recommendations

Recommendation: Leaders should make sure that there is effective housing support for all prisoners, including those on remand.
**Not achieved**

**Recommendations**

Prison offender managers should not be cross-deployed to other duties and be allowed to carry out their intended work to support prisoners to progress.
**Achieved**

The monitoring of mail and telephone calls should be consistently applied in line with national guidelines.
**Not achieved**

# Appendix I About our inspections and reports

HM Inspectorate of 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, court custody and military detention.

All inspections 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.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For men's prisons the tests are:

**Safety**
Prisoners, particularly the most vulnerable, are held safely.

**Respect**
Prisoners are treated with respect for their human dignity.

**Purposeful activity**
Prisoners are able, and expected, to engage in activity that is likely to to benefit them.

**Preparation for release**
Preparation for release is understood as a core function of the prison. Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by HM Prison and Probation Service (HMPPS).

**Outcomes for prisoners are good.**
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

**Outcomes for prisoners are reasonably good.**
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant

concerns. Procedures to safeguard outcomes are in place.

**Outcomes for prisoners are not sufficiently good.**
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

**Outcomes for prisoners are poor.**
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work 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.

Five key sources of evidence are used by inspectors: observation; prisoner and staff surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council (GPhC). Some are also conducted with HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

## This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 6, 2023) (available on our website at

https://www.hmiprisons.justiceinspectorates.gov.uk/expectations/). Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of prisoners and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

**Inspection team**

This inspection was carried out by:

| | |
|---|---|
| Martin Lomas | Deputy Chief Inspector |
| Deborah Butler | Team leader |
| Nadia Syed | Inspector |
| Ian Dickens | Inspector |
| Angela Johnson | Inspector |
| Esra Sari | Inspector |
| Rick Wright | Inspector |
| Helen Downham | Researcher |
| Alexander Scragg | Researcher |
| Sam Moses | Researcher |
| Jasjeet Sohal | Researcher |
| Stephen Eley | Lead health and social care inspector |
| Paul Tarbuck | Health and social care inspector |
| Simon Newman | Health and social care inspector |
| Richard Chapman | Pharmacist |
| Bev Gray | Care Quality Commission inspector |
| Nick Crombie | Ofsted inspector |
| Jane Hughes | Ofsted inspector |
| Saher Nijabat | Ofsted inspector |
| Andrew Thompson | Ofsted inspector |
| Martyn Griffiths | Offender management inspector |

# Appendix II Glossary

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.

**Care Quality Commission (CQC)**
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

**Catch 22**
Catch 22 is a registered charity providing a range of support services in prisons and in the community. In prisons, its aim is to provide long-term support to prisoners, to promote positive outcomes and reduce reoffending.

**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.

**Connecting Communities**
An NHS England RECONNECT service working with individuals up to 12 weeks pre-release and up to six months post-release to support and empower them to engage with their own health care needs.

**CrossFit**
A branded fitness regime aimed at improving physical, mental and emotional health.

**Family days**
Many prisons, in addition to social visits, arrange ‘family days’ throughout the year. These are usually open to all prisoners who have small children, grandchildren, or other young relatives.

**Key worker scheme**
The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison

officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

**Leader**
In this report the term 'leader' refers to anyone with leadership or management responsibility in the prison system. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

**MAPPA**
Multi-Agency Public Protection Arrangements: the set of arrangements through which the police, probation and prison services work together with other agencies to manage the risks posed by violent, sexual and terrorism offenders living in the community, to protect the public.

**Offender management in custody (OMiC)**
The Offender Management in Custody (OMiC) model, which has been rolled out in all adult prisons, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1 October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

**PAVA**
PAVA (pelargonic acid vanillylamide) spray is classified as a prohibited weapon by section 5(1) (b) of the Firearms Act 1988.

**POhWER**
A charity providing advocacy, information and advice for people who experience disability, vulnerability, distress and social exclusion.

**Prison to PhD**
An organisation that encourages and supports higher education for prisoners.

**Protected characteristics**
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

**Protection of adults at risk**
Safeguarding duties apply to an adult who:
- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

**Secure video calls**
A system commissioned by HM Prison and Probation Service (HMPPS) that requires users to download an app to their phone or computer. Before a call can be booked, users must upload valid ID.

**Shannon Trust**
A national charity which provides peer-mentored reading plan resources and training to prisons.

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

**Spice**
A psychoactive substance which induces effects akin to cannabis.

**StandOut**
A company that provides programmes for prisoners during custody and after release to support rehabilitation.

**Sustainable accommodation**
HMI Prisons defines sustainable accommodation as that which is still available to the person after three months. It can be privately owned or rented, social housing provided by the local council, or residing with friends/family.

**Time out of cell**
Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

**Virtual campus**
Internet access for prisoners to community education, training and employment opportunities.

# Appendix III  Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are:

## Prison population profile

We request a population profile from each prison as part of the information we gather during our inspection. We have published this breakdown on our website.

## Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

## Prison staff survey

Prison staff are invited to complete a staff survey. The results are published alongside the report on our website.

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

This publication is available for download at: http://www.hmiprisons.justiceinspectorates.gov.uk/

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