



Report on an unannounced  
inspection of

## **HMP Wandsworth**

by HM Chief Inspector of Prisons

13 and 20–24 September 2021



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## Introduction

The decision by the prison service to reduce the number of prisoners held at Wandsworth by 300, as well as the work of the dynamic and experienced governor, had stopped this busy local prison from being overwhelmed by its many challenges.

There were not enough staff to make sure prisoners received even the most basic regime; for example, they sometimes had to choose between exercise, ordering from the kiosk and having a shower. Gym sessions were regularly cancelled and much of the essential resettlement and sentence progression work was not happening because prison offender managers and PE staff were deployed on the wings to backfill staff absences. One group of prisoners from Trinity Unit, who came blinking into the sunlight, told me that it was the first time they had been outside for more than a week.

The education provider had failed to do enough to engage prisoners or develop learning opportunities for a population that was desperately bored. The education block had sat unused since March 2020 and most of the very limited provision came in the form of work packs. Education staff were barely doing any face-to-face teaching, so it was not entirely clear how their time was being spent.

Nearly half of the prisoners were foreign nationals, many of whom come from eastern Europe. The prison, the education service and, in particular, Home Office staff, were not doing enough to support this group of prisoners. There were 37 prisoners over their tariff waiting for a decision on when or if they would be deported. Some foreign national prisoners had even been told on the day of their release that they were to continue to be held in the jail. A local charity, BEST, had stayed on site during the pandemic and were doing invaluable work in supporting foreign national prisoners while, inexplicably, Home Office staff had absented themselves from the prison for more than a year. In the meantime, prison officers and other staff had to deal with the consequences of their inaction. Even since Home Office staff had returned, working what appeared to be limited hours, they were not running surgeries on the wing and prisoners were lucky if they got a phone call.

The infrastructure of the jail needed a lot of work: cells and landings were often tatty, some of the showers were awful and outside areas were strewn with rubbish. The inpatient mental health unit, due to be refurbished, was not a fit place to care for seriously unwell patients. Fortunately, there had also been some impressive improvements: the legal visits and video conferencing took place in an excellent facility and the visits hall had been decorated with prisoner-painted murals.

Communication between the governor through a range of media (including Radio Wanno) had meant that prisoners were kept well informed about the pandemic and any developments in the prison. This may have contributed to the generally calm atmosphere in the jail – which we witnessed – despite the paucity of the regime. Interactions between officers and prisoners were,

because of staffing shortages, largely transactional. Key work was very limited, although prisoners recognised that often staff were trying to do their best.

Understandably, the governor had been focused on keeping the day-to-day functions of the prison going as he dealt with the extensive list of challenges that we highlight in this report. He now has the opportunity, with an improving leadership team, to put in more robust assurance systems around some crucial functions such as use of force, safeguarding and violence reduction. There had been nine self-inflicted deaths since our last inspection. The prison must continue to respond to the Prisons and Probation Ombudsman's reports to make sure that everything is done to reduce the risk to the most vulnerable prisoners.

As some of the concerns about the pandemic begins to reduce, leaders will have the opportunity to focus on developing longer-term plans for the jail that set targets and introduce effective systems for monitoring and review. This will mean that some of the more complex concerns can be addressed, such as the regime (including access to work and education), the support for foreign national prisoners and the development of the staff team.

Leaders in this crumbling, overcrowded, vermin-infested prison will need considerable ongoing support from the prison service, notably with the recruitment and retention of staff, improving the infrastructure of the jail and making sure that external agencies such as the Home Office and the education provider pull their weight. It is hard to see how HMP Wandsworth's limited progress can be sustained if prisoner numbers in this jail are allowed to increase as they are scheduled to do next April.

**Charlie Taylor**  
HM Chief Inspector of Prisons  
October 2021

# About HMP Wandsworth

## Task of the prison

Local category B reception and resettlement adult male prison.

## Certified normal accommodation and operational capacity (see Glossary of terms)

Prisoners held at the time of inspection: 1,364

Baseline certified normal capacity: 1,334

In-use certified normal capacity: 1,325

Operational capacity: 1,368

## Population of the prison

- 4,615 new prisoners received each year (around 88 per week).
- 613 foreign national prisoners, about 45% of the population.
- 41% of prisoners from black and minority ethnic backgrounds.
- Just under half the population were on remand and nearly three-quarters were unsentenced.
- Nearly half of sentenced and just over half of unsentenced prisoners stayed for three months or less.
- 160 prisoners released into the community each month.
- 967 prisoners receiving support for substance misuse.
- 531 prisoners 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: South London and the Maudsley NHS Trust

Substance misuse treatment provider: Change Grow Live

Prison education framework provider: Novus

Escort contractor: Serco

## Prison group

London

## 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 – resettlement unit

Addison and Jones – health care inpatient units

**Name of governor and date in post**

Graham Barrett OBE, October 2019

**Leadership changes since the last inspection**

Jeanne Bryant, May 2017 – September 2019

**Prison Group Director**

Ian Bickers

**Independent Monitoring Board chair**

Tim Aikens

**Date of last inspection**

26 February – 9 March 2018

## Section 1 Summary of key findings

- 1.1 We last inspected Wandsworth in 2018 and made 63 recommendations, seven of which were about areas of key concern. The prison fully accepted 40 of the recommendations and partially (or subject to resources) accepted 17. It rejected six of the recommendations.
- 1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

### Progress on key concerns and recommendations

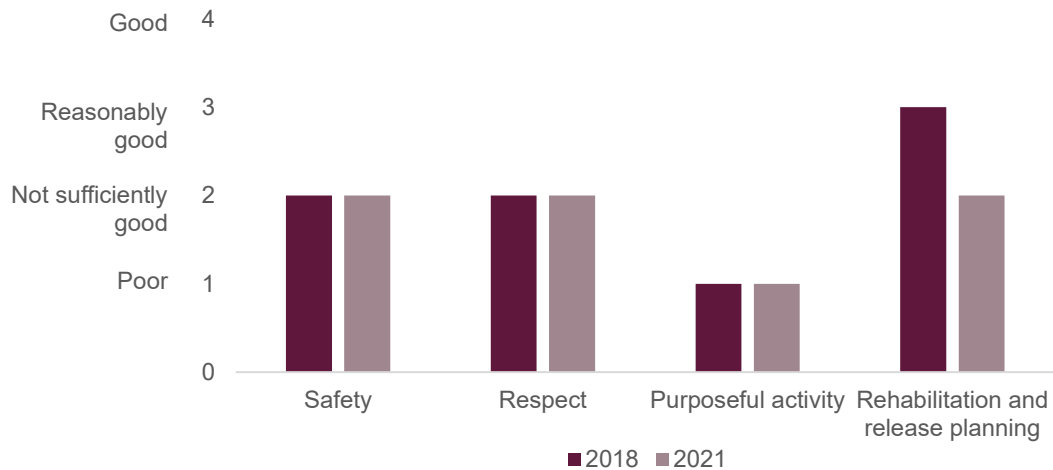
- 1.3 Our last inspection of Wandsworth took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.
- 1.4 At our last full inspection, we made three recommendations about key concerns in the area of safety. At this inspection we found that one of those recommendations had been achieved and two had been partially achieved.
- 1.5 We made two recommendations about key concerns in the area of respect. At this inspection we found that neither recommendation had been achieved.
- 1.6 We made two recommendations about key concerns in the area of purposeful activity. At this inspection we found that one of those recommendations had not been achieved and the other had not inspected. Ofsted carried out a progress monitoring visit (alongside our inspection) to assess the progress that leaders and managers had made towards reinstating a full education, skills and work curriculum. They judged that it was too early to assess whether recommendations made at the last inspection had been achieved.

### Outcomes for prisoners

- 1.7 We assessed outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We have also included a commentary on leadership in the prison (see Section 2).
- 1.8 At this inspection of HMP Wandsworth we found that outcomes for prisoners had stayed the same in three healthy prison areas and declined in one.
- 1.9 These judgements seek to make an objective assessment of the outcomes experienced by those detained. We have taken into account

the prison’s recovery from COVID-19, as well as the ‘regime stage’ at which the prison was operating (as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services).

**Figure 1: HMP Wandsworth healthy prison outcomes 2018 and 2021**



## Safety

At the last inspection of Wandsworth in 2018 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained not sufficiently good.

- 1.10 Reception was welcoming and processes were thorough. Procedures for identifying prisoners at increased risk following court appearances had improved, as had the first night interviews. First night cells were clean, but many had insufficient or broken furniture. Not all new arrivals were offered the opportunity to shower. Induction was good and information was available in a range of languages.
- 1.11 In our survey, over half of respondents said they had felt unsafe at some point during their stay and 22% said they felt unsafe now. The recorded number of assaults had increased over the last 12 months and assaults against staff were higher than at similar prisons. Although data monitoring had improved, the prison lacked a longer-term plan to reduce violence. The challenge, support and intervention plan (CSIP, see Glossary of terms) casework model for perpetrators of violence was not operating effectively and there was no formal support for victims.
- 1.12 There were limited incentives to encourage positive behaviour and the scheme was ineffective in addressing poor behaviour. Too many adjudications had been remanded for a long time.
- 1.13 Use of force incidents had increased significantly since the last inspection, but only around 20% of staff had received up-to-date training. There were strengths in some aspects of governance, but



there had been no formal monitoring meetings and senior managers did not investigate all incidents involving the use of batons or PAVA incapacitant spray. Officers did not always switch on body-worn cameras early enough to provide evidence and CCTV footage was not routinely downloaded to check that force used was justified and proportionate.

- 1.14 Use of special accommodation in the last 12 months was high and not always in exceptional circumstances. However, leaders had taken action to address this and consequently special accommodation had not been used since April 2021.
- 1.15 The daily regime for prisoners in the segregation unit had improved since the last inspection, but it was still too limited and reintegration planning was not meaningful. Prisoners held in the unit were positive about their relationships with staff. The unit's communal areas were clean, but cells were grubby with ingrained dirt and exercise yards remained grim.
- 1.16 Most aspects of security were proportionate, but new arrivals were strip-searched in addition to going through the body scanner. The flow of security information was processed efficiently, and monthly local tactical briefings were based on relevant intelligence and objectives. There was an appropriate focus on counter terrorism. The prison also had a good strategic approach to tackling drug supply.
- 1.17 There had been nine self-inflicted deaths since the last inspection in 2018 and two further deaths related to drug misuse. The prison had acted swiftly in response to the recommendations from the Prisons and Probation Ombudsman (PPO) investigation reports received to date.
- 1.18 The rate of self-harm had more than doubled during the year but remained comparatively low for the type of prison. The prison had taken action to address levels of self-harm, underpinned by daily reviews of incidents and scrutiny of data. There was no published overall safety strategy and supporting action plan to make the prison safer. The quality of assessment, care in custody and teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm varied too widely across the prison. The large team of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) was well supported and available on a rota to those requiring them.

## Respect

At the last inspection of Wandsworth in 2018 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained not sufficiently good.

- 1.19 Over 60% of prisoners in our survey said that most staff treated them with respect and that there were staff they could turn to if they had a problem. We observed some friendly and positive interactions, but the poor regime and staffing shortfalls undermined the quality of staff relationships with prisoners in providing support and rehabilitation. The key worker scheme was not working as intended by the Offender Management in Custody (OMiC) model (see Glossary). Plans to restore the scheme were neither fully developed nor realistic.
- 1.20 Despite a recent reduction in population, nearly three-quarters of prisoners were still sharing cells designed for one. While most cells were now adequately equipped, vandalism was a concern. Many prisoners complained to us about a lack of clean clothing and sheets, and the organisation of cleaning materials was chaotic. However, leaders had made concerted efforts to make sure that staff responded to electronic cell bells promptly, which was positive.
- 1.21 The refurbishment of showers in wings on the Heathfield unit was welcome, but in the Trinity unit communal showers on the wings were unsatisfactory. A combination of a poor regime and damage meant that prisoners could often go several days without a shower. Despite efforts to control vermin, there was still a major problem with rats, mice and pigeons. Despite work to control vermin, including many rats, mice and pigeons, this was still a major problem.
- 1.22 Over half of prisoners in our survey said that the food was good, compared with just 34% at similar prisons. However, meals were served too early and staff distributed the evening meal at cell doors, which further restricted opportunity for time out of cell. Hotplate trollies used to transport food were filthy.
- 1.23 Prisoner consultation and communication were a real strength at Wandsworth. The prison broadcast information to all prisoners via Radio Wanno and there was a new prison TV channel. Prisoners could now make applications through the electronic kiosks and responses were now more prompt. Complaints were reasonably well managed. Provision for legal visits and court video-conferencing facilities were impressive.
- 1.24 Strategic oversight of equality and diversity work remained underdeveloped. There was no tailored strategy and meetings had only recently resumed. There was a lack of regular consultation with protected and minority groups. However, discrimination complaints were well managed. Nearly half the population identified as black or minority ethnic and in our survey they reported broadly similar perceptions to white prisoners.
- 1.25 Support for the many foreign national prisoners was insufficient. Wing staff did not always use professional telephone interpreting when required. Home Office immigration staff had only recently returned to the prison having left many foreign nationals unsupported throughout the pandemic. They appreciated the work of BEST, a charity befriending and supporting foreign national prisoners in Wandsworth,

and, more recently, similar support from Catch 22. However, detainees spent far too long in the prison with their cases unresolved.

- 1.26 The chaplaincy was highly regarded by prisoners and well-integrated into prison life, but the ongoing suspension of corporate worship was a source of frustration for many. Links with community faith groups were excellent.
- 1.27 Health care provision was reasonably good, but the environment on the inpatient unit was unsuitable for patients. There were staffing shortages in all clinical services, affecting mental health services more severely due to the lack of available agency staff. Patients requiring transfer to secure mental health inpatient services continued to wait far too long.
- 1.28 Primary health care services were well led. A committed and enthusiastic staff team provided a safe and effective service, despite some long waiting times. Non-attendance rates at both internal and external hospital appointments were high. Substance misuse and dental services were both good. Pharmacy services were reasonable, although officer management of queues was ineffective in preventing potential medicines diversion.

### **Purposeful activity**

At the last inspection of Wandsworth in 2018 we found that outcomes for prisoners were poor against this healthy prison test.

At this inspection we found that outcomes for prisoners remained poor.

- 1.29 Ofsted carried out a progress monitoring visit of the prison alongside our full inspection and the purposeful activity judgement incorporates their assessment of progress. Ofsted's full findings and the recommendations arising from their visit are set out in Section 5.
- 1.30 In our survey, prisoners reported too little time spent unlocked, especially at weekends when 91% said they had less than two hours a day out of cell. Time unlocked for most prisoners was unpredictable and for some as little as 45 minutes. Access to exercise was inadequate, particularly for prisoners on Trinity unit who repeatedly complained about going for days, and sometimes weeks, without time in the open air.
- 1.31 The library remained closed and although prisoners could order books, relatively few were delivered each day. COVID-19 restrictions had reduced the PE programme, which was compounded by a shortage of gym staff and their frequent redeployment.
- 1.32 The main education block had been closed since March 2020 and few prisoners were regularly engaged in any purposeful work or learning. Too many had not completed an education induction, such as assessments of their mathematics and English abilities. There were insufficient activity spaces to meet the needs of the population and not

enough prisoners had been enrolled on to even the limited number of education places available. The education provider had been slow to reintroduce vocational training to the curriculum, and prisoners had very limited opportunities to gain accredited qualifications.

- 1.33 Too many education courses developed prisoners' skills only to level 1, which was below the ability level of many. Tutors' written feedback to prisoners was of an inconsistent quality. Information, advice and guidance to help prisoners understand the education or work options was not good enough, and leaders had been too slow to introduce support for those with learning difficulties and/or disabilities. However, prisoners close to the end of their sentences benefited from newly introduced support.
- 1.34 Prison leaders had identified many of the weaknesses with the education curriculum and the quality of teaching and had worked productively with education provider leaders as they planned to make improvements.

### Rehabilitation and release planning

At the last inspection of Wandsworth in 2018 we found that outcomes for prisoners were reasonably good against this healthy prison test.

At this inspection we found that outcomes for prisoners were now not sufficiently good.

- 1.35 Face-to-face visits had resumed in June 2021 and take-up was good. While they had been suspended the prison had redecorated the visits hall and it was now impressive. The use of secure video calls (see Glossary) was reasonable, but more could have been done to encourage foreign national prisoners to use the facility. In-cell telephones were a great help for prisoners in maintaining family contact. The prison and PACT (Prison Advice and Care Trust) staff had been creative in encouraging contact between prisoners and their families.
- 1.36 Nearly three-quarters of the population were unsentenced and the turnover of prisoners was high. A good prisoner needs analysis, supported by a strategy, focused on key areas for their improvement. The monthly reducing reoffending meeting was well attended and demonstrated good links with the rest of the prison.
- 1.37 Almost all eligible prisoners had an assessment of their needs on arrival and most had an OASys (offender assessment system) assessment that had been completed in the last 12 months. Sentence plan objectives were appropriate, and most prisoners we spoke to had a reasonable understanding of them. However, in our survey, only 6% of prisoners, against 45% in similar prisons, said that staff were helping them to achieve their targets.

- 1.38 Contact between prison offender managers (POMs) and prisoners was undermined by their cross-deployment to other duties. This caused much frustration and reduced opportunities for POMs to support the progression of prisoners on their caseload. Home detention curfew (HDC) processes were managed well, but some problems beyond the control of the prison led to some prisoners being released after their eligibility date.
- 1.39 Public protection procedures were well managed. However, the prison was not monitoring mail and telephone calls for all new arrivals, as they should have done under national guidelines. There was reasonably good information exchange between the prison and community offender managers to develop robust risk management release plans.
- 1.40 The demand for resettlement help was high with 160 prisoners a month released. Following unification of probation services, provision for resettlement was not yet effective. Under the new contract, the housing provider, St Mungo's, no longer provided support for prisoners on remand, which was a significant gap. Only 45% of prisoners released in the last year had accommodation fixed for their first night in the community.
- 1.41 Resettlement plans lacked depth and did not always lead to a positive outcome, and prisoners we spoke to were not always aware of what was being done to address their resettlement needs. However, practical release arrangements were good and several organisations provided through-the-gate support.

## Key concerns and recommendations

- 1.42 Key concerns and recommendations identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.
- 1.43 During this inspection we identified some areas of key concern and have made a small number of recommendations for the prison to address those concerns.
- 1.44 **Key concern:** Although leaders were making good use of data to measure daily and weekly progress, governance arrangements were not sufficient to make sure that longer term plans, targets and monitoring were taking place in a number of important areas such as violence reduction, use of force, key work, safety and equality and diversity.

**Recommendation: 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 (To the governor)**

1.45 **Key concern:** Over half of respondents to our survey reported that they had felt unsafe at some point during their stay. There was no formal support for victims. Violence was increasing and the number of assaults on staff was high. The management of perpetrators of violence was weak, too many investigations into incidents were not thorough enough, and there was no embedded violence reduction strategy or action plan.

**Recommendation: 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.**

(To the governor)

1.46 **Key concern:** The use of force was high and there were no formal governance meetings. Staff involved in incidents did not always record de-escalation techniques or switch on body-worn cameras early enough to provide sufficient scrutiny. Not all incidents involving the use of batons and PAVA incapacitant spray were investigated by senior managers and too much use of force documentation was missing.

**Recommendation: 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.**

(To the governor)

1.47 **Key concern:** Wandsworth remained one of the most overcrowded prisons in the country with most prisoners sharing a cell built for one. The shower areas on Trinity were poor. The physical environment in the mental health inpatient unit was unacceptable, did not meet infection control standards and had ligature points that had not been remedied to reduce the risk to patients. The control of vermin needed greater focus, including measures to prevent food waste and rubbish being thrown from cell windows.

**Recommendation: All living conditions, including the inpatient unit and Trinity unit, should be improved to safe and decent standards.**

(To the governor)

1.48 **Key concern:** There was insufficient support for the many foreign national prisoners held at Wandsworth. Home Office immigration staff had only recently returned to the prison, face-to-face contact was limited, and wing surgeries were still suspended. Legal documents were often served too late, and prisoners and detainees spent far too long in prison with their cases unresolved.

**Recommendation: Foreign national prisoners and detainees should have their cases reviewed promptly and have timely**

**access to information, help and face-to-face support.**

(To the Home Office)

- 1.49 **Key concern:** The lack of primary mental health and inpatient staff resulted in patients not having their mental health needs met in a safe or timely manner. This was creating significant risks affecting the monitoring of referrals, assessments taking place within agreed timescales and ensuring that the outcome of assessments was fully documented.

**Recommendation: 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.**

(To the governor)

- 1.50 **Key concern:** Patients requiring transfer to secure mental health inpatient services continued to wait far too long for a bed. Only four of the 18 patients transferred to a mental health hospital under the Mental Health Act in the last six months had done so in fewer than 14 days. The remaining 14 patients waited from 15 to 226 days, which was unacceptable.

**Recommendation: 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.**

(To HMPPS and the governor)

- 1.51 **Key concern:** The daily regime remained far too limited and most prisoners continued to spend more than 22 hours a day locked in their cells, with some denied access to the open air for days at a time. Opportunities to engage in purposeful activity remained very limited and too many prisoners were unemployed. Access to the library and the gym and education were poor.

**Recommendation: 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.**

(To the governor)

- 1.52 **Key concern:** Following unification of the Probation Service, the housing provider no longer supported prisoners on remand. This resulted in the large number of remand prisoners not being able to access support, for example to secure tenancies or deal with rent arrears.

**Recommendation: Leaders should make sure that there is effective housing support for all prisoners, including those on remand.**

(To HMPPS and the governor)

## Notable positive practice

- 1.53 We define notable positive practice as 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.
- 1.54 Inspectors found six examples of notable positive practice during this inspection.
- 1.55 An assessment, care in custody and teamwork (ACCT) case management handover record had been introduced to identify which staff were responsible for the support of prisoners subject to ACCT. (See paragraph 3.39.)
- 1.56 The prison made effective use of available technology, including radio and TV, to support prisoner consultation and communication in a modern and informative manner. (See paragraph 4.20.)
- 1.57 A recently appointed bail information officer had worked with over 2,000 prisoners who might have been eligible to apply for bail in the last six months, which was an extremely useful resource given that almost half the population were on remand. (See paragraph 4.25.)
- 1.58 The assistant psychologist had delivered notable mental health training for prison officers and health care orderlies, which enabled officers and patients to come together to understand each other's responses to certain behaviours. (See paragraph 4.82.)
- 1.59 The provision of a dental surgeon on site enabled a wider range of dental treatment within the prison (See paragraph 4.99.)
- 1.60 The public protection team regularly reviewed logs completed by staff who monitored prisoner telephone calls to provide an extra layer of quality assurance. (See paragraph 6.16.)



## Section 2 Leadership

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

- 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 governor's strong, committed and visible leadership had successfully sustained the prison through the pandemic, which had seen four COVID-19 outbreaks. Some very poor living conditions, the short time unlocked and a lack of space for prisoners to exercise regularly outdoors had made the period of the pandemic particularly challenging.
- 2.3 Leaders understood the strengths and weaknesses of the prison and had a focus on improving basic standards. Daily scrutiny by leaders and managers of incidents and data was driving some improvements.
- 2.4 The key priority for leaders was to make the prison safer following seven self-inflicted deaths since December 2020 – three of which had occurred in quick succession in June 2021. The prison had no published safety strategy or coordinated action plan. (See key concern and recommendation 1.44.) However, leaders showed a commitment to making improvements and had taken some swift action to address identified deficiencies.
- 2.5 Wider support from HMPPS to prevent further deaths was being channelled through the 'safety taskforce' providing, for example, additional training, an extra manager and a temporary reduction of 270 prisoners in operational capacity. We were concerned that plans to return the prison to full capacity in April 2022 would jeopardise safety unless key issues, including staffing shortfalls, overcrowding, the poor environment and lack of space for regular exercise, were addressed.
- 2.6 The governor was taking action to challenge an ingrained negative culture, including sexism and racism, among some staff. A 'climate assessment' of what it was like to work in the prison had also been carried out by the HMPPS Tackling Unacceptable Behaviours Unit.
- 2.7 There were some good examples of leadership that had improved outcomes for prisoners, such as in visits, early days work, reducing reoffending and the chaplaincy.
- 2.8 Although leaders had eased some restrictions just before our visit, the regime remained severely limited and unpredictable. Prisoners told us that they had not had access to the open air for several days and for

more than a week in some cases, which was wholly unacceptable, and leaders were not aware of the scale of this problem. There was little education in classrooms and few other activity places.

- 2.9 Staffing shortfalls were preventing the prison from running a decent and predictable regime. More than 30% of prison officers were either absent or unable to work their full duties. Around a quarter were less than a year in post and more than 10% had resigned in the last 12 months. There was a shortage of gym staff and they were frequently redeployed to other duties, as were prison offender managers. In our survey, most of the staff who responded said that morale was low and many commented on the lack of opportunity for the training they needed. Leaders had also failed to give appropriate attention to the key worker scheme.
- 2.10 Although there had been considerable investment in improving living conditions, HMPPS and prison leaders had failed to tackle the unacceptably poor environment, particularly on Trinity and Addison units.
- 2.11 Communication between staff and prisoners was a strength. The governor regularly provided updates through a range of media, such as broadcasts to prisoners through Radio Wanno. Staff received regular bulletins, including a weekly digest of information on safety and a comprehensive daily report.
- 2.12 Leaders had worked effectively with partners and had taken robust action in response to performance failings by a previous resettlement service provider. The education provider was currently subject to an improvement action plan, at the instigation of the prison. The Home Office immigration service had not been on site for much of the pandemic but had recently returned.
- 2.13 Although leaders were making good use of data to measure daily and weekly progress, governance arrangements were not sufficient to make sure that longer term plans, targets and monitoring were taking place in a number of important areas such as violence reduction, use of force, key work, safety and equality and diversity. (See key concern and recommendation 1.44.)

## 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 Most arrivals travelled from nearby courts and disembarked from escort vehicles relatively quickly. The vehicles we viewed were clean and well equipped.
- 3.2 Reception staff were welcoming and quickly put new arrivals at their ease during the initial identification interview before they were located into holding rooms to await the full reception process. Although clean, these rooms were bare and lacked any useful information. In our survey, over two-thirds of prisoners said they spent two hours or more in reception which was too long. No one was offered a shower on arrival, even though there would have been ample time for this.
- 3.3 The reception process was thorough and, in response to recommendations from PPO investigations into recent prisoner deaths, included a full assessment of whether a prisoner's risk had increased following court appearances or other key events.
- 3.4 New arrivals and those subject to licence recall were prioritised for the prison's body scanner to identify any contraband. Prisoners such as court returns and the relatively few transfers from other prisons were only scanned if there was supporting intelligence. All arrivals were strip searched, which was disproportionate for those who had been scanned or who had been strip searched on departure from another prison.
- 3.5 All new arrivals attended the first night assessment centre for a range of interviews, including a thorough assessment of immediate risk by first-night Prisoner peer supporters, including a Listener (a prisoner trained by the Samaritans to provide confidential emotional support to fellow prisoners) were on hand to put new arrivals at ease, help them gain an understanding of what was going to happen over the next few days and offer support where needed.
- 3.6 Translated information and telephone interpreting services were available, and multilingual staff were well used to support prisoners with limited or no English.
- 3.7 New arrivals were taken to first night cells on the induction wing (E). Cells we inspected were clean and equipped with basic necessities, such as a kettle, bedding and, where appropriate, a telephone, but

furniture was often insufficient in double cells and in a poor state, with broken lockers. Although night staff were aware of the location of new prisoners, we were not assured that additional safety checks were routinely carried out.

- 3.8 Staff on the wing told us that new arrivals were generally offered a shower if they arrived on to the first night wing by 7.30pm, but it was evident from staff and prisoners that for some it could be almost 24 hours until they could wash.
- 3.9 In our survey, 82% of prisoners said that they had undertaken induction, compared with 66% at the last inspection. The three-day induction consisted of the initial arrival information, a secondary health screen on day two, followed by more in-depth on day three when prisoners had had the chance to settle in. This included information on regime processes and timings, immigration advice, probation support, education and work opportunities and health and well-being advice. We considered this to be an effective way of delivering induction.

## Recommendations

- 3.10 **All new arrivals should be offered a shower.**
- 3.11 **Searching procedures should be proportionate to the risk posed and not applied automatically.**

## Managing 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

- 3.12 In our survey, over half of all respondents said they had felt unsafe at some time during their stay and 22% felt unsafe now, which were fewer than in 2018. However, more prisoners who had been in local authority care or who identified as having a disability or a mental health issue reported they had felt unsafe.
- 3.13 The recorded number of prisoner assaults had been on an upward trend over the last 12 months, with assaults on staff much higher than in similar prisons.
- 3.14 Although the prison gathered daily data on incidents that were shared with all departments during a morning briefing, it lacked a longer-term plan to identify the causes of violence and had too little focus on improvement. For example, although data were gathered for monthly strategic safety meetings, they did not give enough attention to violence, there was not enough analysis to explore its root causes and

there was no longer term strategy or any action planning to make the prison safer. (See key concerns and recommendations 1.44 and 1.45.)

- 3.15 The casework approach to managing perpetrators of violent behaviour using the challenge, support and intervention plan (CSIP) was not operating effectively. For example, not all investigations explored the reasons for the violent incident. As a result, behaviour management plans were not tailored to the specific needs of the prisoners and not all target plans were up to date. We found one prisoner on a CSIP who had been involved in further violent incidents but whose plan had not been reviewed. Most officers we spoke to were not confident in the purpose and application of the scheme and were not up to date with which prisoners were on a CSIP, and not all prisoners to whom we spoke were aware of their plans. Although we did not find prisoners isolating in their cell due to fears for their safety, there was no formal support for victims of intimidation.
- 3.16 The basic level of the incentives scheme had been mostly suspended during the pandemic and a temporary policy reflected the changes. Prisoners told us that they were only able to receive a job if they were at the enhanced level, which was, also evidenced by electronic records. Although this policy encouraged prisoners to behave, there was little opportunity for them to demonstrate positive behaviour as they spent most of their time locked in their cell.
- 3.17 Other incentives to encourage positive behaviour were limited and the scheme was generally ineffective in addressing individual prisoners' poor behaviour. For example, although just over half of prisoners were at the enhanced level, we found that some had been involved in violent incidents but had not had their incentive level reviewed.

## **Recommendation**

- 3.18 **There should be a wide range of incentives to encourage prisoners' positive behaviour and effective systems to address poor behaviour.**

## **Adjudications**

- 3.19 As at the last inspection in 2018, not all adjudication hearing records were detailed enough to understand the prisoner's experience and conduct reports were routinely absent. Most punishments were proportionate.
- 3.20 Quarterly meetings to discuss adjudication data and review tariff awards had re-started in November 2020. Although data were presented there was no further analysis to identify any emerging patterns or disproportionality. The quality assurance of adjudication hearings had recently paused and we were told that the new deputy governor would undertake this task.
- 3.21 A total of 179 adjudications had been referred to the police from as far back as November 2019, which was too long for the process to deter

violent behaviour. Furthermore, a high proportion of adjudications had not been proceeded with due to the delays in the case being heard, which undermined efforts to address poor behaviour.

## **Recommendation**

- 3.22 Managerial oversight of disciplinary procedures should make sure that all hearings are held fairly and completed within a reasonable time.**

## **Use of force**

- 3.23 There had been 1,398 use of force incidents in the last 12 months, a significant increase since 2018: this was surprising given that most prisoners had experienced very little time unlocked in the last year. The prison told us that it had made sure that all uses of force were recorded, which had been a deficiency at the last inspection.
- 3.24 There had been 18 incidents involving a baton since January 2021 and in seven of these, prisoners had received a strike. Two incidents involved the use of PAVA incapacitant spray. Senior managers did not routinely complete 'lessons learned' investigations into these incidents and we were not assured that oversight of the use of force was effective in determining whether these uses were proportionate or necessary. (See key concern and recommendation 1.46.)
- 3.25 There were strengths in some aspects of governance and evidence that management of the use of force had improved recently. For example, a full-time use-of-force instructor viewed all body-worn camera footage and reported any concerns to senior managers and outstanding paperwork was reported at the senior managers' daily meeting.
- 3.26 There had been no formal meetings with a wider range of staff to monitor use of force and too much documentation was still missing, including 315 officer statements and around a third of forms to record injuries to the prisoner. The documentation we reviewed did not always record what led up to an incident and often did not record any use of de-escalation techniques. We observed an incident where there was not enough effort to persuade the prisoner to comply peacefully and concluded that the force used was not proportionate under the circumstances. Staff training in approved use-of-force methods had been paused during most of the COVID-19 period, but even with the national dispensation applied to extend the minimum gap between refresher courses, only around 20% of staff were in date with this. (See key concern and recommendation 1.46.)
- 3.27 The prison did not have enough body-worn cameras for all staff and several were broken; the prison told us a further 200 cameras had been ordered. Our review of camera footage showed that staff who wore them did not switch them on early enough to provide valuable evidence or effective scrutiny, and CCTV footage was not routinely

downloaded to capture the whole incident. (See key concern and recommendation 1.46.)

- 3.28 There had been 18 recorded uses of special accommodation in the last 12 months, which was higher than we normally see and an increase since the last inspection. In the documentation we reviewed, we found that it had not always been used in exceptional circumstances. For example, prisoners were placed into special accommodation for a cooling-off period, which was inappropriate, and some could have been removed sooner. However, leaders had taken appropriate action arising from quality-assurance checks, and special accommodation had not been used since April 2021.

### **Segregation**

- 3.29 There were 18 prisoners on the segregation unit during the inspection. Two were on multi-officer unlocks, including the use of personal protective equipment (PPE), and one at-risk prisoner was on an open assessment, care in custody and teamwork (ACCT) case management document with frequent observations. Prisoners in the unit were positive about their relationships with staff, but staff told us that they were 'burnt out'. We observed staff working hard to fulfil the regime, but this meant that at times some prisoners were unlocked and escorted by staff in PPE, which was not appropriate, and the recording of the ACCT document was not kept up to date.
- 3.30 The unit had been refurbished in December 2020 and the communal areas were clean, but the toilets and sinks in the cells had not been replaced and were grubby with ingrained dirt and most had graffiti. The exercise yards remained grim with bedding and rubbish hanging from the razor wire.



**Segregation cell with ingrained dirt**



**Segregation exercise yard**

- 3.31 Some prisoners were allowed to have televisions in their cells and most had wind-up radios and books, but the daily regime in the unit was still too limited to a shower, phone calls and only 30 minutes in the fresh air. Although this was an improvement since 2018, the regime was



often cancelled due to a lack of staff, leaving prisoners to choose two out of the three entitlements. Prisoners told us they did not mind this, as it was a better regime than elsewhere in the prison.

- 3.32 Reintegration planning was not meaningful. The care and management plans for longer-term prisoners were not detailed or had enough time-bound targets to support them. Although monthly data were gathered and shared with the governor, formal meetings to monitor the use of segregation and to identify and investigate trends had been suspended.

### Recommendation

- 3.33 **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.**

### 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 use and effective drug supply reduction measures are in place.

- 3.34 A serious security breach had led to an escape in 2019; we were given some assurance that action to prevent further escapes had been taken in response to the investigation that followed. However, current local security data evidenced some concerns in the physical aspects of security.
- 3.35 Most aspects of security were proportionate, but our review of person escort records found category D prisoners handcuffed during an escort, which was not necessary.
- 3.36 A good number of intelligence reports had been submitted in the last 12 months and were mostly processed efficiently, but 53 intelligence-led cell searches had not been completed since April 2021. Monthly local tactical briefing meetings were based on relevant intelligence received from the establishment and suitable objectives were set. Wider meetings to share intelligence with the prison were reasonably well attended, but actions were not monitored to measure progress. The prison had an appropriate focus on counter-terrorism and the designated team was well managed.
- 3.37 There were processes to protect prisoners from misconduct and we were assured that complaints were taken seriously. Prisoners we spoke to knew how to make a confidential complaint about staff but were concerned about the consequences from staff and other prisoners if they reported wrongdoing.

- 3.38 In our survey, 26% of prisoners said it was easy to get illicit drugs in this prison, significantly fewer than in 2018. Nevertheless, several prisoners told us that drugs were easily available. The prison had a current drug strategy and action plan, and monthly drug strategy meetings were well attended and monitored emerging trends. There were plans to open an incentivised substance-free living wing. Although there had been some improvements to physical security measures to tackle drug supply, and mandatory drug testing had begun during the inspection week, more staff training was needed in key areas, such as the gatehouse and the post room, to provide a consistent approach.

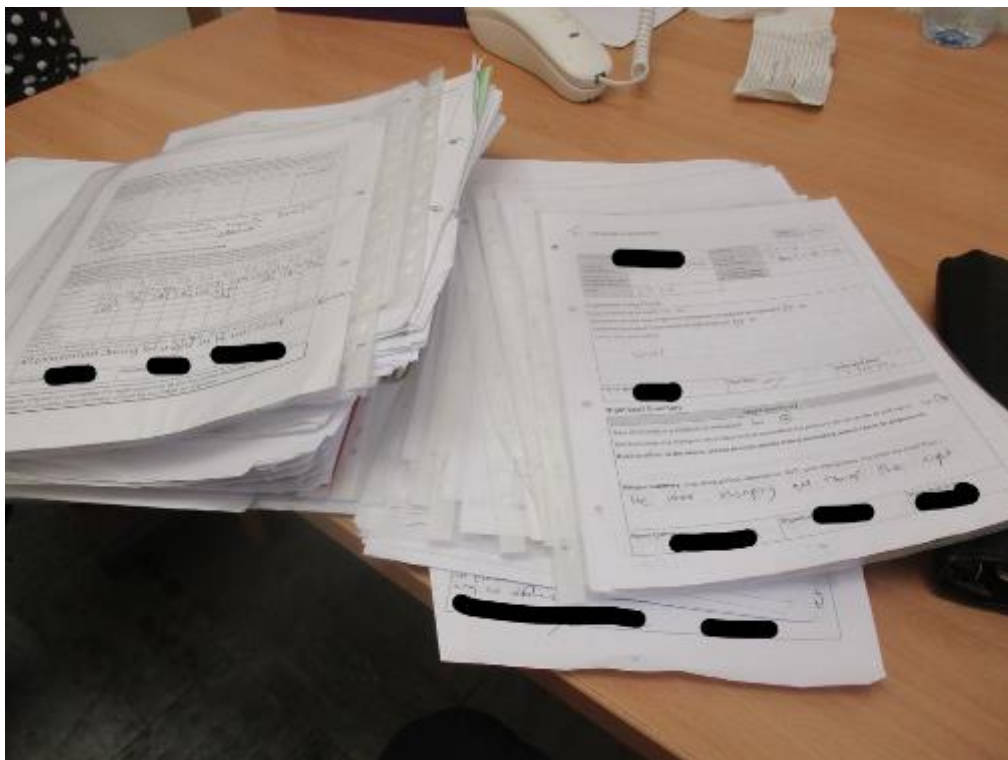
## Safeguarding

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

- There had been nine self-inflicted and two drug-related deaths at the prison since the last inspection. Three Prisons and Probation Ombudsman (PPO) final reports had been received, as well as early learning points. PPO recommendations had largely been addressed and a useful PPO review meeting had recently been introduced.
- 3.39 The rate of self-harm had doubled in the previous 12 months and was slightly higher than at the last inspection, although among the lowest for the type of prison. The prison had taken actions to address self-harm levels. These had included improvements to early days provision, ACCT case coordinator training, a wide review of data, daily reviews of incidents and the introduction of a specific ACCT handover document that identified the key staff responsible for the support of prisoners subject to ACCT each period. However, it still lacked an overall up-to-date safety strategy and supporting action plan to inform the wider staff group and to make the prison safer. (See key concern and recommendation 1.44.)
- 3.40 There were around 30 open ACCT documents during our inspection, which were open for an average of 24 days. The prison managed some very complex and prolific self-harmers, which often led to the need for constant supervision. In the previous three months, an average of 10 prisoners had been subject to constant supervision, the longest for 21 days. While the high death rate may have influenced decision-making, we considered that some ACCTs were kept open unnecessarily.
- 3.41 Prisoners on ACCTs to whom we spoke said that they appreciated the support from staff checking on them, but that the prolonged periods locked up exacerbated their low mood.

- 3.42 There was a wide disparity in the quality of ACCT documentation across the prison. On Heathfield Unit, they were generally in good order and easy to follow. Most evidenced adherence to required observations and support conversations. Where there were omissions, there had been some investigations and remedial actions to improve the overall quality of support and recording. On Trinity Unit, the ACCT documents were poor. Folders were chaotic with key elements either missing or lost among a jumble of pages falling out of them. Managers took remedial action to rectify this while we were at the prison.



**Trinity ACCT document**

- 3.43 The large team of Listeners was well supported by the prison and the Samaritans. There was a rota for support call-outs. All wings had access to Listener suites, but some were bare and bleak; there was a refurbishment programme under way to address this.
- 3.44 Night staff knew which prisoners were on ACCTs and most had received a comprehensive handover. All carried anti-ligature knives and were well briefed on emergency cell-entry procedures.

### **Recommendation**

- 3.45 **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.**

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

- 3.46 The head of safety was the nominated adult safeguarding manager who regularly attended the local safeguarding adults board. A safeguarding policy identified pathways of reporting and support. Links between safeguarding staff and other key functions in the prison were sound and we saw evidence that referrals led to the provision of support for 'at-risk' prisoners returning to the community.

## 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, over 60% of respondents said that most staff treated them with respect and there were staff they could turn to if they had a problem. Many prisoners to whom we spoke could name good staff members and almost all interactions we observed were friendly and helpful. Despite regular shortfalls, staff were visible on residential landings and it was good that they did not routinely congregate in their offices, as we often see elsewhere.
- 4.2 Nevertheless, the very restricted regime combined with a high level of staff sickness absence inevitably put a strain on relationships and undermined promotion of a professional ethos to encourage support and rehabilitation for prisoners. The need for prisoners to complete their domestic tasks within a minimal time unlocked (see paragraph 5.1) reduced the opportunity for meaningful staff engagement to encourage rehabilitation. This was also reflected in our staff survey where over half of those who responded said that their morale was low; some attributed this to the lack of opportunity to engage in more positive work than simply locking and unlocking prisoners.
- 4.3 The key worker scheme was not working as intended by the Offender Management in Custody (OMiC) model (see Glossary of terms) and was not given appropriate attention by leaders. OMiC offices on residential units were unfit for purpose and were often used to store rubbish or broken furniture. Local data showed around 120 recorded contacts a month between key workers and their prisoners, but this included telephone calls to cells that were not always answered, so the true level of meaningful contact was much lower. Despite local monitoring to improve staff entries in prisoners' electronic case notes, there was still a focus on recording negative behaviour rather than positive interactions.
- 4.4 Prison leaders did not routinely quality assure key worker records and we found that contacts were irregular or often completed remotely by staff on restricted duties. This impeded the building of relationships and missed the opportunity to take into account potential physical evidence of developing problems. The officer responsible for leading a recent review of keywork had moved to a new post and plans to restore the key work scheme lacked ownership and were neither embedded nor realistic.

## Recommendation

- 4.5 **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.**

## 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 Despite a reduction of around 300 prisoners, Wandsworth remained, as in 2018, one of the most overcrowded prisons in the country. HMPPS data evidenced that around 73% of all prisoners were still sharing cells designed for one, which were cramped and lacked privacy. Prisoners sleeping on the upper bunk often had to use other furniture to climb on to their beds, which was not appropriate or safe.
- 4.7 The problem that prisoners felt most acutely was the lack of clean clothing and sheets, which many complained about. In our survey, only 45% said that they normally had enough clean, suitable clothes for the week, against the comparator of 64%. The wing laundry facilities were inadequate and domestic washing equipment was not able to keep up with demand. Some units had only one working washing machine and on H wing, the dryer was also broken. Prison leaders had made improvements to the prison laundry and prisoners could now use this for personal washing, although many feared losing their clothes.
- 4.8 While there were enough stocks of cleaning materials and prisoner clothing at the time of our visit, their organisation was chaotic. Designated cleaning or wing stores were often used for depositing broken furniture or rubbish, and cleaning materials were spread across several different areas, making access more difficult.
- 4.9 The prison had benefited from a temporary senior lead whose primary focus for much of the previous six months had been to improve living conditions and the decency aspects of prison life. This role had enabled a greater focus on making sure that basic standards were met, and most cells were now adequately equipped with necessary items, such as furniture, kettles and a television. Regular decorating parties had improved cells, but many still had damaged flooring, and vandalism remained a problem often resulting in cells being taken out of use.
- 4.10 The showers on Heathfield unit had been refurbished, but those on Trinity were poor, dirty, lacked privacy and were often out of order. For example, at the time of our visit there were only around four showers in

use for around 100 prisoners on G wing and H wing had only six showers for 86 mainly double-occupied cells, most of which were occupied by two prisoners. Combined with the poor regime that limited time out of cell, prisoners could often go several days without being able to access a shower. In our survey, only 41% of prisoners, against the comparator of 76%, said they had daily access to showers. (See key concern and recommendation 1.47.)

- 4.11 Despite some work to control the issue, litter and waste food were often thrown from cell windows, contributing to the problem with vermin, including many rats, mice and pigeons. The vermin were not limited to the external areas and we found evidence of rat faeces in living accommodation and offices intended for key workers and offender managers to interview prisoners. (See key concern and recommendation 1.47.)
- 4.12 Leaders had made concerted efforts to make sure that responses to electronic cell bells were prompt. This was tracked daily, and remedial action taken where concerns were identified.

### **Recommendation**

- 4.13 **All prisoners should have access to basic items, including weekly provision of clean bedding, clothes and cleaning materials.**

### **Residential services**

- 4.14 In our survey, 54% of respondents described the food as good, compared with 34% at similar prisons. Around 50 prisoners had continued to work in the kitchen throughout the period of COVID-19 restrictions, but work towards achieving qualifications in catering had yet to recommence.
- 4.15 Serveries were well organised with staff supervision and most prison orderlies wore PPE while handling the food although, meals were served much too early. We observed the hot lunch served as early as 11am and the evening meal, which was a cold option, served as early as 2.30pm. This often left prisoners feeling hungry at night and then eating their meagre breakfast pack. The evening meal was also taken to cell doors by staff, which further limited the opportunities for prisoners to associate.
- 4.16 The hot trollies used to transport food were filthy and it was clear that there was no regular cleaning regime. Dry foods, such as bread and fruit, were often left out in residential areas overnight, which contributed to the vermin problem (see paragraph 4.11).
- 4.17 The prison shop operated under the national contract between HMPPS and DHL and sold a range of goods. New arrivals were offered shop goods on reception, but many had to wait up to 10 days before making a further order, which put them at risk of debt and bullying. Our two previous recommendations addressing this had still not been achieved. Fresh food items, such as fruit, were often delivered to the prison

several days early, which resulted in complaints that they were not fit for consumption. Prisoners could also order a limited range of clothing and electrical items through approved catalogues.

## **Recommendation**

- 4.18 **Lunch should be served no earlier than 12 noon and dinner no earlier than 5pm.**

## **Prisoner consultation, applications and redress**

- 4.19 Prisoner consultation and communication were a real strength at Wandsworth, and it benefited from a dedicated senior lead to oversee this area. The prisoner council had met regularly and there had been Q&A sessions with senior prison leads and key departments.
- 4.20 The well-established prison radio station, Radio Wanno, had been running since 2004 and had been used effectively in conjunction with prisoner consultation to make sure prisoners were kept informed. A new prison TV channel had also been developed to supplement other media and the prison was developing films on various aspects of prison life. The various forms of consultation, Q&A sessions and effective use of media held departments to account when prisoners raised concerns and there was clear evidence that identified actions were tracked.
- 4.21 Although electronic kiosks for prisoners to access services and information had been installed at Wandsworth for several years, they had only recently widened access to functions, such as making applications. The electronic applications were tracked effectively and leaders monitored response times. While this was a positive use of the technology, we found examples where departments did not take responsibility for the concerns raised by the prisoner.
- 4.22 Complaint forms were freely available on wings and the governor quality assured a small sample of responses each month. Most responses were polite and appropriate, but not always prompt. Oversight of complaints had improved and were now reasonably well managed. There was an effective system to log, track and monitor complaints, and thorough analysis of data provided the prison with detailed understanding of trends and themes. The number of complaints was rising, but lower than similar prisons. Some prisoners we spoke to told us they did not have faith in the system, believing that it would not result in any change.
- 4.23 Records of responses to confidential complaints (those submitted directly to the governor) were not kept up to date and we were not satisfied that all responses were full, appropriate or timely.
- 4.24 There was good support for prisoners who needed help with legal matters and provision for legal visits and video-conferencing facilities were impressive. In-person legal visits had resumed in October 2020 and took place in a large, designated area. There were 18 private, well-equipped rooms, all with video-conferencing technology to facilitate



court hearings, contact with legal advisers and probation officers, and inter-prison calls.

- 4.25 Legal visits were available four days a week and the facilities were well used, with enough booking slots to meet demand promptly. A recently appointed bail information officer was providing valuable support and had worked hard to triage over 2,000 prisoners who might have been eligible to apply for bail in the last six months. Given that just under half the population at Wandsworth were on remand, this was an extremely useful resource.
- 4.26 The prison held 15 'access to justice' laptops for prisoners to use to undertake necessary legal work, and the library stocked a range of legal texts, including Prison Service Instructions and translated materials, which prisoners could access by request.

## **Equality, diversity and faith**

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 of terms) and any other minority characteristics 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.

## **Strategic management**

- 4.27 Strategic oversight of equality and diversity remained underdeveloped. There was a general policy but no tailored strategy setting out the priorities and vision to improve outcomes for prisoners across all protected characteristics at Wandsworth. (See key concern and recommendation 1.44.)
- 4.28 Aside from one meeting in October 2020, equality meetings focusing on prisoners that met every two months had only resumed in March 2021 and there had been little progress on the limited action plan. Ownership of the work was not prison wide and it did not have a sufficiently high profile.
- 4.29 There remained delays of more than five months before HMPPS released national equality data and, while the data raised no notable concerns for prisoners in most protected groups, the prison was not reviewing it systematically. The analysis and sharing of local data to identify potential disproportionate treatment of protected groups was beginning to improve but was still insufficient and did not yet drive coordinated or strategic action planning.
- 4.30 The small equality team had experienced some staffing pressures recently. The team was supported by named senior managers responsible for leading most relevant protected characteristics, but not enough work had taken place.

- 4.31 The lack of regular consultation with protected and minority groups, even before the impact of the pandemic, left the prison poorly placed to understand the needs and experiences of prisoners. (See key concern and recommendation 1.44.)
- 4.32 Equality and foreign national representatives were available on most wings and those we spoke to said they felt supported. However, they were not always unlocked by wing staff to undertake work, which was a source of frustration.
- 4.33 More work was needed to engage the help and support of community-based agencies focused on promoting diversity and inclusion.
- 4.34 In the previous 12 months, 88 discrimination incident reporting forms (DIRFs) had been submitted, of which 36 were in the last six months, which was less than at our last inspection. Responses to them were well managed and were respectful and mostly thorough, but not always timely. The Zahid Mubarak Trust had recently resumed support to review a sample of DIRFs, and the governor or his deputy quality assured all of them, which was positive. DIRFs were freely available on wings, but not all prisoners were aware of them. Some prisoners we spoke to were wary of submitting a DIRF believing that if they complained about staff, that would result in negative repercussions for them.

### **Protected characteristics**

- 4.35 Nearly half of the population were from a black or minority ethnic background; in our survey, they reported broadly similar perceptions to white prisoners. Although responses to DIRFs indicated a challenge to discriminatory behaviour, some prisoners told us about perceived unfair treatment, which required further exploration. There was no regular consultation with black and minority ethnic prisoners. One forum had met in the last 18 months, but it was unclear what actions, if any, had been taken forward following prisoners' feedback.
- 4.36 There had been a forum in June 2021 as part of Gypsy, Roma and Traveller History month, but more needed to be done to engage with these prisoners to understand the reasons for their low level of self-identification. In our survey, 5% of prisoners identified as Gypsy, Roma or Traveller, compared with the prison's data of just 1%.
- 4.37 The prison continued to serve Westminster Magistrates' Court where all European arrest warrant extradition hearings in England and Wales were heard. There was insufficient support for the many foreign national prisoners, who accounted for about 45% of the population. They included 37 held under immigration powers beyond the end of their sentence and who were subject to deportation and should have been held in immigration removal centres or in the community. A growing backlog of prisoners seeking asylum were still waiting for their cases to be assessed. Detainees spent far too long in the prison with their cases unresolved. (See key concern and recommendation 1.48.)

- 4.38 Most Home Office immigration staff had only recently returned to work in the prison, having left many prisoners and detainees unsupported throughout the pandemic. Face-to-face contact was limited, and wing surgeries were still suspended. Important and complicated legal paperwork, such as authority to detain notifications (IS91s) was often not served to prisoners and detainees in enough time for them to understand, appeal or agree to its implications. (See key concern and recommendation 1.48.) Legal documents were always issued in English only. Professional telephone interpreting services were not always used on wings when required, although we saw some evidence that they were used by health care and first night staff and for prisoners on ACCTs. While staff and prisoners spoke a wide range of languages, there was too much reliance on using their skills to interpret for prisoners, which was inappropriate, especially when dealing with sensitive matters or when accuracy was required.
- 4.39 BEST, a charity befriending and supporting foreign national prisoners in Wandsworth, had remained on site throughout the pandemic and had continued to provide valuable support that was greatly appreciated. Catch 22, a further organisation providing support for foreign nationals, had very recently been commissioned and, so far, had focused efforts on helping applicants for European settlement status.
- 4.40 In our survey, prisoners with disabilities were more negative than those without, especially in the areas of safety. Reasons for this were unclear, as many prisoners we spoke to felt well supported and the delivery of care was good. There was no formal buddy system, but the prison made reasonable adjustments to living conditions where needed and some facilities, such as newly adapted cells on C wing, were excellent. There were 39 prisoners who needed assistance in the event of an emergency evacuation, but not all staff were aware of their needs and their plans were not readily available to all staff.
- 4.41 About 15% of the population were under 25 and about the same proportion were over 50. Consultation to understand their needs was limited and specific support and provision were lacking.
- 4.42 There had been some recent efforts to engage with gay, bisexual and transgender prisoners, and more so than for other protected groups. There had been some forums and efforts to celebrate LGBTQ+ History month, including providing books, information displays and broadcasts on Radio Wanno. Support for the two transgender prisoners held at the time of the inspection was reasonable.
- 4.43 In our survey, prisoners who had been in local authority care were more negative than those who had not in several areas. However, the prison did not routinely identify this group and there was no specific support for them. Support for British ex-service personnel was good and the Transition Intervention and Liaison Service (TILS) had continued to provide a service face-to-face throughout the pandemic.

## Recommendations

- 4.44 **Professional telephone interpreting should be used to communicate with prisoners who do not speak English when confidentiality or accuracy is required.** (Repeated recommendation 2.44)
- 4.45 **There should be a time limit on immigration detention.** (Repeated recommendation 2.42)

## Faith and religion

- 4.46 The dedicated, well-led chaplaincy provided a valuable service and was well integrated into wider prison life. Although in our survey only 53% of respondents who had a religion said their beliefs were respected, many prisoners we spoke to appreciated the support from the chaplaincy and held it in very high regard.
- 4.47 Corporate worship been suspended since March 2020, which was a frustration for many prisoners. The team had made good use of Radio Wanno to broadcast Friday prayers and Sunday services, as well as sermons, traditional readings and music on holy days and cultural festivals.
- 4.48 There had been good efforts to prepare for Ramadhan and Eid, but celebrations had inevitably been affected by COVID-19 restrictions and the ongoing lack of a full-time on-site Muslim chaplain. The chaplaincy had worked hard to overcome some of these challenges and had recruited prisoners as 'Ramadhan helpers' to identify those who wished to fast and to distribute religious materials and daily food packs. The chaplaincy had made creative efforts to engage with local mosques and charities to source donations of Islamic and Arabic garments, religious artefacts including Qur'an's, prayer beads, prayer mats and dates to break the daily fast. These were among many examples of its excellent links with community groups.
- 4.49 COVID-19 restrictions and staffing deficiencies meant that not all prisoners could see a chaplain of their own faith. The chaplaincy had only recently appointed a full-time Catholic and an Anglican chaplain. Despite this, the team had continued to provide strong pastoral care and support, and demand was high. Many prisoners had lost a loved one during the last 18 months and good use was made of tablet computers to enable prisoners to view funerals.
- 4.50 The main prison chapel was dilapidated and had not been used for over two years. A programme of refurbishment was planned to start in early 2022. Other prison faith facilities, such as the mosque and multi-faith centre, were adequate, but the facilities for worship on Trinity remained dreary.

## 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.

- 4.51 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 issued one 'requirement to improve' notice following the inspection (see Appendix III) and took further enforcement action in the form of a warning notice, served to the provider on 18 October 2021 under section 29A of the Health and Social Care Act 2008.

### Strategy, clinical governance and partnerships

- 4.52 Strategic health partnership work was in place with constructive oversight from NHS England and NHS Improvement in response to both the pandemic and a series of self-inflicted deaths in custody. There were local governance structures – such as regular delivery board and clinical governance meetings – but service deficits were not always identified or escalated appropriately to these meetings. Commissioners told us they had recently undertaken some work to improve communication between providers (see key concern and recommendation 1.49). Although not all of the death in custody investigations had been completed, Oxleas and South London and Maudsley NHS Foundation Trusts had developed an action plan to address the clinical review recommendations received so far. NHS England and NHS Improvement had provided external oversight to improve scrutiny.
- 4.53 The head of health care provided a clear vision of the service and was well supported by clinical leaders. There were staff vacancies in all clinical areas. Staff shortages in the mental health inpatient unit meant that the unit manager and deputy regularly took part in clinical delivery, which had a detrimental impact on their ability to provide oversight and strategic management. The lack of consistent bank or agency staff to fill staff shortages in the unit had affected continuity of patient care and had been escalated through the incident reporting mechanism. (See key concern and recommendation 1.49.)
- 4.54 Managerial and clinical supervision was not embedded in practice across all health services. While staff felt supported by their line manager and colleagues, the lack of supervision meant a risk that their concerns about individual patient care could not be addressed.
- 4.55 Patient feedback was sought through a 'Have your say' survey with the results reviewed at the health care patient experience committee, where learning was identified and actions taken.

- 4.56 A local infection prevention and control compliance audit had identified that both inpatient units, as well as some treatment rooms, did not meet the required standard. The mental health inpatient environment had deteriorated since our last visit and now had graffiti, stained toilets and uneven and splitting flooring. There was an ongoing concern with the ligature point in all the cells in the unit. Although a new health care building was being built, this would not address the outstanding concerns about the prison's inpatient units. (See key concern and recommendation 1.47.)
- 4.57 Staff had undertaken training in record keeping and the standard of entries was reasonable. Some care plans lacked evidence of patient involvement and many were not easily understandable for those with limited reading skills.
- 4.58 Emergency resuscitation equipment was in good order and monitored effectively. Staff had completed online training in mandatory adult basic life support and were due to take the practical face-to-face component. Emergency response nurses had to complete a competency assessment and immediate life support training. An ambulance was automatically called when there was an emergency.
- 4.59 Patients could submit confidential complaints. Replies were prompt, respectful and addressed the key concerns raised.

### **Promoting health and well-being**

- 4.60 Although there was no overarching local health promotion strategy, health promotion material was visible across the prison. All the posters were in English only, but we were told that health staff had access to professional telephone interpreting for appointments, and there were some leaflets in foreign languages in the health care department.
- 4.61 A range of prevention screening programmes, including bowel cancer and retinal screening, had recommenced: However, screening for abdominal aortic aneurysm (AAA) had not restarted.
- 4.62 Specialist hepatology clinics had continued throughout the pandemic, which had enabled patients with hepatitis C to be assessed and treated.
- 4.63 COVID-19 vaccination clinics had been held and there was an ongoing campaign to encourage vaccination before release. The prison's COVID-19 lead visited prisoners who were uncertain about receiving the vaccine to explore any concerns and provide information. Hepatitis B vaccinations had been suspended since the start of the pandemic. There were 384 patients on the list and the longest wait was over one year.

### **Primary care and inpatient services**

- 4.64 A committed primary care team, well led by senior staff, provided a 24-hour service. The team screened over 80 new arrivals a week, which commenced with a check of the person escort record for external

health communications. Prisoner consent was acquired to share information and risks before requesting community records. All new arrivals received a health screen, including COVID-19 risk assessment. Patients with more complex needs were reviewed by the GP and substance misuse team on their first night, which was positive. There was no relevant information on health services for new arrivals, which was a missed opportunity. All new arrivals were offered a more in-depth health screening on the following day.

- 4.65 Prisoners could request health appointments through the electronic kiosk on the wings. There were some minor delays in responding to these, which was addressed during our visit. Although waiting times for some services were long, those for others had improved since our last visit. Optometry and podiatry, which had stopped during the pandemic, remained the most affected with waits of 12 weeks and 16 weeks respectively. However high-risk cases were triaged, for example, all diabetic patients had been seen. Staff interactions were noted to be caring and effective, and patients were complimentary about the care they received.
- 4.66 The service identified and managed patients with long-term conditions and all the records we viewed demonstrated care planning, timely reviews and interventions. End-of-life and terminally ill patients were managed through joint working with Trinity Hospice.
- 4.67 Non-attendance at health appointments remained high. The oversight of secondary care appointments was robust. Cancellation rates had increased over the summer of 2021 and it was unclear if there had been any work to reduce this figure.
- 4.68 The inpatient unit had a comprehensive admissions policy and was at capacity with several cells out of action. It comprised sections for physical health and mental health. The regime was limited and, although most inpatients were offered a shower daily, during our inspection some had not been offered time in the fresh air for over four days. All inpatients had a care plan and were cared for by both officers and nurses who constantly engaged with them.
- 4.69 Non-attendance rates at external hospital appointments were high, due to both hospital cancellations and operational issues at the prison.
- 4.70 Pre-release health arrangements were very inconsistent. There were no joint working arrangements between the health care and resettlement departments, and no contingency planning to enable continuity of care in the community for prisoners released from court. The high turnover of almost 5,000 prisoners a year and a large remand population resulted in a significant proportion of prisoners leaving with less than 24 hours' notice, which limited planning. However complex patients with clear release dates were managed well on release.

## **Recommendations**

- 4.71 **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.**
- 4.72 **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.**

## **Social care**

- 4.73 Change Grow Live (CGL) provided social care. Four patients were receiving personal care packages; they praised their carers and were very satisfied with the support they received. Each of them had a care plan and was given a summarised version. The care provided was documented on patient records. Equipment and support aids were provided to those who needed them.
- 4.74 The social care staff were new into post and had received a comprehensive induction. Formal supervision had not commenced but management support was available. Carers had completed some basic training and other mandatory training was scheduled, including in ACCT.
- 4.75 There was no peer support worker system. Social care patients could access advocacy services provided by POhWER (a charity providing advocacy, information and advice).

## **Mental health care**

- 4.76 Mental health services were delivered Monday to Friday by a multidisciplinary team from South London and the Maudsley NHS Trust. Two registered mental health nurses (RMNs) also worked on Saturdays.
- 4.77 New arrivals had their mental health needs assessed and, if applicable, were referred to the mental health team. An RMN was required to attend initial ACCT reviews; attendance had improved recently although did not take always place due to insufficient notice.
- 4.78 The service received around 500 referrals a month. There was a high non-attendance rate, although the reasons for this were not always clear. Patients were discussed at a multidisciplinary team meeting with psychiatric input. Monitoring reports did not indicate whether urgent 24- and 72-hour timescales had been met.
- 4.79 We identified 127 patients who had been referred to the mental health services, some of whom had had no documented outcome since March 2021. This was concerning, particularly in light of the recent PPO death in custody recommendations. Managers agreed to review the list promptly.



- 4.80 There was limited psychological support for prisoners with mild to moderate mental health needs. An increase of 4.5 whole-time-equivalent mental health staff had recently been approved to address this gap.
- 4.81 Patients with severe and enduring mental health problems were supported and, where appropriate, the care programme approach was used. Staff developed care plans informed by a comprehensive risk assessment. Patients were prescribed medicines in accordance with their clinical need. Discharges and transfers of care were planned safely and well documented.
- 4.82 The assistant psychologist had delivered notable mental health training for prison officers and health care orderlies, which enabled officers and patients to come together to understand each other's responses to certain behaviours.
- 4.83 Only four of the 18 patients who had transferred to a mental health hospital under the Mental Health Act (MHA) in the last six months had been moved in less than 14 days; the remaining 14 patients waited from 15 up to 226 days. Eight inpatients were awaiting assessment or transfer under the MHA. (See key concern and recommendation 1.50.)
- 4.84 One inpatient had been assessed under the Mental Capacity Act following a joint professionals meeting. However, some aspects of the Act and the Trust's own policy had not been followed. This was raised with the team and head of health care while we were on site, but an investigation had already begun into the issues identified.

### **Substance misuse treatment**

- 4.85 Clinical substance misuse services were provided by South London and Maudsley doctors and Oxleas nurses, and psychosocial services were delivered by CGL. All the services attended drug strategy meetings and contributed to the prison action plan to reduce drug misuse.
- 4.86 There were a high number of referrals each month and most patients were seen promptly. Patients who required opiate substitution therapy resided on a dedicated drug recovery wing. Doctors provided flexible prescribing based on individual needs and in line with national guidance with the exception of Espranor (a freeze-dried buprenorphine wafer) which was not available to prescribers.
- 4.87 The administration of methadone and buprenorphine that we observed was chaotic. Poor queue management by officers meant the medicines hatch was surrounded by patients waiting for their medication as well as those who had already collected it. Nurses and officers did not consistently check patient identification before administering medications or observe patients to make sure they took it.
- 4.88 Patients had access to a range of relevant one-to-one and group-based interventions from CGL. Limited group sessions had continued

throughout the pandemic. Groupwork included self-management and recovery training (SMART), cocaine and cannabis awareness, and brief interventions for alcohol misuse. CGL staff gave patients relevant in-cell work packs on issues such as harm minimisation, drug awareness and skills for coping.

- 4.89 Staff worked with patients to develop individualised care plans with clear objectives. When prisoners transferred to another prison or were released into the community, there was liaison with relevant services to ensure effective discharge planning.

### **Recommendation**

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

### **Medicines optimisation and pharmacy services**

- 4.91 Pharmacy services were well managed with medicines supplied by an in-house pharmacy. In-possession risk assessments were appropriate. Not all cells had lockable storage for in-possession medicines, which increased the risk of diversion.
- 4.92 Medicines were administered by pharmacy technicians and nurses on time, including night-time medication. Staff took appropriate action for patients who missed medicines. Some medicine hatches opened directly on to the wings, which, along with inconsistent supervision by officers, meant that patient confidentiality was not maintained and increased the likelihood of diversion.
- 4.93 A pharmacist screened and checked all first-night arrivals' prescriptions, and clinically reviewed prescriptions, ensured compliance with the formulary and carried out medicines use reviews. Patients with complex conditions were visited on the wing by the pharmacist, which improved access to medicines.
- 4.94 Prisoners with minor ailments could be treated with over-the-counter remedies. There was adequate provision for the supply of medicines out of hours.
- 4.95 The pharmacy was well organised. Medicines management on the wings was mainly good, but methadone supply and supply of controlled drugs from reception was less well managed. There was medicines provision for prisoners leaving the prison, although some released to attend court did not take medicines with them.
- 4.96 There were well-attended monthly medicines and therapeutics meetings. The prescribing of abusable and high-cost medicines was monitored and managed.

## Recommendation

- 4.97 **Officers should manage medication queues to maintain patient confidentiality, enable supervised consumption of medicines and prevent any diversion.**

### Dental services and oral health

- 4.98 In April 2021, Prison Centred Dental Care took over the contract and provided an effective dental service for urgent and ongoing treatment. The dentist undertook wing-based triage twice a week for prompt identification of need. However, waiting times for routine and specialist care had been affected by the pandemic restrictions. There were 154 prisoners waiting for a first dental appointment: with the longest wait at six weeks, 82 waiting for treatment, and the longest wait at 22 weeks. We were told that all waiting times had reduced since April 2021.
- 4.99 The dental service operated every day and an oral dental surgeon attended once a month. The provision of a dental surgeon enabled a wider range of treatment within the prison and was good practice. Oral health promotion took place during the patient's appointment.
- 4.100 The dental surgery held up-to-date policies and procedures, and supervision and training records. Although small, it functioned effectively and was clean.

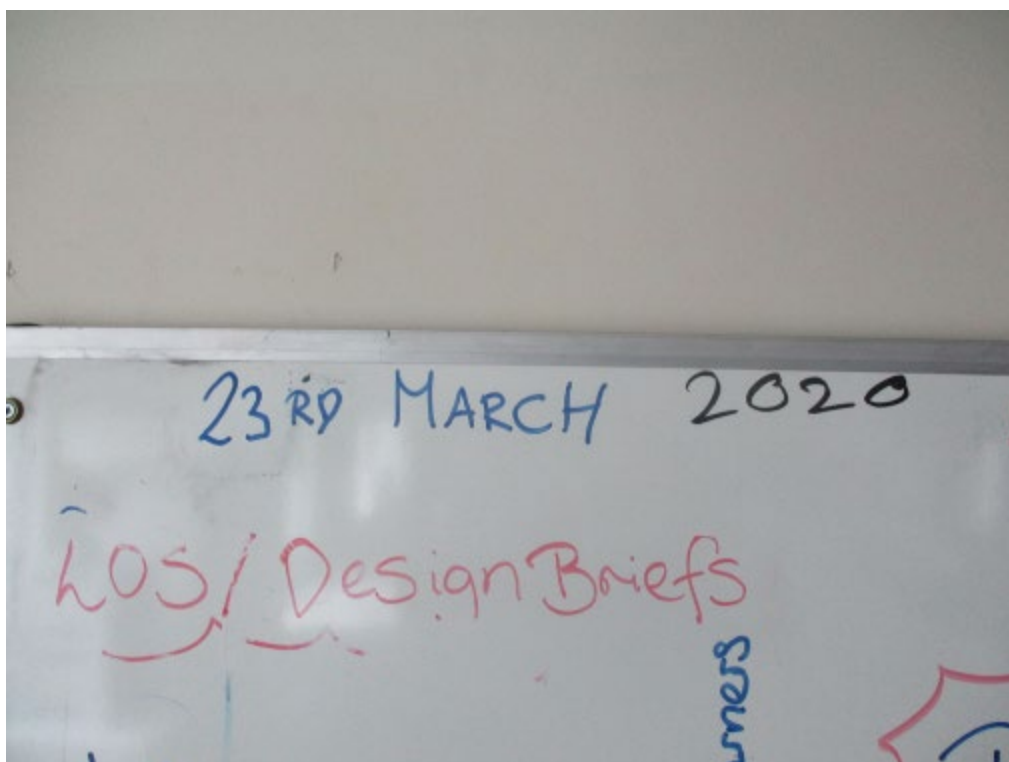
## Section 5 Purposeful activity

**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 of terms) and are encouraged to engage in activities which support their rehabilitation.

- 5.1 In our survey, almost three-quarters of prisoners said they had less than two hours a day unlocked during the week, rising to an extremely high 91% at weekends. Prisoners repeatedly told us of being locked up for more than 23 hours a day in the weeks leading to the inspection – some had as little as 45 minutes a day out of their cell. The regime was inadequate, and it was almost impossible for prisoners to get a shower, use the electronic kiosks and manage their day-to-day needs in the very limited time unlocked. (See key concern and recommendation 1.51.)
- 5.2 Access to the open air was also inadequate for many and woeful on Trinity, which was at best 45 minutes to an hour every three days. Prisoners frequently complained of long periods, sometimes amounting to weeks, without any outside exercise. In our survey, only 4% reported access to exercise more than five times a week against the comparator of 67%. (See key concern and recommendation 1.51.)
- 5.3 Although around 350 prisoners were identified as having a work or education place, we observed very few engaged in any purposeful work or learning for more than a couple of hours a day. There had been support for some in-cell education, but classroom activity had been suspended since the beginning of the pandemic, as exemplified in this poignant remnant of the last in-house education session in March 2020.



#### **Last education session**

- 5.4 The library remained closed, and although prisoners could order books weekly through wing prisoner library representatives, only around 20 books a day were delivered to wings, which was poor. Small trolleys of donated books across the prison were restocked weekly.
- 5.5 Although there were three gym areas and an outside all-weather pitch, access to PE was far too limited, with often just 12 to 16 prisoners engaged in activities for each one-hour session. The records for the previous two weeks showed that only 350 prisoners were able to attend PE against a planned 2,190. Not only was the PE programme already reduced due to COVID-19 restrictions, but a shortage of trained staff and their frequent redeployment also meant that the gym had been completely closed for half of the sessions. No PE sessions took place on Friday afternoons or the whole weekend. (See key concern and recommendation 1.51.)

### **Education, skills and work activities**



This part of the report is written by Ofsted inspectors. From May 2021 Ofsted began carrying out progress monitoring visits to prisons to assess the progress that leaders and managers were making towards reinstating a full education, skills and work curriculum. The findings and recommendations arising from their visit are set out below.

- 5.6 Ofsted assessed that leaders were making insufficient progress towards ensuring that staff teach a full curriculum and provide support to meet prisoners' needs, including the provision of remote learning.
- 5.7 There were not enough activity spaces in education, skills and work to meet the needs of prisoners. Staff from the education provider had not been able to enrol enough prisoners on to even the limited number of education spaces available. This meant that too many prisoners had little to occupy them during the day. They were rightly disappointed by the lack of opportunity to develop their knowledge of subjects such as English as a foreign language.
- 5.8 Staff did not adequately check what prisoners already knew and could do in English and mathematics and, as a result, too many were not able to enrol on to education courses to develop their skills.
- 5.9 Leaders had not adapted the induction process sufficiently well to support the many prisoners who had limited English, who expressed frustration at the lack of support for them. There were ambitious and well-considered plans to develop the induction, but it was too early to judge the effectiveness of these.
- 5.10 The curriculum was not broad enough to meet the needs of prisoners. Education leaders offered many education courses only to level 1, which was below the ability level of many prisoners. Education provider leaders had been slow to reintroduce vocational training to the curriculum. Prisoners had very limited opportunities to gain accredited qualifications in the subjects they studied.
- 5.11 A minority of prisoners completed education activities through in-cell work packs. Leaders and tutors had devised good-quality materials, and prisoners could access basic resources, such as dictionaries, to support their learning. However, tutors did not provide enough face-to-face support when prisoners struggled with their studies, and the amount of support varied depending on the prisoner's wing.
- 5.12 Tutors' written feedback to prisoners on their work packs was of inconsistent quality. In too many cases, they did not support prisoners sufficiently to correct errors or understand misconceptions. Too many tutors started to cover new topics with prisoners before checking they had a firm understanding of previous topics.
- 5.13 Prison leaders had identified many of the weaknesses with the education curriculum and the quality of teaching. They had focused on improving in-cell work packs through rigorous quality checks and made sure that tutors received suitable training and support to develop their teaching skills. Leaders had also begun to hold the education provider leaders to account for poor performance and worked productively with them to make further improvements.
- 5.14 Prisoners did not benefit from good enough information, advice and guidance (IAG) to help them understand their education or work

options while at the prison. Staff responsible for IAG did not hold meetings with prisoners early enough in their sentences. They also produced skills action plans that did not cover in enough detail the circumstances, needs and career aspirations of prisoners. Leaders understood the issues with IAG and had tried various approaches to improve this, such as sending leaflets to prisoners about their options. Despite this, too many prisoners did not know about the options they had and did not know how they could get further IAG to find out more.

- 5.15 Those prisoners who were close to the end of their sentences benefited from well-structured and targeted support. This helped them to understand their employment and training options after release from prison. A small number of prisoners had started work or training upon release as a result of this support.
- 5.16 Leaders had been too slow to introduce support for prisoners with learning difficulties and/or disabilities (LDD). Prisoners rightly reported frustration at the difficulties this led to when completing in-cell packs, or to get more help for their identified LDD needs. A small number believed that their LDD need meant they could not attend education classes. A few prisoners had recently started to receive better-quality LDD support, which they valued highly.
- 5.17 The small number of prisoners who had roles in workshops benefited from well-planned work opportunities. These included adequate choices for the few vulnerable prisoners held at the prison. They learned an array of useful new skills from their trainers, for example, sewing and cutting skills in the textiles workshop.
- 5.18 In other vocational areas, such as industrial cleaning, well-qualified peer trainers provided good-quality demonstrations to prisoners. Prisoners attended workshops at high rates and worked diligently.
- 5.19 Leaders had recently introduced a process to monitor and track prisoners' acquisition of employment-related skills within workshops, but it was not used effectively by trainers to develop the skills that prisoners needed most.

## **Recommendations**

- 5.20 **Leaders should ensure that they fully use all activity spaces, so that a high proportion of prisoners participate in purposeful activity.**
- 5.21 **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.**
- 5.22 **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.**

## Section 6 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.**

### Children and families and contact with the outside world

Expected outcomes: The prison 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 In-person social visits had resumed in June 2021, having operated intermittently since the onset of the pandemic, and the prison had increased the number of sessions at the beginning of September 2021. All prisoners could have two one-hour visits a month on Monday to Thursday; there were no slots at weekends. Overall take-up, particularly for the afternoon sessions, was good.
- 6.2 While visits were suspended, the prison had redecorated the visits hall and this area was now impressive, featuring interesting, bright and creative paintings and artwork, creating a comfortable and warm environment for prisoners and their visitors. The hall facilitated visits safely, and prisoners and their families welcomed the recent easing of some restrictions, such as allowing physical contact and the ability for children to move around and access toys and colouring packs.





#### Visits hall artwork

- 6.3 Prisoners now had access to in-cell telephones and were able to use them 24 hours a day if they had credit, which helped maintain family ties. They could send and receive correspondence via the 'email a prisoner' scheme (allowing families and friends of prisoners to send emails into the prison), which was valued by prisoners and was well used.
- 6.4 Secure video calling (see Glossary of terms) had been introduced in August 2020 and prisoners were able to have two half-hour calls a month. The use of the technology had steadily increased but was now declining slightly with the resumption of social visits. Overall uptake was reasonable, with about two-thirds of capacity used, but more could have been done to raise awareness among foreign national prisoners and encourage them to use the facility, especially as many of their families could not visit them in person. The room for video calling did not offer sufficient privacy, even with the use of headphones.
- 6.5 The Prison Advice and Care Trust (PACT) and prison staff worked well together and had been creative in encouraging contact between prisoners and their families during the COVID-19 restrictions. Prisoners' children were invited to enter a drawing competition in which prisoners received copies of their drawings and an additional visit. Children received free books and the winners received high street vouchers, along with their drawings displayed in the visits hall. Other positive initiatives included prisoners having a 'selfie' picture taken against the artwork in the visits hall and printed on to postcards to send home, Father's Day crafting card packs sent to children and letter-writing home packs for prisoners.

- 6.6 The pre-pandemic opportunities and courses to develop and rebuild family relationships, such as family days and homework clubs, remained suspended. However, PACT staff had adapted the 'Dad's reconnected', 'Going home', 'Good communication', and 'Anger and stress' courses into in-cell packs and over 200 workbooks had been completed since March 2020. There were plans to resume family days in October 2021.

## Reducing risk, rehabilitation and progression

Expected outcomes: Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

- 6.7 The prison held a complex population with varied needs and a significant turnover. Nearly half of sentenced and just over half of unsentenced prisoners stayed at the prison for three months or less before they were moved on or released. Nearly three-quarters of the population were unsentenced, which was more than other local prisons and more than at our last inspection.
- 6.8 Managers in the offender management unit (OMU) were committed to developing the service effectively, and the head of reducing reoffending had a clear strategic approach to improving provision and service delivery. The prison had a current and well-presented needs analysis, completed by HMPPS London psychological services, based on a survey of 10% of the prison population and relevant data. This had informed the prison's reducing reoffending strategy, which considered the resettlement pathways and focused on key areas of improvement. The monthly reducing reoffending meeting continued to meet regularly, was well attended and demonstrated good links between the reducing reoffending team and the rest of the prison.
- 6.9 However, efforts to reduce risk and to rehabilitate and progress prisoners were undermined by staff shortages. Cross-deployment of prison offender managers (POMs) to other duties equated to the loss of two full-time staff on top of three vacancies. This caused frustration for both POMs and prisoners, particularly as redeployment usually happened at the last minute. As a result, contact with individual prisoners was regularly cancelled. There was a knock-on impact to the work of non-prison officer POMs, who had to cover urgent tasks for cross-deployed colleagues and then cancel their own planned work. The impact on prisoners was that many had little contact with their nominated POM, who should have been providing support, encouragement and motivation, and helping them to progress.
- 6.10 Cases were allocated appropriately between prison and probation POMs. The two groups were located in different parts of the prison, with resettlement staff in a third area. Plans to bring these teams together had no clear timescale. In the interim, this dispersal of staff

and the different line management structures meant that work was insufficiently coordinated. While prison POMs sought advice from their probation colleagues, they would benefit from closer working relationships.

- 6.11 Almost all eligible prisoners had had an assessment of their risks completed in the last 12 months by either POMs or community offender managers, depending where they were in their sentence, in line with the Offender Management in Custody (OMiC) model (see Glossary). The backlog of OASys (offender assessment system) assessments had been reduced; at the time of our inspection, 16 initial assessments were outstanding.
- 6.12 Most of the assessments of risks that we reviewed were of a sufficient standard, and sentence plan objectives were appropriate. Most prisoners we interviewed were aware of their sentence plan and had a reasonable understanding of its objectives. In our survey, only 6% of prisoners, against the comparator of 45%, said that staff were helping them to achieve their objectives. Prisoners we interviewed also reported a perception of having to use their own initiative to seek out available opportunities to advance their progression. This was a consequence of both the cross-deployment of prison POMs and the effect of COVID restrictions on probation POMs coming into the prison.
- 6.13 The prison held 38 prisoners serving indeterminate sentences who were allocated appropriately to probation POMs. Additional provision for these prisoners was very limited, which had the potential to delay their progress.
- 6.14 Home detention curfew (HDC) processes were managed well. Twenty per cent of prisoners who were eligible were released on HDC, which was slightly lower than at our previous inspection. Some problems beyond the control of the prison still led to some prisoners – such as those sentenced with very little time left before release – being released after their eligibility date, but the prison was active in progressing applications where it could.

## **Recommendation**

- 6.15 **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.**

## **Public protection**

- 6.16 The application of public protection procedures to protect children and other potential victims was mostly well managed and supported by a dedicated and experienced team. At the time of our inspection, seven prisoners were subject to offence-related monitoring. Provision to monitor their communications was robust and up to date with no backlog in listening to records of phone calls. Public protection clerks regularly reviewed logs completed by staff monitoring prisoner calls to provide an extra layer of quality assurance. However, the prison was

still not following national guidelines in monitoring the mail and telephone calls of all new arrivals.

- 6.17 There was reasonably good information exchange between the prison and community offender managers to develop robust risk management release plans. This resulted, for example, in good use of referrals to approved premises for prisoners assessed as high risk of harm. However, POMs told us that staff shortages in the London Probation Service meant they sometimes struggled to transfer responsibility for the prisoner to the community offender manager at the appropriate time, resulting in reduced timescales to plan for release.
- 6.18 The inter-departmental risk management team (IDRMT) meeting provided good oversight of release planning for prisoners known to be high risk of harm and those subject to multi-agency public protection arrangements (MAPPA). Prisoners were discussed at the meeting each month up until their release, which was positive. The meeting evidenced examples of the prison escalating concerns to the community about the need to increase MAPPA management levels where they thought this was suitable, which demonstrated a good understanding of the need to manage risk appropriately.

### Recommendation

- 6.19 **The monitoring of mail and telephone calls should be consistently applied in line with national guidelines.** (Repeated recommendation 4.26)

### Categorisation and transfers

- 6.20 Initial categorisations were completed on time with no backlog at the time of our inspection, but 29 categorisation reviews were outstanding and a consequence of cross-deployment and competing priorities for staff. Reviews were not completed face to face, which was a gap and a missed opportunity to motivate and support prisoners.
- 6.21 Despite some difficulties during the pandemic, prisoners were able to transfer to other establishments to progress. Links between POMs and staff arranging transfers were established to make sure information was exchanged well. At the time of our inspection, four prisoners assessed as suitable for open conditions were waiting to be transferred.

### Interventions

Expected outcomes: Prisoners are able to access interventions designed to promote successful rehabilitation.

- 6.22 As a local prison, Wandsworth did not deliver any accredited behaviour programmes to reduce the risk of reoffending. The range of other work to help prisoners address their attitudes, thinking and behaviour was

limited, which was exacerbated by the lack of motivational work completed by POMs with prisoners on their caseload.

- 6.23 The prison provided some in-cell work packs, for example, on drugs awareness. Prisoners we spoke to valued having something to do to pass the time and thought that they had learned from the workbooks. However, with one or two notable exceptions, it was rare to hear that their work had been discussed with them. This was a missed opportunity to capitalise on motivation and to embed and apply learning.
- 6.24 Before the unification of resettlement services into the Probation Service, the community rehabilitation company had provided some specialist support for prisoners who had experienced abuse or other personal trauma. Although this need was still identified during assessments by the resettlement team, at the time of our inspection there was no specialist support for these prisoners.
- 6.25 Support to help prisoners manage finance, benefit and debt problems was reasonable. Demand for help was high; in our survey, 70% of prisoners said they needed help to arrange benefits and 61% for help with finances.
- 6.26 Following a gap in provision, prisoners could now again open bank accounts through the resettlement team. The Department for Work and Pensions provided staff in the prison to assist prisoners with benefit claims. A helpline provided by the charity Standout supported prisoners approaching release and included advice about benefits; it was well used and had been accessed by approximately a quarter of prisoners who had been released.

## Release planning

Expected outcomes: The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

- 6.27 The demand for resettlement help was high, with an average of 160 prisoners released each month, but more work was needed to embed a quality resettlement service. In the last six months, only 70% of prisoners had an assessment of their resettlement needs before release. Plans lacked depth and did not always lead to a positive outcome. Prisoners we spoke to were not always aware of what was being done to address their resettlement needs and, in our survey, only 50% of those due for release in the next three months said that anyone was helping them prepare for their release. This lack of certainty about the future generated considerable anxiety.
- 6.28 In our survey, 69% of prisoners said they needed help to find accommodation but only 36% said they were getting this. The prison's data showed that only 45% of prisoners released in the last year had accommodation fixed for their first night of release.

- 6.29 St Mungo's, the housing provider, no longer provided support for prisoners on remand, following the unification of resettlement services with probation. This resulted in a large number of remand prisoners not being able to access support to secure tenancies or deal with rent arrears, which was a significant gap. (See key concern and recommendation 1.52.) The prison was part of a national HMPPS 'reducing reoffending accelerator project', under which a new role had recently been created to develop relationships with statutory and non-statutory housing providers, and make sure that prison staff were equipped to identify and signpost prisoners to housing services. It was too early to assess outcomes for this positive initiative.
- 6.30 Practical release arrangements were good. Prisoners could charge mobile phones in reception and could access suitable clothing and holdalls for their belongings. Positively, several organisations worked with prisoners to provide through-the-gate support, collectively supporting around a sixth of all releases.
- 6.31 The unification of probation services had left the resettlement team with concerns about future contractual arrangements, and the loss of direct line management was a gap in the drive for improvement. There had been interim support from managers in other prisons, but a long-term resolution was needed.

## Section 7 Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

### Key concerns and recommendations

- 7.1 Key concern 1.44: Although leaders were making good use of data to measure daily and weekly progress, governance arrangements were not sufficient to make sure that longer term plans, targets and monitoring were taking place in a number of important areas such as violence reduction, use of force, key work, safety and equality and diversity.

**Recommendation: 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.**

(To the governor)

- 7.2 Key concern 1.45: Over half of respondents to our survey reported that they had felt unsafe at some point during their stay. There was no formal support for victims. Violence was increasing and the number of assaults on staff was high. The management of perpetrators of violence was weak, too many investigations into incidents were not thorough enough, and there was no embedded violence reduction strategy or action plan.

**Recommendation: 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.**

(To the governor)

- 7.3 Key concern 1.46: The use of force was high and there were no formal governance meetings. Staff involved in incidents did not always record de-escalation techniques or switch on body-worn cameras early enough to provide sufficient scrutiny. Not all incidents involving the use of batons and PAVA incapacitant spray were investigated by senior managers and too much use of force documentation was missing.

**Recommendation: 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.**

(To the governor)

- 7.4 Key concern 1.47: Wandsworth remained one of the most overcrowded prisons in the country with most prisoners sharing a cell built for one. The shower areas on Trinity were poor. The physical environment in the mental health inpatient unit was unacceptable, did not meet infection control standards and had ligature points that had not been remedied to reduce the risk to patients. The control of vermin needed greater focus, including measures to prevent food waste and rubbish being thrown from cell windows.

**Recommendation: All living conditions, including the inpatient unit and Trinity unit, should be improved to safe and decent standards.**

(To the governor)

- 7.5 Key concern 1.48: There was insufficient support for the many foreign national prisoners held at Wandsworth. Home Office immigration staff had only recently returned to the prison, face-to-face contact was limited, and wing surgeries were still suspended. Legal documents were often served too late, and prisoners and detainees spent far too long in prison with their cases unresolved.

**Recommendation: Foreign national prisoners and detainees should have their cases reviewed promptly and have timely access to information, help and face-to-face support.**

(To the Home Office)

- 7.6 Key concern 1.49: The lack of primary mental health and inpatient staff resulted in patients not having their mental health needs met in a safe or timely manner. This was creating significant risks affecting the monitoring of referrals, assessments taking place within agreed timescales and ensuring that the outcome of assessments was fully documented.

**Recommendation: 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.**

(To the governor)

- 7.7 Key concern 1.50: Patients requiring transfer to secure mental health inpatient services continued to wait far too long for a bed. Only four of the 18 patients transferred to a mental health hospital under the Mental Health Act in the last six months had done so in fewer than 14 days. The remaining 14 patients waited from 15 to 226 days, which was unacceptable.

**Recommendation: 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.**

(To HMPPS and the governor)



- 7.8 Key concern 1.51: The daily regime remained far too limited and most prisoners continued to spend more than 22 hours a day locked in their cells, with some denied access to the open air for days at a time. Opportunities to engage in purposeful activity remained very limited and too many prisoners were unemployed. Access to the library and the gym and education were poor.

**Recommendation: 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.**

(To the governor)

- 7.9 Key concern 1.52: Following unification of the Probation Service, the housing provider no longer supported prisoners on remand. This resulted in the large number of remand prisoners not being able to access support, for example to secure tenancies or deal with rent arrears.

**Recommendation: Leaders should make sure that there is effective housing support for all prisoners, including those on remand.**

(To HMPPS and the governor)

## Recommendations

- 7.10 Recommendation 3.10: All new arrivals should be offered a shower.  
(To the governor)
- 7.11 Recommendation 3.11: Searching procedures should be proportionate to the risk posed and not applied automatically.  
(To the governor)
- 7.12 Recommendation 3.18: There should be a wide range of incentives to encourage prisoners' positive behaviour and effective systems to address poor behaviour.  
(To the governor)
- 7.13 Recommendation 3.22: Managerial oversight of disciplinary procedures should make sure that all hearings are held fairly and completed within a reasonable time.  
(To the governor)
- 7.14 Recommendation 3.33: 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.  
(To the governor)
- 7.15 Recommendation 3.45: 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.  
(To the governor)

- 7.16 Recommendation 4.5: 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.  
(To the governor)
- 7.17 Recommendation 4.13: All prisoners should have access to basic items, including weekly provision of clean bedding, clothes and cleaning materials.  
(To the governor)
- 7.18 Recommendation 4.18: Lunch should be served no earlier than 12 noon and dinner no earlier than 5pm.  
(To the governor)
- 7.19 Recommendation 4.44: Professional telephone interpreting should be used to communicate with prisoners who do not speak English when confidentiality or accuracy is required. (Repeated recommendation 2.44)  
(To the governor)
- 7.20 Recommendation 4.45: There should be a time limit on immigration detention. (Repeated recommendation 2.42)  
(To the Home Office)
- 7.21 Recommendation 4.71: 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.  
(To the governor)
- 7.22 Recommendation 4.72: 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.  
(To the governor)
- 7.23 Recommendation 4.90: Medication should be administered in line with professional standards by consistently checking patient identity.  
(To the governor)
- 7.24 Recommendation 4.97: Officers should manage medication queues to maintain patient confidentiality, enable supervised consumption of medicines and prevent any diversion.  
(To the governor)
- 7.25 Recommendation 5.20: Leaders should ensure that they fully use all activity spaces, so that a high proportion of prisoners participate in purposeful activity.  
(To the governor)
- 7.26 Recommendation 5.21: 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.  
(To the governor)

- 7.27 Recommendation 5.22: 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.  
(To the governor)
- 7.28 Recommendation 6.15: 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.  
(To the governor)
- 7.29 Recommendation 6.19: The monitoring of mail and telephone calls should be consistently applied in line with national guidelines.  
(To the governor)

## Section 8 Progress on recommendations from the last full inspection report

### 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. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

#### Safety

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

At the last inspection, in 2018, early days processes did not focus enough on identifying risks and induction was poor. There was a thoughtful approach to violence reduction, but its impact on outcomes was unclear. The amount of force used was similar to other prisons, but governance was weak. The segregation unit was well managed. Security was generally proportionate. Drug supply reduction work was improving but still not sufficiently effective. There had been six self-inflicted deaths since the previous inspection and there was uneven progress in addressing Prisons and Probation Ombudsman (PPO) recommendations. Outcomes for prisoners were not sufficiently good against this healthy prison test.

##### **Key recommendations**

Prisoners should receive a private and detailed assessment of needs and vulnerability before being moved to adequately prepared first night accommodation. They should have additional checks and support on their first night. All new arrivals should receive a comprehensive induction, directly overseen by staff with attendance tracked centrally. (S40)

##### **Achieved**

Managers should make use of detailed analysis of outcomes and trends to measure the impact of safer custody and other work, and to drive improvement. (S41)

##### **Partially achieved**

A robust strategic approach to preventing suicide and self-harm should be supported by an up-to-date action plan. ACCT procedures should be thoroughly implemented. All recommendations from the Prisons and Probation Ombudsman investigations should be implemented and monitored. Officers should be clear about their responsibility to preserve life, when to enter a locked cell and what to do in an emergency. Officers should carry anti-ligature knives. (S42)

##### **Partially achieved**

## **Recommendations**

The most effective and dignified methods that are available should be used to identify contraband on prisoners being received into the establishment. Strip-searching should only be used where it is clearly justified by evidence of effectiveness or individual risk. (1.10)

**Not achieved**

All prisoners should be able to access their personal property on their first night in custody. (1.11)

**Not achieved**

Managers should ensure that the IEP scheme is an effective tool for behaviour management. (1.16)

**Not achieved**

Reports of the use of force should be completed by every officer involved and should provide a detailed explanation for the use of force and a full description of the experience of the member of staff. (1.26)

**Not achieved**

All trained staff should wear body cameras. (1.27)

**Not achieved**

Paperwork authorising the use of special accommodation should provide clear justification for its use and should demonstrate regular reviews by a senior manager. (1.28)

**Not achieved**

Segregated prisoners should have the opportunity to spend at least one hour in the open air and make a telephone call every day. (1.33)

**Not achieved**

A full intelligence picture should be gathered, acted on without delay and used effectively to prioritise and manage identified risks. (1.42)

**Partially achieved**

The mandatory drug testing programme should be adequately resourced to complete the required level of target testing and all requested suspicion tests within required timeframes. (1.43)

**Not achieved**

The Listener rota should provide adequate cover across the prison at all times, and Listener suites should be prepared and ready for use. (1.49, repeated recommendations 1.36 and 1.37)

**Achieved**

## Respect

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

At the last inspection, in 2018, staff-prisoner relationships were generally reasonable, but many staff were not engaging well with prisoners. Living conditions varied widely across the prison; a recently started refurbishment programme was long overdue. There were considerable weaknesses in applications and complaints systems. Catering was reasonably good. Equality and diversity work had improved but remained weak. Faith provision was good. Despite shortcomings in some elements of health care, including social care, health services were reasonably good. Outcomes for prisoners were not sufficiently good against this healthy prison test.

### Key recommendations

The living conditions should be improved to an acceptable standard. Managers and staff should ensure that a culture of institutional self-respect is firmly established, supporting a clean and decent environment for staff and prisoners alike. (S43)

**Not achieved**

The prison should systematically identify prisoners' protected characteristics. Equality monitoring data should be up to date, cover all key areas of prison life, and lead to thorough investigation and action where necessary. All prisoners should know how to report discrimination incidents. (S44)

**Not achieved**

### Recommendations

Managers should ensure that staff learn and practise habits of positive interaction with prisoners. (2.5)

**Achieved**

All prisoners should be able to have a shower every day in clean and well-maintained facilities with adequate privacy. (2.11, repeated recommendation 2.8)

**Not achieved**

Cell call bells should always be answered within five minutes. (2.12)

**Achieved**

Breakfast should be served in the mornings, rather than being issued in packs the previous night, and lunch should be served between noon and 1.30pm. (2.17)

**Not achieved**

Newly arrived prisoners who are waiting for a shop order should be able to purchase enough goods to avoid debt to other prisoners. (2.18, repeated recommendation 2.125)

**Not achieved**

Complaints and applications should be acknowledged and answered promptly, with reliable tracking and monitoring to ensure good use of and confidence in these systems. (2.26)

**Achieved**

Prisoners should have swift and easy access to legal visits, bail information and advice. (2.27)

**Achieved**

There should be a time limit on immigration detention. (2.42)

**Not achieved** (recommendation repeated, 4.46)

Detainees should only be held in prisons in exceptional circumstances. (2.43)

**Not achieved**

Professional telephone interpreting should be used to communicate with prisoners who do not speak English when confidentiality or accuracy is required. (2.44)

**Not achieved** (recommendation repeated, 4.45)

Prisoners with disabilities should have their needs assessed and reasonable adjustments made to meet these needs. (2.45)

**Achieved**

Wing officers should know which prisoners in their care require assistance in the event of an emergency. (2.46)

**Not achieved**

Older and disabled prisoners who are retired or unfit to work should not be locked in their cell during the core day. (2.47)

**Not achieved**

All faith facilities should be bright, well decorated and structurally sound. The main chapel should be repaired to ensure the roof does not leak and the walls are free from water damage. (2.50)

**Not achieved**

Prisoners should have timely access to all primary care services, equivalent to the community. (2.76)

**Achieved**

The failure-to-attend rate for all clinics should continue to be monitored and appropriate remedial action taken to reduce it. (2.77)

**Partially achieved**

All patients on the inpatient units should have access to a therapeutic regime. (2.78)

**Not achieved**

Effective joint working between the prison, local authority and health providers should ensure prisoners with social care needs are promptly identified, assessed and given appropriate and safe support by staff and peers. (2.82)

**Not achieved**

The range of primary mental health services should be extended to support prisoners with mild and moderate mental health problems more fully. (2.92)  
**Partially achieved**

All discipline officers should receive mental health awareness training to enable them to identify and support prisoners with mental health conditions. (2.93)  
**Not achieved**

Patients requiring a transfer under the Mental Health Act should be transferred expeditiously and within the current transfer guidelines. (2.94, repeated recommendation 2.112)  
**Partially achieved**

The substance misuse strategy, including supply reduction, should be informed by a current needs assessment and supported by a comprehensive action plan. It should be reviewed at well-attended monthly substance misuse strategy meetings. (2.101)  
**Achieved**

Prisoners on all wings should have easy access to the full range of psychosocial support services in a suitable environment. (2.102)  
**Partially achieved**

All medicines should be administered at the required time and officers should manage and supervise all medicine queues effectively, to protect patient confidentiality and reduce opportunities for bullying and diversion. (2.111)  
**Not achieved**

Patients should be provided with a facility to store their medication securely. (2.112, repeated recommendation 2.94)  
**Not achieved**

The pharmacy should provide effective oversight and governance of the purchase of Paracetamol from the canteen list to ensure safe use. (2.113)  
**No longer relevant**

## **Purposeful activity**

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

At the last inspection, in 2018, too many men had poor time out of cell. Library provision was reasonable, but access varied widely across wings. Prisoners were positive about gym provision. The management of activities had improved but there was so far limited evidence of improved outcomes. There was insufficient activity for the population and too many places were not being used. Attendance was poor and too many prisoners were not completing courses or achieving qualifications. Outcomes for prisoners were poor against this healthy prison test.



## **Key recommendations**

The time unlocked should be increased and prisoners should have daily access to association and outside exercise provided at publicised scheduled times.

(S45)

**Not achieved**

There should be enough activity places to provide educational, vocational and work places for the whole population. Participation and attendance in activities should be consistently high, and punctuality should be good, ensuring that working time is fully productive. A high proportion of prisoners who start on any course should complete it and achieve the qualification. (S46)

**Not assessed at this inspection**

## **Recommendations**

Available data on the number and category of prisoners borrowing books and other resources should be better used, to ensure full equitable access to the library and to promote the benefits of using library services to all prisoners.

(3.14)

**Not achieved**

Prison managers should ensure that the allocation process is equitable and efficient and that prisoners always attend a course of direct benefit to them.

(3.24)

**Not assessed at this inspection**

Prison managers should ensure that all positive outcomes arising from the resolution of weaknesses in induction, initial assessment, attendance and engagement in purposeful activities can be tracked and measured using accurate data. (3.25)

**Not assessed at this inspection**

Prison and Novus managers should ensure that protocols for the administration of learner withdrawals from courses are applied consistently and accurately, leading to a significant and measurable reduction in withdrawals. (3.26)

**Not assessed at this inspection**

Agencies involved in coordinating and organising prisoners' progress to education, training or employment (ETE) on release should have accurate data on the numbers progressing to ETE. (3.27)

**Not assessed at this inspection**

Prison and Novus managers should ensure that all prisoners receive a timely and effective induction to education, skills and work which includes an accurate assessment of their English and mathematics skills. The outcomes of initial assessment should be recorded promptly and made available to teachers so that they can plan and promote individuals' learning and track their progress effectively. (3.37)

**Not assessed at this inspection**

Prison and Novus managers should ensure that teachers' professional practice improves so that all teaching, learning and assessment becomes at least good. (3.38)

**Not assessed at this inspection**

Prison and Novus managers should ensure that prisoners with learning support plans receive adequate and effective support during education and training sessions without detriment to other prisoners' learning. (3.39)

**Not assessed at this inspection**

## **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 2018, a range of courses and regular family days helped prisoners to maintain and develop links with their families. Visits provision was reasonable. Resettlement functions were not well enough coordinated. There had been substantial progress in improving offender assessment system (OASys) assessment completion rates, but a significant number were still outstanding. Good work was done with higher risk prisoners, but there was not enough contact with most others. The timeliness of home detention curfew (HDC) had improved considerably in recent months. With some exceptions, public protection procedures were well managed. Resettlement planning and work was generally reasonable. Outcomes for prisoners were reasonably good against this healthy prison test.

## **Recommendations**

Family days and other opportunities for prisoners to rebuild and maintain relationships with their families should not be restricted by IEP status or adjudication history. (4.6)

**Achieved**

A wide range of hot and cold food and drinks should be available for visitors to buy. (4.7)

**Not achieved**

Offender supervisors should be redeployed only in exceptional circumstances. (4.21)

**Not achieved**

The reducing reoffending needs analysis should incorporate OASys data to reflect effectively need relating to the reduction of risk and harm. (4.22)

**Achieved**

All prisoners meeting the criteria should have an up-to-date OASys which is appropriately orientated towards managing and addressing risk of harm and reoffending. (4.23)

**Partially achieved**

The criteria for downgrading prisoners' security category should be clarified and applied consistently. (4.24)

**Achieved**

All men identified as presenting a risk to children and/or who are subject to harassment restrictions should be informed at the earliest opportunity and restrictions should be explained. (4.25)

**Achieved**

The monitoring of mail and telephone calls should be consistently applied in line with national guidelines. (4.26)

**Not achieved** (recommendation repeated, 6.19)

All prisoners with an identified need should be able to access appropriate interventions to address their offending behaviour. (4.31)

**Not achieved**

Outcome data on debt management and sustainable housing should be made available routinely, analysed through the reducing reoffending strategy group and used to determine the most effective interventions for prisoners. (4.32)

**Partially achieved**

All sentenced prisoners should have a clear resettlement plan outlining all work that has been undertaken to reduce the risk of reoffending and what is outstanding. This should include the work of all departments. (4.37)

**Partially achieved**

The reducing reoffending strategy group should ensure that all departments share activity data appropriately to facilitate pre-release engagement and through-the-gate support. (4.38)

**Achieved**

## Appendix I About our inspections and reports

Her Majesty's 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, police and 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 benefit them.

### **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 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 Her Majesty's 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 one of the following:

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

**Recommendations:** will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

**Examples of notable positive practice:** 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 provides a summary of our inspection findings 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 5, 2017) (available on

our website at <https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/>). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 7 lists all recommendations made in the report. Section 8 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 Appendix IV: 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:

Charlie Taylor	Chief inspector
Sara Pennington	Team leader
Ian Dickens	Inspector
Natalie Heeks	Inspector
Lindsay Jones	Inspector
Sally Lester	Inspector
Jade Richards	Inspector
Paul Rowlands	Inspector
Caroline Wright	Inspector
Annie Bunce	Researcher
Rahul Jalil	Researcher
Helen Ranns	Researcher
Shannon Sahni	Researcher
Sarah Goodwin	Lead health and social care inspector
Tania Osborne	Health and social care inspector
Richard Chapman	Pharmacist
Dayni Johnson	Care Quality Commission inspector
Bev Gray	Care Quality Commission inspector
Saul Pope	Ofsted inspector
Montserrat Perez	Ofsted inspector

## Appendix II Glossary of terms

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

### **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>

### **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.

### **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.

### **Offender management in custody (OMiC)**

The Offender Management in Custody (OMiC) model, being rolled out across the closed male prison estate, 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.

**Personal protective equipment (PPE)**

Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

**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 visit can be booked, users must upload valid ID.

**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).

**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.



## Appendix III Care Quality Commission Requirement Notice



Care Quality Commission (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>

The inspection of health services at HMP Wandsworth was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see <https://www.justiceinspectores.gov.uk/hmiprison/about-hmi-prison/working-with-partners/>). The Care Quality Commission issued 'requirement to improve' notices following this inspection.

### Requirement Notices

#### Provider

South London and Maudsley NHS Foundation Trust

#### Location

Maudsley Hospital (HMP Wandsworth)

#### Location ID

RV504

#### Regulated activities

Treatment of disease, disorder, or injury  
Diagnostic and screening procedures.

#### Action we have told the provider to take

This notice shows the regulations that were not being met. The provider must send CQC a report that says what action it is going to take to meet these regulations.

#### Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.

#### How the regulation was not being met

There were insufficient numbers of staff deployed on Addison Unit. There were six band 5 nurse vacancies and one band 6 nurse vacancy. Staff we spoke with told us they were regularly short staffed and that temporary staff regularly

cancelled at short notice. We reviewed a sample of dates in August and September and found that there were three whole shifts which were short of one nurse, including one night shift which meant that there was only one unqualified nurse on duty. We identified a further three shifts where the unit was short by one nurse and the ward manager extended his hours to provide cover. We also found one night shift where the ward manager provided cover.

There were insufficient numbers of staff deployed in the primary care mental health team. There were nine vacancies which impacted on the stage one and two service available to patients with mild to moderate mental health needs.

## **Appendix IV 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.

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