Report on a full announced inspection of

Isle of Man prison

20 – 24 March 2006

by HM Chief Inspector of Prisons

ISBN-13: 978-1-84726-069-7
ISBN-10: 1-84726-069-1

Printed and published by:
Her Majesty's Inspectorate of Prisons
1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

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Introduction

We last inspected the Isle of Man prison in 2001. At that time, we recognised, as did the island authorities, the inadequacy of the accommodation available to house men, women and children. We also pointed out some of the changes in procedures and regime that were necessary in order to ensure that prisoners were held in a safe and purposeful environment, and to reduce the chance of their reoffending.

At the time of this inspection, a new prison was under construction. This is very welcome, and will deal with some of the underlying problems of providing decent accommodation for prisoners, and sufficient space for them to develop the work and educational skills that can assist successful resettlement. While the prison had taken steps to mitigate the effects of poor accommodation, and to increase educational opportunities, there is very limited scope to do so, within the existing prison. It will be essential, in the new prison, not only to provide space for more work and education, but also to create a regime, and an environment, that prioritises the acquisition of skills and training.

It was, however, disappointing that many of our other recommendations to provide interim improvements had not been taken forward, or had only recently been grappled with. Procedures for managing self-harm and bullying were virtually non-existent, with poor recording and little systematic support or intervention. This was particularly surprising, as personal officer work was well-developed, and written entries in prisoners' history sheets were among the best we have seen. Too much reliance, however, was placed upon staff's informal knowledge of individual prisoners, gathered in an environment where they were necessarily in close contact. A more systematic approach will be needed in a new prison, where more facilities will be available within prisoners' own cells.

Resettlement services, too, had not developed as we would have hoped. There was little effective sentence or custody planning, and too much reliance on a single, over-stretched probation officer. There was no sense that the whole prison was engaged in seeking to reduce reoffending: indeed, the familiarity of staff with many prisoners could result in assumptions, on both sides, that reoffending was to be expected. The management of life-sentenced and vulnerable prisoners caused particular concern, as the conditions in which they were held were likely to reinforce, rather than reduce, offending behaviour.

We were particularly concerned about healthcare provision in the prison, where none of our key recommendations had been implemented, with consequences for prisoners' mental and physical health. There was no clinical management or leadership, no health needs assessment had been carried out, and prescribing practices were both unsafe and illegal. This required urgent and immediate attention; but in the medium term, we welcome the fact that healthcare will be provided directly by the island's health service, and would urge that arrangements for this are expedited.

The Isle of Man prison has many strengths – most noticeably, the approach and knowledge of prison staff. It has been operating under severe physical restrictions. It has also, until recently, lacked the consistent and systematic management that is needed to ensure that the commitment of staff is translated into positive outcomes for prisoners, and for the community.

The move to a new prison provides a new opportunity. But, as we said at the last inspection, it is vital that prison managers, and the island authorities, ensure that systems and plans are in place now, to maximise the benefits of the new environment and ensure that current strengths are built on. In particular, we would urge the Department of Home Affairs, with other relevant

departments, to examine the possibility of putting in place an end-to-end offender management system for the island, which could draw on the close relationships and physical proximity of the agencies which could participate in such an approach. There is no reason why the Isle of Man, with the benefit of its new prison, should not provide a model of effective practice, aimed at reducing reoffending and protecting the public in the longer term.

Anne Owers June 2006
HM Chief Inspector of Prisons

Fact page

Task of the establishment
The Isle of Man Prison Service serves the public by keeping in custody those committed by the courts. Their duty is to keep prisoners in custody, maintain order and control, to treat prisoners with dignity, fairness and respect, and provide opportunities to help them lead law-abiding lives after release.

Area organisation
Isle of Man

Number held
64 Male
2 Female

Certified normal accommodation
92

Operational capacity
92

Last inspection
Full announced : 2 – 7 December 2001

Brief history
This Victorian prison has occupied this site since 1891. The prison kitchens and C and D wings were built in 1988. The reception and segregation unit (E wing) were added in 1998.

Description of residential units
- A wing — Adult male and vulnerable prisoners
- B wing — Young male
- C wing — Adult male, enhanced wing
- D wing — Adult and young female

Healthy prison summary

Introduction

HP1 All inspection 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. The criteria are:

Safety	prisoners, even 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
Resettlement	prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the Department of Home Affairs.

...performing well against this healthy prison test.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

...performing reasonably well against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

...not performing sufficiently well against this healthy prison test.
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.

...performing poorly against this healthy prison test.
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.

HP3 At the time of the last inspection, the need for a new prison had been clearly identified. At the time of this inspection, building work had begun at the new site, and it was hoped that the new prison would be occupied by December 2007.

Safety

HP4 Court liaison arrangements and reception processes were good but first night and induction procedures were poor. Reported levels of bullying and self-harm were low, but the systems required to prevent and monitor these were weak. Though staff knew prisoners well, nearly half the prisoners surveyed said they had felt unsafe. The segregation area was clean, but was used inappropriately for new arrivals and self-harmers. Provision for vulnerable prisoners was wholly inadequate. Security was not sufficiently well-resourced. There was limited detoxification support; mandatory drug testing was running at a12% positive rate.

HP5 The prison was responsible for the staffing of escorts to court and escort times were short. In our survey, all the questions relating to staff treatment on escort were answered positively. We saw staff preparing prisoners for what they might find on arrival at the prison, which may have contributed to the fact that 75% of respondents to our survey said they had felt safe on their first night.

HP6 Prisoners were well treated in reception. Reception for all women prisoners took place in the women's wing. New prisoners were offered a free telephone call home and a shower on arrival. They were also given a free first night canteen pack. A cell-sharing risk assessment was started.

HP7 There was no identified first night centre and first night arrangements were little more than a completed checklist. First night cells were dirty, and there were poor arrangements for contact with families. Some new arrivals were inappropriately held in the segregated area.

HP8 Staff believed they knew their prisoners but it was not always clear that changes of status were accorded sufficient significance. Prisoners who had been held on remand and returned to the prison with a long sentence after conviction were not necessarily identified for special care and attention.

HP9 There was no induction programme despite the fact that a third of prisoners were new to custody. Key information was therefore being passed on from prisoner to prisoner, with the risk that it was not always accurate.

HP10 There was no formal anti-bullying policy. Sixteen reports about bullying had been submitted in the previous four years but it was not clear whether this was an accurate reflection of the situation. The true level of bullying was unclear and this was not assisted by the absence of exit interviews or prisoner surveys. Forty nine per cent of prisoners surveyed said they had felt unsafe and 33% said they had been victimised.

HP11 Suicide and self-harm matters were managed within a wider safer custody agenda but there was no specific policy or action plan. The establishment was severely challenged by a small number of prisoners engaging in serious self-harming, one of whom had been transferred to England. Earlier recommendations to introduce a Listener scheme had been considered but not taken forward and there was no care suite. Entries in self-harm monitoring records (Folder 5s) were superficial and the monitoring process was ineffective.

HP12 The segregation area was clean. Prisoners spoke well of staff in the area but the only adjudication we observed was procedurally flawed and there were gaps in the records authorising the segregation of prisoners. The segregated area had been used too frequently for prisoners who were self-harming and one of the special cells had sometimes been used to house a serial self-harmer for weeks.

HP13 The space and regime available to vulnerable prisoners was wholly inadequate. In the absence of any structured programme to challenge underlying attitudes, there was a risk that the prisoners simply reinforced each other's negative outlooks and behaviours.

HP14 The security department was operating well but was in reality just one member of staff. Arrangements to organise security intelligence were in place and there was liaison with the local police. In the absence of any other security staff, there was no competitive analysis of trends. Closed visits were reviewed and restrictions removed as soon as possible.

HP15 Positive drugs tests were running at 12% and an additional 19% tested positive for prescribed medication. Prisoners received with a prescribing arrangement in place were maintained potentially for long periods. There was no psychosocial support to assist those undergoing detoxification.

Respect

HP16 Staff–prisoner relationships were good. Staff treated prisoners decently and the prisoners we spoke to were appreciative of this. The buildings, facilities and regime opportunities were poor. Opportunities for young adults were extremely limited and regime opportunities for women were worse. Holding children under the age of 18 in the prison was entirely inappropriate. Catering services, the prison shop and the personal officer scheme were providing a good basic service. Healthcare services were not professionally delivered and posed serious risks to prisoner safety and staff professional registration.

HP17 The distinctive needs of 17 year-olds, who were held in the same accommodation and with the same regime as 20 year-olds, were not being met. The regime was as limited as that for adults except that young people could not progress to the better conditions in C wing. We were told that a new secure unit with the capacity to manage all children in custody was now open on the island. We consider that that is the appropriate place to hold children.

HP18 Physical conditions for women prisoners were adequate but the regime opportunities open to them were virtually non-existent. There were no incentives to progress and few educational or physical education opportunities. Those opportunities that did exist clashed. Both women prisoners complained of boredom.

HP19 Some of the residential accommodation was very poor, although staff were on duty to facilitate access to lavatories for prisoners from cells in A, B and D wings that had no integral sanitation. There was no evidence of a policy on offensive displays. Access to telephones was restricted by the need to use a staff member to dial the call, and the roster system used meant that one prisoner was unable to phone for six days.

HP20 Prisoners could wear their own clothes and spare clothing could be provided if required. Laundry was done in house and we heard no complaints about laundering clothing or bedding.

HP21 Catering was acceptable but women prisoners complained that food was often stodgy. Young people said the menu choice was slow to change and too predictable. Some meals we saw looked appetising and were well presented. The evening meal was served too early.

HP22 We heard no complaints about purchasing through the prison shop. Prisoners could make orders weekly and, although there was no opportunity to prepare food, fruit could be purchased.

HP23 Legal services were arranged through a senior officer who was based at court, which ensured that she was able to see all new prisoners and had developed good relationships with lawyers. These arrangements were not recorded and facilities in the prison for legal visits were of poor quality.

HP24 The chapel was used as a general purpose area. It did not provide an appropriate, calm, respectful environment and only 31% of respondents to our survey felt their religious beliefs were respected. Individual chaplaincy team members were seen as helpful. Prisoners of non-Christian faiths were provided for individually. The sole Muslim prisoner had been given a Koran and prayer mat. No imam visited the establishment and indeed there was no imam resident on the Isle of Man.

HP25 There was no incentives scheme for women prisoners and the scheme for young people was a simple but effective daily points system to reflect residential behaviour. The incentive for adult men was a move to the better living environment of C wing, although this was more a result of being employed than any analysis of behaviour. Prisoners new to the prison might not have realised that transfer to the better accommodation was linked to participating in work. There was no incentives scheme for vulnerable prisoners.

HP26 The personal officer scheme broadly worked well. Wing files were filled in diligently and fully by staff who clearly knew the prisoners in their charge. A good guidance booklet had been produced, although this needed to be reissued for the benefit of newer staff. In our survey, 38% of respondents said they found their personal officer helpful or better.

HP27 Staff–prisoner relationships were generally good but there was evidence in some recorded notes that staff could be dismissive about some of those who were regularly in the prison or had been known to the service for many years. We observed compassion towards individual prisoners and help was offered in resolving difficult domestic situations. In our survey, 71% of respondents said they had someone to turn to for advice and help and 73% said most staff treated them with respect. Staff did not challenge negative behaviours among prisoners so the benefit of good staff–prisoner relationships was not effectively exploited.

HP28 There were no race relations management arrangements. There was no Isle of Man legislation to cover race relations. Some foreign national prisoners had recently been received as serving prisoners and held solely as immigration detainees. Good individual attention was paid to these prisoners, with access arranged to consulates

and immigration authorities. However, the establishment should not hold unconvicted detainees.

HP29 There had been no health needs assessment despite our recommendation of 2001. Clinical governance arrangements were lacking and clinical supervision was absent. We had major concerns about the safety of arrangements for the management of medicines and their distribution, which put at risk the prisoner to whom they were given and the professional status of staff involved. There was no health promotion programme and chronic disease management was lacking.

Purposeful activity

HP30 There were the beginnings of an education programme but it still operated at a very low level. The physical education department offered time in the small gymnasium to as many different groups in the prison as possible. The only work available to prisoners was domestic and carried no opportunity to gain qualifications. Allocation was not sophisticated and was capable of manipulation by more knowledgeable prisoners. The library service was very poor indeed. The regime clashed in some areas and prisoners were not able to attend activities due to an uncoordinated core day.

HP31 Apart from 11 posts in the kitchen and laundry and sporadic opportunities to work with trades staff, the only available work was cleaning. Work allocation was not centrally managed, with allocation of places being determined by wing managers on a first come first served basis. No accreditation was currently in place, although NVQs for kitchen workers were in the process of development.

HP32 Although there had been some development in education, it was still marginal to the main work of the establishment. However, the quality of the one-to-one teaching observed was assessed as good. Two temporary buildings were used for classrooms but there was too little space. The existing wage systems acted as a disincentive to participate in education as prisoners could earn more as cleaners.

HP33 There was a well equipped, though cramped, weights and fitness conditioning area but no sports hall or outdoor sports facility. Use was made of community sports facilities for selected prisoners but the selection criteria for this were not transparent. Physical education staff tried to encourage participation among different groups of prisoners but there was little by way of accreditation or active health promotion.

HP34 The library was located in a multi-use room. Books were locked away in metal cabinets and it was not a stimulating environment. The published timetable for access was not reliable. Library stock was refreshed every three months but there were few talking books or books in languages other than English. No attempt had been made to find out what prisoners wanted or needed.

HP35 Time out of cell was inadequate in some areas. Exercise and association times were rarely interrupted but the association facilities were very limited.

Resettlement

HP36 There was no island-wide overarching strategy to which the prison could contribute to assist resettlement or seek to reduce reoffending. The resettlement needs of prisoners were not clear. Sentence planning applied only to those serving over 12 months and very little structured intervention was available. Finding accommodation was hampered by the lack of supported accommodation on the island. Offending behaviour programmes were not offered. Public protection work needed to be developed. There was as yet no proactive management of life-sentenced prisoners. There was provision for regular visits but the visits area was barely fit for purpose. There was no effective throughcare for drugs, and no services for alcohol abusers.

HP37 There was no overall strategy on the island to tackle reoffending and the prison had therefore had to invent a role for itself. Much of this relied on a seconded part-time probation officer, who carried out reintegration work on offending behaviour, risk assessment and sentence planning. Immediate resettlement needs were identified on reception. Those returning to live on the island but who had not yet acquired resident status or lived there for five years could forfeit their right to work while not yet having earned the right to access benefits. We came across no use of temporary release to aid resettlement.

HP38 There were no sentence planning arrangements for those serving less than 12 months. For those serving over 12 months, a prisoner development plan was drawn up and reviewed quarterly. A risk assessment tool was used but there was no linkage between risks identified and targets set.

HP39 At the time of the inspection, there were three life-sentenced prisoners, one of whom was categorised as category A and lived in the segregated area on E wing. There was no recognisable life sentence management strategy. Until recently, lifers had been transferred to England and Wales to serve the balance of their sentence but there had been a recent legal challenge to this policy and such transfers had been put on hold. No work had begun to deal with the underlying issues behind their offending. It was not clear how the prison would manage life-sentenced prisoners if the legal challenge was upheld.

HP40 Although island probation policy documents made brief reference to the situation in the prison, there was no prison-based policy to deal with public protection. Prison staff attended multi-agency meetings, which were led by the local police, but these provided no opportunity for the prison to initiate action. While there was good informal knowledge about individuals, there was no coherent approach to ensure that all public protection cases were identified, monitored and reviewed.

HP41 There was clear potential for successful integrated offender management jointly with other key agencies including probation, drugs and alcohol services and social services.

HP42 No offending behaviour programmes were currently offered. A recent attempt to introduce a victim awareness group had proved unsuccessful because of scheduling problems. Some individual work was being carried out with a serious sexual offender. It was important that all such work was properly supervised and validated.

HP43 Family contacts were maintained through letters, visits and telephone calls. Mail was issued promptly and visits could be taken weekly. While this served the needs of those who were resident on the island, there were difficulties for those who were not. The visits room was cramped and provided a poor environment. The governor had introduced a 'surgery' for families to discuss any concerns and this had been welcomed.

HP44 There was no drugs throughcare strategy and very little support for prisoners with alcohol problems. The only voluntary drugs testing took place on C wing. There was a need for better overall coordination of provision of island drugs and alcohol services.

Main recommendations

HP45 A bullying analysis should be undertaken and the results used to develop a bullying strategy. All staff should be trained in how to deal with incidents.

HP46 The safer custody committee should develop and oversee a strategy to help reduce the risk of self-harm and to provide the necessary support and services to those prisoners who threaten or attempt to self-harm.

HP47 The arrangements for the delivery of healthcare to become the responsibility of the Isle of Man Health Service should be expedited.

HP48 A health needs assessment of prisoners should be carried out and a health delivery plan devised to ensure that the correct services, including out-of-hours cover, are in place to meet the needs of the population.

HP49 There should be sufficient purposeful activity for all prisoners, with the opportunity to gain educational and skills qualifications.

HP50 Juveniles under 18 should not be held in the Isle of Man prison.

HP51 Women should be held in separately-managed accommodation, with facilities and procedures that are specific to their needs.

HP52 The Department of Home Affairs, with other relevant bodies, should consider developing a comprehensive multi-agency strategy for reducing reoffending and providing end-to-end management of offenders during and after imprisonment.

HP53 The prison should develop and implement a resettlement strategy, based upon the assessed needs of its different populations.

Section 1: Arrival in custody

Courts, escorts and transfers

Expected outcomes:
Prisoners travel in safe, decent conditions to and from court and between prisons. During movement the individual needs of prisoners are recognised and given proper attention.

1.1 Prison staff were responsible for court custody, provided the escort service and worked in the prison reception, which enabled good communication. Prisoners were not held in court cells for long periods and escort journeys were short. Some prisoners arrived without a warrant. Information was not available in languages other than English.

1.2 Prison staff provided the escort services and were responsible for court custody, which enabled good communication between the two areas and meant that prisoners were given information about the prison at an early stage. The escort vehicles were in good condition but did not have enough space to store property. Prisoners were handcuffed after a justified risk assessment. Escort staff spoke to prisoners respectfully. No comfort breaks were offered as the journey was just three miles.

1.3 There were few late arrivals and prisoners were held in police cells after 7.30pm. Property and any private cash accompanied the prisoners we saw arriving.

1.4 Some prisoners were being received into the establishment without warrants being issued.

1.5 There were no video link facilities.

Recommendation

1.6 All prisoners should be accompanied by a valid warrant to justify their custody.

First days in custody

Expected outcomes:
Prisoners feel safe on their reception into prison and for the first few days. Their individual needs, both during and after custody, are identified and plans developed to provide help. During induction prisoners are made aware of prison routines, how to access available services and how to cope with imprisonment.

1.7 Reception staff were courteous and the reception area was safe and clean. Holding rooms lacked information and contained only cardboard furniture. First night arrangements were inadequate and prisoners spent their first night in cells that were unfit for purpose. There was no recognised first night centre or induction programme. Those new to the prison were therefore not being told what they needed to know.

Reception

1.8 Escort staff handed all relevant information to reception staff and sensitive information was handled appropriately. There was no vulnerable prisoner strategy but the duty governor was informed of any prisoner requesting protection (see section on vulnerable prisoners). Female prisoners were taken straight to the female unit to go through the reception procedures.

1.9 The reception area was safe and clean. Reception staff were courteous but referred to prisoners by their surnames only. Prisoners were routinely asked if they were new to custody and treated appropriately but those who had been on remand and who returned from court having been convicted were not given an additional interview to determine how the change in status might affect their circumstances. Prisoners expressed disappointment at not having access to someone to speak to in reception about their experience. Prisoners could have a meal at court but only 65% of respondents to our survey had been given something to eat on their first day at the prison. Although a Governor's order had been issued in 2005 regarding procedures to ensure all prisoners were provided with a meal on their first day, it was not clear that this was happening in all cases.

1.10 The holding rooms contained only cardboard furniture. There was little information available and none in languages other than English. New receptions were placed in the segregation unit during patrol periods.

1.11 All prisoners were strip searched appropriately and few complained about the process.

1.12 Prisoners were informed of their telephone and visits entitlements. They could use the reception telephone to make a free call and were also offered a shower. This was confirmed by the majority of respondents to our survey. All prisoners were seen by healthcare and substance-related issues were addressed. Our survey also showed that nearly all prisoners left with a reception pack.

1.13 Prisoners' property was sealed and stored in a secure area. Access was through the application process. A secure lockable cabinet was used to store prisoners' valuables but access to it was not controlled. Prisoners were compensated for any missing property.

1.14 Prisoners being released were given a maximum of only £5 discharge grant (see section on reintegration planning). Only prisoners serving a sentence of over four years were given holdall bags; those serving shorter sentences were given a black plastic bag or a clear HM Prisons bag.

First night

1.15 All documentation was gathered in one file and sent with the prisoner to the wing where they would spend their first night. There was no recognised first night centre and most prisoners went to A wing if spaces were available. The wing manager carried out an initial interview but not in private. The interview included some information relating to a cell-sharing risk assessment. We saw one Polish prisoner with a history of self-harm being placed in the segregation unit for overnight observations. The same prisoner, who spoke very little English, was not offered the opportunity to use a translator. He was then allocated a single cell even though he knew another prisoner on the same unit who could speak Polish.

1.16 The first night cells were dirty and had no internal sanitation or electricity.

1.17 Prisoners were introduced to their personal officer but these officers did not wear name badges. Prisoners were not clear what would happen during their first night. They were given an induction booklet but this was available in English only. Night staff were not sufficiently trained to deal with new receptions. They lacked first aid, fire and suicide prevention training.

1.18 New receptions were told that it might be some weeks before they had any employment. Depending on the association rota, they were not always allowed out of their cell on their first night. Contact with family and friends was also extremely poor as some prisoners had to wait several days for their turn to make a telephone call and this was limited to 10 minutes. The establishment initially had to make all calls on behalf of prisoners and, with the limited number of telephones available, this severely restricted access (see section on contact with family and friends).

Induction

1.19 There was no recognised induction programme, even though 36% of the population had not been in prison before. This left them open to being misinformed about routines by other prisoners. In our survey, only 16% of respondents thought they had had some type of induction and only 7% said they had been told everything they needed to know about the establishment. The brief information sheet was available only in English and did not cover some important areas, such as how to make complaints and applications. The wing manager would carry out an initial interview in the office used by other staff and within hearing of other prisoners.

1.20 Newly arrived prisoners were kept locked up when they should have been occupied by an induction course. No needs assessments were carried out, and offending behaviour needs were not identified at this point. The chaplain and probation staff saw all new receptions but only briefly. No one-to-one interviews took place where prisoners could discuss any issues arising from imprisonment or any thoughts of self-harm or suicide.

Recommendations

1.21 All prisoners should be given a meal on their first day in custody.

1.22 An alternative to cardboard furniture in the holding rooms should be found and relevant information displayed in a range of languages.

1.23 Staff should address prisoners by their first name or title and surname.

1.24 All prisoners should be offered a shower, telephone call and access to a Listener or Samaritan in reception.

1.25 A more robust control system for the reception safe should be introduced and access to it restricted to staff working in the area.

1.26 Newly arrived prisoners should not be held in the segregation unit.

1.27 The accommodation available to newly arrived prisoners should be clean and fit for purpose.

1.28 The wing manager's initial interview should take place in private and should include all elements of a cell-sharing risk assessment. An interpreter should be used when communication is difficult.

1.29 All staff should wear name badges.

1.30 Staff should be properly trained to address the needs of newly arrived prisoners.

1.31 Prisoners being released should be given a non-branded bag for their possessions.

1.32 A comprehensive induction programme should be introduced. This should be delivered by trained staff, include representatives of all relevant agencies and begin the day after reception. Once introduced, its effectiveness should be monitored through prisoner surveys.

1.33 The immediate needs or concerns of new arrivals should be addressed and offending behaviour needs identified.

1.34 The information sheet given to new arrivals should be available in a range of languages and cover all relevant areas.

Section 2: Environment and relationships

Residential units

Expected outcomes:
Prisoners live in a safe, clean and decent environment within which they are encouraged to take personal responsibility for themselves and their possessions.

2.1 The majority of cells had no electricity or integral sanitation. The fabric of the prison was in poor repair and many communal areas were dirty. Prisoners had access to cleaning materials and laundry arrangements were good.

2.2 There were four residential wings (A to D wings) and a segregation unit (see fact page).

2.3 Cells on A wing (adult male) and B wing (young male) had no integral sanitation or electricity. During lock-up, prisoners had to use the cell call button to access the toilets.

2.4 C wing (adult male) offered a better standard of accommodation with integral sanitation and in-cell televisions. The aim was to encourage prisoners to earn a move to this wing through compliance and good behaviour. This was undermined by the absence of any effective incentives and earned privileges scheme. The procedure for getting on to this wing was not transparent and prisoners complained of unfair treatment (see section on incentives and earned privileges).

2.5 D wing (female) held adults and young people in single cells or a dormitory. It was brighter and cleaner than the other wings but, like A and B wings, had no in cell electrics or sanitation.

2.6 The fabric of the prison was in poor condition and much of the accommodation was unfit for purpose. Communal areas were dirty, despite the fact that much of the work available to prisoners was domestic.

2.7 Not all staff were familiar with the governor's order relating to offensive displays. We saw several examples of inappropriate items, much of it extremely graphic, on display throughout the prison, including on the young people's wing and in vulnerable prisoners' cells.

Hygiene, clothing and possessions

2.8 Responses to questions in our survey about access to cleaning materials and showering arrangements were better than the comparators.

2.9 As recommended following our last inspection, arrangements had been put in place to deploy staff to allow prisoners to come out of their cells to use the lavatory and put an end to slopping out. Staff on A and B wings recorded the time each prisoner spent out of cell for this but no one appeared to know why. Staff reported that prisoners sometimes threw parcels of excrement from windows but this did not happen during the inspection.

2.10 Prisoners could wear their own clothes and items were supplied to those who had none. The prison ran a small laundry, which catered adequately for institutional items such as bedding

and towels, and for prisoners' own clothes. We heard no complaints about these arrangements.

2.11 Most prisoners had to eat meals in their cells (see section on catering).

Recommendations

2.12 All cells should have electricity and integral sanitation.

2.13 All areas of the prison should be maintained and kept clean.

2.14 An offensive displays policy should be published regularly to staff and prisoners and should be adhered to throughout the prison.

Housekeeping point

2.15 Staff should stop recording the times that prisoners use the toilets.

Juveniles

2.16 Children of 17 were held in adult prison conditions without any specialist provision. They were unable to access the alternative secure accommodation on the island.

2.17 Eighteen juveniles had been received into the prison in the two years before our inspection. None were present or admitted during the inspection itself, although the police did bring a pregnant 17 year-old with outstanding fines to the prison during the week. She was discharged after her mother had paid the fines.

2.18 The distinctive needs of juveniles were not recognised or met and these young people were subject to exactly the same regime and conditions as 18-20 year-olds. Indeed, in one major respect this younger group was disadvantaged in that they could not move on to enhanced accommodation.

2.19 There were none of the additional protective arrangements that we would have expected for juvenile prisoners. There was no child protection policy or work practice, and social services did not have a profile within the prison. There was no form of advocacy service for this group of young people and, apart from the good quality informal monitoring by staff for all prisoners, nothing more robust to ensure that juveniles were kept safe.

2.20 A five-bed secure unit had been built on the island since our last inspection. We were told that this seldom operated with more than two residents. However, the island's legislation prevented this specialist resource from accommodating 17 year-olds. As a result, children (under international law, all those under 18) continued to be placed in a penal setting when much more appropriate secure accommodation remained unused.

Recommendation

2.21 Children under 18 should not be placed in an adult prison setting.

Women prisoners

2.22 The prison offered accommodation for up to 11 female prisoners including young adults. Only two female prisoners were currently being held but the regime available was extremely poor. There were no specific policies for, or management of, women prisoners.

2.23 D wing offered discrete accommodation for up to 11 female prisoners. There were no policies on how to manage the distinct needs of women prisoners and staff working on the female unit had not received specific training in managing females in custody.

2.24 A pleasant day room and kitchen were available and both were reasonably furnished. There was a television, a DVD player, a computer with limited games, a sewing machine and a small selection of books. There was no incentives and earned privileges scheme for women and, as with juveniles, they could not move on to enhanced accommodation.

2.25 Only two female prisoners, aged 21 and 50, were being held during the inspection. Staff consistently referred to these women as 'girls'. Both women had personal officers and the sensitive and informative comments in their wing files demonstrated that residential staff had a good understanding of their needs and concerns.

2.26 The main frustration for women was the lack of activity. At the time of the inspection, their regime was almost non-existent. Apart from an arts and craft class offered one morning a week, the women said they rarely had the opportunity to leave the unit. What limited regime the women had was undermined by the regime clashes that were evident throughout the prison (see section on activities). We witnessed an example of this when physical education staff arrived to see if the women wanted to use the gym just when they were due to leave for the arts and crafts class. Activities such as education that were available off-wing to male prisoners were usually provided on the unit for the women, adding to the generally claustrophobic atmosphere. This lack of stimulation risked damaging the mental well being of women prisoners.

Recommendations

2.27 There should be distinct policy documents focusing on the needs of female prisoners and covering all areas of life and work within the prison.

2.28 Staff working on the female unit should receive specific training on the distinct needs of women prisoners.

2.29 A suitable daily regime should be offered to women prisoners to ensure they are kept fully occupied throughout the day.

2.30 Staff should not refer to women prisoners as 'girls'.

Staff–prisoner relationships

Expected outcomes:
Prisoners are treated respectfully by staff, throughout the duration of their custodial sentence, and are encouraged to take responsibility for their own actions and decisions. Healthy prisons should demonstrate a well-ordered environment in which the requirements of 'security', 'control' and 'justice' are balanced and in which all members of the prison community are safe and treated with fairness.

2.31 Prisoners generally spoke well of staff and we observed relaxed and courteous exchanges between staff and prisoners. Most prisoners felt staff treated them with respect but some reported negative experiences. There were many examples of staff making particular efforts to help or support prisoners. There was a risk that some relationships could become too comfortable.

2.32 Throughout the inspection, prisoners generally spoke well of staff and told us that most were approachable and helpful. Our survey showed that 71% of prisoners had a member of staff they could turn to for help if they had a problem and 73% said that most staff treated them with respect. The exchanges we observed between staff and prisoners were relaxed and courteous; many prisoners were addressed by their first name and some used first or nicknames when talking to staff. As this was the only prison on the island, some prisoners were inevitably known or even related to prison staff. This situation appeared to be managed sensitively and appropriately.

2.33 From talking to staff and reading their entries in wing history sheets, it was clear that they knew a great deal about the prisoners and their circumstances. We found numerous examples of staff making special efforts to respond to personal crises, to support prisoners who were feeling vulnerable or to manage patiently those demonstrating demanding or difficult behaviour.

2.34 We did not observe any inappropriate behaviour or comment by staff but there was evidence in wing history sheets and prisoners' formal complaints of some thoughtless comments that had or could have caused offence to prisoners. This was reflected in our survey, in which 39% of respondents said they had been victimised (insulted or assaulted) by staff and 29% had experienced insulting remarks made about them, their family or friends. Both of these figures were significantly higher than the comparators. Comments made in our survey also indicated that some prisoners had negative experiences of staff.

2.35 Many prisoners had been in the prison several times and there was a risk that relationships with staff could become too comfortable and undemanding. Overall, prisoners were treated as individuals and staff worked hard to mitigate some poorer aspects of the environment and regime. Consideration needed to be given to the possible impact of the new prison environment (where all prisoners would have their own cell and television) on the dynamic between staff and prisoners.

Recommendations

2.36 The safer custody committee should investigate prisoners' perception of staff victimisation and take any action necessary.

2.37 Staff should challenge as well as support prisoners.

2.38 Managers should anticipate potential changes to dynamic security as a result of the move to the new prison and ensure that appropriate training and guidance is given to staff.

Personal officers

Expected outcome:
Prisoners' relationships with their personal officers are based on mutual respect, high expectations and support.

2.39 The personal officer scheme was well established. Prisoners knew their personal officers and over a third found them helpful. Recording of contact with the prisoner was mostly high quality but there was no evidence of management checks to ensure this was consistent. Personal officer work tended to focus on welfare issues and there were areas of unmet need in terms of purposeful activity and resettlement.

2.40 The personal officer scheme was well established. Prisoners were allocated a personal officer and at least one back-up officer, normally within the first 24 hours of arrival. Personal officers were responsible for introducing themselves to prisoners and for maintaining regular contact to check on their welfare. In our survey, 44% of respondents said they had met their personal officer within the first week and 38% rated their personal officer as helpful or very helpful. Both these figures were significantly better than the comparators.

2.41 The frequency and quality of personal officer entries in prisoners' wing records were among the best we have seen in recent inspections. Most reflected a high level of contact with the prisoner and provided insight into the prisoner and the issues that were currently important to them. Some files were of poorer quality and there was no indication that management checks were made routinely.

2.42 Not all officers had received a copy of the booklet for staff on the role of personal officer. The booklet rightly linked personal officer work with sentence planning and resettlement but little had been done to develop these areas so that the essential links could be made with personal officer work. Prisoners' custody files were held centrally and wing history files did not contain any reference to each prisoner's offending record. Personal officer work tended to centre on day-to-day welfare issues. Motivating prisoners to make the most constructive use of the time in prison and helping them to address their offending behaviour continued to be areas of unmet need.

Recommendations

2.43 Management checks should be put in place to ensure that all personal officers maintain and record their contact with prisoners and that personal officer entries are of consistently good quality.

2.44 Personal officers should provide input and advice on all matters relating to their prisoners, such as labour allocation, incentives and earned privileges, sentence planning and resettlement.

Section 3: Duty of care

Bullying

Expected outcome:
Everyone feels safe from bullying and victimisation (which includes verbal and racial abuse, theft, threats of violence and assault). Active and fair systems to prevent and respond to bullying behaviour are known to staff, prisoners and visitors, and inform all aspects of the regime.

3.1 The prison had no anti-bullying strategy; only a governor's policy statement was available. There had been no staff training and the coordinator had no time set aside to carry out his duties. Over half the population stated that they had felt unsafe but few incidents had been recorded over the last few years. Lack of training was reflected in the way that staff dealt with bullying incidents. No prisoner survey had taken place.

3.2 The principal officer responsible for anti-bullying coordination had no time dedicated to this task. There was no anti-bullying strategy and staff had not been trained in how to deal with incidents. No analysis had taken place to determine any patterns or common places of bullying, nor had there been any survey of prisoners to establish how the prison could be made safer. Prisoners were made aware that bullying was unacceptable during their initial talk but this message was not reinforced throughout sentence.

3.3 Staff did not deal consistently with bullying incidents as they had not been trained or given clear guidance. Victims of bullying were not supported properly and bullies were not offered any programme to challenge their behaviour. The strategy adopted was to move both parties when incidents occurred.

3.4 In our survey, 33% of respondents said they had been victimised, 29% said they had been insulted by other prisoners and 49% had felt unsafe. However, only 16 incidents of bullying had been recorded in the last four years and no prisoners were currently being monitored for bullying. When there was a bullying incident, no separate documentation was opened on either the bully or the victim.

3.5 The safer custody committee met fortnightly and was chaired by the prison governor. Injury to inmate forms (F213s) and unexplained injuries were rarely discussed. There were references to prisoners but management strategies were not discussed. There was no opportunity for victims or bullies to discuss their experiences.

3.6 Prisoners' families and friends were not used as a source of information to help identify those prisoners likely to be bullied, and proven incidents of bullying were not being used to inform preventative measures. Comprehensive records of bullying incidents were not maintained and some staff were unaware of the documentation they were required to complete when discovering a potential bullying incident.

Recommendations

3.7 Support should be offered to victims of bullying and a programme to challenge bullying introduced.

3.8 The establishment should carry out a survey to establish why and where prisoners feel unsafe.

3.9 The safer custody committee should discuss unexplained injuries, F213s and the management of bullies.

3.10 Bullies and victims should be invited to speak to the coordinator about their experiences to support better management of future instances.

3.11 Families and friends should be used as a source of information to help identify prisoners who are likely to be bullied.

3.12 Staff should complete the appropriate documentation when they discover a potential bullying incident.

Self-harm and suicide

Expected outcome:
Prisoners at risk of self-harm or suicide are identified at an early stage, and a care and support plan is drawn up, implemented and monitored. Prisoners who have been identified as vulnerable should be encouraged to participate in all purposeful activity. All staff are aware of and alert to vulnerability issues, and appropriately trained and have access to proper equipment and support.

3.13 There was a comparatively low level of suicides and incidents of self-harm. Resources for managing those identified as at risk were unsatisfactory and support planning was poor. However, staff provided support to individuals. The safer custody committee had no strategy or action plan and there was no cross-referencing of self-harm, bullying or other security information. The suicide prevention coordinator was a prison officer and lacked the necessary authority. There was no Listener scheme. Prisoner access to Samaritans was good but not confidential.

3.14 The last self-inflicted death at the prison had been in 1996 and the number of prisoners placed on self-harm monitoring was comparatively low (31 instances in 2005 and five to date in 2006). Early and supportive interventions by staff (see section on staff-prisoner relationships) may have helped to prevent prisoners from becoming depressed or considering self-harm. However, provision for those who were suicidal or self-harming was very poor. The only area of respite was the segregation unit, which was unsuitable and unacceptable. A small number of prisoners were serious self-harmers and one had been transferred to an English prison.

3.15 Suicide prevention formed part of the safer custody committee but it was not working to any safer custody policy or action plan. Close attention was paid to checking the progress of individual prisoners assessed as at risk of self-harm but the notes of the meetings reflected

little monitoring of trends or cross-referencing between self-harm, bullying and other security intelligence.

3.16 There were no current open self-harm monitoring forms (Folder 5s). We read the last 10 closed files. Compared to the high quality entries in wing history sheets, recording in Folder 5s was inadequate. Some entries, including those of healthcare staff, were illegible and observations rarely reflected any contact with the prisoner. Prisoners were checked at predictable intervals, with gaps of several hours in some cases. Managers had highlighted some of these shortfalls but there was no clear action plan to address them.

3.17 The management of Folder 5s was a linear process, with each member of staff completing their assessment before passing it on to the next. There was no forum at which relevant staff discussed the prisoner and agreed or reviewed an action plan. As a result, the involvement of the prisoner was not always apparent. The decision to close a Folder 5 was made by a single governor and the reason was not always obvious from the file record. The last training for staff in suicide prevention had taken place over 12 months previously and none had yet been scheduled for 2006.

3.18 The suicide prevention coordinator (SPC) was a prison officer, which presented some difficulties in terms of his authority and scope of influence. He was not allocated specific time for his duties but combined them with his general wing duties. He had no deputy but said that other members of the safer custody committee would cover in his absence. He had no dedicated filing space or use of a computer (only staff above the rank of senior officer had access to the prison computer system). The SPC saw all new prisoners and completed a section of the first night documentation. He acted as the liaison point for the local Samaritans.

3.19 A decision had been taken not to introduce a Listener scheme due to the small number of prisoners. Prisoners had access to a Samaritan telephone (use of which was monitored) and to Samaritan volunteers who visited every Tuesday evening and attended at other times in an emergency. There was a formal protocol between the prison and the Samaritans and the Samaritan coordinator attended the safer custody meetings. With no care suites and limited office space, Samaritan volunteers usually had to see prisoners on the main wing or in their cell, both of which were unsatisfactory and compromised confidentiality.

Recommendations

3.20 The management of Folder 5 cases should be reviewed to ensure the delivery of good quality care and support plans including the appropriate involvement of prisoners.

3.21 A care suite large enough to cater for the needs of the population should be made available.

3.22 All staff should be fully trained in suicide prevention.

Race relations

Expected outcomes:
All prisoners experience equality of opportunity in all aspects of prison life, are treated equally and are safe. Diversity is embraced, valued, promoted and respected.

3.23 With no primary race relations legislation on the island, prison managers had not been motivated to develop policy and practice in the areas of race relations or diversity. No infrastructure was in place to promote race equality or manage racist incidents. The lack of monitoring meant managers could not prove that all prisoners received equality of opportunity. An officer had volunteered recently for the role of diversity officer.

3.24 There was no primary race relations legislation in the Isle of Man and there had therefore been no impetus for prison managers to draw up a policy specific to the management of the prison. The prison continued to hold Irish prisoners, who would be considered a minority ethnic group under UK law and prison procedures, and the recent arrival of some foreign national prisoners meant that up to 10% of prisoners were from minority ethnic backgrounds.

3.25 Despite our recommendation in 2001, no race relations officer or equivalent had been appointed and no policy or practice developed. None of the prison staff had attended diversity training and no infrastructure was in place to promote race equality or manage racist incidents. A prison officer had recently volunteered to take on the role of race relations/diversity officer. He was drawing up policies and procedures in his own time based on his experience of working in the English Prison Service. In the absence of any clear strategic direction from managers, it was unclear how emerging policies would be taken forward. There was a risk that the management of diversity would become the task of just one staff member rather than being seen as the duty of all staff and accepted as a corporate responsibility.

3.26 No specific equal opportunities policy or action plan had been developed for the prison. Information about prisoners and staff was not collected to ensure that discrimination was not taking place. In our discussions with prisoners, some expressed the view that Manx prisoners received preferential treatment in some areas. Staff disputed this but had no means of demonstrating equal treatment and challenging such perceptions.

Recommendations

3.27 Race relations and diversity policies and procedures should be developed.

3.28 There should be ethnic monitoring of all key aspects of prison life, and action taken to redress any differential outcomes.

3.29 The diversity officer should be supported by a diversity or race relations management team, receive suitable training and be allocated sufficient time to complete these duties.

Foreign nationals

Expected outcomes:
Prisoners who are foreign nationals should have the same access to all prison facilities as other prisoners. All establishments should be aware of the specific needs that prisoners who are foreign nationals have and implement a distinct strategy, which aims to represent their views and offer peer support.

3.30 In the past, the needs of the small number of foreign national prisoners held in the prison had been managed on an individual basis. At the time of the inspection, there were four Irish prisoners and one Polish prisoner. A few months before the inspection, the prison had started

to receive immigration detainees as there was no specific immigration detention facility. A range of services had quickly been put in place and was now being formalised.

3.31 Historically, the prison had not held a large number of foreign national prisoners and arrangements such as translation services and telephone calls to home countries had therefore been managed on an individual basis. During the inspection, one Polish prisoner received a short prison sentence but, apart from four Irish national prisoners, he was the only foreign national who had been charged with or convicted of a criminal offence.

3.32 In November 2005, a number of Chinese and South African men had arrived at the prison under immigration detention orders. Most had been released within a few weeks but two South African detainees remained. We were told that detainees (referred to as illegal immigrants) were held in prison as the immigration department had no dedicated accommodation in which to hold them pending enquiries about their status or prior to them being excluded from the island. The prison was not a suitable place to hold detainees who had not been charged or convicted of a criminal offence.

3.33 Prison staff had made prompt arrangements to meet the specific needs of these detainees: interpreting services had been used; wing history sheets showed that detainees had early and ongoing contact with the Isle of Man immigration department and their respective embassies or consulates; foreign language newspapers were obtained from local newsagents or specialist outlets in London; those who did not receive visits were given a free 10-minute weekly telephone call and this was recorded in their wing history file.

3.34 For all other purposes, detainees were treated as remand prisoners. The officer who had volunteered to act as diversity/race relations officer (see paragraph 3.24) had acted as personal officer to the five Chinese detainees and was formalising some of the procedures and services that had been set up at short notice. Managers accepted that the management of foreign national prisoners and immigration detainees was in need of development.

Recommendation

3.35 Immigration detainees held solely under administrative powers and who have not been charged with or convicted of criminal offences should not be held in prison.

Family and friends

Expected outcomes:
Prisoners are encouraged to maintain contact with family and friends through regular access to mail, telephones and visits.

3.36 Arrangements to ensure that prisoners could maintain contact with their family and friends were adequate. There were some complaints about how privileged mail was handled and problems with the telephone system. The visits area was very poor but the atmosphere at visits was friendly and relaxed.

Mail

3.37 In our survey, 54% of respondents, higher than the comparator of 45%, said they had problems sending or receiving mail. Prisoners we spoke to complained specifically about privileged correspondence being opened before they received it. Staff acknowledged that privileged mail had sometimes been opened in error and said this happened when letters sent by solicitors were not marked clearly.

Telephones

3.38 The major problem with the telephones was congestion of the lines in the evening caused by the limited number of outside lines available. Calls therefore had to be booked in advance and had to be made through the gate rather than prisoners being allowed to telephone out directly. In our survey, 42% of respondents said they had problems getting access to the telephone. We also received numerous complaints about telephone calls during the inspection, most of which related to prisoners feeling they had no control and calls being cut off abruptly.

Visits

3.39 Convicted prisoners were entitled to have one 45-minute visit a week and applied for these by sending their visitors an order via a wing letterbox. Visitors then had to book the visit in advance by telephone. Remand prisoners were entitled to three 30-minute visits a week, which were booked in the same way. The booking arrangement appeared to work efficiently and we received no complaints about it.

3.40 Double visits, booked via the wing senior officer, were available for family members or friends who did not live on the island. These enabled people who were travelling a long distance to stay over and take visits on two consecutive afternoon periods. Accumulated visits were available to prisoners from the Isle of Man who were serving their sentence in UK establishments. This facility was used about once a year. Similar arrangements were in place for prisoners serving their sentence on the island but this option had never been taken up.

3.41 The visits area had not changed since our last inspection. Although clean and freshly decorated, there were no facilities for visitors apart from a recently installed water cooler and a few children's books and games. The room was extremely small and contained seven tables. The claustrophobic atmosphere and lack of provision made the visiting arrangements entirely unsatisfactory.

3.42 All prisoners received their visits in the same area. This included men who had been convicted of crimes against children, who were placed at a table where they could be closely monitored. One life-sentenced prisoner whose crime had provoked strong feelings among friends and relatives of the victim received visits separately in the E wing corridor where staff were better able to ensure that security was maintained.

3.43 Staff working in the visits area lived in the same community and knew most of the visitors, which meant there was quite a friendly atmosphere in the visits hall. Searching was carried out discreetly and where necessary staff were confident enough to exercise their discretion in a reasonable way.

3.44 The governor had recently introduced a 'surgery' where visitors were invited to meet him at an agreed time to deal with any problems or seek advice. This initiative was clearly advertised in the visits area and we received some feedback that visitors welcomed it.

3.45 There had been 30 closed visits in the first three months of the year. These were held in an extremely small space on E wing. This area was claustrophobic but, unlike the main visits area, there was no toilet for visitors' use.

Recommendations

3.46 Suitable visiting facilities should be provided.

3.47 Prisoners should have access to an efficient telephone system.

3.48 Prisoners should receive privileged mail unopened.

Applications and complaints

Expected outcomes:
Effective application and complaint procedures are in place, are easy to access, easy to use and provide timely responses. Prisoners feel safe from repercussions when using these procedures and are aware of an appeal procedure.

3.49 The primary application and complaint system aimed to resolve issues at the lowest level. Despite this, governors dealt with a comparatively high number of applications each month. Applications were not monitored and the written responses often did not fully address the issue raised. The number of prisoners who said they had been made or encouraged to withdraw a complaint was significantly higher than the comparator.

3.50 Applications and complaints were dealt with as part of the same system. Prisoners who had something they wanted to ask for or complain about were encouraged in the first instance to talk to their personal officer or a member of wing staff. If the matter could not be sorted out at this level, the prisoner completed a general application form that was sent to the wing senior officer and, if necessary, passed to a governor to resolve.

3.51 Over the previous 12 months, an average of 32 applications a month had reached governor level, which was high given the size of the population. Almost a quarter of the 65 completed applications we sampled requested a change of employment or access to the outside sports party. An effective labour allocation process would have rendered these unnecessary. In complex or sensitive cases, the governor usually interviewed the prisoner, although this was rarely reflected in the written response. We found several cases, including allegations against members of staff, where the only recorded response was 'advised'.

3.52 Compared to the comparator of 12%, 40% of prisoners said they had been made or encouraged to withdraw a complaint. We found some complaints against staff which had been withdrawn by prisoners following an interview with a governor. The recording of these investigations and discussions with the prisoner was insufficient to demonstrate if the eventual outcome was appropriate and justifiable. We were pleased to find responses to applications in which managers acknowledged when the prison had been at fault and offered an apology.

Copies of completed application forms were not held centrally and there was no monitoring of applications or the quality of responses.

3.53 Application forms were readily available on all wings but only applications to the Independent Monitoring Board could be submitted confidentially. Guidance to prisoners dated January 2006 explained the use of 'confidential cover' to write direct to the governor but few of the prisoners we spoke to were aware of this option. Several prisoners had taken complaints to the Home Affairs office and to the European Court of Human Rights.

Recommendations

3.54 Prisoners should be able to submit confidential application and complaint forms.

3.55 Routine monitoring of applications should be introduced to identify trends and enable action to be taken to address common sources of complaint. The timeliness and quality of responses should be monitored.

Legal rights

Expected outcomes:
Prisoners are told about their legal rights during induction, and can freely exercise these rights while in prison.

3.56 A legal services officer was based at the court and saw all prisoners when they were committed to custody. She had not been formally trained. Facilities for legal visits were poor but prisoners said gaining access to their legal representative was not a problem.

3.57 A senior officer based at the court was responsible for legal services, although she had not received any formal training. The main court building housed seven court rooms, acting as criminal, family and civil courts. Prisoners were seen at the time of their court hearing and any assistance required was provided almost immediately. Prisoners who required advocates (solicitors) were given a list of possible firms and details of their areas of expertise.

3.58 The legal services senior officer's main role was managing the custody suite at court but she also frequently worked in the prison and prisoners could therefore contact her once they were in custody. No formal record of applications was maintained and no files were kept on the advice given to each prisoner.

3.59 The senior officer had established good working relationships with many of the local advocates and felt able to approach them informally for information and advice.

3.60 Prisoners representing themselves were provided with extra writing materials and could make daily telephone calls to progress their case. There was one such prisoner at the time of our inspection and arrangements for him were good. Prisoners could have an unlimited number of special letters for legal correspondence.

3.61 Legal visits could take place at any time as long as there was space available. The prison had only one professional visits room, which was extremely small and cramped. Advocates were locked in this room with their client and had to telephone staff when they had finished their visit. This was not particularly safe and one advocate had requested that he see one of his

clients in the closed visits facility because he felt uncomfortable with the 'normal' arrangements in that case.

3.62 With the move to the new prison in 2007, discussions were taking place on the possible contracting out of court escorting duties to a private contractor. If this were to be the case, effective safeguards would be required to ensure that an appropriate level of legal rights service could continue to be provided to prisoners.

Recommendations

3.63 The facilities for legal visits should be improved.

3.64 The legal services officer should receive formal training.

3.65 A register of all applications made to the legal services officer should be maintained and the assistance provided recorded.

Section 4: Healthcare

Expected outcomes:
Prisoners should be cared for by a health service that assesses and meets their needs for healthcare while in prison and which promotes continuity of health and social care on release. The standard of healthcare provided is equivalent to that which prisoners could expect to receive in the community.

4.1 Healthcare services were limited and prisoners were not receiving the level of healthcare they could expect to receive in the community. We found little evidence that the prison was meeting its objectives of attending to prisoners' mental and physical well being. Prison health services were not linked to the Isle of Man health service[1]. Despite our previous recommendations, no health needs assessment had been undertaken, there was no clinical management or leadership, no clinical IT system, no evidence of clinical audit and no clinical policies. Women could not see a female doctor, there was no out-of-hours healthcare service, no nurse-led clinics and practically no health promotion. Mental health services provided by the Isle of Man National Health Service were not integrated with the healthcare department. For the vast majority of patients, the administration and in some cases the prescribing of medications was unsafe.

Environment

4.2 The small healthcare department was on the first floor of B wing and inaccessible to anyone with disabilities. One room was used as a general treatment area as well as being where medical sundries were kept and medications were stored and prepared. The dual use of the room was unsatisfactory. Emergency equipment such as a full intubation kit was also stored in the room and there were no recorded checks on any of it. The automated external defibrillator was not in use because only a few staff (and not all healthcare staff) had received the necessary training. The other room was a general office and doctor's surgery. Both rooms had examination couches but offered little privacy. Cleaning, when it occurred, was carried out by healthcare staff. There was no waiting room.

4.3 Medicines in the treatment room were securely stored in locked metal cupboards. Controlled drugs were stored in accordance with safe custody requirements, although the keys to the cupboard were left in the lock during the working day. A separate lockable storeroom within the treatment room was also used for medicine storage. A few medicines for use as special sick, including paracetamol tablets, were stored unsecured on top of the bench.

4.4 The treatment room also contained a fridge. Contrary to professional requirements, this had no thermometer and no records of the fridge temperature were available. The fridge also contained a selection of food used by staff.

4.5 The health promotion material available for prisoners to read was limited to a few posters and leaflets. There was none on any of the wings.

[1] A decision had been taken by the Isle of Man government that health services in the prison would be delivered by the island health services once the new prison opened and preparations for this were underway.

4.6 A television room was used as a station for supplying A wing prisoners with medications through a gated doorway. The room was barren and did not provide a good environment for discussion. No drinking water was available for patients to take their medicine. Medicines for patients on B wing were supplied from the main treatment room through the gated doorway. Prisoners on D wing received their medicines from a separate treatment room on the wing, where medicines were stored unsecured on top of a desk. Medicines for prisoners on C wing and the segregation unit were delivered to the cells.

Staffing

4.7 The department was headed by an acting senior officer who had let his nursing registration lapse some years ago. Two of the three other staff were registered general nurses and one was a paramedic. One of the nurses was female. All considered themselves to be healthcare officers. Registered nurses are accountable for their own practice; such accountability cannot be delegated to unqualified staff without suitable training and assessment of competence. The job descriptions for healthcare staff were vague. None of the staff had clinical supervision and there were no formal arrangements for continuous professional development. For example, staff had not had vaccination training or training in anaphylaxis required to administer vaccinations safely. Only two staff, one of whom was the paramedic, had received resuscitation training in the last 12 months. The paramedic had also delivered this training to some discipline staff. One of the nurses was undertaking a diploma course in substance use by distance learning.

4.8 Healthcare staff were not part of the Isle of Man Nursing & Midwifery Advisory Council, which was chaired by the chief nurse of the island. Nurses' registration details were not checked to ensure that they were registered with the Council and therefore allowed to practise as registered nurses. We checked both the nurses' registration details and found them to be in date.

4.9 Healthcare staff provided services from 8am until 9pm daily. Two staff were on duty during the core day on weekdays but only one at weekends. Discipline staff said they would contact healthcare staff at night if necessary but there were no formal on call arrangements and healthcare staff only undertook the task out of goodwill.

4.10 Two male general practitioners (GPs) were contracted to provide a daily clinic on weekdays. They were on call from 8am to 6pm during the week but there were no arrangements for out-of-hours cover at night or during the weekends.

4.11 The pharmacy service provided by a local community pharmacy was little more than a supply service. The arrangement appeared informal and there was no service level agreement in place. The pharmacist attended the bi-monthly drug strategy committee meetings but did not routinely visit the prison or have any contact with patients.

4.12 The Isle of Man medicines and therapeutics committee, chaired by one of the GPs who attended the prison, had devised a medications formulary that was by default used at the prison. The committee carried out audit of prescribed medication usage across the island but information about prescribing patterns was not shared with the prison.

4.13 No allied health professionals visited the prison, although there were some informal arrangements for district nurses or other nurse specialists to visit if requested by healthcare staff.

Records

4.14 Clinical records were stored in the GP surgery/general office. Most entries in the notes were poor, not timed and illegible. There were no care plans and no evidence of liaison with other prison staff such as the safer custody officer. Substance use clinical notes were filed separately from the clinical notes and there was no system to amalgamate them with the main clinical record at any time.

4.15 Most old clinical records were also stored in the GP surgery and were used if a prisoner returned to the prison. The notes of any prisoners considered by healthcare staff unlikely to return were sent for secure storage.

4.16 Medication administration charts for each wing were stored in folders in the treatment room. The charts, one for each patient, were used to manage and record medicine supplies. Contrary to Royal Pharmaceutical Society (Great Britain) guidance, the pharmacy supplied duplicate labels for dispensed medicines. Healthcare staff attached these duplicate labels to the administration charts and each administration of medicine was recorded adjacent to the corresponding label.

4.17 Staff admitted that the administration charts were not always filled in at the time of supply due to the lack of space in the treatment room. Supplies from the remote medication rooms were recorded at the time of preparation of the medication rather than at the time of supply because administration charts were not taken to the remote rooms. This increased the risk of administration error and could have resulted in inaccurate records. No acceptable records were made for special sick supplies. There was no system for recording medication errors or interventions. The most recent reference source available in the healthcare centre was a British National Formulary from March 2004.

4.18 National Health Service prescription forms issued were faxed to the pharmacy by healthcare staff to authorise dispensing. The pharmacy then delivered the dispensed medicines to the prison on the same day and collected the original prescription forms. The prescriptions were hand written as no clinical IT system was available at the prison. Furthermore, only the senior officer had access to the intranet system used in the prison.

4.19 The few formal clinical policies that did exist were poorly written. There was no consistency and no system for them to be reviewed. We also found examples where policies that did exist were not adhered to. The prison did not have a clinical governance policy to ensure quality of patient care. There was no policy for obtaining patient consent for treatment or procedures, although the reception screening paperwork included consent for healthcare staff to get a prisoner's previous medical records from their GP or other healthcare professionals.

4.20 Few statistics about healthcare were kept and those that were kept by the acting senior officer were not routinely shared with anyone. There was no health needs assessment or health delivery plan.

Delivery of care

4.21 New arrivals were seen within 30 minutes by a member of the healthcare team. The reception screening paperwork was relatively comprehensive. Hepatitis B vaccinations and other health promotion services were not routinely offered. Staff said that patients could ask if they wanted anything but it was unclear how prisoners knew this. The prisoner handbook gave only brief

information about healthcare services, such as how to report sick. The published wing routines did not even mention the times that medications were available.

4.22 The doctor undertook a daily clinic, for which there was no waiting list. Prisoners posted a completed application form in a confidential box on each wing and were then collected by a member of healthcare staff when the doctor arrived. Healthcare staff did not use any formal triage algorithms but said that they would deal with a prisoner's problems themselves if they thought they could. The doctor had no specific time to do his clinic but tended to arrive at lunchtime.

4.23 Female prisoners were seen in the small medical room on D wing. They did not have easy access to a female GP. The two women we met said this had not been an issue for them but acknowledged that other women may prefer to see a female doctor. The prison handbook stated that prisoners could request to see a female member of healthcare staff rather than a GP specifically. We were assured that it might be possible to arrange for a prisoner to see a female GP if requested but this was not part of the GP contract.

4.24 Prisoners in segregation could see the GP by using the same application system as prisoners in the main prison. The GP saw them in their cells.

4.25 There were no primary care clinics or any registers for life-long conditions. While national service frameworks and National Institute of Clinical Excellence guidance were adopted by the Isle of Man National Health Service, prison healthcare staff were not aware of them and did not follow them except when the GP took them into consideration when treating a patient. Healthcare staff appeared not to understand the concept of ensuring that evidence-based practice was used to plan patient care.

4.26 There were no health promotion clinics such as well man or well woman clinics. Smoking cessation aids were available but smoking cessation counselling was not offered, although some prison officers were about to undertake smoking cessation training. There was no policy for issuing condoms to prisoners, either in the prison or on release. Staff told us that no one had ever requested them.

4.27 Prisoners requiring ante-natal care were visited by a community midwife and the GP would be involved in their shared care.

4.28 Dispensed medicines were received at the prison appropriately labelled by the pharmacy for the named patients. The normal practice was for these medicines to be put in baskets labelled with the name of the individual prisoner. Once a week, healthcare staff transferred the medicines from their original containers to weekly medicine dosage supply cassettes labelled only with the patient's name. Every day, the medicines were taken out of the cassette and put in small plastic pots, again labelled only with the patient's name. At this stage, staff signed the patient administration record to indicate that the patient had taken the medication when this was clearly not the case. The pots of medications were then used to administer the tablets. This was unnecessary and unlawful. It involved secondary dispensing, which was outside the authority of the nurses and the other healthcare staff and contrary to Nursing & Midwifery Advisory Council guidance. It also introduced two additional stages into the process, which increased the risk of error. Storing medicines in containers bearing only the name of the patient was also contrary to Medicines Act labelling requirements and increased the risk of error or adverse incident.

4.29 We witnessed medicines being given to prisoners by registered nurses and unqualified staff. The latter had received no local training, which was also contrary to Nursing & Midwifery Advisory Council guidance.

4.30 Patients could obtain their medicines twice a day during daily treatment times, the timing of which varied from wing to wing. Patients requiring more frequent doses or a night-time dose were given these loose (without a container) to save until later. Queues for medications were not supervised by discipline staff and prisoners therefore had ample opportunity to swap their medications or bully others into handing them over. In our survey, prisoners said that prescribed medications were sold or used to barter with other prisoners. During the inspection, one patient reported to healthcare that he had lost his Diazepam 10mg tablets during a gym session. He said the two loose tablets had been in his pocket and must have fallen out.

4.31 Methadone mixture and subutex tablets were dispensed by the pharmacy for named patients and daily supplies were administered by healthcare staff from the dispensed packs. A controlled drug register was maintained for these medicines but was used only to record the dispensed medicines received from the pharmacy, with administration charts providing the only record of supplies to the patient.

4.32 There was no formal in-possession policy. Most medicines were administered to patients by healthcare staff but a few were given in-possession at their discretion. Such medicines tended to be creams or inhalers and occasionally a course of antibiotics. Prisoners on C wing were given their medicines in-possession as a privilege associated with being on this wing. These were supplied in the packs dispensed by the pharmacy in two week quantities. No risk assessments were undertaken to determine whether in-possession medication was appropriate for individual prisoners. Patient information leaflets (PILs) were provided with most in-possession medicines but not otherwise.

4.33 No medicines were available for purchase by prisoners and there was no access to any medicines, including paracetamol, when the healthcare centre was closed. There was no formal special sick policy. A number of medicines were available for supply by healthcare staff for treatment of minor ailments such as headache or indigestion. No agreed list of these 'special sick' medicines existed and it appeared that all healthcare staff had absolute discretion as to which medicines could be supplied. Supplies of these medicines appeared to be limited to simple remedies such as paracetamol, aspirin, lactulose and linctus.

4.34 Arrangements were in place to enable healthcare staff to supply stilnoct (a prescription-only medicine) in the absence of a doctor. This allowed staff, at their discretion, to supply one or two tablets as a single dose at night to any prisoner complaining of sleeplessness. The supply was recorded in a book and apparently reported to the doctor on his next visit. The doctor was supposed to record the supply on the front of the administration chart but that did not seem to happen. Supplies were intended to be for one-off situations but this appeared to be flexible and the records showed that a number of prisoners had received several doses. A simple protocol was in place but it was not sufficiently robust and did not meet the criteria necessary for a patient group directive.

4.35 A similar arrangement was in place to allow healthcare staff, at their discretion, to initiate detoxification regimes involving administration of chlordiazepoxide or dihydrocodine (both prescription-only medicines) for new prisoners believed to be suffering withdrawal symptoms. The supplies were recorded and reported to the doctor, who then retrospectively authorised the treatment. There had been occasions when the doctor had deemed the treatment regime inappropriate and terminated it. The simple protocol in place did not meet the requirements of a patient group directive and the system did not appear to be subject to audit.

4.36 Other than the usual checks undertaken during dispensing, the pharmacist did not carry out reviews of prescribed medication. No formulary was available and there were no systems for clinical review of medication by the pharmacist or audit of medicines liable to abuse or inappropriate supply. In the first three months of 2006, there had been three security finds of prescription medications during cell searches, including one of 72 diazepam tablets; none had been prescribed to the prisoner found to have them in their possession.

4.37 Prisoners who needed to see the dentist were taken out to a private dentist. There were two appointments each Wednesday and Thursday afternoon. During the inspection, eight prisoners were waiting for appointments, although three had appointments booked. Out-of-hours appointments could be arranged but at extra cost to the prison.

4.38 Prisoners were taken to Nobles hospital for out-patient appointments, including physiotherapy, genito-urinary medicine and all secondary care. They were risk assessed by security staff before they went but all were accompanied by at least one officer. Appointments were never cancelled. There had been 168 hospital escorts in 2005 excluding bed watches but including one appointment in England and seven pre-admission appointments (an appointment where nursing staff assess a patient prior to surgery).

4.39 Prisoners on medication leaving the prison were given at least a week's worth to take home. A letter detailing the medications prescribed was also faxed to their GP. Healthcare staff made GP appointments for prisoners who had a GP.

Mental health

4.40 Mental health services were poor and there was little communication between healthcare staff at the prison and mental health services in the community. Any arrangements by community staff to see prisoners were made through the probation team or directly with the unit where the prisoner was located. Healthcare staff were therefore unaware of any such appointments. Community mental health care staff described difficulties in liaising with the healthcare team, incidents of advice being ignored and a lack of cooperation. There were no formal protocols regarding referrals, information-sharing or services provided.

4.41 No registered mental health nurses worked at the prison. Prisoners with primary mental health problems were seen by the GP. Counselling services were limited: prisoners could be referred to Cruse, Relate or the Samaritans but generic counselling was not available. Community mental health staff said that generic counselling services had been withdrawn from the prison some time ago amid fears for a counsellor's safety. The concerns appeared not to have been acknowledged by prison managers and the counselling service had therefore ceased.

4.42 Anti-depressant and sedative medication appeared to be over-prescribed. We spoke to several prisoners who appeared to be over-medicated.

4.43 The clinical psychiatrist did not provide regular sessions to the prison but would see prisoners on the rare occasions they were referred by the GP. He did, however, visit the prison to see prisoners for court and legal reports but these reports were not shared with the healthcare team. We found one example of a prisoner subject to a Folder 5 (self-harm monitoring) where healthcare staff had indicated in the paperwork that he had been referred to psychiatry services, inferring that the psychiatrist would be able to provide information to the safer custody team looking after him. In reality, the prisoner was being seen by the psychiatrist for a court report, so the information was never shared with prison staff apart from a brief entry in his clinical records to indicate that he had been seen.

4.44 Mental health staff did not routinely write in either the prisoner's wing file or clinical record, so there was no contemporaneous record of care given. While the care programme approach (CPA) was not formally used on the Isle of Man, the principles were adhered to on the island. However, no prisoners had a CPA package.

4.45 A psychiatrist from the drugs and alcohol team saw prisoners who were receiving maintenance therapy (see section on substance use).

Recommendations

4.46 The prison healthcare team should adopt and adhere to the Isle of Man National Health Service hospital clinical governance strategy, to provide a framework for ensuring the delivery of high quality healthcare to prisoners.

4.47 Healthcare staff should familiarise themselves with national service frameworks, National Institute of Clinical Excellence guidance and other sources of evidence-based practice in order to ensure that prisoners receive the same level of healthcare as they would in the community.

4.48 Healthcare staff should be formal members of the Isle of Man Nursing & Midwifery Advisory Council.

4.49 All staff who work in the healthcare department should be deemed competent to do so.

4.50 There should be a formal system for checking nurses' professional registrations annually.

4.51 There should a review of emergency resuscitation equipment to ensure that relevant equipment is available for use at all times by trained staff. Such equipment should be subject to regular, auditable checks.

4.52 Clinical records should be timed, dated, signed and legible. All records (including medication administration records) should be contemporaneous and clinical records should contain comprehensive information about patients from all healthcare professionals involved in their care.

4.53 The few clinical policies that exist should be reviewed and policies to cover the range of practices undertaken should be devised.

4.54 All staff should have formal clinical supervision and continual professional development. Training should include resuscitation skills and immunisation and vaccination updates annually.

4.55 Female prisoners should have easy access to a female GP.

4.56 Healthcare staff should use formal triage algorithms to assess patients.

4.57 Dispensed medicines should remain in the containers supplied by the pharmacy and should not be repackaged at the prison.

4.58 The supply of duplicate dispensing labels for attachment to administration charts is contrary to Royal Pharmaceutical Society (Great Britain) guidelines and should stop.

Administration charts should be produced at the pharmacy in accordance with prescriptions dispensed.

4.59 Administration charts should be referred to and filled in at the time that the medicine is administered or supplied. Facilities should be available to allow this to happen. Omits should be recorded.

4.60 Patients should not be given loose medication to be taken at a later time. The number of daily treatment times should be increased to enable patients to access their medication at the necessary times and drinking water should be available to the patient at the time of administration.

4.61 A formal special sick policy should be introduced and medicines suitable for supply by healthcare staff should be clearly defined. Prescription medicines and prescription-only medicines should not be included in the special sick formulary. Patient group directives should be devised and approved by the Isle of Man National Health Service before implementation.

4.62 Controlled drug records in use at the prison should serve the purpose of providing a transparent audit trail, so that the use of controlled drugs can be easily monitored and cupboard stock can be easily reconciled.

4.63 A clear in-possession policy should be developed to allow medicines in use to be held in possession by all prisoners unless contra-indicated by a documented risk assessment carried out on an individual basis.

4.64 The pharmacist should be encouraged to take a more active role in the provision of pharmacy services at the prison. This should include direct contact with prisoners, clinical medication reviews and audit of medicines liable to abuse.

4.65 The island medicines and therapeutics committee medications formulary should be formally recognised for use in the prison.

4.66 A clinical IT system should be provided to enable clinical audit, computer-generated prescriptions and better access to patient medical records.

4.67 Mental health services should be developed to ensure continuity of care between community and prison. There should be a formal service level agreement and clear protocols regarding referrals, information-sharing and the care programme approach to ensure that patient care is not compromised.

4.68 A maximum/minimum thermometer should be obtained for the medicines fridge, which should be used only to store medicines. Daily records of maximum and minimum temperatures should be maintained, the thermometer should be reset after each reading and the regulator adjusted when necessary to maintain the temperature within the range 2 to 8 Celsius.

4.69 Keys to medicine cupboards should be held by the person in charge of the department at all times and not left in locks.

4.70 All medicines should be held securely at all times.

Housekeeping points

4.71 The couches in healthcare where patients are examined should be shielded by privacy screens.

4.72 Health promotion materials should be made freely available to prisoners.

4.73 Patient information leaflets should be supplied with medication wherever possible. Notices should be prominently displayed to advise patients of the availability of leaflets on request.

4.74 Current editions of all required reference books should be available at the prison.

Good practice

4.75 *The arrangements made by healthcare staff for prisoners on release, such as making GP appointments, promoted continuity of care for prisoners.*

Section 5: Activities

Education and library provision

Expected outcomes:
Education provision meets the requirements of the Common Inspection Framework (separately inspected by Ofsted and ALI). Prisoners are encouraged and enabled to learn both during and after sentence, as part of training and sentence planning and have access to good library facilities.

5.1 Provision for education was poor. There was no culture to promote the value of education and prison managers did not regard it as a priority. Day-to-day delivery was hampered by scheduling problems, resulting in resources being wasted. The library was a poor resource and provided a limited service.

5.2 The education contract was with the Isle of Man College. The education manager was based at the college and, as specified in the service level agreement, worked six hours a week for the prison. She was responsible for maintaining the quality of the staff and curriculum. She also liaised with the examination boards, planned and oversaw the timetabling and carried out the initial assessments of new students. She was assisted by a prison education officer who had three days a week dedicated to this task. The education officer was responsible for the day-to-day running of education as well as the advertising and promotion of classes. She also oversaw the library and dealt with any immediate problems experienced by tutors. Agreement had been reached with the college that the education manager would be based full-time at the prison from September 2006 while still being an integral part of the college structure and systems. To strengthen the overall management arrangements, the governor had decided that the education manager should become a member of the senior management team, and to increase the time allocated to the education officer.

5.3 No full-time education was available for prisoners. According to data supplied by the establishment, 46% of prisoners were involved in some form of part-time education. The average class size was six. Teaching took place in two portacabins, one of which was quite well equipped with computers, though the classrooms were very cramped. A range of vocational, non-vocational and recreational classes was run, with a total of 7,000 prisoner hours taught in 2004/05.

5.4 Educational assessments were carried out only on prisoners sentenced to more than three months, which meant that those serving short-term sentences were unlikely to get any education. The initial assessments were used to help place students in appropriate classes. However, documentation was rudimentary and no comparator information was being maintained so it was difficult to determine if the overall delivery of education was improving.

5.5 Classes were allocated on a week-to-week basis and the education officer visited all residential areas daily in an attempt to make sure that the published timetable was followed. This was difficult because there were regular and quite serious scheduling problems caused by the lack of coordinated management of education, work and regimes. During the inspection, a college tutor had to be cancelled when the class could not take place because a visiting probation officer had been allocated the only room available. We were told that situations like this were not unusual and therefore resources were often wasted. Further problems with the

timetable included prisoners being taken to visits or the gym when they should have been at a class.

5.6 These difficulties were exacerbated by a limited timetable, which operated only from 10am to noon and from 2pm to 4pm. The times were further restricted for female prisoners, who had their lunch at 11.30am.

5.7 Unless a prisoner was unemployed, there was no financial incentive to attend education. Workers were generally on a much higher rate of pay and did not earn any extra if they attended classes.

Library

5.8 The library was run by the part-time education officer (see paragraph 5.2) who, while diligent, had received no specialist training and had very little spare time to allocate to the library. She was assisted by a prison orderly.

5.9 Access to the library was advertised on posters displayed on the units. These said that prisoners could attend the library once a week but this was not always the case as sessions were cancelled if the education officer or library orderly was unavailable. Only 23% of respondents to our survey said they had access to the library at least once a week.

5.10 Prisoners on E wing were particularly disadvantaged as they could not visit the library and instead had to select books from a list.

5.11 The library was located in the same space as the chapel. Books were kept in locked metal cabinets and the atmosphere was sterile. We saw little evidence of prisoners remaining in the library after they had selected their books.

5.12 The library stock mainly comprised fiction books. It was changed every three months when the island mobile library would recycle 400 books. There were few talking books and little material in languages other than English.

Recommendations

5.13 The education manager should be a permanent member of the senior management team.

5.14 The governor should carry out a review of the education service, paying particular attention to assessments and scheduling. An action plan should be produced and the education manager given the authority to implement it.

5.15 Prisoners should be actively encouraged to attend education.

5.16 The timetabling of activities should be reviewed to eliminate regime clashes.

5.17 The wage structure should not unfairly disadvantage prisoners in education.

5.18 The education officer should ensure that the library service is improved.

5.19 Wing staff should ensure that all prisoners get the opportunity to attend the library once a week.

5.20 The library stock should be extended to include talking books and material in languages other than English.

Work

Expected outcomes:
Prisoners are engaged in safe work and are treated fairly. Work should prepare prisoners for employment on release and help to reduce offending.

5.21 No vocational training opportunities were available. The only work carried out by prisoners was being done to service the establishment. Allocation of work places was not always done fairly and no single manager had overall responsibility for this area.

5.22 Most of the work taking place in the prison involved prisoners carrying out routine domestic activities. This was essentially to ensure that the prison was kept clean and sufficient food was being prepared. Prisoners were not given the opportunity to undertake vocational training.

5.23 Work places were allocated by wing managers rather than being managed centrally. The process involved prisoners being invited to place their name against a list of jobs. They were then offered a job when one became available. Prisoners who were familiar with the system had an unfair advantage. Experienced prisoners, for example, would express a preference to work in the kitchen, knowing that this would automatically permit them to move to the enhanced accommodation on C wing.

5.24 There were 11 work places in the kitchen and laundry. A further three or four posts were intermittently available in the trades department where prisoners could assist with plumbing or work with an electrician. All other work involved domestic cleaning. No accredited training was available, although some planning had been carried out to introduce this for kitchen workers and cleaners.

Recommendations

5.25 A senior manager should be allocated responsibility for the overall provision and management of work.

5.26 The number of work placements should be increased and the quality improved.

Physical education and health promotion

Expected outcomes:
Physical education and facilities meet the requirements of the common inspection framework used by Ofsted and the Adult Learning Inspectorate (separately inspected by ALI). Prisoners are also encouraged and enabled to take part in recreational PE, in safe and decent surroundings.

5.27 Physical education facilities were barely adequate. The small enthusiastic physical education team made best use of the limited resources.

5.28 The physical education (PE) department comprised one senior officer and two officers. These staff were currently rostered to work evening shifts twice a week, carrying out general duties on the wings, but this was due to change in April 2006 when they would work solely within their own rota.

5.29 The gym comprised a small, reasonably well-equipped weights and conditioning room. There was no hall or outdoor facility.

5.30 The published schedule allowed prisoners to attend the conditioning room on most days. PE staff were pro-active in seeking out prisoners to attend sessions, sometimes to the detriment of other scheduled activities (see section on education). In our survey, 64% of respondents, against a comparator of 32%, said they could access the gym at least twice a week.

5.31 Gym staff tried to gear activities to the different groups of prisoners, such as organising circuit training for young adults and aerobic exercises for women.

5.32 Weekly trips were organised to the local sports centre where up to eight prisoners participated in organised games. The head of security determined who was granted this opportunity, based on his own risk assessment. A number of prisoners complained about how such decisions were made.

5.33 The showering arrangements in the gym were adequate. Records were maintained of all accidents and there had been only one in the last six months.

5.34 A number of prisoners had completed a level 1 Football Association coaching certificate and the senior officer was due to undertake a course that would enable him to deliver training in weightlifting.

Recommendation

5.35 There should be a transparent and fair allocation system for trips to the sports centre.

Faith and religious activity

Expected outcomes:
All prisoners are able to practise their religion fully and in safety. The chaplaincy plays a full part in the life of the establishment and contributes to the overall care, support and resettlement of prisoners.

5.36 The overall arrangements for meeting the religious needs of mainstream prisoners were adequate but only ad hoc arrangements existed for prisoners on E wing, women prisoners and non-Christian prisoners. The chapel was a very poor facility.

5.37 The chaplaincy team comprised three part-time representatives of the Methodist, Anglican and Catholic churches. It was led by a Catholic priest and met as a group every month. The team also had quarterly meetings with the governor. Each chaplain carried keys and told us they felt integrated into the establishment and well supported by prison staff.

5.38 One of the chaplains attended the prison each day. The chaplains had access to the local inmate database system and used this information to make sure they met new prisoners within

48 hours of arrival. They also visited each of the residential areas daily, including the segregation unit. In our survey, just over 50% of respondents, similar to the comparator, said they could speak to a member of their religious faith if they wanted to. We also received a number of unsolicited comments about how accessible and helpful the chaplains were.

5.39 Commitments in the community meant that the chaplains could not conduct Sunday services in the prison. Instead, three short inter-faith services were held each Saturday for prisoners on A, B and C wings. Only about four or five prisoners attended each service. There were no routine services for segregated, vulnerable or female prisoners, although special arrangements could be made on request. A special service, for example, had been organised in the prison to coincide with the funeral of a friend of one of the women prisoners. The prisoner concerned had requested permission to attend the funeral but the governor had decided against it. Such special arrangements were, however, rare.

5.40 The chapel was in extremely poor condition. It was badly decorated, sparsely furnished, doubled as the library and was often used for other purposes. Its location between A and B wings meant that access for women and vulnerable prisoners was difficult to organise and in practice these groups never used it. As it was not a dedicated area, it could not provide a calm atmosphere and quiet space to worship. In our survey, only 31% of respondents said their religious beliefs were respected.

5.41 We were told that the vast majority of prisoners were Christian and that arrangements could be made if any non-Christian prisoner requested to see a religious leader from their own faith. We spoke to the only Muslim prisoner currently held at the prison, who was generally content because he had been issued with a Koran, a prayer mat and a prayer hat. He did, however, say that he would have welcomed some contact with an Imam but was unsure how to go about this. The onus appeared to be on the prisoner.

Recommendations

5.42 All prisoners should have access to regular religious services.

5.43 The religious needs of non-Christian prisoners should be actively addressed.

5.44 There should be suitable accommodation within the new prison to cater for the religious needs of all prisoners.

Time out of cell

Expected outcomes:
All prisoners are actively encouraged to engage in out of cell activities, and the establishment offers a timetable of regular and varied extra-mural activities.

5.45 While enhanced prisoners on C wing usually spent at least 10 hours out of their cell each day, the regime for other prisoners was poorer and some were unlocked for only two or three hours. Wing routines were published and adhered to and the weekend regime was comparable to that during the week. Association facilities were limited and prisoners reported high boredom levels. The exercise yard was inadequate and uninviting. The whole prison was shut down once a month for staff training but the need for this was unclear.

5.46 In our survey, 19% of respondents, significantly higher than the comparators of 9% (weekdays) and 5% (weekends), said they spent 10 or more hours out of their cells during the week and at weekends. The enhanced regime on C wing almost certainly accounted for the majority of these prisoners. The time out of cell experienced by prisoners on other wings was substantially lower than 10 hours and for some amounted to only two or three hours.

5.47 There was little for prisoners to do when unlocked and they recorded high levels of boredom. The opportunities for vulnerable and female prisoners were particularly impoverished.

5.48 Wing routines were displayed on notice boards and prisoners confirmed that they were usually adhered to. The weekend regime was not severely restricted, with prisoners offered an hour's exercise and association, including evening association. In surveys, 61% of respondents, significantly higher than the comparator of 40%, said they went on association more than five times a week. Prisoners on A wing complained that association there was split so that only one landing was unlocked at a time (either in the afternoon or the evening).

5.49 The exercise yard was bland and uninviting with no seating or access to toilets. It was small and some prisoners described it as claustrophobic and overly institutional. Only a third of respondents to our survey said they went on exercise three or more times a week.

5.50 As at our last inspection, the whole prison was shut down for staff training on one day every month. Given that only control and restraint training had been delivered in the previous year, this appeared too restrictive.

Recommendations

5.51 All prisoners should spend at least 10 hours out of their cell, except in exceptional circumstances.

5.52 The range and quality of out of cell activities should be improved.

5.53 Arrangements for staff training should not involve a total shutdown of the prison.

Section 6: Good order

Security and rules

Expected outcomes:
Security and good order are maintained through positive relationships between staff and prisoners based on mutual respect as well as attention to physical and procedural matters. Rules and routines are well-publicised, proportionate, fair and encourage responsible behaviour. Categorisation and allocation procedures are based on assessment of a young person's risks and needs; and are clearly explained, fairly applied and routinely reviewed.

6.1 Security measures were broadly appropriate and rules were not excessively applied. The security department was not well staffed and needed additional resources. Information was well managed and there were systems to exchange intelligence with the police. The policies to prevent drugs from coming in were balanced and closed visits were reviewed. There was no formal process of categorisation except to determine the number of staff required to escort them outside the prison. Night arrangements were unsafe. One category A prisoner was being held during the inspection, although the procedures behind this decision were not clear.

6.2 The security department comprised one member of staff and there was no cover in his absence. Events and incidents could pile up, which was frustrating and inefficient for the post-holder and the prison. Information submitted was entered on the security intelligence computerised system and there was analysis on a four-by-four system. A police liaison officer visited weekly and good relationships with the police ensured that relevant intelligence could be passed on.

6.3 Security intelligence relating to bullying was redirected but not appropriately acted on (see section on bullying).

6.4 There had been occasions when the security department had had to deal with staff corruption issues and there were procedures in place to handle these difficult issues confidentially. The prison also sometimes held prisoners who were closely related to staff members and had made arrangements to manage the situation.

6.5 Closed visits were normally imposed following a positive mandatory drugs test and were reviewed monthly. Individual visitors found to be in possession of drugs were normally placed on closed visits but other visitors to the same prisoner were not automatically restricted. No visitors were barred from visiting during the inspection.

6.6 The prison rules were not excessive and the adjudication record showed that petty infringements of the rules did not immediately lead to adjudication.

6.7 During our night visit, we observed prisoners being unlocked to use the toilet by staff who had in their possession keys to other cells and other parts of the prison. Night staff also lacked training in some essential areas, such as suicide prevention, fire training and first aid. Some night staff could not tell us where to locate some vital healthcare equipment.

Categorisation

6.8 As the only prison on the Isle of Man, the establishment held all categories of prisoner, including women, young adults, 17 year-olds and, at the time of our inspection, one category A prisoner. Security recategorisation did not take place. Prisoners were categorised as to how many staff, from one to three, they would require to escort them to court or hospital. This was determined by the head of security every month. Two prisoners had been authorised to work outside the prison unsupervised.

6.9 The prison was holding one life-sentenced prisoner in the segregation unit under category A conditions. This prisoner had been held in the unit for over 18 months and had an extremely limited regime. No interventions were taking place to reduce his risk or even to ensure that his risk was not increasing.

6.10 He had been categorised as category A following a discussion with the Lifer Unit in London regarding his possible transfer to a prison in England and Wales. However, there was no paperwork in his prison file to demonstrate that a formal multidisciplinary and multi-agency review had been held before the decision to increase his security categorisation had been taken. While he undoubtedly posed a serious risk, not least because of his index offence, the decision to categorise him as a category A and therefore subject him to all the limitations associated with this were not transparent.

Recommendations

6.11 Absences of the security department manager should be covered by a trained substitute.

6.12 Staff should be trained to the required standard to ensure prisoners' safety at all times, especially at night.

6.13 Keys should be secured before prisoners are allowed to use the toilet facilities.

6.14 A formal process to categorise prisoners as high or exceptional risk should be introduced.

Discipline

Expected outcomes:
Disciplinary procedures are applied fairly and for good reason. Prisoners understand why they are being disciplined and can appeal against any sanctions imposed on them.

6.15 Segregated accommodation was clean and tidy. Two prisoners were held there during the inspection. The accommodation was also used to house new receptions and prisoners who had self-harmed. There were few adjudications and awards were consistent. Special cells had also been used to house self-harmers. Some prisoners remained in segregation for extended periods.

6.16 The segregated accommodation was on E wing. There were six ordinary cells and two special cells, one of which was covered by closed-circuit television. All were clean and tidy but equipped only with cardboard furniture. There was no adjudication room and adjudications were held in a corridor outside the special cells.

6.17 We were able to observe only one adjudication. The prisoner was issued his notice of report immediately before the adjudication was about to begin and so had no opportunity to prepare his answer to the charge. He had not been examined by a member of healthcare staff and his fitness to undergo cellular confinement should it be awarded had therefore not been determined. He was not advised of his rights to appeal or how to do so. Throughout the adjudication, he was referred to by surname only. Records of other adjudications showed a better approach.

6.18 In the previous year, only three adjudications had been referred to the Board of Visitors, who retained the right to add days for offences committed in the prison. Even offences of testing positive for mandatory drugs tests were routinely dealt with by one of the adjudicating governors. The usual award was a combination of loss of earnings and a period of cellular confinement. Prisoners who tested positive were routinely restricted to closed visits for three months and could well have seen this as an adjudication award rather than as an administrative matter separately reviewed.

6.19 Under custody rule 39, the segregation of prisoners for reasons of good order or discipline beyond five days required the authority of the Board of Visitors. Local forms had been devised to record the signature of the Board member authorising segregation but some that we saw had not been signed within the required time.

6.20 The two prisoners being held in segregation during the inspection were allowed showers, telephone calls and daily outdoor exercise. There were also opportunities to 'associate', which in practice mostly meant watching television or using a computer game on their own.

6.21 Segregated accommodation and the special cells were used for the management of prisoners who were self-harming and to accommodate new receptions during patrol periods. One prisoner who had self-harmed had recently been held in the special cell for over two weeks. This was unacceptable. Concepts like constant watch, permanent staff interaction or provision of a television in a cell to provide distraction had not been exhausted before use of the segregated option. This demonstrated a lack of imagination and a punitive approach towards prisoners in crisis that was at odds with the tolerant and understanding approach exhibited elsewhere in the prison.

6.22 We were told that in extreme circumstances a woman prisoner might be held in the segregated area but this was rare and had not occurred in the previous two years. When it did occur, the regime for men and women was adversely affected.

Recommendations

6.23 Adjudications should ensure that prisoners have adequate time to prepare their defence, are seen by healthcare staff in advance and are advised of their appeal rights.

6.24 The segregated area and the special cells should not be used to manage prisoners who are self-harming or to hold new receptions during patrol states.

6.25 Segregated women and men should be kept separately at all times.

Incentives and earned privileges

Expected outcomes:
Incentives and earned privilege schemes are well-publicised, designed to improve behaviour and are applied fairly, transparently and consistently within and between establishments, with regular reviews.

6.26 Apart from a recent development on B wing, the incentives and earned privileges scheme had not changed since the last inspection. There was little to motivate adult male prisoners and nothing at all for female prisoners. Criteria for selection for the enhanced wing were unclear and disadvantaged some prisoners. Prisoners' behaviour and particularly their progress in activities and addressing offending behaviour were not assessed systematically.

6.27 Following our last inspection, we recommended that a full range of incentives and earned privileges (IEP) be implemented across the prison. This had not been acted on and the opportunities on offer remained impoverished, with none available for female prisoners. No monitoring systems were in place to ensure fair application of IEP and there was no basic level within the existing schemes. The arrangements failed to provide adequate motivation for all prisoners to behave appropriately, actively engage in activities and address their offending behaviour.

6.28 For adult male prisoners, the extent of the IEP scheme continued to be a move from A to C wing, which provided single cells and in-cell sanitation and electricity. All wings in the new prison would provide these facilities, making it important that alternative incentives were introduced. The published criteria for selection to C wing detailed only what could be taken into consideration and we were not surprised that prisoners were confused and perceived the system to be unfair. In our survey, only 2% of prisoners, significantly lower than the comparator of 45%, felt they had been treated fairly in their experience of the IEP scheme.

6.29 Referral to C wing was usually at the instigation of the personal officer and depended on the prisoner being in work. At least half of the 19 places on C wing were pre-allocated to certain jobs such as the kitchen and trades (see section on work). Although C wing staff told us that some prisoners had been 'demoted' and sent back to A wing, there was little evidence in current wing history sheets that prisoners' behaviour was systematically assessed or reviewed.

6.30 A limited but structured IEP scheme had been introduced on B wing (young male) in October 2004. By this, young people were awarded daily marks based on expected standards of behaviour, which were published and understood. Anyone achieving the required marks on two consecutive days had access to a games console, a selection of games and a personal computer during association. These privileges were withdrawn if the score slipped on any given day. The scheme provided a sound foundation for further development.

Recommendations

6.31 A full range of incentives and earned privileges should be implemented across the whole prison.

6.32 The incentives and earned privileges scheme should be operated consistently and fairly, with staff and prisoners being clear about the criteria for promotion and demotion.

Vulnerable prisoners

6.33 Accommodation for vulnerable prisoners was poor and their regime was minimal. The dormitory and double cells along with the limited intervention were likely to encourage the reinforcement of negative views and distorted thinking.

6.34 There were seven vulnerable prisoners (VPs) at the time of the inspection, and they were held in two discrete areas – a dormitory and two double cells – which were separated from the rest of the prison. One VP was the fiancé of the victim of another prisoner, held in the same location; only a very basic risk assessment had been carried out to ensure the safety of both men. Staff did not routinely supervise the VP areas. In the new prison, it might be possible to manage such prisoners on normal location.

6.35 Four of the VPs were in one cramped dormitory. For these men, apart from daily open air exercise periods and occasional opportunities to visit the physical education area, this room was their total living space. One cell had been converted into a television and computer education room. On the next floor were two cells that could be gated off from the stairwell to permit association in cells, but there were no facilities.

6.36 The seconded probation officer undertook some one-to-one work with one sex offender. In the absence of any structured intervention, there was a risk that prisoners reinforced negative and distorted thinking.

Recommendations

6.37 There should be a strategy for managing vulnerable prisoners, to ensure their safety and provide an environment that challenges negative attitudes.

6.38 Vulnerable prisoners should have a structured regime, with opportunities to work.

6.39 There should be accredited offending behaviour programmes for sex offenders to reduce the likelihood of their reoffending.

Section 7: Services

Catering

Expected outcomes:
Prisoners are offered varied meals to meet their individual requirements and food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

7.1 A reasonable range of meals was available but prisoners did not have access to water at night and most had to eat in their cell. Prisoners working with food did not have health checks and had no opportunities to gain recognised qualifications.

7.2 The kitchen was staffed by a senior officer, two officers and five prisoners. A pre-select menu system was in operation offering all prisoners the choice of two dishes for lunch and three for the evening meal. The weekly menu was changed every three months but some prisoners complained that the choice became too predictable.

7.3 Meals were served on the residential wings from heated trolleys or thermal boxes. Food temperatures were checked before leaving the kitchen but not before serving. The food we saw was well presented and looked appetising. In our survey, 39% of respondents, against a comparator of 21%, said the food was good or very good. However, some women prisoners complained to us about the limited range of healthy meals and said that many were 'stodgy' and high in fat and carbohydrates.

7.4 Breakfast was made on the day it was served and prisoners were offered a hot breakfast each morning at 8.30am. Lunch was served at noon (11.30am for women prisoners). While some provision for supper was made and given to prisoners during the serving of the tea meal, the meal itself was served too early at 4.45pm and prisoners complained that they often ate their supper at the same time. In addition, there was no facility for prisoners to access drinking water during the night and other lock up periods; flasks were not provided routinely.

7.5 The catering department had conducted a survey shortly before our inspection. The main points highlighted were that prisoners felt they did not have enough time to eat their food and did not like eating in cell. Female prisoners and those on C wing could eat communally.

7.6 Medical diets were catered for but the establishment did not have a halal certificate and was inexperienced in the preparation of cultural and religious dishes. Historically, this issue had been addressed by employing prisoners from different cultural backgrounds to cook specific dishes themselves.

7.7 A health screening form was in place for prisoners working in the kitchen. However, we could not find any completed forms and prisoners said they had not been asked to fill one in. Prisoners working in the kitchen and as wing servers had been given basic training on the serving of food but those working in the kitchen had received no further training. There was no opportunity to obtain recognised qualifications, although some catering staff were training to be assessors in order that qualifications could be offered in the future.

Recommendations

7.8 The evening meal should be served between 5pm and 6.30pm.

7.9 Prisoners should have access to water and the means to make a hot drink during lock up periods.

7.10 The menu should be reviewed to ensure that a suitable range of healthy, low fat dishes is provided.

7.11 A range of cultural and religious dishes should be offered. These should be prepared in an appropriate manner.

7.12 Health screening for prisoners working with food should be robustly applied.

7.13 There should be opportunities for prisoners to gain recognised qualifications in food preparation and catering skills.

7.14 All prisoners on normal location should be able to dine communally.

Prison shop

Expected outcomes:
Prisoners can purchase a suitable range of goods at reasonable prices to meet their ethnic, cultural and gender needs, and can do so safely, from an effectively managed shop.

7.15 The prison canteen system offered a range of goods and prisoners were generally satisfied with the service. Orders were bagged and delivered weekly and prisoners could get the balance of their available funds on request. A survey had been carried out.

7.16 The prison shop was run by an administrative grade member of staff and two prisoners. Orders were bagged and delivered to the units once a week. The shop manager had carried out a prisoner survey to assess prisoners' requirements.

7.17 The canteen list, which was issued to each prisoner but not displayed on all units, offered a good range of items and prices were comparable to those in the high street. Over-the-counter medication was not available and the range provided for minority ethnic prisoners was very limited. However, prisoners could make special requests that the member of staff would buy from the local shop if the items were on the facilities list. Prisoners had the opportunity to buy fruit but there were no food preparation areas on the units. There was no catalogue system.

7.18 New arrivals were given a free canteen pack that included a telephone voucher on reception. Smokers' packs were also available. Anyone arriving with private cash could buy additional items that week. Prisoners who had to appear in court or attend appointments received their canteen on the normal delivery day.

7.19 Prisoners had access to an up-to-date account list, which was shown to them privately.

Recommendations

7.20 Over-the-counter medication should be added to the canteen list.

7.21 A survey of minority ethnic prisoners' needs should be carried out and items added as necessary.

7.22 The shop manager should not shop for items for prisoners. A catalogue system should be introduced.

Housekeeping points

7.23 The canteen list should be on display on notice boards on residential units.

Section 8: Resettlement

Resettlement strategy

Expected outcomes:
Resettlement underpins the work of the whole establishment, supported by strategic partnerships in the community and informed by assessment of the risk that prisoners pose and their needs so as to minimise the likelihood of reoffending on release.

8.1 There was no island strategy on reducing offending and the prison had no resettlement strategy in place. No multidisciplinary meetings were held to discuss the resettlement of prisoners and resettlement issues were primarily tackled by one probation officer who was struggling to cope with all the demands. Resettlement was often dealt with on a case-by-case basis.

8.2 There was no reducing reoffending strategy in operation on the Isle of Man to which the prison could contribute. The prison had not devised a resettlement strategy outlining the services it could offer prisoners to help them prepare for their release and successful resettlement. A throughcare policy had been devised but focused primarily on the sentence planning arrangements for prisoners sentenced to 12 months or more rather than all areas of resettlement for all prisoners.

8.3 In reality, resettlement issues of prisoners fell to the one seconded probation officer who was often quite successful in dealing with individual cases. However, he was struggling to cope with all the demands as he also had a supervision case load. There were no resettlement meetings and no multidisciplinary team working towards reducing prisoners' risk on release.

8.4 No formal needs analysis had been conducted to ascertain what services prisoners needed, although a basic resettlement checklist was completed on all new receptions on arrival. This information was forwarded to the seconded probation officer and he would, where possible, attempt to address some of the issues raised or make referrals to other agencies. This intervention was extremely limited as few services were available to prisoners within the prison.

8.5 This data had been collated by the probation officer over about 12 months but was not used in a strategic way to inform the prison or the Home Affairs Department of the services required. It indicated that 20% of prisoners had drug issues on reception, 33% had alcohol issues, 18% were homeless and 23% had problems with debt. Over half (51%) felt they needed help with education but there was little incentive to address this in the prison.

Recommendations

8.6 A multidisciplinary approach should be taken to the effective resettlement of prisoners within the prison and regular strategic planning meetings should be held.

8.7 A thorough needs analysis should be conducted to ascertain the resettlement needs of prisoners entering the prison and this information used to secure services to address each identified area of need.

8.8 A system should be introduced to ensure that all prisoners' resettlement needs are identified on reception and addressed before release.

Sentence and custody planning

Expected outcomes:
All prisoners have a sentence or training plan based upon an individual assessment of risks and needs, regularly reviewed and implemented throughout and after their time in custody.
Prisoners, together with all relevant staff, are involved with drawing up and reviewing plans.

8.9 The 26 prisoners serving 12 months or more were subject to a prisoner development plan. No sentence or custody planning was in place for the remainder of the population. Prisoners subject to a prisoner development plan had a risk assessment to identify outstanding areas of risk but targets set on a prisoner's plan did not always reflect these.

8.10 Prisoner development plans (PDPs) were in place for those prisoners sentenced to 12 months or more. This applied to 26 prisoners at the time of our inspection. A risk assessment (LSIR) was conducted on these prisoners following sentencing. This took into account the social exclusion report (SER) written for the court hearing.

8.11 An initial PDP involving the prisoner, internal and external probation staff and the residential principal officer was usually produced within a month of the prisoner arriving in custody. However, only 4% of respondents to our survey, against a comparator of 15%, said they had been involved or very involved in the development of their sentence plan. Personal officers were requested to write a contribution but these varied considerably in quality. The prisoner development panel reviewed the LSIR and the SER and considered issues including security level, education and offending behaviour work, domestic issues and pre-release plans.

8.12 Each prisoner's PDP was reviewed every three months by the same personnel and new targets were set or existing targets amended. However, while some reports consulted by the review board contained useful information and indicated areas that the prisoner needed to work on, targets set were often inappropriate and unrelated to the areas of need. One target for a life-sentenced and potentially dangerous prisoner was to get on to the outside sports party that visited facilities in the local town. Options available within the prison to address offending behaviour were extremely limited (see sections on offending behaviour programmes and reintegration planning).

8.13 Sentence planning was not used to ensure that prisoners used their time in custody constructively to reduce their risk to the public on release. It did not direct prisoners into educational courses or to agencies that could help address areas of risk. There was little or no incentive for the prisoner to comply with the targets set as there were no repercussions for those who failed to comply. Reducing a prisoner's risk was not seen as the responsibility of all staff and, although each PDP was now available to all staff in resettlement files held in a central office, there was little evidence that staff even knew of their existence.

8.14 No sentence or custody planning was in place for those serving less than 12 months, the majority of the population. In preparation for our inspection, the establishment had highlighted this shortfall and devised a short sentence plan form but this was not yet in use.

Recommendations

8.15 Targets set by the review board should relate to areas of risk and need and should aim to reduce a prisoner's risk of reoffending.

8.16 Prisoners who do not comply with targets should be challenged appropriately, by all staff.

8.17 Sentence planning should be introduced for prisoners held on remand and those sentenced to less than 12 months.

Life-sentenced prisoners

Expected outcomes:
Life-sentenced prisoners should receive equal treatment in terms of their treatment and the conditions in which they are held. These expectations refer to specific issues, which relate to the management of life-sentenced prisoners.

8.18 Potential life-sentenced prisoners were being identified at an early stage but there were no special arrangements to deal with them. There was no lifer management team and only three members of staff were trained in meeting the needs of these prisoners. Reviews took place quarterly but targets set to meet risk factors were not relevant and did not offer any risk reduction strategies.

8.19 Prisoners likely to receive a life sentence were identified while on remand. Once identified, however, very little was done for them in terms of support, identifying risk factors, addressing offender behaviour needs or offering any explanation of tariffs. The prison strategy was to transfer these prisoners to a prison in England or Wales.

8.20 The prison was currently being challenged in the courts by life-sentenced prisoners who objected to being transferred to prisons in England and Wales. In the meantime, it had done very little to address prisoners' needs and it was unacceptable that some life-sentenced prisoners had spent an excessive amount of their sentence (up to four years) without addressing any offending behaviour work. Of equal concern was that the establishment had nothing in place should the court rule against it.

8.21 The three life-sentenced prisoners in the establishment were not being managed. The documentation we inspected showed that these prisoners were doing little work and that the work being done with them was being delivered by untrained personnel.

8.22 Life-sentenced prisoners were sometimes held in the segregation unit and we discovered one who had been there for over a year. (See section on segregation.)

Recommendations

8.23 The prison should develop a strategy for dealing with potential and recently-sentenced life-sentenced prisoners, and a contingency plan for supporting those held on the island for longer periods.

8.24 A designated lifer manager should be appointed, and staff should be trained to deal with life sentenced prisoners, support potential lifers, and be able to identify risk factors.

Offending behaviour programmes

Expected outcomes:
Effective programmes are available to address the identified risks and needs of prisoners, to allow timely progression through sentence.

8.25 No offending behaviour programmes were being run. Attempts to carry out this work had been unsuccessful.

8.26 The prison-based probation officer had recently attempted to set up a victim awareness group and had identified five prisoners he felt would benefit from this type of intervention. However, this initiative had been unsuccessful because it had proved impossible to overcome the practical problems associated with running a group in a secure setting. The biggest difficulty was making sure that individuals could be timetabled to attend meetings at a set time. From our discussions with the probation officer, it was clear that there was no history or tradition of running programme work within the prison and the establishment was simply not geared up for this.

8.27 The probation officer was carrying out some one-to-one work with a high-risk sex offender using a version of the sex offender treatment programme. He was undertaking this work on his own but was receiving monthly supervision from an outside consultant. It was unclear whether this work had been properly validated and its effectiveness monitored.

Recommendations

8.28 A needs analysis should be undertaken to obtain an accurate picture of what type of interventions are required to address offending behaviour. Relevant offending behaviour work should then be introduced based on the findings.

8.29 All programme work (either in groups or individually) should be accredited and properly supervised. All identified work should delivered by a programmes team.

Reintegration planning

Expected outcomes:
Prisoners are supported to return to the community in safety and dignity, using community and family links and appropriate licence and curfew arrangements to meet their practical needs and maximise the prospects for avoiding reoffending on release.

8.30 Prisoners resettlement needs were identified on reception but there were few services available to address them. A careers adviser was available for only a small number of prisoners. The few courses to address some resettlement needs available through education

also reached only a few prisoners. The employment, benefits and housing system on the island unfairly disadvantaged some prisoners.

8.31 All prisoners were required to complete a basic resettlement checklist on reception (see section on resettlement strategy). Only a limited number of interventions were available within the prison and on the island itself. The one hostel on the island offered only nine spaces and supported housing was available only to prisoners who originated from that area before being sent to custody. It was difficult to secure for ex-offenders. About 20% of prisoners were released with no fixed abode. Prison staff suggested that this figure was actually much higher, as many prisoners stayed at friends' homes.

8.32 A careers adviser visited once a month but only 16 prisoners had been seen in the previous year. The education department offered a small number of courses to address some resettlement needs but due to the wage structure (see section on education) and the lack of effective and meaningful sentence planning (see section on sentence planning), there was no real incentive for prisoners to attend these classes. A personal and social and health education (PSHE) course had been introduced in 2004. It comprised 11 modules including sessions on sex and relationships, drug education, healthy lifestyles and emotional well being. Sixty-two modules had been awarded since 2004. A drug and alcohol course had also been introduced two months before our inspection and work was ongoing with about 10 prisoners.

8.33 The seconded probation officer had attempted to introduce offence focus group work but this had faltered due to regime clashes that were evident throughout the prison (see section on activities). One victim awareness course that started with five participants had ended in a one-to-one session with one prisoner as the other four were engaged in other activities (see section on offending behaviour programmes).

8.34 In our survey, only 16% of respondents, against a comparator of 38%, knew where to get help with securing employment on release; 14%, against a comparator of 40%, knew who could help with finding somewhere to live; 14%, against a comparator of 31%, knew who could help with their finances; and only 24%, against a comparator of 45%, knew who could help them claim benefits. There was little promotion on the residential wings about what educational courses were on offer or what support the seconded probation officer could provide.

8.35 There was no discharge board to ensure that all prisoners were seen in sufficient time before their release to address any area of outstanding need. Prisoners released from the prison were given a discharge grant of only £5 and then only if they had less than £5 in private cash. Many prisoners complained that this was insufficient to enable them to establish themselves on release without turning to criminal activity. At the same time, the Isle of Man benefits system determined that non-Manx prisoners and those who had not been on the island for at least five years were ineligible for assistance towards the cost of private accommodation or general income support. Prisoners who wanted to return to England and Wales were given a ferry ticket and often found themselves in Liverpool with only £5 and nowhere to go. This problem had been identified by the seconded probation officer and a business case had been put forward to the Home Affairs Department to increase the discharge grant for these prisoners due to fear of embarrassment for the Isle of Man if prisoners. Prisoners convicted of a serious offence could potentially have their work permit for the Isle of Man withdrawn.

8.36 One case was going through the parole process during the inspection. Procedures to begin the process were generally sound and administration staff spoke knowledgeably of the prisoners considered. Since March 2005, seven prisoners had been released on parole, three had been refused, one was refused and given a 12-month review period, and one was in the middle of the process.

8.37 There was no system for release on temporary licence (ROTL) to enable prisoners to prepare for their eventual release. In a few individual cases prisoners were paroled to attend hospital appointments and funerals of relatives but no form of resettlement licence was in operation.

8.38 A system of executive release was in operation if the prison reached its operational capacity. In these instances, probation, prison and police staff met to decide which prisoner could be released before the end of sentence. This had happened twice in the last 12 months.

Recommendations

8.39 A formal discharge board should be introduced to deal with prisoners' immediate resettlement needs on release.

8.40 A sufficient range of services should be available to address prisoners' resettlement needs while in custody. These services should be published to all prisoners.

8.41 A system of release on temporary licence should be introduced to help prisoners prepare for successful resettlement in the community.

8.42 A discharge grant comparable to that offered in England and Wales should be provided to all prisoners regardless of the balance of their private cash account.

Public protection

Expected outcomes:
Arrangements are in place to assess and manage the risks presented to the public by prisoners during sentence and after release. Clear systems operate to ensure that all affected prisoners are fully informed of the arrangements, the implications for them individually and the avenues available to them for challenge.

8.43 Public protection was an area of weakness that required a major overhaul.

8.44 There were no established procedures or policies to deal with public protection. The only work being done was carried out by the establishment-based probation officer who worked four days a week and had no cover in his absence.

8.45 The probation officer checked the local inmate database system for all new admissions and cross-referenced this with the probation department's own database. Surprisingly, there was no routine formal contact with the island probation department if a prisoner was admitted to the prison following a serious offence. If the establishment-based probation officer discovered that an incoming prisoner was a Schedule One[2] offender, he would notify social services. There were, however, no routine arrangements to notify the mail censor or visits staff about the presence of a Schedule One offender. There appeared to be no mechanism for identifying or dealing with cases of harassment or racial hatred.

8.46 Staff from the prison were invited to attend all the multi-agency meetings held in the community involving offenders. The probation officer or the head of security normally represented the establishment. These meetings were chaired by the police, and records

[2] Offences against children set out in Schedule One of the Children's and Young Persons' Act 1933

showed that they dealt mostly with offenders who had at one point been in prison but were now in the community. It was, however, unusual for a meeting to be held prior to release of someone thought to present a possible risk to the public.

8.47 Prison staff had good informal and anecdotal knowledge of high profile offenders, many of whose cases had been fully covered in the local media. However, there was no systematic formal approach to ensure that all high-risk or public protection cases were identified, monitored and reviewed.

8.48 Given the small scale of the criminal justice system and the relatively low number of high-risk offenders being dealt with, it should be possible to operate an effective model of offender management on the island. (See main recommendation HP52)

Recommendations

8.49 A public protection policy, based on best practice, should be introduced.

8.50 All high-risk cases should be actively supervised by a probation officer for the duration of the sentence and prison staff should schedule conferences before a prisoner is released.

Substance use

Expected outcomes:
Prisoners with substance-related needs are identified at reception and receive effective support and treatment throughout their stay in custody, including pre-release planning. All prisoners are safe from exposure to and the effects of substance use while in the establishment.

8.51 The prison had developed and implemented its own drug strategy supported by a drug strategy group that met bi-monthly. Clinical support was available for prisoners requiring it, although there continued to be inconsistencies in its application. Voluntary drug testing had recently been introduced but was available only to some prisoners. The service lacked coordination and clear throughcare links and there was little by way of psycho-social provision to support those receiving clinical services.

8.52 The prison drug strategy had initially been drawn up in 2005 but had been updated in January 2006. It was set within the wider context of the Isle of Man drug strategy to ensure that the development of provision reflected what was available in the community. The document usefully outlined the range of provision available within the prison but lacked clear strategic targets for the forthcoming year to ensure appropriate developments. It was driven by the drug strategy group, which was scheduled to meet bi-monthly, with the chair also representing the prison on the Isle of Man drug and alcohol strategic group reporting to the Chief Minister. Only about 50% of invited representatives had attended the drug strategy meetings in the last year.

8.53 A 'drugs in prison' survey of prisoners had been undertaken in August 2005. The response rate had been relatively low (46%) but it was nonetheless disappointing that none of the results had been incorporated into the prison's drug strategy document.

8.54 Clinical services for detoxification and maintenance were available and 12 prisoners were receiving such support (four on methadone, seven on buprenorphine [subutex] and one on

DF118s [dihydrocodeine]). An alcohol detoxification programme was also available. Most prisoners arriving at the prison with drug-related problems were already known to the community drug and alcohol (DAT) team and any maintenance programme already established would be continued by the prison following confirmation. DF118s could be prescribed following a confirmatory test for anyone not known to the DAT until they were able to see a GP (usually the next day). Although a protocol had been agreed between the prison and the DAT, there was very little documentation to support the available clinical regime. Clinical services were determined by one of the GPs or the psychiatrist from the DAT during his weekly session.

8.55 Of the 12 prisoners currently being maintained, only three were subject to a reducing regime. While the GPs and the psychiatrist were clearly keen to work with the prisoners to address their specific needs and reflect treatment regimes in the community, it was not clear under what circumstances prisoners would be encouraged to move towards abstinence. This was despite the prison's strategic statement that abstinence at the point of release was its goal. Prisoners we spoke to who were subject to maintenance regimes were fairly positive, although one had been on a maintenance programme for over two years and another for over seven months.

8.56 The DAT psychiatrist regularly reviewed maintenance cases but there was little provision to support the psychological side of addiction (alcohol and drugs). Some informal support was provided by healthcare staff but this appeared to be unstructured. In November 2005, education had begun to offer two hours a week group work and two hours a week individual work specifically for substance misuse. Prisoners spoke positively about it but there was little coordination. Given the extent of substance misuse at the prison, the level of provision was also inadequate.

8.57 The lack of coordination was also reflected in the throughcare of drug users. Information from education was shared with probation but not healthcare, and healthcare did not always share details of its work with probation but usually did share it with the DAT. As a result, there was no central point of contact for either the DAT or probation to ensure continuity of care on release. At the same time, no formal pre-release work was undertaken to ensure that harm reduction and overdose risk messages were given.

8.58 Voluntary drug testing had been introduced at the prison in September 2005 but provision was limited to the enhanced wing (C wing). Given that prisoners had to be drug-free to get on C wing initially, voluntary testing was not made available to those with a drug problem to act as an incentive or support their progress. To date, the positive VDT rate was 3%. Prisoners testing negative were entitled to a free 10-minute telephone call, although this was not available to those who tested positive only for prescribed medication, even though the prison recorded this as a negative test. Prisoners testing positive were not necessarily excluded from C wing but their cases would be reviewed. Given the voluntary nature of the programme, it was not appropriate that participants were subject to a full search before testing.

8.59 A number of prison staff were concerned about a culture of medication use, particularly tranquilisers, by prisoners. This was reflected to some extent in the 'drugs in prison' survey, where 79% of all prisoners surveyed were on some form of medication. It was also reflected in mandatory drug testing (MDT) figures. For the six months up to the inspection, the MDT positive rate was 12% but a further 19% had tested positive for benzodiazepines, which were 'consistent with medication' and classified as negative. Similarly six of the 24 drug-related security finds in 2005 and three of the seven to date in 2006 were prescription medications.

8.60 Levels of substance misuse training at the prison were very low. Only one of the four healthcare staff was pursuing substance misuse training or a specific qualification and there was no prison-wide drug awareness training for staff. We were told that four members of staff were due to undertake some training that would enable them to act as a resource to prisoners and other officers, and potentially offer basic substance awareness training. This had been identified in drug strategy group minutes in July 2005 but had not yet come to fruition.

Recommendations

8.61 The prison drug strategy document should include annual objectives supported by action plans to direct the development of service provision.

8.62 Attendance at the bi-monthly drug strategy meetings should be prioritised by all members.

8.63 Clinical provision should be reviewed and supported by a detailed clinical policy incorporating detoxification and maintenance protocols to ensure consistency.

8.64 Clear criteria should be established and agreed to support maintenance as distinct from reducing regimes.

8.65 The provision of non-clinical psycho-social support for those with substance misuse problems should be extended.

8.66 The coordination and linking of provision inside the prison to post-release services in the community should be clarified and include harm reduction and overdose risk information.

8.67 Voluntary drug testing should be available to all prisoners.

8.68 Participants in voluntary drug testing should not be subject to full searches before testing.

8.69 A review should take place of the current medication prescribing and alternatives for benzodiazepines used where possible.

8.70 Drug awareness training should be given to all staff.

Section 9: Recommendations, housekeeping points and good practice

The following is a listing of recommendations and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

Main recommendations — To the Department of Home Affairs

9.1 The arrangements for the delivery of healthcare to become the responsibility of the Isle of Man Health Service should be expedited. (HP47)

9.2 Juveniles under 18 should not be held in the Isle of Man prison. (HP50)

9.3 Women should be held in separately-managed accommodation, with facilities and procedures that are specific to their needs. (HP51)

9.4 The Department of Home Affairs, with other relevant bodies, should consider developing a comprehensive multi-agency strategy for reducing reoffending and providing end-to-end management of offenders during and after imprisonment. (HP52)

Main recommendations — To the Governor

9.5 A bullying analysis should be undertaken and the results used to develop a bullying strategy. All staff should be trained in how to deal with incidents. (HP45)

9.6 The safer custody committee should develop and oversee a strategy to help reduce the risk of self-harm and to provide the necessary support and services to those prisoners who threaten or attempt to self-harm. (HP46)

9.7 A health needs assessment of prisoners should be carried out and a health delivery plan devised to ensure that the correct services, including out-of-hours cover, are in place to meet the needs of the population. (HP48)

9.8 There should be sufficient purposeful activity for all prisoners, with the opportunity to gain educational and skills qualifications. (HP49)

9.9 The prison should develop and implement a resettlement strategy, based upon the assessed needs of its different populations. (HP53)

Recommendations — To the Department of Home Affairs

Public protection

9.10 A public protection policy, based on best practice, should be introduced. (8.49)

Courts, escorts and transfers

9.11 All prisoners should be accompanied by a valid warrant to justify their custody. (1.6)

First days in custody

9.12 All prisoners should be given a meal on their first day in custody. (1.21)

9.13 An alternative to cardboard furniture in the holding rooms should be found and relevant information displayed in a range of languages. (1.22)

9.14 Staff should address prisoners by their first name or title and surname. (1.23)

9.15 All prisoners should be offered a shower, telephone call and access to a Listener or Samaritan in reception. (1.24)

9.16 A more robust control system for the reception safe should be introduced and access to it restricted to staff working in the area. (1.25)

9.17 Newly arrived prisoners should not be held in the segregation unit. (1.26)

9.18 The accommodation available to newly arrived prisoners should be clean and fit for purpose. (1.27)

9.19 The wing manager's initial interview should take place in private and should include all elements of a cell-sharing risk assessment. An interpreter should be used when communication is difficult. (1.28)

9.20 All staff should wear name badges. (1.29)

9.21 Staff should be properly trained to address the needs of newly arrived prisoners. (1.30)

9.22 Prisoners being released should be given a non-branded bag for their possessions. (1.31)

9.23 A comprehensive induction programme should be introduced. This should be delivered by trained staff, include representatives of all relevant agencies and begin the day after reception. Once introduced, its effectiveness should be monitored through prisoner surveys. (1.32)

9.24 The immediate needs or concerns of new arrivals should be addressed and offending behaviour needs identified. (1.33)

9.25 The information sheet given to new arrivals should be available in a range of languages and cover all relevant areas. (1.34)

Residential units

9.26 All cells should have electricity and integral sanitation. (2.12)

9.27 All areas of the prison should be maintained and kept clean. (2.13)

9.28 An offensive displays policy should be published regularly to staff and prisoners and should be adhered to throughout the prison. (2.14)

Juveniles

9.29 Children under 18 should not be placed in an adult prison setting. (2.21)

Women prisoners

9.30 There should be distinct policy documents focusing on the needs of female prisoners and covering all areas of life and work within the prison. (2.27)

9.31 Staff working on the female unit should receive specific training on the distinct needs of women prisoners. (2.28)

9.32 A suitable daily regime should be offered to women prisoners to ensure they are kept fully occupied throughout the day. (2.29)

9.33 Staff should not refer to women prisoners as 'girls'. (2.30)

Staff-prisoners relationships

9.34 The safer custody committee should investigate prisoners' perception of staff victimisation and take any action necessary. (2.36)

9.35 Staff should challenge as well as support prisoners. (2.37)

9.36 Managers should anticipate potential changes to dynamic security as a result of the move to the new prison and ensure that appropriate training and guidance is given to staff. (2.38)

Personal officers

9.37 Management checks should be put in place to ensure that all personal officers maintain and record their contact with prisoners and that personal officer entries are of consistently good quality. (2.43)

9.38 Personal officers should provide input and advice on all matters relating to their prisoners, such as labour allocation, incentives and earned privileges, sentence planning and resettlement. (2.44)

Bullying

9.39 Support should be offered to victims of bullying and a programme to challenge bullying introduced. (3.7)

9.40 The establishment should carry out a survey to establish why and where prisoners feel unsafe. (3.8)

9.41 The safer custody committee should discuss unexplained injuries, F213s and the management of bullies. (3.9)

9.42 Bullies and victims should be invited to speak to the coordinator about their experiences to support better management of future instances. (3.10)

9.43 Families and friends should be used as a source of information to help identify prisoners who are likely to be bullied. (3.11)

9.44 Staff should complete the appropriate documentation when they discover a potential bullying incident. (3.12)

Self-harm and suicide

9.45 The management of Folder 5 cases should be reviewed to ensure the delivery of good quality care and support plans including the appropriate involvement of prisoners. (3.20)

9.46 A care suite large enough to cater for the needs of the population should be made available. (3.21)

9.47 All staff should be fully trained in suicide prevention. (3.22)

Race relations

9.48 Race relations and diversity policies and procedures should be developed. (3.27)

9.49 There should be ethnic monitoring of all key aspects of prison life, and action taken to redress any differential outcomes. (3.28)

9.50 The diversity officer should be supported by a diversity or race relations management team, receive suitable training and be allocated sufficient time to complete these duties. (3.29)

Foreign nationals

9.51 Immigration detainees held solely under administrative powers and who have not been charged with or convicted of criminal offences should not be held in prison. (3.35)

Family and friends

9.52 Suitable visiting facilities should be provided. (3.46)

9.53 Prisoners should have access to an efficient telephone system. (3.47)

9.54 Prisoners should receive privileged mail unopened. (3.48)

Applications and complaints

9.55 Prisoners should be able to submit confidential application and complaint forms. (3.54)

9.56 Routine monitoring of applications should be introduced to identify trends and enable action to be taken to address common sources of complaint. The timeliness and quality of responses should be monitored. (3.55)

Legal rights

9.57 The facilities for legal visits should be improved. (3.63)

9.58 The legal services officer should receive formal training. (3.64)

9.59 A register of all applications made to the legal services officer should be maintained and the assistance provided recorded. (3.65)

Healthcare

9.60 The prison healthcare team should adopt and adhere to the Isle of Man National Health Service hospital clinical governance strategy, to provide a framework for ensuring the delivery of high quality healthcare to prisoners. (4.46)

9.61 Healthcare staff should familiarise themselves with national service frameworks, National Institute of Clinical Excellence guidance and other sources of evidence-based practice in order to ensure that prisoners receive the same level of healthcare as they would in the community. (4.47)

9.62 Healthcare staff should be formal members of the Isle of Man Nursing & Midwifery Advisory Council. (4.48)

9.63 All staff who work in the healthcare department should be deemed competent to do so. (4.49)

9.64 There should be a formal system for checking nurses' professional registrations annually. (4.50)

9.65 There should a review of emergency resuscitation equipment to ensure that relevant equipment is available for use at all times by trained staff. Such equipment should be subject to regular, auditable checks. (4.51)

9.66 Clinical records should be timed, dated, signed and legible. All records (including medication administration records) should be contemporaneous and clinical records should contain comprehensive information about patients from all healthcare professionals involved in their care. (4.52)

9.67 The few clinical policies that exist should be reviewed and policies to cover the range of practices undertaken should be devised. (4.53)

9.68 All staff should have formal clinical supervision and continual professional development. Training should include resuscitation skills and immunisation and vaccination updates annually. (4.54)

9.69 Female prisoners should have easy access to a female GP. (4.55)

9.70 Healthcare staff should use formal triage algorithms to assess patients. (4.56)

9.71 Dispensed medicines should remain in the containers supplied by the pharmacy and should not be repackaged at the prison. (4.57)

9.72 The supply of duplicate dispensing labels for attachment to administration charts is contrary to Royal Pharmaceutical Society (Great Britain) guidelines and should stop. Administration charts should be produced at the pharmacy in accordance with prescriptions dispensed. (4.58)

9.73 Administration charts should be referred to and filled in at the time that the medicine is administered or supplied. Facilities should be available to allow this to happen. Omits should be recorded. (4.59)

9.74 Patients should not be given loose medication to be taken at a later time. The number of daily treatment times should be increased to enable patients to access their medication at the necessary times and drinking water should be available to the patient at the time of administration. (4.60)

9.75 A formal special sick policy should be introduced and medicines suitable for supply by healthcare staff should be clearly defined. Prescription medicines and prescription-only medicines should not be included in the special sick formulary. Patient group directives should be devised and approved by the Isle of Man National Health Service before implementation. (4.61)

9.76 Controlled drug records in use at the prison should serve the purpose of providing a transparent audit trail, so that the use of controlled drugs can be easily monitored and cupboard stock can be easily reconciled. (4.62)

9.77 A clear in-possession policy should be developed to allow medicines in use to be held in possession by all prisoners unless contra-indicated by a documented risk assessment carried out on an individual basis. (4.63)

9.78 The pharmacist should be encouraged to take a more active role in the provision of pharmacy services at the prison. This should include direct contact with prisoners, clinical medication reviews and audit of medicines liable to abuse. (4.64)

9.79 The island medicines and therapeutics committee medications formulary should be formally recognised for use in the prison. (4.65)

9.80 A clinical IT system should be provided to enable clinical audit, computer-generated prescriptions and better access to patient medical records. (4.66)

9.81 Mental health services should be developed to ensure continuity of care between community and prison. There should be a formal service level agreement and clear protocols regarding referrals, information-sharing and the care programme approach to ensure that patient care is not compromised. (4.67)

9.82 A maximum/minimum thermometer should be obtained for the medicines fridge, which should be used only to store medicines. Daily records of maximum and minimum temperatures should be maintained, the thermometer should be reset after each reading and the regulator adjusted when necessary to maintain the temperature within the range 2 to 8 Celsius. (4.68)

9.83 Keys to medicine cupboards should be held by the person in charge of the department at all times and not left in locks. (4.69)

9.84 All medicines should be held securely at all times. (4.70)

Education and library provision

9.85 The education manager should be a permanent member of the senior management team. (5.13)

9.86 The governor should carry out a review of the education service, paying particular attention to assessments and scheduling. An action plan should be produced and the education manager given the authority to implement it. (5.14)

9.87 Prisoners should be actively encouraged to attend education. (5.15)

9.88 The timetabling of activities should be reviewed to eliminate regime clashes. (5.16)

9.89 The wage structure should not unfairly disadvantage prisoners in education. (5.17)

9.90 The education officer should ensure that the mobile library service is improved. (5.18)

9.91 Wing staff should ensure that all prisoners get the opportunity to attend the library once a week. (5.19)

9.92 The library stock should be extended to include talking books and material in languages other than English. (5.20)

Work

9.93 A senior manager should be allocated responsibility for the overall provision and management of work. (5.25)

9.94 The number of work placements should be increased and the quality improved. (5.26)

Physical education and health promotion

9.95 There should be a transparent and fair allocation system for trips to the sports centre. (5.35)

Faith and religious activities

9.96 All prisoners should have access to regular religious services. (5.42)

9.97 The religious needs of non-Christian prisoners should be actively addressed. (5.43)

9.98 There should be suitable accommodation within the new prison to cater for the religious needs of all prisoners. (5.44)

Time out of cell

9.99 All prisoners should spend at least 10 hours out of their cell, except in exceptional circumstances. (5.51)

9.100 The range and quality of out of cell activities should be improved. (5.52)

9.101 Arrangements for staff training should not involve a total shutdown of the prison. (5.53)

Security and rules

9.102 Absences of the security department manager should be covered by a trained substitute. (6.11)

9.103 Staff should be trained to the required standard to ensure prisoners' safety at all times, especially at night. (6.12)

9.104 Keys should be secured before prisoners are allowed to use the toilet facilities. (6.13)

9.105 A formal process to categorise prisoners as high or exceptional risk should be introduced. (6.14)

Discipline

9.106 Adjudications should ensure that prisoners have adequate time to prepare their defence, are seen by healthcare staff in advance and are advised of their appeal rights. (6.23)

9.107 The segregated area and the special cells should not be used to manage prisoners who are self-harming or to hold new receptions during patrol states. (6.24)

9.108 Segregated women and men should be kept separately at all times. (6.25)

Incentives and earned privileges

9.109 A full range of incentives and earned privileges should be implemented across the whole prison. (6.31)

9.110 The incentives and earned privileges scheme should be operated consistently and fairly, with staff and prisoners being clear about the criteria for promotion and demotion. (6.32)

Vulnerable prisoners

9.111 There should be a strategy for managing vulnerable prisoners, to ensure their safety and provide an environment that challenges negative attitudes. (6.37)

9.112 Vulnerable prisoners should have a structured regime, with opportunities to work. (6.38)

9.113 There should be accredited offending behaviour programmes for sex offenders to reduce the likelihood of their reoffending. (6.39)

Catering

9.114 The evening meal should be served between 5pm and 6.30pm. (7.8)

9.115 Prisoners should have access to water and the means to make a hot drink during lock up periods. (7.9)

9.116 The menu should be reviewed to ensure that a suitable range of healthy, low fat dishes is provided. (7.10)

9.117 A range of cultural and religious dishes should be offered. These should be prepared in an appropriate manner. (7.11)

9.118 Health screening for prisoners working with food should be robustly applied. (7.12)

9.119 There should be opportunities for prisoners to gain recognised qualifications in food preparation and catering skills. (7.13)

9.120 All prisoners on normal location should be able to dine communally. (7.14)

Prison shop

9.121 Over-the-counter medication should be added to the canteen list. (7.20)

9.122 A survey of minority ethnic prisoners' needs should be carried out and items added as necessary. (7.21)

9.123 The shop manager should not shop for items for prisoners. A catalogue system should be introduced. (7.22)

Resettlement strategy

9.124 A multidisciplinary approach should be taken to the effective resettlement of prisoners within the prison and regular strategic planning meetings should be held. (8.6)

9.125 A thorough needs analysis should be conducted to ascertain the resettlement needs of prisoners entering the prison and this information used to secure services to address each identified area of need. (8.7)

9.126 A system should be introduced to ensure that all prisoners' resettlement needs are identified on reception and addressed before release. (8.8)

Sentence and custody planning

9.127 Targets set by the review board should relate to areas of risk and need and should aim to reduce a prisoner's risk of re-offending. (8.15)

9.128 Prisoners who do not comply with targets should be challenged appropriately, by all staff. (8.16)

9.129 Sentence planning should be introduced for prisoners held on remand and those sentenced to less than 12 months. (8.17)

Life-sentenced prisoners

9.130 The prison should develop a strategy for dealing with potential and recently-sentenced life-sentenced prisoners, and a contingency plan for supporting those held on the island for longer periods. (8.23)

9.131 A designated lifer manager should be appointed, and staff should be trained to deal with life sentenced prisoners, support potential lifers, and be able to identify risk factors. (8.24)

Offending behaviour programmes

9.132 A needs analysis should be undertaken to obtain an accurate picture of what type of interventions are required to address offending behaviour. Relevant offending behaviour work should then be introduced based on the findings. (8.28)

9.133 All programme work (either in groups or individually) should be accredited and properly supervised. All identified work should delivered by a programmes team. (8.29)

Reintegration planning

9.134 A formal discharge board should be introduced to deal with all prisoners' immediate resettlement needs on release. (8.39)

9.135 A sufficient range of services should be available to address prisoners' resettlement needs while in custody. These services should be published to all prisoners. (8.40)

9.136 A system of release on temporary licence should be introduced to help prisoners prepare for successful resettlement in the community. (8.41)

9.137 A discharge grant comparable to that offered in England and Wales should be provided to all prisoners regardless of the balance of their private cash account. (8.42)

Public protection

9.138 All high-risk cases should be actively supervised by a probation officer for the duration of the sentence and prison staff should schedule conferences before a prisoner is released. (8.50)

Substance use

9.139 The prison drug strategy document should include annual objectives supported by action plans to direct the development of service provision. (8.61)

9.140 Attendance at the bi-monthly drug strategy meetings should be prioritised by all members. (8.62)

9.141 Clinical provision should be reviewed and supported by a detailed clinical policy incorporating detoxification and maintenance protocols to ensure consistency. (8.63)

9.142 Clear criteria should be established and agreed to support maintenance as distinct from reducing regimes. (8.64)

9.143 The provision of non-clinical psycho-social support for those with substance misuse problems should be extended. (8.65)

9.144 The coordination and linking of provision inside the prison to post-release services in the community should be clarified and include harm reduction and overdose risk information. (8.66)

9.145 Voluntary drug testing should be available to all prisoners. (8.67)

9.146 Participants in voluntary drug testing should not be subject to full searches before testing. (8.68)

9.147 A review should take place of the current medication prescribing and alternatives for benzodiazepines used where possible. (8.69)

9.148 Drug awareness training should be given to all staff. (8.70)

Housekeeping points

Residential units

9.149 Staff should stop recording the times that prisoners use the toilets. (2.15)

Healthcare

9.150 The couches in healthcare where patients are examined should be shielded by privacy screens. (4.71)

9.151 Health promotion materials should be made freely available to prisoners. (4.72)

9.152 Patient information leaflets should be supplied with medication wherever possible. Notices should be prominently displayed to advise patients of the availability of leaflets on request. (4.73)

9.153 Current editions of all required reference books should be available at the prison. (4.74)

Prison shop

9.154 The canteen list should be on display on notice boards on residential units. (7.23)

Good practice

Healthcare

9.155 The arrangements made by healthcare staff for prisoners on release, such as making GP appointments, promoted continuity of care for prisoners. (4.75)

Appendix 1

Inspection team

Anne Owers	HM Chief Inspector of Prisons
Francis Masserick	Team leader
John Simpson	Inspector
Janine Harrison	Inspector
Gail Hunt	Inspector
Ian MacFadyen	Inspector
Elizabeth Tysoe	Healthcare inspector
Steve Gascoigne	Dental inspector
Bill Massam	Ofsted inspector
Laura Nettleingham	Researcher
Lucy Trussler	Research trainee

Appendix 2a

Population profile – Adult males

(i) Status	Number of prisoners	%
Sentenced	38	74.51%
Convicted but unsentenced	2	3.92%
Remand	9	17.65%
Civil Prisoners (illegal entrants)	2	3.92%
Detainees (single power status)		
Detainees (dual power status)		
Total	51	100%

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	11	28.95%
6 months to less than 12 months	3	7.89%
12 months to less than 2 years	7	18.43%
2 years to less than 4 years	4	10.53%
4 years to less than 10 years	8	21.05%
10 years and over (not life)	2	5.26%
Life	3	7.89%
Total	38	100%

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month	6	14.29%		

1 month to 3 months	13	30.96%	5	55.56%
3 months to 6 months	8	19.05%	4	44.44%
6 months to 1 year	3	7.14%		
1 year to 2 years	5	11.90%		
2 years to 4 years	5	11.90%		
4 years or more	2	4.76%		
Total	42	100%	9	100%

(iv) Main offence	Number of prisoners	%
Violence against the person	17	33.33%
Sexual offences	5	9.80%
Burglary	2	3.93%
Robbery		
Theft & handling	4	7.84%
Fraud and forgery	1	1.96%
Drugs offences	16	31.37%
Other offences	4	7.84%
Civil offences		
Offence not recorded/Holding Warrant	2	3.93%
Total	51	100%

(v) Age	Number of prisoners	%
21 years to 29 years	23	45.10%
30 years to 39 years	13	25.49%
40 years to 49 years	11	21.57%

50 years to 59 years	1	1.96%
60 years to 69 years	3	5.88%
70 plus years		
Please state maximum age	(64)	
Total	51	100%

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	32	62.75%
Between 50 and 100 miles of the prison	13	25.49%
Over 100 from the prison		
Overseas	2	3.92%
NFA	4	7.84%
Total	51	100%

(vii) Nationality	Number of prisoners	%
British (Manx)	49	96.8%
Foreign Nationals	2	3.92%
Total	51	100%

(viii) Ethnicity	Number of prisoners	%
White		
British (Manx)	47	92.16%
Irish	2	3.92%
Other White		
Mixed		

White and Black Caribbean		
White and Black African	2	3.92%
White and Asian		
Other Mixed		
Asian or Asian British		
Indian		
Pakistani		
Bangladeshi		
Other Asian		
Black or Black British		
Caribbean		
African		
Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group		
Total	51	100%

(ix) Religion		
Baptist	2	3.92%
Church of England	17	33.33%
Roman Catholic	12	23.53%
Other Christian Denominations	2	3.92%
Muslim	1	1.97%

Sikh		
Hindu		
Buddhist		
Jewish		
Other		
No Religion	17	33.33
Total	51	100%

Appendix 2b

Population profile – Young males

(i) Status	Number of prisoners	%
Sentenced	4	80%
Convicted but unsentenced		
Remand	1	20%
Civil Prisoners		
Detainees (single power status)		
Detainees (dual power status)		
Total	5	100%

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	1	25%
6 months to less than 12 months	2	50%
12 months to less than 2 years	1	25%
2 years to less than 4 years		
4 years to less than 10 years		
10 years and over (not life)		
Life		
Total	4	100%

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month	1	25%		

1 month to 3 months	3	75%		
3 months to 6 months			1	100%
6 months to 1 year				
1 year to 2 years				
2 years to 4 years				
4 years or more				
Total	4	100%	1	100%

(iv) Main Offence	Number of prisoners	%
Violence against the person	2	40%
Sexual offences		
Burglary		
Robbery		
Theft & handling	1	20%
Fraud and forgery		
Drugs offences	1	20%
Other offences	1	20%
Civil offences		
Offence not recorded/Holding Warrant		
Total	5	100%

(v) Age	Number of prisoners	%
17 years		
18 years	1	20%
19 years	1	20%

20 years	3	60%
21 years		
Total	5	100%

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	4	80%
Between 50 and 100 miles of the prison		
Over 100 from the prison	1	20%
Overseas		
NFA		
Total	5	100%

(vii) Nationality	Number of prisoners	%
British (Manx)	5	100%
Foreign Nationals		
Total	5	100%

(viii) Ethnicity	Number of prisoners	%
White		
British (Manx)	5	100%
Irish		
Other White		
Mixed		
White and Black Caribbean		
White and Black African		

White and Asian		
Other Mixed		
Asian or Asian British		
Indian		
Pakistani		
Bangladeshi		
Other Asian		
Black or Black British		
Caribbean		
African		
Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group		
Total	5	100%

(ix) Religion		
Baptist		
Church of England	1	20%
Roman Catholic	1	20%
Other Christian Denominations		
Muslim		
Sikh		
Hindu		

Buddhist		
Jewish		
Other		
No Religion	3	60%
Total	5	100%

Appendix 2c

Population profile – Women

(i) Status	No of Women	No of YOs	%
Sentenced	2		66.67%
Convicted but unsentenced		1	33.33%
Total	2	1	100%

(ii) Sentence	No of sentenced women	No of sentenced YOs	%
Less than 6 months	1		50%
6 months to less than 12 months	1		50%
Total	2		100%

(iii) Length of stay	No of Women	No of YOs	%
Less than 1 month	1		33.33%
1 month to 3 months	1	1	66.67%
Total	2	1	100%

(iv) Main Offence	No of Women	No of YOs	%
Violence against the person		1	33.34%
Theft & handling	1		33.33%
Drugs offences	1		33.33%
Total	2	1	100%

(v) Age	No of Women	No of YOs	%
18 years to 20 years		1	33.34%
21 years to 29 years	1		33.33%
30 years to 39 years			
40 years to 49 years			
50 years to 59 years	1		33.33%
Please state maximum age			
Total	2	1	100%

(vi) Home address	No of Women	No of YOs	%
Within 50 miles of the prison	1	1	66.67%
Between 50 and 100 miles of the prison			
Over 100 from the prison			
Overseas (Mainland)	1		33.33%
NFA			
Total	2	1	100%

(vii) Nationality	No of Women	No of YOs	%
British (Manx)	2	1	100%
Foreign Nationals			
Total	2	1	100%

(viii) Ethnicity	No of Women	No of YOs	%
White			
British (Manx)	2	1	100%
Irish			
Other White			
Total	2	1	100%

(ix) Religion	No of Women	No of YOs	%
Baptist			
Church of England			
Roman Catholic		1	33.33%
Other Christian Denominations			
Muslim			
Sikh			
Hindu			
Buddhist			
Jewish			
Other			
No Religion	2		66.67%
Total	2	1	100%

Appendix 3

Summary of questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of a representative proportion of the prisoner population was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

The baseline for the sample size was calculated using a robust statistical formula provided by a Home Office statistician. Essentially, the formula indicates the sample size that is required and the extent to which the findings from a sample of that size reflect the experiences of the whole population.

At the time of the survey on the 21 February 2006 the adult male prisoner population at Isle of Man was 52. The baseline sample size was 52. Overall, this represented 100% of the adult male prisoner population.

Selecting the sample

All 52 prisoners were sampled and completion of the questionnaire was voluntary. Refusals were noted and no attempts were made to replace them. Three respondents refused to complete a questionnaire.

Interviews were carried out with any respondents with literacy difficulties. In total, no respondents were interviewed.

Methodology

Every attempt was made to distribute the questionnaires to each respondent on an individual basis. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- have their questionnaire ready to hand back to a member of the research team at a specified time;
- to seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire.

Response rates

In total, 46 respondents completed and returned their questionnaires. This represented 88% of the adult male prison population. The response rate was 88%. In addition to the three respondents who refused to complete a questionnaire, two questionnaires were not returned and one was returned blank.

Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted, in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey, are the comparator figures for all prisoners surveyed in local prisons. This comparator is based on all responses from prisoner surveys carried out in twenty-four local prisons since April 2003.

In the above document, statistically significant differences are highlighted. Statistical significance merely indicates whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading and where there is no significant difference, there is no shading.