Report on an announced inspection of

# La Moye Prison, Jersey

27 June –1July 2005

by HM Chief Inspector of Prisons

Crown copyright 2006
ISBN 1-84473-855-8
Printed and published by:
Her Majesty's Inspectorate of Prisons
1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

# Contents

**Introduction** 5

**Fact page** 7

**Healthy prison summary** 9

## 1 Arrival in custody

Courts, escorts and transfers 19
First days in custody 19

## 2 Environment and relationships

Residential units 23
Staff–prisoner relationships 25
Personal officers 26

## 3 Duty of care

Bullying 27
Self-harm and suicide 29
Child protection 30
Race relations 32
Foreign national prisoners 33
Family and friends 34
Applications and complaints 37
Legal rights 37

## 4 Healthcare

39

## 5 Activities

Education and library provision 47
Work 48
Physical education and health promotion 50
Faith and religious activity 51
Time out of cell 52

## 6 Good order

Security and rules 55
Discipline 57
Incentives and earned privileges 61

## 7 Services

Catering 63
Prison shop 65

## 8 Resettlement

Resettlement strategy 67
Sentence and custody planning 67
Life-sentenced prisoners 68
Offending behaviour programmes 69
Substance use 70
Reintegration planning 73
Public protection 75

## 9 Recommendations, housekeeping points and good practice

77

## Appendices

I Inspection team i
II Prison population profile – young men ii
III Prison population profile – adult men iv
IV Prison population profile – women vii
V Summary of prisoner questionnaires and interviews ix

# Introduction

La Moye prison needs to fulfil the functions of an entire prison system. As the only prison in Jersey, it holds men, women and children charged or convicted across a wide range of criminal offences.

This inspection found some serious deficits in the processes and procedures needed to support that varied group of prisoners. Few of the recommendations in our previous report in 2001 had been actioned four years later. As a consequence, the safety and security of prisoners and staff, and the likelihood of prisoners' rehabilitation, were compromised. However, we also found examples of extremely good relationships between prisoners and staff, some of whom went out of their way to try to make good some of the systemic deficiencies.

Safety and security are key issues for prisons. La Moye lacked proper first night or induction procedures, and a large proportion of men and women felt unsafe on their first night. Prisoners told us that bullying was a serious problem, yet there were no systems to deal with it, other than to remove victims to a succession of separate areas, including an unstaffed and unsupervised unit which was little more than a collection of cupboards. This was used as an escape route from the vulnerable prisoners' unit, which was itself a location for bullying. Staff supervision of prisoners in some areas was poor, and there was no proper monitoring of incidents, assaults and complaints. Suicide and self-harm procedures were in place, though they relied too much on healthcare staff, and there was inappropriate use of strip-conditions for those at risk of self-harm.

Systems to support physical security were also weak. Potential weapons and escape equipment were lying around the prison. Night security was of particular concern, with unlocking procedures that placed both staff and prisoners at risk.

Crucially, the prison had no reliable prisoner database. As a result, it was unable to assess prisoners' needs or seek to meet them. This was a particular issue in relation to black and minority ethnic and foreign national prisoners. La Moye held a number of Madeiran Portuguese-speaking prisoners, nearly all of whom were located on the vulnerable prisoners' unit. There were no race relations or foreign national policies or procedures: indeed the resignation of the race relations liaison officer two years previously had not even been noted by the prison until our pre-inspection visit. Although many black and minority ethnic prisoners reported good relationships with staff, a quarter of young adults said they had been victimised by other prisoners because of their race.

Most living units lacked integral sanitation, and some prisoners needed to slop out in the mornings. However, we were impressed, in most areas of the prison, by the proactive relationships between staff and prisoners: most prisoners told us they knew their personal officer, and had a member of staff to whom they could turn. Healthcare was also well delivered, though there was need for better mental health provision. Food was better than we normally see.

Prisoners were rarely locked in their cells. However, there was not enough for them to do. There was very little by way of education or training, to try to provide prisoners with the skills they might need to gain employment on release, and to reduce the likelihood of reoffending. Education amounted to 25 hours of one teacher's time; there was little full-time employment, and what there was was mundane or domestic. This meant that prisoners entering La Moye were likely to leave without experiencing the positive interventions that might make it less likely that they would reoffend.

Nor had the prison yet addressed prisoners' resettlement needs. There were no policies, little sentence planning and very little, other than limited drug rehabilitation, to help prisoners address their offending behaviour, or prepare them for release. Very few prisoners, compared to other prisons we have inspected, knew where to get help in finding housing, employment or other support.

The prison held two discrete populations: women and children. The physical environment for the women was poor, and the work opportunities limited. Access to sanitation was unsatisfactory, and until the week of the inspection there had been no proper reception procedures for them. They were effectively out of the line of sight of prison managers. Their accommodation and opportunities needed urgently to be improved.

We did not consider La Moye to be an appropriate place to hold children. Very little education was available, and child protection arrangements and staff training were inadequate. No risk or vulnerability assessments of children were carried out.

La Moye is a complex establishment, with a diverse mix of prisoners. It has had to increase its capacity over the last five years, as more men and women have been sentenced to prison, and for longer periods. One of our main recommendations is that its complexity is reduced, by holding all juveniles separately, in the purpose-built unit now being constructed on Jersey. Having done that, there is an urgent need to put in place some of the infrastructure and resources that the prison needs to carry out its core task.

Both prison managers and those responsible for custodial provision in Jersey are aware of the need to tackle the underlying issues at La Moye, in order to ensure that the prison plays an effective part in crime reduction and public protection. Their task will be to retain the positives in the prison – particularly its good staff–prisoner relationships – while putting in place the systems and procedures that can ensure safety and help reduce reoffending. This needs to be done as a planned package, so that strengthened processes run hand in hand with increased opportunities for prisoners. Our second main recommendation, therefore, is that a performance improvement plan, including time-bound targets and costings, should be agreed between the prison and the Home Affairs Committee. We hope that this report, and our recommendations, will assist in that process.

**Anne Owers** **September 2005**
**HM Chief Inspector of Prisons**

# Fact page

### Task of the establishment
La Moye is a multi-functional establishment serving the courts and people of Jersey through the provision of secure accommodation for male and female prisoners. The prison caters for adults, young adults and juveniles (if required).

### Area organisation
States of Jersey

### Number held
172

### Normal accommodation (not certified)
184

### Operational capacity
184

### Last inspection
Full inspection: April 2001

### Description of residential units
Seven residential units accommodate up to 184 prisoners, with separate wings for women and young adults, discrete segregation units for adult men and young adults, and a vulnerable prisoner unit on E wing. Remand and convicted adult prisoners are located on A, B, and C wings, and there are 35 enhanced-level prisoners on H wing. A wing is a voluntary drug testing unit and is used as the feeder accommodation for H wing. G wing is designated for young adults. The female unit is in a discrete area in the main accommodation building.

# 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 La Moye Prison, Jersey, caters for all people remanded or sentenced to custody within its jurisdiction. It therefore fulfils a number of roles – it is a local and training prison, women's prison, adult male prison, young offender institution, and a juvenile facility that, occasionally, holds boys and girls under school-leaving age. In this report we have mostly identified differences in provision for the different groups under our usual headings.

### Safety

HP3 Most prisoners reported feeling safe, but there were systemic weaknesses. Men, women and children travelled to the prison together and there was no written information about newly received prisoners. There were inappropriate arrangements for strip-searching, particularly of children. There were no special first night arrangements, no documented risk assessments, or vulnerability assessments for children, and no induction programmes. Despite evidence of widespread bullying there were no anti-bullying or violence reduction strategies. Levels of supervision in some parts of the prison were unsafe, and the management of vulnerable prisoners caused particular concern. Self-harm and suicide arrangements were over-medicalised, and there was too much use of the strip-cell for prisoners in distress. However, in other respects distressed prisoners were treated safely and monitoring was done well. Child protection measures were inadequate. We had concerns about some segregation and disciplinary procedures, and security lapses that compromised staff and prisoner safety.

HP4 Men, women and children travelled on the same vehicle to the prison. This practice was unacceptable and could be easily avoided, as receptions of women and children were infrequent. Very little, or no, information arrived with prisoners at their first reception, and prisoner escort forms were not used.

HP5 Reception was clean and tidy but had little information for new arrivals. Women bypassed reception procedures and went straight on to F wing, which had far worse facilities for receiving prisoners. Prisoners were booked in in an efficient manner and did not spend long in reception. Staff were welcoming, prisoners were put at their ease in a relaxed atmosphere, and the use of first names was commonplace. However, strip-searching procedures were inappropriate. Prisoners, including children, were strip-searched routinely by one member of staff, which was unacceptable. There were not enough holding cells to separate men, women and children if they arrived together.

HP6 Our survey revealed that a large proportion of men and women felt unsafe on their first night in prison. There were no special first night arrangements. Prisoners could spend their first night in a variety of locations. There were no risk assessments, no cell-sharing risk assessments, and no special vulnerability assessments for children. The only intervention was a personal interview with a member of staff on the wing, to complete a form opened in reception. New prisoners were offered telephone calls. There was no induction programme on any wing.

HP7 Prisoners said that bullying was a serious problem, and our observations confirmed this. The prison's response to bullying had been to create more areas to hold vulnerable prisoners, with some held separately from others. The largest vulnerable prisoner unit was on E wing, but during our inspection, it became clear that some bullies had arranged to move there. There were no formal systems to prevent this. There was no strategy for tackling bullies, or support systems for victims, and the victim was often moved away from normal location.

HP8 The most extreme manifestation of this policy was in the old reception unit, where up to seven prisoners were held in a tiny area. Some were in cells which were in fact former cupboards, had no natural light, and no cell door other than a curtain. The prisoners were locked in the unit and left unsupervised. They had no emergency cell call system and had to press the general alarm to attract the attention of staff. Such conditions were totally unacceptable.

HP9 There was no anti-bullying strategy, committee or other arrangements and no violence reduction strategy. A draft policy document had been written but not published. It was copied from HM Prison Service policies and its information did not directly relate to local issues. There had been a needs analysis but its findings had not been used to inform the draft policy. Allegations of bullying were not formally investigated in most cases, and complainants did not receive responses. Security information reports were not used to communicate concerns, and the content of complaints forms was not analysed by numbers or location. The number and nature of adjudications, assaults or self-harm monitoring were not correlated. The situation was made worse because staff supervision was poor in some areas. Groups of prisoners were left for long periods on their own when they were unlocked, particularly on the second and third landing, of E, B, and C wings. The prison seemed unable to identify the extent of the problem, and this area required urgent management attention.

HP10 In contrast, self-harm and suicide management arrangements were in place. There was a published strategy document. The governor chaired a suicide prevention committee with inclusive membership. The nominated coordinator provided good statistical information, which the committee used to identify trends and problem areas. However, systems were over-reliant on healthcare staff. The healthcare manager

organised and conducted all reviews, and most F2052SHs (self-harm monitoring forms) were opened by healthcare staff after referral from residential units. Personal officers and other residential staff had little involvement in reviews. However, they made regular and informative written entries in F2052SHs. Training in suicide prevention was not delivered (apart from on initial officer training) but staff carried ligature shears. We were concerned that strip-cells were used to manage some cases of self-harm.

HP11 There were inadequate child protection arrangements. With nine juveniles held over the previous six months, this was a significant weakness. The child protection coordinator was keen but had no allocated time to carry out specialist duties. That officer represented the prison at the Jersey equivalent of the area child protection committee; no member of the senior management team was present. There was inadequate training of staff. Such training will be a priority if the prison is to continue to hold children. Apart from some ad hoc education provision, there were no special arrangements for children. No additional support, such as social or youth workers, was available for detained children. The practice of strip-searching children needed to be reviewed and systems for risk assessments needed to be improved. Jersey was proposing to build a secure unit to hold all 15 year olds and we supported this proposal. Indeed, we questioned whether a separate unit for all juveniles might not be a better idea, as this would better protect children. Representatives of the prison should be involved in the development of the local youth action team to strengthen preventative strategies and ensure young people are diverted from custody wherever possible.

HP12 There were three separate segregation areas for male adults (E wing), young males (G wing) and women (F wing). Some cells on the E wing unit had in-cell sanitation but the rest had none. The lack of staff continuity on E wing was problematic and led to inadequacies with documentation. However, there were good relationships between staff and prisoners and we observed staff dealing sympathetically with some very disturbed people. Both E and G wing units were used regularly to hold vulnerable prisoners, some for long periods with no proper review of their status. Efforts were made to provide vulnerable prisoners with a level of regime, including association, physical exercise and access to the library. Those on E wing could also pay for in-cell television. For those segregated for good order or disciplinary reasons there was no formal written authorisation, notes in wing files were limited, and statutory visitors did not always visit each day.

HP13 Not all adjudicators had attended a recognised training course, and there were no standardisation meetings and no agreed tariffs for specific offences. Hearings took place in wing offices, which were unfit for the purpose. Prisoners were informed verbally that they had been placed on report, with no written information explaining the process or their entitlements. There were instances where charges had not been fully investigated, and a prisoner's incentives and earned privileges level could be reduced as an adjudication award for a single incident.

HP14 Most staff were trained in control and restraint techniques. Recorded levels of the use of force were low, with only 12 incidents in 2005 to date and only 11 in 2004, but there was some evidence of under-reporting. Use of force documentation was generally completed to a good standard. There was only one special cell, which was in E wing segregation unit. This was routinely laid out with strip-clothing, but we were satisfied that normal clothing was not automatically removed. The special cell had been used on five occasions to date in 2005 and three times in 2004. On at least

three occasions in 2005, placement in the special cell had been authorised solely to prevent self-harm. Authorisation documentation was generally completed to a good standard but the time of removal from the special cell was not routinely recorded.

HP15 There were a number of security concerns that affected the safety of staff and prisoners. There were not enough staff in the security department to operate effective security systems; there was little use of security information reports; no security committee; and no security meetings for at least five years. Despite the good relationships between staff and prisoners, dynamic security was not a key part of the security system. We saw potential weapons and escape equipment lying around the prison, and tool security was abysmal. There was a significant problem with illicit items entering the prison, and over the past 18 months, over 100 mobile telephones had been found inside the prison.

HP16 Despite this, officers on 'shopping runs' for prisoners were not searched when they returned to the prison, making them vulnerable to pressure from both sides of the prison fence. Routine searches of prisoners' cells were not carried out due to staff shortages, and even target searches were not always completed. Contingency plans had been revised but were not being tested, and security keys rings had not been sealed. Night unlocking arrangements, usually to allow use of the toilet, were of particular concern. Solitary officers, carrying a full bunch of keys, unlocked cells, many of which were doubled, putting themselves and other prisoners at serious risk of harm.

HP17 The detoxification protocols were not in line with best practice, and resources were insufficient to introduce methadone. The treatment regime was judged to be safe if not ideal. Jersey law does not allow for mandatory drug testing, but a form of voluntary testing was available. In our survey, prisoners told us that it was easy to get drugs.

## Respect

HP18 Very few prisoners had in-cell sanitation. Much of the prison was in a poor state of repair, but prisoners had good access to showers and wore their own clothes. Staff–prisoner relationships were close, but needed greater management oversight to ensure they were appropriate. Management arrangements for ensuring equal treatment for minority groups were entirely inadequate. There was no auditable complaints system. The prison made little provision to enable prisoners to practise their religion. Healthcare provision was generally good.

HP19 Cells in most living units were small, poorly furnished and most lacked integral sanitation. Prisoner access to toilet facilities at night depended upon night staff answering cell bells and unlocking prisoners one at a time. Prisoners complained to us that it could take up to one hour to have their cell bells answered. Prisoners were 'slopping out' in the mornings.

HP20 The standards of cell cleanliness were generally acceptable with some notable exceptions (particularly on E wing). Cell inspections were carried out in the young adult wing, and prizes were awarded to encourage cleanliness. Some rooms not designed as living accommodation had been converted for that use, most notably the

dormitory on E wing and the storerooms, cupboards and office in the old reception unit. Conditions in these areas were crowded and put pressure on limited facilities.

HP21 Association facilities were generally poor, and the rooms used for communal dining were small, ill equipped and run down. In-cell power was supplied by cables hooked to power sockets outside of cells. This practice had not been risk assessed, and needed to be. Prisoners had daily access to showers and telephones during association.

HP22 All prisoners were allowed to wear their own clothing, and there was good access to clean bedding and washing facilities.

HP23 Different incentives and earned privileges schemes operated for adult males, young people and women. There was no system on the vulnerable prisoner unit. The schemes were not well publicised, and prisoners on B and C wings had little understanding of how their scheme operated. Enhanced status for adult males was location-based and only available for those within the last two years of their sentence, but serving more than 12 months. Access to enhanced status for women and young people was easier, although the system for women was not really effective.

HP24 Most staff and prisoners had good relationships. We saw impressive examples of staff interacting with prisoners, seeking to help them through practical or emotional support, or even trying to get them work after release. Many staff clearly cared about their charges. But some prisoners had very little contact with staff, and it was rare to find staff challenging poor behaviour.

HP25 All prisoners were allocated a personal officer and most knew who they were, but formal contact was not made and recorded. Personal officers did not maintain a diary of contact or make routine entries in personal files. There was no policy document or guidelines to inform officers what was expected of them. Prisoners knew whom to go to if they had a problem, and officers helped prisoners with their problems, but this was usually achieved informally and outside the scheme.

HP26 The prison food was of a good standard and our survey results for this were better than the benchmarks. Prisoners could eat communally. All kitchen workers and one servery worker were trained in food hygiene. The kitchen was clean and well decorated. Food was appropriately stored and temperature checks were recorded. The menu cycle offered adequate meal choices, but there was no provision for Madeiran prisoners, the largest minority group. The gap between meal times was too long at night. We had some concerns about food hygiene, food temperature and the control of prisoners at the point of serving. There was no catering committee or formal means for prisoners to feed back their views about food.

HP27 The prison shop sold a modest range of items. No hobby items were available, and only one product was specifically aimed at meeting the needs of women. There were no products for any black or minority ethnic group, except hot chilli sauce. Reception packs were available, although not for women, as they missed out on the reception process. Advances of earnings were not made.

HP28 The prison lacked a prisoner database, which meant that it could not monitor race and diversity issues effectively. There was a small healthcare database and race featured on it, although the categorisations used were locally devised. According to that source, roughly 17% of the population were black or minority ethnic (Madeiran,

Bengali, Irish and Black British/Caribbean). Race relations had received little managerial attention since the last inspection, and none of the recommendations in our 2001 report had been implemented. There was no local race relations policy, no race relations management team, no race relations liaison officer (RRLO) and no systems for reporting racial abuse. The RRLO had resigned from his post in 2003, and this was not discovered until our pre-inspection visit in May 2005. There were no plans to appoint a new RRLO to carry out race relations duties. Black and minority ethnic prisoners, including young adults, reported good relationships with staff and other prisoners. However, there was an acceptance of racist name-calling between young adults without appropriate challenge. In our survey, 25% of young adult respondents said they had been victimised by prisoners because of their race, significantly worse than the 4% benchmark.

HP29 The prison could not readily identify the total number of its foreign national population. However, statistical information provided by reception and healthcare suggested they made up roughly 15% of the black and minority ethnic population, the largest number being Madeiran. There was no foreign nationals policy and the support offered to this group was very limited. No immigration and detention support was available. However, some foreign nationals received a five-minute international telephone call in lieu of visits. Nearly all Madeirans were held on the vulnerable prisoner unit.

HP30 Survey results on applications and complaints were disappointing. There was one system for both processes, with no centralised record. There were some records in individual wing ledgers, but these were incomplete and inconsistent. Most forms were used for applications, rather than complaints. Although many issues were resolved informally, prisoners were reluctant to make formal complaints. There were no management checks on the subject matter or the appropriateness of responses.

HP31 No staff were trained in legal services work and no facility time was available. Prisoners had very limited access to legal reference books. However, access to external legal advisers was available through a free phone system. We were unable to judge the effectiveness of this system but in our survey prisoners responded positively.

HP32 The ability to practise their religion was minimal for prisoners of all faiths. There was no chapel, no coordinating chaplain, no daily chaplaincy team or regular visiting ministers. A Methodist preacher had conducted a one-off service, two nuns visited regularly, and an imam had agreed to visit occasionally to speak to Muslim prisoners. This was in breach of legal requirements and needed urgent attention.

HP33 Healthcare provided a good service. There was a nurse-led primary care service that had further improved since 2001. Staff were professional, competent and caring and provided good clinical care, despite the cramped healthcare centre and the absence of wing-based facilities. All healthcare staff were nurse-qualified and the skill mix was good, if limited. There was no formal nurse triage and only a few nurse-led clinics, such as smoking cessation. There was no clinical supervision and no clinical governance. The pharmacy service was supply-only and in-house services were needed. Patients had good access to doctors from a local practice. The dental waiting list was relatively short, as was the waiting list to see the physiotherapist. Patients also had reasonable access to secondary care in the local hospital. Specialist mental health nursing care was limited and provided from the local forensic psychiatric team. There were no secure mental health beds on the island, and minimal primary mental healthcare for prisoners.

HP34 We strongly supported the proposals for service development submitted to the health and social services and home affairs committees. The appointment of a health promotion coordinator in the prison was a good first step. We also strongly supported plans to shift responsibility for prison healthcare and funding from the home affairs committee to health and social services committee to better meet the healthcare needs of prisoners.

## Purposeful activity

HP35 There was insufficient education and training provision for any of the population, both in terms of the hours available and the breadth of the curriculum. Although there was little unemployment, the work available was of low quality, and work skill qualifications were not available. Library facilities were meagre, and there was no sports hall. Prisoners had considerable amounts of time out of cell.

HP36 The provision of education was significantly below the required levels. The prison had just 25 hours a week of one teacher's time and occasional sessional teachers. The range of education offered included English for speakers of other languages, literacy and numeracy, basic computer skills, European computer driving licence, Maths GCSE, Spanish, yoga, first aid, bookkeeping and accountancy, and GCSE/A level distance learning courses. All prisoners on distance learning courses had to pay 50% of course costs, which had an impact on those on low income. If school-aged children were held, one teacher could be provided on a grace-and-favour basis until they left, but this was not guaranteed. Provision for prisoners in learning averaged one to two hours a week. One module in City and Guilds horticulture was available, but there was no other vocational training.

HP37 There were proposals for prison education to become the responsibility of the education committee rather than the home affairs committee. We supported such a move.

HP38 There was little full-time unemployment. The prison operated a labour pool from which people could be sent to workplaces where a shortfall had occurred. Work opportunities for male adults included kitchen, laundry, French polishing, refurbishment and manufacture of garden furniture, upholstery, vehicle painting, making emergency blankets, pallet making, gardening and wing cleaning. The provision for young adults was limited to vehicle washing and valeting, and motorcycle repair and wing cleaning. There were not enough work opportunities and training for women, who were restricted to gardening or wing cleaning. No work attracted recognised work skills qualifications.

HP39 The prison had no monitoring system for prisoner time out of cell, but we noted that prisoners were rarely locked in their cells and the prison routine allowed all prisoners to have association at weekends.

HP40 The library facilities were generally poor with an inadequate selection of educational and recreational books. External library agencies provided cast-off books. There were links with the external library service, and some prisoners could access outside library facilities monthly. There was a small selection of books on the corridors for young people but none for vulnerable young people. There had been no attempt to match

prisoners' cultural, social needs and interests. Reference books were limited across the prison.

HP41 Physical education facilities were limited – most noticeably by the lack of a sports hall – and the only provision was recreational, with some weights and exercise cycles. Access was good for adult male prisoners on A, B and C wings. There was less access for women and young adults, although some cardio-vascular equipment was available for use on their wings, and they had access to sports and games in the evenings.

## Resettlement

HP42 The prison offered little to help prevent reoffending. There was no clear resettlement policy, no needs analysis and little meaningful sentence planning, or programmes or other activity, to help prisoners address their offending behaviour, other than limited drug rehabilitation. Conditions for visitors were sparse and unwelcoming. There were no systems for enhancing public protection.

HP43 The prison had no resettlement policy, committee or clear management lead. Work on resettlement matters was haphazard and patchy. Local restrictions had been imposed on temporary release, and the absence of parole in Jersey created additional difficulties. There was valuable strategic work to develop a small, open unit to introduce some form of post-custody supervision.

HP44 Sentence planning was uncoordinated, fragmented and largely ineffective. There were individual pockets of good work, particularly in the female wing, which could be a model for future improvements. Funding had been agreed to appoint three additional staff from January 2006 specifically to develop this area.

HP45 There were no special arrangements for lifers, except for initial 'special watch'. All cases were subject to early transfer to the mainland, and had to be arranged between governors. Delays in sentencing were arising, caused by changes in legislation. There were potential human rights issues for island lifers who wished to serve their time on the island.

HP46 No accredited offending behaviour programmes were available to prisoners. There had been no needs analysis and there were no plans to conduct one. There was clear scope to introduce programme work for drug importers.

HP47 Most prisoners remained in Jersey after release. Survey results about preparation for release were poor. There was little systematic activity, although there were individual cases where officers had provided help to individuals. There was also some useful temporary release work, and some limited casework from in-house psychology and probation staff. There was a proposal for a new scheme involving community work, paid work and tagging. Job Club provided a weekly surgery, but there were poor links with housing providers. Support for prisoners returning to the UK was particularly poor as there were no routine links with UK probation.

HP48 The prison’s first drug strategy meeting had taken place during the month of our inspection. The draft strategy document was already outdated. The focus was on supply reduction, and there was no action plan or performance measures, no linkage

of supply and demand initiatives and no reflection of the needs of the different populations. A newly appointed drug strategy coordinator was keen to move things forward. This needed to be a priority. The single alcohol/drugs counsellor provided one-to-one counselling and drug/alcohol awareness courses, but was employed for only 25 hours a week; this was wholly inappropriate. There was no voluntary drug testing; but there was compliance testing within the incentives and earned privileges scheme, which was over-punitive.

HP49 The main visits room had uncomfortable, fixed plastic seating and two long, fixed tables. Seating was close together, there was little privacy, and the area appeared crowded and was noisy. There was a lack of information notices for visitors, no facilities for refreshments, no children's play area and no visitors' centre. Evening visits and family visits were offered. The latter took place off-site in more pleasant surroundings.

HP50 There was no public protection policy, committee or any accurate management data available. As a result, it was not possible to identify, monitor and review all relevant cases confidently. Although staff had above average knowledge about local cases, there was an over-reliance on anecdotal means of identifying high-risk cases. The seconded probation officer carried out some useful work, but the lack of a permanent post undermined the consistency required. Agencies on the island were debating which model of public protection to adopt, and this also needed to be decided as a priority.

## Main recommendations

**HP51 Children and juveniles should be held in a separate secure unit.**

**HP52 The prison should have a prisoner database and IT system so that it can effectively analyse and manage its prisoner population.**

**HP53 The States of Jersey should consider transferring responsibility for prison health and education to the island's health and education departments.**

**HP54 The prison should draw up a Performance Improvement Plan, using the detailed recommendations in this report, and setting priorities and timed targets for action. It should include :**

- **Effective first night and induction processes**
- **A violence reduction strategy, and systems, procedures and staff training to deal with bullying**
- **Procedures for identifying and supporting vulnerable prisoners in appropriate locations**
- **Refurbishment of the accommodation for women, and specific policies and practices to meet their needs**
- **Effective child protection measures, while children remain at La Moye**
- **Systems to record prisoners' ethnicity, monitor access to regime facilities by race and ethnicity, identify and meet the needs of black and minority ethnic and foreign national prisoners**
- **Facilities for religious observance that meet statutory requirements**
- **A review of security, and the implementation of effective procedures and management systems**
- **The introduction of more education and skills training**

– A resettlement needs analysis, followed by the implementation of effective resettlement strategy, supported by a committee and led by a manager.

HP55 New night unlocking arrangements should be introduced immediately to ensure that an officer unlocking a cell does not carry other keys. The remaining keys should be held in a place where no prisoner has immediate access.

# 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 Prisoners were transported the short distance from La Moye to the courts in Jersey's one cellular vehicle. Adult men, women, children and vulnerable prisoners travelled together. No personal information accompanied prisoners, other than their committal documents.

1.2 Police provided the court escort service in Jersey. The distance from La Moye to the island's courts was short, and there were no excessive journey times or late arrivals.

1.3 The prison received new prisoners every day of the week, including weekends. Adult men, women, children (both male and female) and vulnerable prisons travelled together in Jersey's one cellular vehicle. Although the distances were small and the time spent on vehicles was short (usually less than half an hour), the practice was unacceptable and, with the low numbers involved, unnecessary and easily avoided.

1.4 Prisoners arrived at La Moye without any personal information from the other agencies that had looked after them previously. There was no form of prisoner escort record. It was not clear how important information about a prisoner would be conveyed from other agencies to prison staff. We were told that important medical information about individuals was passed on by the police surgeon. However, there was no information accompanying one young person with a serious medical condition who arrived during the inspection.

1.5 Staff knew many new receptions already from previous sentences, and there was a heavy reliance on this. But there were no safeguards or systems to cover prisoners who were not known to staff.

### Recommendations

1.6 **Adult men, women and children should be transported separately to and from La Moye and the courts.**

1.7 **A prisoner escort record should be introduced.**

## 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 a prisoner's induction into the prison he/she is made aware of prison routines, how to access available services and how to cope with imprisonment.**

1.8 Staff in reception were welcoming. New arrivals could be located on any of five different wings. There were no first night arrangements and no formal assessments of prisoner risk, suitability to share a cell or vulnerability. There was no induction process for newly arrived prisoners.

## Reception

1.9 New receptions averaged only around seven per week. Most new arrivals were processed through the new reception on H wing. However, women were received straight on to F wing, which was not designed for receiving prisoners and had worse facilities. We could see no reason why all new arrivals should not be processed through the new reception. When we pointed this out the prison agreed, and by the end of the week newly arrived women prisoners were also processed through the new reception.

1.10 Reception was a reasonable facility. It was extremely clean and well maintained. However, there were only two holding rooms, which were unscreened, and lines of sight from the staff office into one of these rooms were poor. The shortage of holding rooms could cause problems if women, men, children and vulnerable prisoners came in together. There was no proper strategy or contingency to deal with such a situation. We were told that staff would manage such a situation as they saw best, if and when it arose.

1.11 New prisoners were booked in in an efficient manner, and did not spend long in reception. Staff were welcoming and put prisoners at their ease in a relaxed and informal atmosphere. Use of first names was normal. Prisoners were offered a shower and given a hot meal from H wing servery.

1.12 The arrangements for searching newly arrived prisoners were unacceptable. Most prisoners, including children, were strip-searched routinely by just one member of staff, unless another officer happened to be in the vicinity. This was unacceptable practice for searching any prisoner, but had particularly serious child protection implications. A member of healthcare staff also attended reception for a health screening interview with new receptions.

1.13 In La Moye's reception the dressing gown that should have been provided to prisoners during a strip-search had been replaced with an anti-ligature strip-gown. Strip-clothing is designed to replace prisoners' normal clothing as a last resort to prevent self-harm, and its routine use in reception was inappropriate. When this was pointed out, it was removed immediately.

1.14 All newly arrived children were routinely strip-searched in reception. Although this was done sensitively, it was not based on any risk assessment. Especially as all new arrivals had several searches before they arrived at La Moye, it was inappropriate to subject children to routine strip-searching.

1.15 Prisoners were issued with a smoker's or non-smoker's shop pack in reception. As women had bypassed reception until the week of the inspection, they had not previously benefited from this.

## First night

1.16 Prisoners spent their first night in one of a variety of locations. Adult men were usually assigned to C2, but could also go on to B wing. Prisoners requesting protection were allocated

to E wing. Young male prisoners went on to G wing. Women prisoners of all ages were allocated to F wing.

1.17 There were no special first night procedures to ensure the safety of new arrivals. There were no formal risk assessments or assessments of the suitability of individuals to share cells. There were no special vulnerability assessments of children. The only intervention was a brief interview with a member of staff on the wing, when the information sheet opened in reception was completed.

1.18 In our survey, we asked prisoners if they felt safe on their first night. Although many newly arrived prisoners had been at La Moye before, more than 30% of respondents, and 50% of women respondents, said that they felt unsafe on their first night. This position had worsened since the last inspection, when only 15% of prisoners surveyed said that they felt unsafe on their first night.

1.19 An example of some of the comments we received was from an adult male prisoner who said: 'the first night, I won't forget for the rest of my life how depressed and painful I was in the cell'.

## Induction

1.20 There was no formal induction programme on any wing. On F wing, staff went through procedures with new receptions on the day they arrived, and a prisoner Insider saw all new arrivals and explained about life inside La Moye. Prisoners on other units did not benefit from even this limited service. Although peer supporters were not a substitute for an induction programme, this system could be expanded to other units in the short term, at no cost.

1.21 All new prisoners who passed through the main reception were given a booklet about La Moye. However, much of the information in it was out of date and the content needed reviewing, ideally in consultation with the prisoner population.

1.22 In the absence of a proper induction programme the prison had no means of assessing individuals' needs and risk areas, making referrals where necessary or setting early custodial targets and objectives for prisoners.

## Recommendations

1.23 **No prisoner should be strip-searched with only a single member of staff present.**

1.24 **All newly arrived prisoners should be received into the reception area on H wing.**

1.25 **There should be a proper first night strategy including, as a minimum, procedures for assessing individual risk factors and suitability to share a cell.**

1.26 **There should be formal vulnerability assessments of all newly arrived children.**

1.27 **An induction programme should be designed and implemented.**

1.28 **Prisoner Insiders should be trained to operate as peer supporters on all wings.**

1.29 **The content of the induction leaflet should be reviewed and updated in consultation with prisoners.**

## Housekeeping point

1.30 Anti-ligature strip-clothing should not be used for strip-searches in reception.

# 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 Except for H wing, cells on most on the residential units were small, poorly furnished and lacked integral sanitation. The standards of cell cleanliness were generally good. Association facilities were generally poor, and the rooms used for communal dining were small and run down. The female wing (F wing) and the vulnerable prisoner unit on E wing were particularly dreary and cramped. All prisoners could wear their own clothing. Prisoners had good access to clean bedding and washing facilities, and daily access to showers. Prisoners in the converted, former reception unit were held in unsafe conditions.

### Accommodation and facilities

2.2 Seven residential units accommodated up to 184 prisoners. None of the accommodation was certified.

2.3 There were separate units for adult men, women and young people, and a vulnerable prisoner unit (VPU) on E wing. All residential units were accessible through a single corridor in the main prison.

2.4 Remand and convicted adult prisoners were located on A, B, and C wings. H wing housed 35 enhanced-level prisoners. A wing was designated as a drug-free unit and used as the feeder accommodation for H wing. G wing was designated for young people. F wing, for women, was in a discrete area in the main prison.

2.5 All residential units had a mixture of single, double and dormitory cells. There were communal association rooms, but little office and interview room accommodation. Apart from H wing, the general conditions of the wings were poor. Although generally clean, they were old and tired looking. Communal areas on the older units were small, landings were narrow, and sight lines were poor. Association facilities were generally poor, and the rooms used for communal dining in residential units (apart from H and G wing) were small, ill equipped and run down.

2.6 The female wing was particularly dreary and cramped, with a marked lack of recreational equipment. The communal areas in F wing were dark and needed decoration. There was a room with a rowing machine and exercise bike, but this was too small for purpose. The dormitory, accommodating nine prisoners, was crowded.

2.7 Except for H wing, cells on the residential units were small, poorly furnished and lacked integral sanitation. Access to toilet facilities at night depended upon night staff answering cell bells and unlocking prisoners one at a time. Single officers answered cells bells at night and allowed prisoners to use the toilets. Prisoners complained that it could take up to one hour for their cell bells to be answered due to the number of people who required attention. As a result, many prisoners slopped out in the mornings.

2.8 Most cells had in-cell televisions. In-cell electricity was supplied by cables hooked to power sockets outside cells. Risk assessments had not been carried out. Cables on the third landing of C wing were laid across the communal floor and posed an obvious trip hazard.

2.9 A variety of rooms not designed as living accommodation had been converted for that purpose, most notably the dormitories on E and F wings, and the storerooms, cupboards and office in the old reception unit. Conditions in these areas were crowded, putting pressure on limited facilities.

2.10 E wing (the VPU) was in a particularly poor state. It was originally designed to hold up to 18 prisoners in single accommodation. At the time of inspection, it held 43. There were dormitories that were converted classrooms, and most of the cells designed for single occupation had been doubled up. The old reception unit (near A wing) had recently been converted into accommodation for prisoners deemed unable to cope on the VPU. The conversion was crude. Storage space, holding rooms and offices had been turned into makeshift bedrooms for up to two prisoners. There were no doors to separate the rooms, and prisoners had tacked blankets to the doorways for greater privacy. There were no windows in the bedrooms and no natural light. Seven adult male prisoners occupied the 'unit'. There was a single emergency alarm bell in the small association room but no general call system to allow prisoners to reach staff for situations that were not emergencies.

2.11 H wing was clean, well decorated and bright. Cells were equipped with in-cell power and were well furnished. All had in-cell televisions. Association facilities were good. Pool tables and communal televisions were in a good condition and well looked after by prisoners.

## Clothing and possessions

2.12 All prisoners were allowed to wear their own clothes. Good quality prison clothing was issued to those who preferred not to wear their own. Prisoners had weekly access to wing laundries on all residential units, run by wing orderlies.

2.13 Personal items sent in were processed quickly through reception and often reached the prisoner the same day. Some items for everyday use (such as socks and underwear) were always delivered to the prisoner on the day they arrived. Prisoners could have their own bed sheets and bedding sent or handed in on visits. Prison bedding was available through weekly applications.

2.14 In our survey, 99% of respondents said that they were offered enough clean and suitable clothing for a week.

## Hygiene

2.15 Prisoners had adequate supplies of their own toiletries. Soap, toothpaste and shampoo sachets were available on the residential units on request. Toiletries were available in the prison shop and there were no restrictions on the amount that prisoners could have in-possession.

2.16 Prisoners had good access to showers during periods of association. In our survey, 100% said they could have a shower every day.

2.17 We did not see systems for prisoners to get cell cleaning materials, but they were issued with mops, vacuum cleaners and other cleaning items on request. There were weekly cell inspections on the young adult wing (G wing) with prizes for the cleanest cell.

2.18 Cells were generally clean and free from graffiti. Mattresses were in good condition and were exchanged as necessary.

### Recommendations

**2.19 There should be a full health and safety risk assessment of the arrangements for in-cell electricity.**

**2.20 The converted accommodation in the old reception unit is unfit for purpose and should be refurbished or closed. An emergency cell call system should be installed there as a matter of urgency.**

**2.21 There should be a programme of refurbishment for A, B, C, E, F and G wings.**

**2.22 All cells should be fitted with integral sanitation.**

## 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.**

2.23 Staff–prisoner relationships were in general friendly. Some good informal work helped prisoners to address their needs. Staff did not challenge inappropriate language or behaviour.

2.24 Our survey recorded that 80% of respondents felt that most staff at the prison treated them with respect.

2.25 We were impressed by the friendly nature of relationships between prisoners and staff. The use of first names was not uncommon, although not universal. Many of the staff knew prisoners from the small community outside the prison, and this was reflected in the nature of many of the interactions we saw. Some staff knocked on doors before entering, and there were greetings at unlocking times.

2.26 Because of the lack of prisoner opportunities for learning, addressing offending behaviour or making resettlement plans, we were unable to judge the extent of staff involvement in helping prisoners to change their lifestyles. However, there were examples where individual staff or groups of staff had worked with prisoners informally to help them address drug or other problems, and there had been cases where staff had arranged jobs for prisoners after release. There were no recording systems for these types of activity and we were unable to judge the extent of the informal help for prisoners. Many staff at La Moye genuinely cared about the

prisoners in their care, and did what they could to assist them, with little help or guidance from prison managers.

2.27 Some areas of the adult prison appeared to have few visible officers, and staff–prisoner contact was minimal. We saw inappropriate behaviour or language go unchallenged in all the male parts of the prison. For example, one officer was barged out of the way by a young adult on G wing. There was no apology and the officer made no attempt to correct this behaviour.

# Personal officers

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

2.28 All prisoners were allocated personal officers and most knew who they were, but there was no formal contact or records. Prisoners knew whom to go to if they had a problem, and staff helped them. However, this was generally done informally.

2.29 Prisoners were interviewed by wing managers as they arrived and given the name of their personal officer. Lists were displayed on boards in wing offices. Prisoners knew who their personal officers were, but many said they had not seen them formally since their arrival.

2.30 Formal contact between prisoners and personal officers was not scheduled or recorded. There were no identifiable entries in wing files from personal officers to indicate systematic work with prisoners. Entries in wing files were predominantly concerned with day-to-day behaviour and did not generally deal with the personal and individual circumstances of prisoners. Some entries in wing files showed a good knowledge of the prisoner's personal circumstances, but these were unrelated to the formal personal officer scheme. Personal officers did not routinely approach their prisoners to monitor their welfare, challenge their patterns of behaviour or support their progress.

2.31 There was no policy document to describe the role of the personal officer at La Moye. Staff were not issued with guidance on what they were expected to do and when, and were not allocated time to see prisoners formally. The scheme was not well supported by managers.

2.32 Most prisoners felt that staff were generally responsive when they had problems. In our survey, 76% said that there was a member of staff that they could go to if they had a problem.

## Recommendations

2.33 **A policy document should be published setting out the operation of the personal officer scheme and managerial responsibilities, and there should be guidance for personal officers on their role.**

2.34 **There should be routine management checks of personal officers' contact time and the quality of entries in prisoners' personal files.**

2.35 **Personal officers should have scheduled times to carry out their duties.**

# Section 3: Duty of care

## Bullying

**Expected outcomes:**
**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 did not have any organised systems to identify or deal effectively with incidents of bullying, and victims were simply moved to one of the vulnerable prisoner locations. As a result, related incidents were under-reported and many were missed altogether. Prisoners believed that bullying was a serious issue, yet the prison was unable to identify the extent of the problem. The main vulnerable prisoner wing, E wing, was also a location for bullying, and held a mixed population of prisoners, who were located there without any proper assessment by staff.

3.2 There was no published anti-bullying policy, anti-bullying coordinator or dedicated committee at La Moye that could measure and monitor the extent of bullying. There was no staff training programme. Officers said that they relied upon their good relationships with prisoners to tackle bullying as it happened.

3.3 A draft policy had been written in 2004 but had not been implemented. Its content was based on strategies used in England and Wales, and did not consider local conditions or an analysis of the required resources for implementation.

3.4 The prison psychologist had carried out a prisoner survey in May 2004 on the nature and extent of self-reported bullying. Sixty prisoners (including young people) were surveyed: 71% said that bullying was a serious problem, and 61% that it was better to get help from prisoners than staff if they were being bullied. Managers and staff were unaware of these results. The information had not been analysed and was not informing strategies for dealing with the apparent problem.

3.5 Allegations of bullying were not formally investigated and prisoners did not receive responses to complaints. There was no log of bullying incidents. Of the 50 most recent applications from prisoners requesting segregation for their own protection, 38 were because of threats or bullying from other prisoners. These requests were accepted without formal investigation of the circumstances.

3.6 Attention was given to suspected victims rather than alleged perpetrators. Victims were moved systematically to the vulnerable prisoner unit on E wing with no assessment of the possible risk to themselves or others. Officers arranged transfers to E wing without the authority of residential managers, and there was no scrutiny of the reasons that informed the authorisation for segregation of these prisoners. There were no reviews of changing circumstances after a prisoner was admitted to E wing, and there were no reintegration plans or any interventions to allow prisoners to develop coping strategies.

3.7 The number of people requesting places of safety far exceeded the prison's capacity to provide appropriate accommodation. E wing had been designed to accommodate 18 prisoners and held 43. Nearly all of the small cells, designed for one, held two prisoners, and an old classroom converted into a dormitory accommodated up to eight prisoners. These areas were not supervised regularly, and there were no records to show that officers patrolled them. C1 landing was used as an overflow unit for those unable to find space on E wing.

3.8 Some prisoners told us they were afraid to come out of their cells during association and that bullying on E wing was a real problem. Staff did not record instances where prisoners were known to be spending time in their cells when unlocked.

3.9 Prisoners who complained that they were not safe on E wing were housed in the old reception unit, accommodated in converted storerooms and cupboards. Seven prisoners were sharing accommodation separated by blankets hanging from doorways (see paragraph 2.10). Prisoners there were not supervised, and were locked in the unit and left alone for most of the day and night without staff support or supervision.

3.10 Staff supervision was poor in some areas of the residential units. Groups of prisoners were left on their own for long periods when unlocked, particularly on the second and third landings of A, E, B, and C wings. Three officers were designated to supervise prisoners on A, B and C wings. They were unable to supervise all of the nine landings where prisoners had access while unlocked. This provided good opportunities for bullies.

3.11 Information to identify the extent of the problem or to identify areas of particular risk was not used. Security information reports (SIRs) were not used to communicate concerns, and the contents of complaints from prisoners were not analysed. In 2004, there had been no SIRs from staff on possible incidents of bullying.

3.12 There were no correlations between the number and nature of adjudications, assaults by prisoner on prisoner, recorded suicide and self-harm attempts, or other relevant information that might have indicated bullying behaviour.

## Recommendations

3.13 **An anti-bullying coordinator should be appointed.**

3.14 **An anti-bullying committee should be set up to monitor and measure the quality of the anti-bullying strategy.**

3.15 **Staff should be trained in anti-bullying procedures.**

3.16 **There should be systems to ensure that all information concerning bullying is correlated, communicated and used to inform intervention.**

3.17 **Prisoners should not be located in the vulnerable prisoner unit without an examination of the reasons for application and an assessment of risk.**

3.18 **A senior manager should give authority for segregation at the request of the prisoner.**

3.19 **A senior manager should monitor the population profile of E wing each month.**

3.20 **Managers should ensure that staff can supervise prisoners adequately.**

# Self-harm and suicide

**Expected outcomes:**
**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, are appropriately trained and have access to proper equipment and support.**

3.21 There were reasonable systems for prisoners at risk of self-harm or suicide, although they were over-reliant on healthcare staff. The healthcare manager organised and conducted all reviews, and most F2052SHs (self-harm monitoring forms) were opened by healthcare staff after referral from residential units. Personal officers or other residential staff had little involvement in case reviews. Strip-conditions were used to manage some cases of self-harm.

3.22 A self-harm and suicide strategy document had been written and published. Its content set out, in simple language, the prison's guiding principles, priorities and targets, and described underlying factors in the causes of self-harm and suicide.

3.23 The healthcare manager had been nominated as the prison's suicide prevention coordinator and managed the process and intervention methods on a day-to-day basis. A suicide prevention committee had been set up to manage the systems prescribed in the policy. Meetings were held monthly and were chaired by the governor. Although attendance at these meetings was good, not all areas of the prison were represented. Healthcare, psychology and probation departments were consistently represented, but staff from the residential units did not always attend and prisoners were not involved or consulted.

3.24 Good statistical information was provided and was being used by the committee to identify trends and potential areas of concern. However, possible correlations between incidents of self-harm and possible bullying were not made.

3.25 Systems were over-reliant on healthcare staff. All reviews of active self-harm cases were organised and conducted by the healthcare manager. Healthcare staff opened most F2052SHs after referral from residential units. In 2004, they opened 38 of the 47 F2052SHs.

3.26 There were four live F2052SHs during our inspection. The quality of entries was good and concentrated on levels of mood and not single examples of behaviour. The suicide prevention coordinator made daily management checks. All cases were communicated to staff during a formal handover period each morning. Case reviews were held on time. They were organised by the suicide prevention coordinator exclusively and regularly attended by the psychologist and a member of the healthcare team. Personal officers, residential managers and the prisoner concerned attended regularly.

3.27 Prisoners had been located in special cells under strip-conditions to manage their self-harming behaviour in three cases in 2005 to date. These situations were not brought to the attention of the suicide prevention committee or documented as any part of the case management process.

## Recommendations

3.28 **Residential managers should be responsible for managing prisoners considered to be at risk of suicide and self-harm.**

3.29 **Residential staff should attend all F2052SH (self-harm monitoring) case reviews.**

3.30 **Residential managers should regularly attend suicide prevention committee meetings.**

3.31 **The suicide prevention committee should examine the correlation between bullying and self-harm each month.**

3.32 **An anti-bullying coordinator should attend all suicide prevention committee meetings.**

3.33 **Prisoners considered at risk of self-harm should not be managed in strip-conditions.**

# Child protection

3.34 Child protection was an area of major weakness and was largely underdeveloped. There was a keen child protection coordinator but systems in place were not properly followed and there was no management oversight. The prison was an entirely unsuitable environment for children.

3.35 The child protection coordinator was an officer who had volunteered for the post. He was extremely keen and willing. He had completed relevant training at the prison training school in the UK and had a firm grasp of basic child protection issues. The coordinator was regarded as the key worker for children throughout the prison, and carried out much useful support work between children and their families, often in his own time. He had no allocated time to carry out this task.

3.36 The child protection coordinator was the prison's representative at the Jersey child protection committee. This was not appropriate, as someone in a management position should have taken this role.

3.37 Although there was a child protection policy, it was clear that there was no common understanding about how the procedures should operate. The coordinator told us that there had never been a referral generated from inside the prison. However, the prison's probation officer said that she had made child protection referrals herself directly to the children's service department in the community. There was no internal child protection committee, and there did not appear to be a nominated senior manager responsible for this area.

3.38 We were unable to determine how many staff had received child protection training. Our best estimate was that approximately half of all staff had completed relevant training. This was a concern given the high level of cross-deployment in the young adult and the women's wings, where children were located. As far as we could establish, staff had had a standard police check only. This was inadequate when there was a prospect of them coming into contact with children.

3.39 A further concern was the absence of any risk assessment or vulnerability assessment of juveniles (those under 18). Juveniles were located in the young adult and women's wings, where the levels of informal welfare support were generally good. Based in these areas, boys would not have come into contact with adults over the age of 21. However, because of the lack of rigour in public protection arrangements (see public protection section), they could still share accommodation with young adults, who could be a risk to them. Girls had their own cell on the women's unit, but unsupervised mixing with adults was possible at times. Although the level of informal support available to the younger population was good, there was no system to assess the distinctive needs of vulnerable children. This needed to be introduced.

3.40 No juveniles were held at the time of the inspection, but there had sometimes been several at a time during the preceding year. Despite the best efforts of staff, and even if the recommended improvements were introduced, the prison was an entirely unsuitable environment for children. Approval had recently been given for a new 12-bed secure unit to be built on the island, where it was hoped to hold 15-year olds. We support this and believe that all juveniles could be held here to properly protect all children required to be kept in secure conditions. Because of the small numbers involved, the local authority had a realistic prospect of being able to avoid placing children in prison.

3.41 A youth action team (YAT) was due to be set up in Jersey, an initiative similar to the youth offending teams (YOT) in the UK. At the time of the inspection, prison staff were not involved in the planning of this new initiative and this was a missed opportunity to strengthen preventative strategies to divert young people from custody.

## Recommendations

3.42 **Children should never be strip-searched by a solitary member of staff and should never be strip-searched without a documented risk assessment beforehand.**

3.43 **A senior member of staff should represent the prison at the Jersey child protection committee.**

3.44 **The child protection coordinator should be allocated protected time to carry out this function.**

3.45 **An internal child protection committee should be set up.**

3.46 **Child protection training should be delivered to all staff who have contact with children.**

3.47 **There should be enhanced police checks on all staff who have contact with children.**

3.48 **There should be risk and vulnerability assessments to ensure that children are not exposed to individuals who might be an unacceptable risk to them, and that their individual needs are met.**

3.49 **Prison staff should be represented in the planning for the youth action team.**

# 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.**

3.50 There were no accurate statistics for black and minority ethnic prisoners at the prison. There had been no work on race relations since 2002, and no training in race relations or diversity for staff.

3.51 The prison did not have accurate figures for its black and minority ethnic population because there was no formal mechanism for recording prisoners' ethnic origins. However, according to the figures supplied by reception and healthcare, approximately 17% of the population were black or minority ethnic (Madeiran, Bengali, Irish and black British/Caribbean). The figures were inaccurate as we saw more Madeiran prisoners than recorded, but they had clearly been included in the white/British category.

3.52 Race relations had received little managerial attention since the last inspection, and there had been no work in this area since 2002. There was no local race relations policy. The prison's equal opportunities and race relations policy statements had been publicised around the prison by the race relations liaison officer (RRLO) in 2002, but were no longer in evidence on the residential wings.

3.53 There was no race relations management team, no systematic recording of prisoners' ethnic origins, no formal mechanism for monitoring different black and minority ethnic groups' access to facilities or services, no promotion of positive race relations or cultural diversity within the prison, and no diversity training for staff.

3.54 The RRLO had resigned from his post at the end of 2003 and had not been replaced, but this fact was not noted until our pre-inspection visit in May 2005. Although the governor said the promotion of good race relations was important to the prison, there were no firm plans to appoint a new RRLO to carry out race relations duties.

3.55 The previous RRLO had been enthusiastic and committed, but had not received any facility time to carry out race relations duties in his two and a half years in post. He had produced a business plan in August 2002, but very few of the objectives had been achieved. He had also carried out an assessment exercise on the language needs of Madeiran young adults, ensured catering arrangements were in place for Ramadan, and compiled a list of Madeiran individuals, including staff, willing to interpret.

3.56 He had also established contact with the RRLO from HMP Moorland, and subsequently, introduced racist incident complaint forms to the residential wings. A racist incident complaint log was created and four incidents were dealt with, although only three were logged during 2002. There was evidence of sound investigative practices and a clear commitment to address issues of discrimination. For example, in one case where an Asian prisoner complained about an officer's inappropriate handling of racist graffiti, the complaint was upheld and the officer received guidance and training on race relations.

3.57 In our survey, 5% of respondents said they had been victimised by prisoners because of their race. On the whole, black and minority ethnic prisoners reported good relationships with staff

and other prisoners. However, there was an acceptance of racist name-calling between young people without appropriate challenge from staff.

3.58 The catering department routinely organised a special menu for Muslim prisoners to celebrate Ramadan. However, no dishes were provided to meet the needs of Madeiran prisoners, who were the largest minority group. There were information leaflets in Portuguese and French in healthcare, and a few Portuguese books in the library, on the women's wing and on the vulnerable prisoner unit.

3.59 Staff reported that one Madeiran and one black member of staff had both received a high level of racial abuse from some staff and prisoners, and this was ignored by management. Management leadership and training in race relations and diversity would help to raise awareness and confidence in dealing with race and cultural issues.

### Recommendations

3.60 **The prison should set up a race relations/diversity committee to champion work on race relations and diversity.**

3.61 **A race relations liaison/diversity officer should be appointed to carry forward the work started by the previous race relations liaison officer.**

3.62 **A programme of training on race relations and diversity should be organised for all prison staff.**

## Foreign national prisoners

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

3.63 The largest number of foreign national prisoners at La Moye were of Madeiran Portuguese origin, and most of them lived on the vulnerable prisoner unit. There was no policy, and few services were targeted to meet the needs of foreign national prisoners generally.

3.64 The prison could not readily identify the total number of its foreign national population. However, statistical information provided by reception and healthcare showed they made up roughly 15% of the population. The largest number of this group was Madeiran-Portuguese (9%), Bangladeshi (3%) and Irish (2.25%). A significant number of foreign nationals lived on the vulnerable prisoner (VPU) unit, and almost all prisoners of Madeiran origin resided on that unit.

3.65 Nobody had responsibility for looking after the needs of foreign nationals. There was no policy and the support offered to this group was limited. There was evidence that some foreign nationals received a five-minute international telephone call in lieu of visits, but this was not offered to all prisoners routinely and there was no formalised system.

3.66 Telephone translation services were not used, but some Portuguese-speaking officers interpreted for prisoners. English for speakers of other languages (ESOL) classes were provided, but for only an hour a week. Reception had kept copies of the prisoner information booklet (compacts) in Portuguese and French, but these were no longer available. The reception risk assessment form was available in French, but this was outdated. Healthcare had information booklets in Portuguese and French, including literature about safer injecting and help available for detoxification and smoking cessation.

3.67 The library had 40 books in Portuguese, and women from F wing could get Portuguese books from the local library every three weeks. The women's wing also had a small collection of foreign language books and magazines that had been left there by prisoners. There was an information leaflet in the visits room, and the dedicated Portuguese officer on the VPU had put together a small collection of two Portuguese/English bilingual dictionaries, 20 Portuguese books (mainly fiction), as well as notices in Portuguese about obtaining visiting orders and making an appointment to see the doctor.

3.68 There was no immigration and detention support available for foreign nationals. Three prisoners said they would be deported on completion of their sentence and had to use their own resources to speak to their solicitors. However, staff on E wing had allowed one prisoner to make calls seeking legal and immigration advice free of charge.

3.69 The foreign nationals we spoke to during the inspection said they had not experienced any racial discrimination. However, the seven foreign nationals (Bangladeshi and Madeiran) whom we spoke to in a focus group discussion were angry and frustrated. They felt that staff ignored their requests for assistance (with free international telephone calls, supervised visits, and immigration and resettlement issues). While they said staff were reasonably pleasant, they lacked knowledge about their needs, and consequently, appeared unsupportive. They said that staff, however, tended to be receptive to requests for help from local men.

## Recommendations

3.70 **The ethnicity and racial origins of all prisoners should be recorded in reception when they arrive.**

3.71 **The prison should produce a policy for dealing with foreign nationals and appoint a coordinator to ensure their needs are met appropriately.**

3.72 **The process of giving foreign national prisoners a free five-minute telephone call or letters in lieu of visits should be formalised, and telephone calls for foreign nationals isolated from family and friends should be subsidised.**

3.73 **Management should examine the reasons why foreign national prisoners, particularly Madeirans, are placed on the vulnerable prisoner unit and should find appropriate solutions.**

# Family and friends

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

3.74 Prisoners' mail was processed quickly. Access to telephones was good, except for those in the old reception unit. The main visits room was cramped and poorly furnished. Facilities for visitors were also poor. Family visits were offered, but only to prisoners on enhanced status.

## Mail

3.75 There were no restrictions on the number of letters prisoners could send or receive. Prisoners received one letter a week to send at public expense, and could buy stationery and stamps from the prison shop.

3.76 All incoming mail was received into the centre office where it was opened, checked for enclosures, and sorted according to residential units. Legal correspondence, when identified, was delivered unopened on the day of arrival. There were no systems to identify mail that had been legitimately targeted for censorship, and there were no public protection measures in place (see section on public protection). Ten per cent of mail was routinely censored.

3.77 Mail was delivered to prisoners on the day of its arrival. Only 23% of those surveyed said that they had experienced problems with sending or receiving mail. Outgoing mail was processed on the residential units and taken to the administration department for posting out on the same day.

## Telephones

3.78 Access to telephones was primarily during association. There were card-operated telephones on all residential units, except for the old reception unit. Prisoners there were given access to the office telephone in the evening at times determined by patrolling officers. These times varied daily. Prisoners had daily access but were unable to plan calls due to the unpredictability of the time that staff visited the unit. Calls were free of charge.

## Visits

3.79 Social visits were offered from 1pm to 4:40pm, Monday to Saturday. Legal visits were available during weekday mornings. Adults, vulnerable prisoners and young people had separate visits. All were given a minimum of 30 minutes a week. Visits for convicted men and women took place between 1:30pm and 3:30pm. The 30-minute entitlement was not strictly adhered to in practice. If the room was not full, prisoners were allowed to continue their visit until 3:30pm.

3.80 Visiting times were from 3:30pm to 4pm for young adults and from 4:10pm to 4:40pm for vulnerable prisoners. These visits were strictly 30 minutes. Remand prisoners were entitled to a 15-minute visit per day but booked visits as convicted prisoners. Prisoners were allowed two adult visitors per visit. There was no set limit on the number of children who could accompany adult visitors.

3.81 Prisoners booked their visits through application on their residential unit. In our survey, 80% of respondents said they could have the number of visits that they were entitled to.

3.82 There was no visitors' centre. A visitors' waiting room next to the main visits room had a few uncomfortable, plastic chairs. Warning notices were displayed in English and Portuguese, but there was nothing to inform visitors about what to expect from their visit or procedures they

could follow to get help with problems. A suggestion box was fixed to one of the walls but there was no paper to write on. There were unanswered suggestions in the box dated January 2005.

3.83 The visits room was small, cramped and needed decoration. Information notices were not displayed. There were no facilities for visitors to buy refreshments, and no facilities for children. The room could accommodate 14 visits per session. It had two long rows of fixed tables with two fixed chairs on one side for visitors and one for the prisoner on the other. Seating for visitors was packed close together. When fully booked, there could be up to 28 adult visitors and an unpredictable number of children. This meant inadequate space between visitors and minimised privacy. It was crowded and noisy.

3.84 Some chairs were broken and the tables were in a poor state of repair. There were no observable public protection measures, although the area was well supervised by three officers. CCTV cameras were in place but were not always in operation due to staff shortages.

3.85 There was one room for closed visits. It was adequately designed and clean. Planned closed visits had been used six times in 2004. Two prisoners were currently on closed visits. There were no formal systems to ensure systematic reviews of prisoners on closed visits. The deputy governor said that he reviewed all cases monthly, but reviews were not recorded. Closed visits were used as a punishment award following adjudication when it had been proved that unauthorised articles had been smuggled in for prisoners during visits.

3.86 A prison drug detection dog screened visitors before admission into the prison. Managers said that closed visits were offered as a result of a single indication from the drug dog. There was no protocol for the use of the dog, and there were no records on the number of single closed visits that had been authorised. No closed visits took place at the time of inspection.

3.87 Prisoners on the enhanced level of the incentives and earned privileges scheme with family difficulties could apply for family visits (see paragraph 5.43). These took place in a local community centre and were supervised by prison staff. The scheme was not open to other prisoners or young adults, regardless of their needs.

## Recommendations

3.88 **There should be a prisoners' telephone in the old reception unit.**

3.89 **A visitors' centre should be established and should provide information on what visitors can expect from their visit and how to receive help when needed.**

3.90 **The physical conditions for visits should be improved to bring them up to an acceptable condition, and there should be better facilities, particularly for those with children.**

3.91 **There should be formal, scheduled, monthly reviews of prisoners on closed visits.**

3.92 **Protocols on the use of the prison drug dog should be written and published.**

## Good practice

3.93 *Adult prisoners on enhanced status with family difficulties could attend family visits in the community.*

# 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.**

3.94 Staff resolved many applications and minor complaints informally. There was no auditable formal complaints system. Prisoners were reluctant to make formal complaints.

3.95 There was only one system and a single form for prisoners to make both applications and complaints. The forms were entitled request/complaint forms but were referred to locally as 'wing application forms' and also 'governor's application forms'.

3.96 The forms were kept on residential wings. In most cases, prisoners used them for making applications rather than complaints. There was no formal, centralised log of prisoner complaints. Some records were kept in individual wing ledgers on E, G and in the centre office for A, B and C wings. However, these were incomplete and inconsistent. For example, there were gaps of over two months between entries on some of the ledgers.

3.97 It was clear from talking to staff and prisoners that many issues were resolved informally by staff, without prisoners needing to make formal applications and complaints. However, prisoners also made it clear that they were reluctant to make formal complaints as they were afraid of having their privileges withdrawn. This was especially apparent on H wing.

3.98 Our survey results in this area were extremely poor and reinforced this message. More than 90% of respondents did not feel that complaints were resolved fairly. The absence of a formal, auditable complaints system made it impossible to verify this perception.

## Recommendation

3.99 **A formal, auditable prisoner complaints system should be introduced.**

# Legal rights

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

3.100 Although there were no legal services trained staff, the needs of prisoners were generally met through the '*batonnier*' system of legal advice. Access to legal reference material was poor, and some prisoners expressed concern at the quality of legal representation they received.

3.101 No staff were trained in legal services. Prisoners could access legal representation and advice on related matters via the '*batonnier*' system. Jersey-based solicitors took on the role of *batonnier* in turn, allocating solicitors to prisoners requiring legal representation. The *batonnier*

could be contacted though a free telephone number publicised on the residential wings or available from wing managers.

3.102 Our survey findings on the services provided by the *batonnier* were generally positive. They provided a source of advice and allocated solicitors efficiently. However, some prisoners were dissatisfied with the quality of legal representation that they eventually received. They felt that, as solicitors in Jersey did not get paid for legal aid cases, they did not always represent them as robustly as they could have done.

3.103 Access to legal reference books was poor, with no provision whatsoever in the prison's library. One of the senior managers had some legal reference material that could be loaned out to prisoners individually. However, this provision had not been publicised to prisoners and few were aware of it.

## Recommendation

3.104 **Legal reference material should be available to prisoners in the prison library.**

# 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 was a nurse-led, primary care service, and the good quality of care we saw at our last inspection had improved. This was supported by our survey. Staff were professional, competent and caring and provided good clinical care, despite a healthcare centre that was cramped, and the absence of wing-based facilities. Nurses were still used for non-clinical work, which meant there was no capacity to introduce formal nurse triage or regular nurse-led clinics. Most healthcare policies were out of date. Mental health services were limited. A comprehensive health needs assessment, published in 2004, had been used to good effect to support joint working between the prison and local services. We supported the proposals for service development and to shift responsibility for prison healthcare and funding from the home affairs committee to the health and social services committee.

## Environment

4.2 The healthcare centre was a single-storey wing situated centrally in the prison off the main corridor and opposite the segregation unit. The environment was generally clean and well equipped, although small.

4.3 The patients' waiting room was immediately inside the entrance and was the only access to the healthcare centre. It had some wooden seating and racks for health promotion material, some of which was in French and Portuguese. Notices were in Portuguese as well as English.

4.4 The door into the nurses' office and the pharmacy was off the waiting room and was locked when healthcare staff were absent or if only one member of staff was present when medicines were administered. A small, barred hatch linked the pharmacy to the waiting room.

4.5 The pharmacy was small and clean. Many medicines were not stored in lockable cupboards but left out on the work surfaces. Many doses were prepared before treatment times and left out on the worktops in 'tots' bearing just the prisoner's name and not identifying the drug itself.

4.6 A portable, lockable medicine trolley was secured to a wall. This contained medicines for prisoners in the segregation unit, the vulnerable prisoner unit, women's and young adults wings. There were no controlled drugs, although a secure cabinet was available if they were needed.

4.7 The pharmacy fridge had a device that ensured continuous minimum/maximum temperature recording to ensure that heat sensitive medicines were stored correctly. Healthcare staff checked the emergency resuscitation drugs regularly. The only reference book, the *British National Formulary*, was out of date.

4.8 A locked gate separated the waiting room from the rest of the healthcare centre. Lockable filing cabinets storing old clinical records were in the corridor. There was a small interview room with comfortable seating, and a gated door that opened on to the garden, which had been an

exercise yard when there were inpatients. This valuable space would have been better used to extend the healthcare centre accommodation.

4.9 The dental surgery was small but reasonably clean and well equipped. Some of the equipment was old and unreliable and needed to be replaced. The equipment, unit, autoclave, compressor and water lines had been regularly serviced and certificated, and met current standards for health and safety. Cross-infection control standards were satisfactory, and emergency oxygen, airways and drugs were available.

4.10 Other accommodation included the healthcare manager's office and the doctors' consulting room. The latter had a connecting door to a treatment room, which had an examination couch. This room was used by the doctor for physical examinations, and by the visiting physiotherapist, optician and chiropodist when required.

4.11 The room used for health screening in reception was clean and adequately equipped.

## Records

4.12 All current clinical records were stored in non-lockable drawers in the nurses' office. A good numbering system enabled old records to be retrieved if prisoners returned to prison.

4.13 We reviewed several sets of notes and were impressed by the overall quality of record keeping. A stand-alone, electronic information system had been introduced and this enabled effective health and demographic data collection, as well as collation of clinic lists. However, it was not a primary care system and was not linked to prescribing or compatible with the GPs' practice system. There was no prison-wide, electronic, prisoner information system and no electronic links between healthcare and other departments.

4.14 There was no pharmacy computer system. Although there were some patient medication records on the computer at the community pharmacy, these were incomplete.

4.15 Prescriptions were written on administration charts on to which additional administration sheets could be added. Duplicate private prescriptions were also written by the doctor and were faxed to the pharmacy for dispensing, with the originals supplied to the pharmacy later that day or the next day. Nursing staff recorded medicines supplied to patients correctly on their administration charts.

4.16 There was evidence on some charts that the doctor had not signed the prescriptions, which made them invalid. There was no system for the pharmacist to review or check prescription charts to ensure clinical appropriateness or legality.

4.17 There was a list of medicines to be supplied as 'special sick', but this also included prescription-only medicines, which was illegal. Supplies were recorded on a separate sheet and not generally recorded on the prisoner's administration card. Staff did not complete an error or intervention log.

4.18 Dental records were held securely in the clinical record, which gave the dentist access to medical histories.

## Staffing

4.19 All healthcare staff were trained as prison officers as well as being nurse-qualified. The healthcare manager had worked at the prison for almost 20 years and had qualifications in both mental health nursing and learning difficulties (RMN/RMNH). As well as running healthcare, for the past two years he had been the lead for suicide and self-harm, and until a month before the inspection was also the drug strategy coordinator.

4.20 There were four other nurses, two of whom were registered general nurses (RGNs) and two were dual-qualified as general nurses with mental health or learning disability training. One of the nurses was on call from home each night. None of the nursing staff had clinical supervision, and there was no clinical governance. Healthcare staff had no administrative support.

4.21 Three doctors, including a woman GP, from a local practice provided medical care, including out of hours and emergency care. Pharmacy was a supply service from a local community pharmacy. The dentist, assisted by an experienced dental nurse, provided six half-day clinical sessions a month.

4.22 Other visiting specialists included a physiotherapist who visited once or twice a week as required, a consultant microbiologist, who came on request, and an optician, who came monthly. A chiropodist was available to see patients when needed.

4.23 Mental healthcare in the prison was limited. A clinical nurse specialist in forensic psychiatry visited for one session weekly, as did a consultant general psychiatrist under a private arrangement. A clinical psychologist visited for one session approximately twice a month.

4.24 There were no regular formal healthcare staff meetings. Although not a member of the senior management team, the healthcare manager attended the monthly wing managers' meetings.

4.25 Most healthcare policies were out of date and needed revision.

## Delivery of care

### Primary care

4.26 The healthcare centre was open between 7.30am and 9pm daily. As from the week of the inspection, a nurse saw all new arrivals in reception for an initial health screening. Before that, there had been different arrangements for male and female prisoners. Staff used a locally devised but comprehensive reception screening tool to review the patient's physical and mental health. This included taking basic physical measurements, such as height, weight and blood pressure, and screening for drugs.

4.27 New arrivals were given a leaflet explaining the range of healthcare available, and asked to sign a medicines compact. Those needing detoxification were started on medication on their first night and seen by a GP at the next surgery. All relevant reception information was entered into the healthcare database. Although there was no chronic disease register, the information was available through using the system. None of the women in the prison were pregnant at the time of the inspection.

4.28 The doctors provided a two-hour surgery on six mornings a week, seeing up to eight patients at each. This allowed a reasonable time for each patient. The female doctor was routinely available to see women on one day a week, but women could be seen at other times if they were happy to see a male doctor. The doctors encouraged patients to see the same doctor on each visit as this improved continuity of care.

4.29 There was no formal application system. Healthcare staff had developed a form, but wing staff were reluctant to use it. Prisoners who wished to see one of the healthcare team usually asked one of the nurses when medicines were being administered, or wing staff telephoned their request to healthcare. There was no formal nurse triage and only a few nurse-led clinics, such as smoking cessation.

4.30 There was also no formal appointments system, but this was largely because the nurses tried to ensure that all patient groups had fair access to care. Patients were often told they had an appointment to attend the healthcare centre the night before or called up the same day so staff could ensure separation of patient groups, given the very limited space in the healthcare centre. Staff made efforts to ensure that prisoners who usually went to work stayed in their cells to be called to the healthcare centre so that they didn't miss their appointment. The system generally worked well as the clinic lists were entered into a daily diary and on to the electronic database. Staff were fully aware of who should be seen when. Patients were followed up if they did not attend.

4.31 Patients not fit to go to work were allowed to 'rest in cell', but there was no formal policy on this.

4.32 All significant events relating to patients were entered on to the database as well as in their clinical record. These included records of referral letters sent to the hospital and any outpatient appointments received. The latter were also noted in the diary and escorts arranged. Although staff were aware that such action had been taken, there was no system to reassure patients that referral letters had been sent.

4.33 Nurses still undertook many non-clinical duties, such as all the administration, escorting patients when required, and cleaning the healthcare centre. As trained prison officers they were also required to perform tasks such as locking up wings and take part in control and restraint operations. This undermined their primary role as nurses.

4.34 Only main wing prisoners could attend the healthcare centre to collect medicines or talk to staff at the four treatment times each day (three at weekends) at 8am, 11.30am, 4.20pm and 8pm. Most medicines were prescribed as not in-possession and therefore administered during these treatment times. They were supplied to prisoners through the pharmacy hatch to the waiting room. There was little privacy, although few patients at a time came into the waiting room. Nurses took patients into another room in the healthcare centre if a private conversation was needed.

4.35 Some items, such as vitamins and creams, were available for prisoners to buy from the prison shop. Paracetamol and indigestion tablets could be issued out of hours from the central office. These supplies were logged on a recording sheet but were not transcribed on to patients' administration charts.

4.36 A nurse distributed medication to women, young adults and men in the segregation and vulnerable prisoner units from a drug trolley, which went to their wings just twice a day at 8am and 8pm. Men in the enhanced wing also had difficulty attending the healthcare centre because of the temporary fence, but most had their medication in-possession.

4.37 The pharmacist had recently begun to visit the prison and had now produced a written report and action plan. He was available to speak to prisoners about their medicines if required, but there was no formal system to facilitate this. The chief pharmacist for Jersey had been involved in a preliminary pharmacy needs analysis for the prison population, but there was no medicines and therapeutics committee, few up-to-date procedures, no formulary for prescribing and no agreed stock levels, and the prison did not receive official drug recalls.

4.38 The dentist usually saw eight patients per session. Very few patients failed to attend. The waiting time for routine treatment was only five weeks. Emergencies that could not be dealt with by the healthcare staff or deferred to the next session were referred to the practitioner's surgery outside or to the dental department at the hospital.

4.39 The dentist treated patients according to need. There was special emphasis on oral hygiene for young patients so that they could access the free dental scheme for young people on the island on release. For women there was also a special concern for an aesthetic result to aid rehabilitation and self-confidence upon release. Treatment for male prisoners, other than pain-relief and functional treatment, depended on their level of cooperation to maintain a high standard of oral hygiene. More advanced treatment was available in very exceptional cases, usually upon referral and /or at cost to the prisoner. Electric toothbrushes and floss were available from the prison shop.

4.40 The physiotherapist was a community physiotherapist who offered a wide range of treatments, and her care was much valued by patients. There was no waiting list. Patients could be referred to the local hospital for hydrotherapy or the sports injury clinic. Nineteen patients also took part in remedial gym sessions, available for an hour each weekday from gym staff in the prison.

4.41 Patients also had reasonable access to secondary care in the local hospital, as well as regular clinics in the prison from a consultant microbiologist who provided advice and screening for blood-borne viruses.

4.42 Healthcare staff saw all patients before their release and gave them a duplicated form with information on help and support agencies. The potential danger of overdosing on opiates on release was highlighted in red in English and Portuguese.

## Mental health

4.43 Specialist mental health nursing care was limited. It was provided from the small, local forensic psychiatric team, which also undertook police/court liaison. The team had a total caseload of about 40 patients, 10 of whom were in prison. A female community psychiatric nurse was due to join the team and would focus on the needs of the women. The local general psychiatry services were available for emergency care but had not been needed in the past year.

4.44 There were no secure mental health beds on the island. Patients who needed inpatient care could be admitted to the local mental health hospital (St Saviours). If a secure bed was needed, patients were transferred to a medium secure unit (The Trevor Gibbons Unit) in Kent, with whom the Jersey mental health service had a service level agreement for two beds (one male and one female). Only one patient was waiting for a psychiatric assessment for transfer to the NHS.

4.45 The consultant general psychiatrist had 21 patients on his caseload and saw four each week. He worked closely with the healthcare manager and the head of psychology, who also saw

patients occasionally for anger management and counselling. Clinical psychology services were very limited, as a local psychologist visited about once a month only.

4.46 There was little primary mental healthcare for prisoners, other than from the GPs. The health needs assessment had highlighted the need for this.

## Working with local health services

4.47 The relationship between the prison and local services differed from that in the UK as all primary care services were private. A comprehensive health needs assessment was published in 2004 and had been used to good effect to support joint working between the prison and local services. We strongly supported the proposals for service development submitted to the health and social services and home affair committees.

4.48 A job description for the appointment of a health promotion coordinator in the prison had been drafted and was a good indicator of the commitment to joint working.

4.49 We also strongly supported plans to shift responsibility for prison healthcare and funding from the home affairs committee to health and social services committee. This was likely to better meet the healthcare needs of prisoners.

## Recommendations

4.50 **The recommendations of the review group to transfer prison healthcare funding should be endorsed to implement the healthcare improvement proposals.**

4.51 **There should be formal mechanisms to promote continued joint working.**

4.52 **Algorithm-based nurse triage should be introduced.**

4.53 **Nurse-led clinics should be introduced.**

4.54 **Administrative staff should be employed to release nurses from non-clinical duties.**

4.55 **Staff shift patterns should be reviewed to maximise resources.**

4.56 **Nurses should not undertake discipline duties, such as control and restraint and locking of wings.**

4.57 **There should be clinical supervision for all staff, and clinical governance should be introduced.**

4.58 **A primary care-compatible IT system should be installed.**

4.59 **The garden space next to the healthcare centre should be developed to provide extra clinical accommodation.**

4.60 **A defibrillator should be provided and all staff (including the dentist and dental nurse) should have training in its use, as well as cardiopulmonary resuscitation.**

4.61 There should be a medicines and therapeutics committee, including the chief pharmacist and doctors, to review all pharmacy policies and procedures and introduce medicines management, review the use of drug administration charts and the use of patient group direction.

4.62 Medication for administration should not be pre-prepared and left out in unlabelled 'tots'.

4.63 All prescriptions, including those for stock medicines, should be faxed through to the pharmacy.

4.64 All pre-packs and medicines issued to prisoners should be labelled in accordance with the Medicines Act requirements, and all dispensed medication should include a patient information leaflet.

4.65 There should be a formal procedure to enable healthcare staff to administer prescription-only medicines from stock in an emergency.

4.66 All prescriptions and instructions to administer drugs should be signed by the doctor involved.

4.67 Agreed pharmacy stock levels should be implemented.

4.68 Discontinued medicines awaiting destruction should be clearly quarantined, and an appropriate, licensed waste remover should be contracted to provide this service.

4.69 The dental unit should be replaced.

4.70 All healthcare policies should be reviewed and updated regularly.

4.71 There should be an increase in mental healthcare provision, including that for patients with counselling needs.

## Housekeeping points

4.72 There should be an application system for requests to see healthcare staff.

4.73 Appropriate, lockable metal cabinets to store medicines should be provided.

4.74 There should be more health promotion material relevant to women.

4.75 Keys to the healthcare centre should not be taken out of the prison.

# Section 5: Activities

## Education and library provision

**Expected outcomes:**
**Education and skills training meet the requirements of the Adult Learning Inspectorate's common inspection framework (separately inspected by ALI). Prisoners are encouraged and enabled to learn both during and after sentence, as part of sentence planning; and have access to good library facilities.**

5.1 There had been some very limited progress since the last inspection but, overall, the range and quality of education provision remained wholly inadequate. The curriculum was impoverished, with most learners offered no more than one or two hours of education a week. Staffing levels were insufficient to meet the identified need. Library provision was poor.

### Education

5.2 Education services to prisoners at La Moye were provided by one teacher for 25 hours a week, with occasional sessional teachers. There was no administrative support. The teacher was enthusiastic and motivated, and supported well by prison officers and her small team. There was good communication between senior management, wing staff and education workers, and a high level of mutual respect between staff and prisoners. However, staffing levels were clearly insufficient. The one teacher was struggling, under very difficult circumstances, to deliver a basic educational programme to a broad range of individuals. She clearly could not meet the needs of the entire population almost single-handedly.

5.3 There was a more structured system of initial assessment since the last inspection, with up-to-date assessment of all learners before they attended education. The Basic Skills Agency entry level assessment was used to develop individual learning plans for young people, but there was no formal or routine recording of results for management purposes. The teacher was involved in the sentence planning process for young people. She also visited some wings to check progress of those attending education. Specific learning needs were identified and support provided, where possible. There was no guarantee of education for school age children.

5.4 Facilities had improved slightly for mainstream prisoners and young people, with the provision of some Portakabin classroom accommodation. However, educational facilities for vulnerable prisoners and women remained unsatisfactory, and there was poor use of the facilities in the evenings and at weekends. For example, there was no study space for prisoners after educational hours. There was good use of areas around the prison to support work activities. Computer hardware and software were dated, and there was limited IT technician support. There was a lack of teaching staff to support the current curriculum.

5.5 There had been no progress in the curriculum since the last inspection. It remained impoverished and inadequate to meet learners' needs. The range of education offered included English for speakers of other languages (ESOL), literacy and numeracy, basic computer skills, European computer driving licence, maths GCSE, Spanish, yoga, first aid, support for book keeping and accountancy, and GCSE and A level distance learning courses.

5.6 Access to education was poor. Most prisoners received insufficient time for education – often as little as one hour per week. Unsurprisingly, there had been an increase in the numbers on distance learning courses, but learners had to pay 50% of costs and this had an impact on those on low incomes. There was very little education provision in the evenings. The curriculum for IT was particularly poor, with a poor range of computers to support learning. The computers were not networked or linked to the internet. There was no clear rationale to support curriculum development – for example, an employment needs analysis.

5.7 Leadership and management were inadequate. There were no systems to assure the quality of education and training. Management information was collected manually. Plans for a more effective partnership arrangement with Highlands College had been slow to develop. A joint plan with the college for the development of education had been considered by the home affairs committee and was due to be submitted to the education committee. We strongly supported this.

### Library

5.8 The library facilities were generally poor, with an inadequate selection of educational and recreational books. There were links with the external library service, and prisoners could access outside library facilities monthly. External library agencies provided cast-off books. There was a small selection of books on the corridors for young people, but none for vulnerable young people. There had been no attempt to match prisoners' cultural, social needs and interests. Reference books were limited across the prison.

### Recommendations

5.9 **The quantity and quality of education offered to prisoners should be increased substantially to meet the needs of the population.**

5.10 **Staffing levels should be increased and administrative support should be provided.**

5.11 **Library resources should be improved.**

## 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 reoffending.**

5.12 Most prisoners were assigned to an activity place, although this was mostly low grade, low skilled work. Nearly all opportunities for prisoners to gain accredited skills in the workplace were being missed. The situation was especially poor for women and young people.

5.13 Most prisoners were assigned to an activity work placement and unemployment levels were low, at just over 10% of the population. However, the working day was short, at around five hours, and most of the work available was low grade and repetitive, offering little skills acquisition. Work available typically included laundry, kitchen, gardens, refurbishment and manufacture of garden furniture, vehicle painting, packing emergency blankets, pallet repair

and wing cleaning. Many prisoners in wing-based jobs, such as servery workers and cleaners, were inadequately supervised and spent much of their time lounging around.

5.14 Even with the limited range of low grade work opportunities available, there were still missed opportunities for accrediting skills gained in the workplace. For example, there were opportunities in catering, industrial cleaning and elsewhere, and also a clear opportunity to train prisoners as forklift truck drivers. The only work area where prisoners could gain qualifications was in the horticultural department, where prisoners had recently gained seven certificates in propagation and planting. This was a good start, but needed to develop considerably further.

5.15 The work provision for young people and women was particularly poor, and did not extend beyond gardening and wing cleaning for most.

5.16 Systems for allocation to work were informal and unclear. There were no recognised criteria for assigning prisoners to jobs, no formal activities allocations board, no safeguards to ensure equality of opportunity, and no systems to appeal against non-selection for jobs. Prisoners not formally assigned to jobs were put into a labour pool, from where they could be selected for work in the prison on an ad hoc basis, if a vacancy arose.

5.17 Despite these arrangements, we saw unfilled places in some of the working areas, such as gardens and woodwork shops. Management of attendance was rudimentary at best. In practice there was little questioning of prisoners' reasons for non-attendance.

5.18 In many cases, there was a strong reliance on prisoners providing skills gained from previous employment to support contract work and train other prisoners, for example, furniture restoration.

5.19 Some work areas were generally cluttered and untidy. Although supplied, personal protective equipment was not used routinely by prisoners. Some eye protection and emergency aid equipment were missing from identified points in the adult vulnerable prisoner unit furniture workshop. We also saw many incidences of tools left lying around and unaccounted for (see paragraph 6.5).

## Recommendations

5.20 **A post of head of learning and skills should be created to oversee the strategic development of work and education at La Moye.**

5.21 **The quality of work available to prisoners should be improved and should enable them to learn useful skills. The emphasis should be on skills acquisition for prisoners.**

5.22 **There should be an improved work allocation system which takes account of individual prisoners identified needs.**

5.23 **There should be monitoring arrangements to ensure prisoners attend work and classes as programmed, and that they attend punctually.**

5.24 **Workplace supervisors should ensure that prisoners use protective clothing and equipment at all times.**

# Physical education and health promotion

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

5.25 The physical education (PE) programme was purely recreational, with no vocational courses offered. The only development since the last inspection was a daily session of remedial PE.

5.26 PE facilities consisted of a single room on the first floor of the main residential area, just off B wing. This room contained weightlifting equipment and a range of cardio-vascular equipment. It could hold around 17 prisoners at any one time. A staff office provided good sight into the area. A separate room, across a corridor, was used for classes, such as spinning, but this was due to be converted into a dining room. However, we were informed that it would still be available for PE classes other than at meal times.

5.27 Other resources included an all-weather, five-a-side pitch and a big concrete pitch next to the young people' wing. Some cardio-vascular equipment was available on the women's, young people's and enhanced wings. Although the facilities were adequate, a sports hall would greatly enhance provision, particularly in the winter.

5.28 Staffing consisted of two PE instructors. They also used some residential staff for supervision of activities. The PE staff said that they were well supported by managers, and that keeping the gym open was always a priority, as it was one of the few means of occupying prisoners during the day at La Moye.

5.29 Access to the main gym was good for most prisoners on A, B and C wings. There was much less access for women and young people. The limited range of cardio-vascular equipment on these wings helped somewhat, although there were some complaints about access to the gym from these areas. Women and young people also had access to outdoor sports and games on some evenings.

5.30 The PE programme was purely recreational, apart from the remedial sessions. There was clearly scope for providing some structured, accredited training in this department.

## Recommendations

5.31 **There should be more physical education equipment on the wings with restricted access to the main gym.**

5.32 **Vocational training should be offered alongside the recreational physical education programme.**

# 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 prison life and contributes to prisoners' overall, care, support and resettlement.**

5.33 The prison was not fulfilling its legal obligation to provide opportunities for all prisoners to practise their faith. There was no chapel and no coordinating chaplain. Prisoners had limited access to services, and no services were offered to prisoners of non-Christian faiths.

5.34 There was no accurate data on the various religious groups in the prison. According to statistics provided by reception and healthcare, 16.3% of prisoners did not have their religious denominations recorded when they arrived at the prison. However, the largest religious groups recorded were Roman Catholic, Church of England, and Muslim.

5.35 Prisoners had less access to services than at the time of the last inspection. There was no daily chaplaincy team in the prison. There was no chapel or dedicated room where prisoners could attend services and no faith courses on offer. Although there had been plans for a new chapel since 2003, these were still at the discussion stage. A chaplaincy room was available, but this was mainly used as a storeroom for religious books and non-religious items.

5.36 The Church of England chaplain retired in 2003 and had not been replaced. Temporary cover was provided for a short period, but lapsed. The Catholic chaplain retired over four years earlier and had been replaced by female assistants, who worked a total of four hours between them. They ran some services but were unable to administer the sacraments. However, two replacement female assistants and a priest were appointed during our inspection.

5.37 The chaplains were dedicated and well thought of by prisoners and staff. They were adaptable and held services wherever space was available. Not all prisoners who wanted to could attend services or see a chaplain of their own faith. On Mondays, one chaplain held a short service on G wing for two to eight young adults, while the other chaplain held a service in the compound for a small group of men who worked in the survival blankets workshop. On Wednesdays, one chaplain held a short service for prisoners on the vulnerable prisoner unit (VPU) in their recreation room, while the other had a one-to-one service for a prisoner on the women's wing followed by a second service in the compound for four women working in horticulture.

5.38 There was no formalised system of requests to see the chaplains. Officers informed the chaplains, on an ad-hoc basis, when prisoners suffered a bereavement, and the chaplains visited them. However, they rarely had the time for one-to-one visits.

5.39 A Methodist preacher (non-keyholder) had provided pastoral support to a prisoner from the VPU for two hours each Thursday since May 2004 and, on request, saw a few prisoners from the same wing for informal chats. This arrangement was initiated by the prisoner and not the prison.

5.40 There had been no support for prisoners of other faiths to attend services for some time. However, during the inspection an imam visited a Muslim prisoner on E wing on a one-off basis.

5.41 There were a few additional religious activities. At Easter and Christmas, the Catholic chaplains held ecumenical services on each of the wings. Three 'Walk Jersey' group visits (testimonials about individual life experiences) were organised for the groups who attended the regular services.

5.42 The St Vincent De Paul society, a Catholic charity, paid for the flight and accommodation for a few women to visit their relatives at La Moye, and in 2005, the visitors were accommodated by the chaplains.

5.43 For an afternoon twice a month, enhanced-level prisoners (mainly from H wing, but not women) with marital difficulties or complex domestic issues could have supervised visits from their partners and children outside the prison environment at the Christian-based organisation Communicare. For the first time in 2004, the Prison Fellowship 'Angel Project' bought gifts for the women on F wing to give to their children at Christmas. A Methodist-based music group, Cornerstone, visited some of the adult wings three times in 2004 and visited the young adults for the first time just before the inspection.

5.44 The limited time available to the chaplains meant they did not routinely visit sick prisoners, prisoners in the various segregated units in the old reception area, the women's wing and the young adult wing, They were not involved in the induction process. Although they had good relationships with staff, they were not involved in meetings or committees.

5.45 The prison was not fulfilling its legal obligation in recording the religious denomination of prisoners, and ensuring that prisoners who wanted to could practise their faith or receive visits from chaplains.

### Recommendations

5.46 **The prison should employ appropriately qualified chaplain(s) to undertake the statutory duties outlined in Prison (Jersey) Rules, 1957.**

5.47 **Religious services should take place in a chapel or in a room dedicated for spiritual worship, and should be accessible to all prisoners weekly. Services should be available to prisoners from non-Christian faiths.**

5.48 **Enhanced-level women prisoners should have equal access to Communicare family visits.**

## Time out of cell

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

5.49 Prisoners were mainly unlocked for most of the day, even at weekends. Association (recreation) took place every weekday evening and at weekends. There was a short period of exercise in the fresh air each day.

5.50 Time out of cell provision was good across the prison. Unemployment levels were low, and even those not employed had reasonable amounts of time out of cell every morning, afternoon and weekday evening. Weekend provision was also very good, with prisoners unlocked and out of their cells all day until after they collected their evening meals.

5.51 Everyone was unlocked for evening recreation from 6:00pm to 8.30pm. Prisoners said this was rarely cancelled.

5.52 We received no complaints from prisoners about the amount of time spent locked in cell. They were far more concerned about the lack of purposeful activities when they were unlocked, as recreation facilities and work opportunities were extremely limited (see sections on residential units and work).

5.53 Half an hour of exercise in the fresh air was scheduled daily, and was taken in various exercise yards. The main yard was extremely dirty and covered in litter. We received a few complaints that exercise was cancelled on occasions. It was unclear who took the decision to cancel exercise, as there were no records of who took the decision and for what reason.

## Recommendation

5.54 **Exercise should only be cancelled with the authority of the duty governor, and there should be a log of the occasions when it is cancelled, who took the decision and for what reason.**

## Housekeeping point

5.55 Exercise yards should be cleaned daily.

# Section 6: Good order

## Security and rules

**Expected outcomes:**
**Security and good order are maintained through proactive staff–prisoner relationships 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 an assessment of a prisoner's risks and needs; and are clearly explained, fairly applied and routinely reviewed.**

6.1 We had serious concerns about security at La Moye. The security department was under-resourced and had few established or effective systems for managing security intelligence. Searching was not completed, despite obvious problems with illicit items entering the prison. There were very poor practices in the security of tools and other items that were potential weapons or escape equipment. Arrangements for unlocking prisoners to use the toilets at night were unsafe and needed urgent review.

6.2 There had been no formal security committee for at least five years. Staffing in the security department consisted of a manager and administration support. The manager, although full-time, worked shifts and was frequently redeployed to other duties. The full-time administrative support member worked mainly on resettlement related work. Staffing in the security department was woefully inadequate, making it impossible to operate effective security systems.

6.3 Only 105 security information reports (SIRs) had been submitted in 2005 to date. This was a low figure given the level of security concerns in the prison, and reflected a general staff apathy towards such matters. Where SIRs had been submitted there had been no analysis of the information in most cases, and no recorded follow-up action. There were no systems for evaluating and using intelligence from SIRs. Individual staff who submitted an SIR had no acknowledgement that their report had been received.

6.4 The level of illicit items entering the prison was very high. Over the previous18 months, over 100 mobile telephones had been found. This statistic, while alarming enough, might understate the problem, as there had been no scheduled searching and little target searching of cells during this period, due to the general shortage of staff.

6.5 The arrangements for the security of tools were particularly poor. In the wood shop some discarded tools were held in boxes in the office. The main tool store, which held many potentially dangerous tools, was left open for prisoners to help themselves. We visited the area at lunch time and found tools lying about unaccounted for. There were also many potential weapons and items of escape equipment in the adjacent compound freely accessible to the prisoners working there.

6.6 As there were few cells with integral sanitation, staff on night duties had to unlock prisoners to use the toilet. There had been no risk assessments and there were no safe systems of work in place. We observed staff unlocking prisoners (some in shared accommodation) on their own while in-possession of their normal security keys. This practice had potentially serious consequences if those unlocked under such arrangements had attempted to breach security.

6.7 The prison had contingency plans but these had not been tested through the 'desk top' method. Key rings for security keys had not been sealed to prevent keys being removed.

6.8 The rules of the prison were not well publicised. They were generally explained in compacts that prisoners were expected to sign on certain wings, although there were no compacts on B, C and E wings.

## Categorisation

6.9 La Moye was the only prison in Jersey and catered for all prisoners, so there was no need for any formal categorisation arrangements. However, it did have to transfer prisoners to prisons in England and Wales regularly because of overcrowding. At the time of inspection, 37 prisoners had been transferred under such arrangements, which cost the Jersey Prison Service on average between £600,000 and £800,000 a year.

## Recommendations

6.10 **There should be a security committee that holds monthly, minuted meetings.**

6.11 **There should be a full review of all work related to security, as a priority, to ensure that it is adequately resourced.**

6.12 **All information submitted on security information reports (SIRs) should be analysed, and a senior manager should record the follow-up action required. Any intelligence identified should be used proactively, and staff submitting SIRs should receive acknowledgement.**

6.13 **Scheduled quarterly searches and target searches of cells should always be carried out.**

6.14 **Tools should be held on shadow boards in secure cabinets and only issued by staff through a tally system. Tools should be returned and accounted for before prisoners leave the area.**

6.15 **All potential weapons and escape equipment should be removed from the prison or stored securely, as a matter of priority.**

6.16 **Contingency plans should be tested regularly through the 'desk top' method.**

6.17 **A comprehensive list of the prison rules should be drawn up and publicised in all residential wings.**

## Housekeeping point

6.18 Security key rings should be sealed to prevent keys being removed.

# 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.**

6.19 The level of adjudications was low. There were no specific punishment tariffs. Prisoners were not encouraged to request witnesses or seek legal representation during governor's adjudications. Reported use of force incidents appeared low, but some under-reporting was likely. On occasions the special cell was used solely to prevent acts of self-harm, which was inappropriate, and the length of time in the special cell was not properly recorded. There were good staff–prisoner relationships in the segregation units. Prisoners were segregated without formal written authority and their segregation was not regularly reviewed, leaving some prisoners segregated for longer than necessary. There was a lack of staff continuity, which contributed to poor recording and inconsistency of the regime offered to segregated prisoners.

6.20 Three senior managers carried out adjudications but only the governor had attended a recognised training course. There were no agreed award tariffs for specific offences. Since the start of 2005 there had been 118 adjudications, 79 for adult males, 34 for young people and five for women. Six of these hearings had been referred to the board of visitors (BOV).

6.21 The prison did not have a formal adjudications room. Hearings took place in various locations, mainly in wing offices. There had been no risk assessments of any of these locations, and they were generally unfit for purpose. All the offices used were small, with office equipment and other potential weapons within reach of the prisoner.

6.22 Under the formal, preliminary procedure at governor adjudications, prisoners were not invited to request witnesses or legal assistance. Senior managers said that witnesses and legal representation were only normally permitted at hearings conducted by the BOV, where remission could be lost. Prisoners were informed verbally that they had been placed on report but received nothing in writing to explain the adjudication process.

6.23 There were no adjudications during the week of inspection. However, we reviewed documentation from completed hearings. The written accounts were generally very brief, and there were a few examples where charges had not been fully investigated.

## Use of force

6.24 The prison had a very high number of staff trained in trained in control and restraint (C&R) techniques. This training was viewed as a priority due to the absence of support from other prisons.

6.25 In 2005 to date, there had been 12 reported use of force incidents, involving five adult men and seven young people. In 2004, there had been a total of 11 use of force incidents, involving six adult men, four young people and one woman. These figures were not entirely accurate as a separate use of force intervention record indicated that the numbers were much higher (49 in 2004 and 27 in 2005). We were told that this log was used to record incidents where C&R teams were deployed but not necessarily used. This was not clear from the information on the log, and it was possible that there had been some under-reporting.

6.26 We reviewed use of force documentation and found that it was generally completed to a good standard, with staff giving a full account of the incident and their involvement. The review also provided assurance that staff tried hard to de-escalate situations before using C&R techniques. Use of force documentation had a section for completion by a member of healthcare staff to assess any injuries to the prisoners, and this was completed on every occasion.

6.27 The prison had one special cell, which was covered by a CCTV camera and situated in the segregation unit on E wing. This cell had been used on five occasions in 2005 and three times the previous year. On at least three occasions in 2005 it had been used solely to prevent acts of self-harm. Use of this type of accommodation under such circumstances was inappropriate, and there should be more suitable arrangements for managing prisoners in crisis (see section on self-harm and suicide).

6.28 The special cell was routinely laid out with strip-clothing, although prisoners were not routinely deprived of their normal clothing when they were placed in this cell. A laminated notice on the front of the cell door informed staff that normal clothing could only be removed if authorised by a governor or medical officer.

6.29 We also observed a planned intervention where a prisoner was relocated from one of the punishment cells into the special cell. Despite extreme provocation, staff remained professional at all times and the situation was resolved passively. The prisoner was allowed to keep his normal clothing on location into the special cell. No video camera was available to record the removal had C&R techniques been necessary.

6.30 Authorisation documentation for placement into the special cell was completed to a good standard, but the time of removal from this accommodation was not recorded routinely. Senior managers told us that prisoners never remained in the special cell for longer than 24 hours. The prisoner we observed being placed in this cell was removed after 21 hours. This was a long time to be in this type of accommodation. There needed to be careful management oversight to ensure that prisoners are taken out of the special cell as soon as the incident has de-escalated.

## Segregation unit

6.31 There were two segregation units, one for adult men on E wing and one for young people on G wing. There was also a designated cell on F wing to hold women prisoners.

6.32 The segregation unit on E wing was on the ground floor. Part of the accommodation was divided by a door that separated vulnerable prisoners from those serving punishment or being held on good order or discipline (GOOD). Accommodation consisted of eight normal cells, one special cell, a wing office, and communal toilets and shower. All cells for vulnerable prisoners had power leads and normal cell furniture. Prisoners could rent a television at £2 per week. Three of these cells also had in-cell sanitation. The three cells for prisoners on punishment or GOOD were very basic and did not even have a table. One of these cells had extremely abusive graffiti on the walls. All cells had a single window, which provided ample natural light. There was a good-sized exercise yard outside the unit.

6.33 On the day of inspection, five prisoners were held in E wing segregation unit: four vulnerable prisoners and one segregated under GOOD. Some of the vulnerable prisoners had been held there for some time, the longest since September 2004. The prisoner held under GOOD was demanding throughout the inspection, and staff dealt with him very professionally. This was even more creditable given that staff shortages meant the unit was mainly covered by staff on

overtime and so there was poor staff continuity. There were no staff selection criteria, and those working in the unit had not been authorised by the governor. When we asked staff for details of the weekly routines on the unit we received inconsistent replies.

6.34 The segregation unit on G wing had accommodation on two floors, but only the ground floor was used at the time of inspection. This area had three normal and one gated cells, as well as an association/dining room and communal toilets and shower. Cells had fixed metal beds and normal cell furniture. None had in-cell power or sanitation. Two of the additional cells on the first floor were covered by CCTV. Young people on the unit had scheduled access to a large, adjacent exercise yard.

6.35 On the day of inspection, three young people were held in the unit on G wing. All were classed as vulnerable prisoners. One was in the gated cell on a constant watch. We were impressed with the level of care and attention from supervising staff. Another young person had been held on the unit for over 12 months.

6.36 We saw many examples of good staff–prisoner relationships in both segregation units. The prison had worked hard to develop an acceptable regime for vulnerable prisoners. They remained unlocked for much of the day and were allowed to associate with each other. They could attend physical education and the library, and also had daily access to showers and exercise. Young people in the segregation unit on G wing could also attend education once a week and could dine in association.

6.37 Those held on GOOD, stage one, were normally located in E wing segregation unit. They did not receive routine daily access to showers. Prisoners were placed on GOOD with no formal written authorisation and remained on it without formal review of status. Similarly, vulnerable prisoners could request segregated conditions and could be held there for long periods with no formal review.

6.38 All prisoners located into segregated conditions were routinely strip-searched without any risk assessment to determine if such a search was necessary. Entries in wing history files were not made daily, and the quality was mixed. Statutory visitors, including a governor, chaplain and medical professional, did not visit all segregated prisoners each day. When they did visit this was not recorded routinely. A member of the BOV did not visit routinely each week.

6.39 At the time of inspection, the designated segregation cell for women prisoners was occupied by a prisoner detoxing. There were no records of its use for segregation, and there were similar shortcomings as elsewhere in relation to statutory visitors and wing file entries.

## Recommendations

6.40 **All senior managers who conduct adjudication hearings should attend a recognised training course.**

6.41 **Punishment tariffs for specific offences should be devised and published to staff and prisoners, and there should be regular, minuted standardisation meetings.**

6.42 **All locations used for adjudication hearings should be risk assessed and cleared of potential weapons before the hearing.**

6.43 **Prisoners placed on governor's report should be able to request witnesses and legal representation, and should be invited to do so as part of the formal process.**

6.44 Prisoners should be given written information before an adjudication that explains the process fully.

6.45 Use of force documentation should be completed on every occasion force is used on a prisoner.

6.46 The special cell should not be used solely to prevent acts of self-harm. The prison should develop more appropriate arrangements to support prisoners in times of crisis.

6.47 Planned control and restraint interventions should be recorded by video camera.

6.48 The time that a prisoner is removed from a special cell should always be recorded. Senior managers should ensure that prisoners in a special cell are closely monitored and returned to normal location at the earliest opportunity.

6.49 There should be published selection criteria for staff working in segregation units to ensure maximum continuity. The governor should authorise all staff who work in the segregation units.

6.50 All prisoners held in segregated conditions should receive daily access to showers.

6.51 A governor should formally authorise in writing the status of prisoners held in segregated conditions, and their ongoing status should be reviewed formally and regularly. Prisoners should be held in segregation no longer than absolutely necessary.

6.52 Prisoners who are located in the segregation units should not be strip-searched routinely but only if necessary following risk assessment.

6.53 Statutory visitors should visit all prisoners in segregated conditions each day, and these visits should be recorded. A member of the board of visitors should visit at least once a week.

6.54 All charges should be fully investigated by adjudicators.

6.55 The punishment cells on E wing should have appropriate cell furniture.

6.56 Entries in wing history files should be made daily, and consistently demonstrate that those held in segregated conditions are being effectively monitored.

6.57 A record should be maintained of all women prisoners held in segregated conditions.

## Housekeeping points

6.58 Strip-clothing should not be laid out routinely in the special cell.

6.59 Cells in the segregation unit should be repainted to remove graffiti, and there should be arrangements to prevent further graffiti.

# 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 prisons, with regular reviews.**

6.60 Advancement in the incentives and earned privileges (IEP) scheme was not available to many adult male prisoners due to the strict criteria of sentence length and time left to serve. Enhanced status for these prisoners was location-based, which further restricted opportunities. Prisoners were demoted inappropriately for a single minor incident and for providing positive voluntary drug tests. No scheme was available to vulnerable prisoners on E wing, and the scheme for women was largely ineffective.

6.61 Three separate IEP schemes operated at La Moye, for adult men, young people and women. There was no IEP scheme for vulnerable prisoners on E wing. Rules relating to each of the schemes were explained in prisoner compacts, but these were not used on B and C wings. No information on the IEP schemes was publicised on the residential wings. Prisoners, particularly those on B and C wings, had little understanding of how the scheme operated. In our survey, all groups of prisoners were negative about the scheme and felt that they had not been treated fairly in it.

6.62 There were three incentive levels for adult men. Prisoners entered the scheme on the standard level but could progress to feeder and enhanced, which were location-based, on A and H wings respectively. To progress to enhanced status, adult male prisoners had to be within the last two years of their sentence and not serving a sentence of less than 12 months. These strict criteria precluded many prisoners from gaining enhanced status. At the time of inspection, 33% of adult men were on enhanced, 20% on feeder and 47% on standard.

6.63 A wing (feeder) could take up to 23 prisoners. Those who met the criteria and had positive comments in their wing history files were moved on from B and C wings as spaces became available. Prisoners on A wing had better facilities, including in-cell electricity (not available on C wing), communal dining, improved association and more items on the facilities list.

6.64 Those who progressed to H wing (enhanced) had the best accommodation in the prison and increased levels of association. All cells had integral sanitation and, subject to risk assessment, prisoners could qualify for resettlement leave and work outside the prison. A system of behaviour warnings operated and, if a prisoner received three behaviour warnings within a 12-week period, he was likely to be removed from the wing. Similarly, if a prisoner was found guilty at adjudication and received any award other than a caution, he was also likely to be removed from H wing. This included some relatively minor offences rather than an established pattern of poor behaviour.

6.65 Prisoners had to agree to voluntary drug tests as part of the compact for both A and H wings. If there was a positive result the prisoner was downgraded automatically.

6.66 It was much easier for women and young people to reach enhanced status. On F wing (women) only two levels operated, standard and enhanced. Of the 14 women prisoners held, 71% were on enhanced and 29% on standard. It normally took around eight weeks for prisoners to qualify for enhanced. They had to agree to provide negative voluntary drug tests

and have positive entries in their wing history files. Once on enhanced status they were subject to similar arrangements as the adult men in relation to downgrading. Accommodation in the women's wing was poor, which limited the effectiveness of the incentive scheme. Those on the enhanced level were allowed a power cable, but as they were in shared accommodation those on the standard level also usually benefited from this. Women on the enhanced level also had an extra visit, increased spending allowance and could, subject to risk assessment, have resettlement opportunities outside the prison.

6.67 The incentive scheme for young people on G wing was based on a Grand Prix circuit, with pits, grid and track levels. At the time of inspection, only one young person (6%) was on the pits level; he was in the segregation unit on G wing. Of the remainder, 11 (61%) were on the grid level and six (33%) were on the track. All young people entered the scheme on the grid level and had to wait for a minimum of 12 weeks before they were considered for progression to the track. A system of behaviour warnings applied, and arrangements for demotion from the track level were similar to those for adult men. However, the published rules for young people did explain that someone could be removed from the track level for a single behaviour warning. Those on the track level had better association facilities on the wing, they could lie in bed on a Sunday, and had more visits and telephone calls. Some young people had been successfully risk assessed for temporary release.

6.68 We reviewed wing history files and found inconsistencies in their completion throughout the prison. Entries on some units were infrequent, but decisions relating to IEP appeared to be generally consistent with the information available.

## Recommendations

6.69 **There should be an incentives and earned privileges (IEP) scheme for vulnerable prisoners on E wing.**

6.70 **Incentive levels for adult men should not be restricted by location.**

6.71 **Enhanced status should be available to all prisoners after a reasonable period of settling in and assessment.**

6.72 **Prisoners should not be downgraded in the IEP scheme for a single, minor incident or for providing a positive voluntary drug test.**

6.73 **The IEP scheme on the women's wing should be more effective.**

## Housekeeping point

6.74 The incentives and earned privileges scheme should be well publicised in all residential units.

# 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 good variety of meals was offered, but very little to suit black and minority ethnic prisoners. Many of the prisoners could dine in association, but there were concerns about the level of supervision of prisoners during meal times. Prisoners told us that the food was often cold and that servery workers did not regularly wear white clothing. Temperature checks were conducted inconsistently.

7.2 The wing manager, four civilian chefs (two on each shift) and 12 prisoners staffed the catering department. The kitchen had difficulties recruiting suitable prisoners because they worked for six and a half days per week and earned less than prisoners employed in the different workshops who worked only five days a week. To redress the imbalance, all prisoners' pay and conditions had been under review since March 2005.

7.3 All kitchen workers and one of the seven servery workers had been trained in food hygiene. The department did not offer vocational training, which was a missed opportunity.

7.4 The kitchen was clean and well decorated, but the floor was worn and stained. The food was stored appropriately and to prevent cross-contamination. Temperature control charts were recorded, and staff and prisoners wore the correct clothing. The department had a cleansing system for the kitchen equipment. One of the kitchen workers was allocated four to five hours each day for cleaning the equipment. The local environmental health officer visited in January 2005 and identified six areas that required attention. All the points were addressed, including the repair of the cracked floor, which needed painting.

7.5 The daily food budget had increased to £2.73 per prisoner. The four-week menu cycle offered four choices for lunch and for dinner. During the week the breakfast choice was two cereals and toast, with boiled eggs on Thursdays. There was a cooked breakfast at weekends. Vegetarian and healthy options, including fish, seafood and salads, were offered routinely, and special diets were catered for. However, national dishes were not provided for Madeiran prisoners, who were the largest minority group. The catering manager said that all the chicken and lamb were halal, but was unable to provide the certificates. For the last few years a special menu had been organised for Ramadan. Separate utensils were not used for halal food.

7.6 Breakfast was served on the wings between 7:45am and 8:30am, lunch between 11:30am and noon, and dinner at 4:30pm. The gap between meal times during the day was too small, and there was a 16-hour gap from the evening meal until breakfast, with no snacks provided to prisoners through this period. The time gap was slightly longer over the weekends.

7.7 H wing was the only wing with a servery. Food was collected from the kitchen in heated trolleys and served from the food trolley along a small corridor on all the units, except for G and H wings. This was far from ideal. The catering staff checked the food temperature, but not consistently. Many prisoners complained that their food was cold by the time they got back to

their cells. On most units one prisoner served the meals and a staff member supervised. Prisoners wore white aprons, hats and gloves, although staff and prisoners told us that this was not normal practice.

7.8 A maximum of 10 prisoners on H wing could dine in their association/dinning room. There was space for some vulnerable prisoners on E wing to eat in their small association room, but most ate in their cells or even outside, weather permitting. Young people were served meals from the kitchen serving-hatch, and their own dining area was large enough to accommodate all of them. The women did not have a heated trolley as the wing was just a few metres from the kitchen. They had a small dining room/association area.

7.9 On A, B and C wings prisoners did not have the opportunity to dine in association. Most of their food was left on dirty windowsills and cold work surfaces. Prisoners queued up and served themselves, including compound and workshop workers who had unwashed hands and dirty clothes. They returned to their cells to eat their meals. The large queue and small number of staff to supervise prisoners was a concern because of the poor quality of the food, and the potential for prisoners to enter each other's cells to bully and assault.

7.10 There had been a review of the serving arrangements for meals. The main dining area was no longer used and there were plans to use this space from July/August 2005 as the new servery area for prisoners on A, B and C wings to dine in association (in two sittings) in one of the gyms. However, staff had concerns about their ability to provide the necessary supervision for the free-flow of prisoners from the wings when the new system was introduced.

7.11 We sampled various dishes at lunch time. The quality and presentation of the food was of a high standard, except on A, B and C wings where the food was cold, having left the kitchen 15 minutes earlier.

7.12 Food comments books were not available on any of the wings. Prisoners who wished to comment about the food could write to the catering manager, but few did. There was no catering committee or formal means for prisoners to feed back their views about the food or make suggestions for improvement. The last food survey had been carried out in 2002. The wing manager said that he looked at the recorded number of menu choices each week and replaced the least popular dishes.

7.13 In our survey, only 30% of respondents felt that the food was good or very good. There were mixed views about the food from the prisoners we spoke to. Many made positive comments, while others said the menu cycle had remained the same for the last two years. Madeiran and Bengali prisoners complained that there were too many potato (mash and chips) dishes, and that the kitchen workers constantly put 'things' in their food. They also claimed to have recently found faeces in the mince dish, which was disputed by their wing and catering staff.

7.14 There was a daily exchange of abuse between the kitchen workers and prisoners from the vulnerable prisoner unit (VPU), whose workshops backed on to the kitchen. Staff agreed that kitchen workers have been overheard making comments such as 'wait till you get your food', implying that their meals had been interfered with. Such behaviour went unchallenged. As each wing had its own, labelled heated trolley, kitchen workers had the opportunity to place things in the VPU food trolley, if they so desired.

### Recommendations

7.15 **Kitchen workers should have parity of pay and conditions with prisoners employed in the workshops.**

7.16 **All prisoners who handle food should be trained in food hygiene, and food serving should conform to food safety and hygiene requirements.**

7.17 **The catering department should offer industry recognised vocational training.**

7.18 **Lunch should not be served before noon, and the 16-hour gap between the evening meal and breakfast should be reduced.**

7.19 **Meals should be provided to suit the cultural tastes of prisoners, particularly those from Madeiran backgrounds who are the largest minority group.**

7.20 **Prisoners, including those on A, B and C wings, should receive an appropriate level of supervision at meal times.**

7.21 **The catering manager should carry out a food survey at least once a year, and ensure that dishes catering for black and minority ethnic prisoners and young people are available on the menu.**

### Housekeeping points

7.22 Separate utensils should be used for halal food.

7.23 Food temperatures should be checked and logged at the point of service. Hot food should not be served below 63ºC.

7.24 Each wing should have a food comments book for prisoners to comment on meals.

## 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.**

7.25 The prison had introduced a new bagging system for all prisoners' shop-ordered goods. Only prisoners on the enhanced wing had their goods delivered creating opportunities for bullying on other wings. Staff still bought goods for prisoners outside the prison on an ad hoc basis. Very few shop items met the needs of women and black and minority ethnic prisoners.

7.26 A bagging system for prisoners' shop-ordered goods had been introduced for all the wings. This arrangement solved the problems of long queues and improved the distribution of goods to the different wings. Prisoners wrote their shop orders on the back of their 'spend slip' and were allowed to spend up to £50 each week, if they had enough funds.

7.27 The shop sold 177 items, including a modest range of toiletries, many sweet items, cigarettes and fresh fruit. Only enhanced-level prisoners could buy dairy products, although women prisoners had a fridge on their wing in which they could have stored dairy products. Missing items or mistakes were rectified the same day that orders were delivered.

7.28 Shop goods were delivered to the women's wing, A wing, and the enhanced wing on Friday mornings. On B and C wings, two to three prisoners at a time collected their goods from the healthcare waiting area on Friday evenings. The orders for young adults on G wing and vulnerable prisoners on E wing were delivered on Saturday mornings. Only prisoners on H wing had their orders delivered to their cells. On all other wings, prisoners had to walk back to their cells from the office or the healthcare with their goods. The lack of staff supervision meant that prisoners could potentially to be bullied for their goods. In our survey, 25% of young adult respondents said they had had their shop items/property taken from them.

7.29 No hobby items were available and, apart from emery boards, only one product was specifically targeted at women. There were no products for any black or minority ethnic group, except for hot chilli sauce. During Ramadan, Muslim prisoners could order dates and Bombay mix from the shop list.

7.30 Officers from the different wings bought goods for individuals outside the prison on an ad hoc basis. Staff from the women's wing shopped for a limited range of toiletries each month. Only women prisoners were allowed to receive goods from a shopping catalogue, if bought by a friend or family member. One staff member let women buy toiletries from her Avon catalogue every six months. Although this was done with good intentions, the practice of buying goods for prisoners was not formalised. It made staff vulnerable to bullying or accusations of corruption, and had the potential to compromise their professional standing.

7.31 Smoker's and non-smoker's packs were issued in reception for new arrivals (see paragraph 1.15). As newly arrived women had not passed through reception until the week of the inspection, they had received only a free £2 telephone card from healthcare, and relied on the goodwill of other prisoners and staff for toiletries and cigarettes.

7.32 Shop staff said that they were flexible in allowing newly arrived prisoners with funds to buy items within 24 hours. However, in our survey, 46% of respondents said they had access to the shop within 24 hours. Prisoners with no private means had to wait until they were paid £2.50 prison wages on Fridays before they could buy from the shop, and only convicted prisoners were eligible to receive prison wages.

7.33 Some prisoners complained that they wanted a broader range of food items and fewer sweets in the prison shop. Women wanted more toiletries and cosmetics.

## Recommendations

7.34 **All shop orders should be delivered to prisoners' cells to minimise the potential for bullying.**

7.35 **Staff should not buy goods for prisoners outside the prison. All purchases, including orders from catalogues, should be made through the prison shop.**

7.36 **The range of goods in the prison shop should be significantly expanded. Prisoners should be surveyed as to their requirements.**

# Section 8: Resettlement

## Resettlement strategy

Expected outcomes:
**Resettlement underpins the work of the whole prison, supported by strategic partnerships in the community and informed by assessment of prisoner risk and need so as to minimise the likelihood of reoffending on release.**

8.1 Resettlement was not a familiar concept in the prison. Apart from some useful work on temporary release, there was no planned approach to prisoners' resettlement needs. There was no management lead or infrastructure in this area and there had been no needs analysis.

8.2 The only evidence of work on resettlement was that carried out in the temporary release boards (see paragraph 8.59). The governor or deputy governor chaired these meetings, which involved staff from different departments examining detailed assessments to match prisoners' needs with the resources available. Unfortunately, there was no evidence of such a methodical approach elsewhere to help prisoners prepare for release.

8.3 There was no senior manager with specific responsibility for resettlement, no policy outlining a strategy and no committee to organise the work. All of these elements needed to be in place, and to be based on a needs analysis of the whole prisoner population. We were told that there was neither the expertise nor the resources for this. (See also paragraph 8.26.)

8.4 The governor had been involved in some important aspects of the development of resettlement. Notably, there had been collaboration with planners to develop an open unit to improve the conditions for those prisoners working outside. The governor was also discussing with local officials the feasibility of some form of post-release supervision on the island.

### Recommendations

8.5 **A senior manager should be appointed with responsibility for resettlement.**

8.6 **A resettlement policy should be produced and a resettlement policy committee convened.**

## Sentence and custody planning

Expected outcomes:
**All prisoners have a sentence or custody 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.**

8.7 The arrangements for sentence planning were inconsistent and erratic. Apart from some emerging improvements in the women's wing, the work practice was poor.

8.8 Sentence planning was not an integrated or routine practice in the prison. In our survey, 61% of respondents said they did not have a sentence plan. Even though about a third of the population were on remand and, therefore, not subject to the planning process, this was still not a good finding. Only 22% of respondents said that they were involved in developing their plan.

8.9 Until recently, the prison's psychologist and the probation officer had been given responsibility for coordinating sentence planning. This was an unsophisticated arrangement, but nevertheless, it did mean that reviews were scheduled regularly each month, and these involved staff from different areas. About a month before the inspection, the governor issued an instruction transferring responsibility for sentence planning from the two specialist staff to wing managers in order to make better use of the specialists' distinctive skills and to give greater responsibility for sentence planning to staff on the wings.

8.10 Apart from the women's wing, this initiative had effectively resulted in the planning system grinding to a halt. It appeared that, in practice, the wing managers had neither the time nor the expertise to carry out this task properly.

8.11 On the women's wing, a planning cycle was being introduced, and staff understood the importance of dealing with prisoners' needs in an organised and systematic way. Although, as elsewhere in the prison, the documentation associated with this process was patchy, the senior officer on the wing had produced some impressive written material. This work, which analysed individual prisoners' needs and set personal targets, stood out as an isolated example of good quality planning.

8.12 We examined files and spoke to staff on all of the other units. We were unable to find evidence of any current, coherent planning work anywhere else.

8.13 Additional funding had been secured for 2005-06 for three new sentence planning officer posts. If these new resources were managed effectively, they could provide the opportunity to make significant improvements.

8.14 The prison was also considering the most appropriate planning system to use. The governor had recently received approval from the Prison Service of England and Wales to adopt the offender assessment system (OASys). The arrangements selected needed to be appropriate to the needs of the local population and compatible with sentence planning tools in the community.

### Recommendation

8.15 **A manager should be allocated lead responsibility for introducing a standard system of sentence planning for all prisoners, and should prepare plans to ensure that the new sentence planning staff can carry out their duties effectively. The system should be compatible with that used by the probation service.**

## 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.**

8.16 There were no specialist facilities or services for life-sentenced prisoners, and the prison worked to transfer them to prisons with more suitable regimes as soon as practicable.

8.17 Two potential lifers were held in the prison at the time of the inspection. We were told that this was unusual, and that the prison had only accommodated two other prisoners in this category in the last five years.

8.18 Apart from a higher level of checking and supervision while their cases were being initially dealt with at court, these prisoners were treated in the same way as other long-term prisoners.

8.19 During the inspection, the governor was involved in organising for these men to be transferred to prisons in the UK. There had been a delay in transferring one of the prisoners because of changes in the local legislation. Sentencing had been postponed until the judiciary had been invested with the powers to set the sentence tariff.

8.20 The prison psychologist and probation officer had worked with the potential lifers on risk assessments. The general records were not in a standard format and the files did not contain sufficient up-to-date assessment material. This could impede a successful transfer and needed to be improved.

### Recommendation

8.21 **Records for life-sentenced prisoners due for transfer should be up to date and comprehensive, and in a format compatible with that at receiving prisons.**

## Offending behaviour programmes

**Expected outcomes:**
**Effective programmes are available to address identified prisoner risk and need, to allow timely progression through sentence.**

8.22 No offending behaviour courses were run at La Moye.

8.23 There were no offending behaviour programmes, and little history of professional, offence-focused work. Given the size and make-up of the prisoner population, a programme approach could be readily adopted, but it was essential that this should be based on a needs analysis of the whole prisoner population.

8.24 Following recommendations from the previous inspection, resources had been invested in setting up an enhanced thinking skills (ETS) course, and some staff had received specialist training for this. As a result, two courses were run in 2003. However, because of staffing difficulties no further courses had run since then, and the staff who had been specially trained were allocated other duties.

8.25 There was a chartered forensic psychologist based in the prison who was qualified and experienced in running offending behaviour programmes. She delivered all the offence-focused work in the prison, along with the prison-based probation officer. This consisted of one-to-one casework with up to 40 prisoners at a time. While this activity was useful,

particularly in relation to risk assessment, there was no means of ensuring that these scarce services were delivered to the prisoners who needed them most.

8.26 The absence of a comprehensive analysis of the prisoner population made it impossible to know the level and extent of their need or to determine the resources they needed. Although we were told that the prison did not have the resources or expertise to carry out such an analysis, we believed that a more planned, professional approach to working with prisoners was essential. The psychologist already had the necessary skills to lead this area of work. She had begun to compile a basic analysis of the prisoners who she worked with, and this needed to be extended to cover all prisoners systematically. Although restricted, we believed that the necessary research could be carried out without incurring large costs, for example, through using a postgraduate student.

8.27 Given the number of prisoners convicted of drug importing offences, there seemed to be scope for specific programme work in this area. It would be useful for the psychologist to consider the viability of this.

### Recommendation

8.28 **A prisoner needs analysis should be used to determine offending behaviour programme work, and the prison-based psychologist should establish formal links with the Prison Service offending behaviour programme unit for advice on how to develop this work.**

## 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 prison.**

8.29 Problematic substance use was a major issue at La Moye. During 2004, 172 prisoners required medical detoxification. The prison's drug and alcohol counsellor was in contact with 143 clients during that year. There was no comprehensive strategy integrating both supply and demand reduction initiatives, and not enough resources to meet to needs of the different populations. We were impressed by the commitment of staff to provide the best care for all prisoners within these limitations.

8.30 Over 50% of prisoners had been convicted for drug-related offences, including importation. In our survey, 41% reported experiencing drug problems on arrival, and a further 16% described their alcohol use as problematic. A health needs analysis, published in 2004, recommended that 'a comprehensive drug and alcohol strategic plan should be developed as a matter of urgency, taking account of the island-wide strategy'.

8.31 The first drug strategy meeting took place in June 2005. A draft policy document focused mainly on supply reduction, was already out-of-date, had no action plan or performance measures, and did not reflect the different needs of the population, such as women, young people and drug importers. The healthcare department operated a comprehensive database, but information was not analysed to inform the strategy.

8.32 A new drug strategy coordinator had been appointed and was keen to develop and implement the policy.

8.33 Representatives from the prison attended Jersey's joint steering group for substance misuse pathways, and there were good throughcare arrangements with community providers.

8.34 All new arrivals were screened and tested at reception. Clinical protocols had been developed, and detoxification regimes started on the first night. Prescribing regimes begun while in police custody were communicated to the GP who saw patients the following morning.

8.35 Detoxification for opiate-dependant receptions consisted of an eight- to 14-day regime of dihydrocodeine (dispensed in liquid form), lofexidine, and symptomatic relief.

8.36 Due to the high cost of heroin on the island, consumption was generally lower than on the mainland, and most prisoners we spoke to were satisfied with their treatment. Prescribing could be extended for those who had used high levels of heroin and methadone before custody. One GP was licensed to prescribe methadone, and pregnant women were maintained on methadone in liaison with the community drug and alcohol service.

8.37 While the current prescribing regime for opiate users was neither in line with the island-wide drug strategy nor the English/Welsh clinical management guidelines, it would be difficult for controlled drugs such as methadone and subutex to be introduced safely as the standard treatment, given the lack of resources and unsuitability of the environment.

8.38 Prisoners were located on the wings unless deemed to require 72-hour observation in one of the camera cells on C1. These cells provided an extremely poor environment and were not fit for purpose. A nurse was on call during nights.

8.39 Medication was dispensed by one nurse from the healthcare centre or taken on to the units for women, young adults and vulnerable prisoners. One of the healthcare officers specialised in substance misuse, but had little time to focus on this patient group. Prisoners felt they had good access to healthcare staff, including the GPs.

8.40 In 2004, 172 prisoners received detoxification treatment: 64 from alcohol, 57 from opiates and a further 51 from benzodiazepines. The prevalence of problematic drinking was high on the island, with 7% of the population assessed as alcohol-dependant (*Health Needs Analysis 2004*).

8.41 A drug and alcohol counsellor, contracted for 25 hours a week at the prison, worked closely with healthcare. In 2004, she had been in contact with 143 prisoners. At the time of our visit, her open caseload was 108.

8.42 The greatest number of clients experienced problems with heroin, followed by alcohol and benzodiazepines; 20% were women, 18% aged 18 or under, and 40% were foreign nationals. The counsellor was of Madeiran background and also spoke French, and provided general translation services when necessary.

8.43 Substance misuse assessments were combined with healthcare screening, and contact recorded on the database. Prisoners could access one-to-one counselling, a drug and alcohol awareness course, as well as Alcoholics Anonymous and Narcotics Anonymous self-help groups. Auricular acupuncture had stopped due to time constraints.

8.44 Although contact was necessarily limited, with short-term remand prisoners often not seen and priority given to pre-release work, we were impressed by the commitment of the counsellor to make services as accessible as possible. She visited the wings daily, with particular attention to women, vulnerable prisoners and young people, and offered evening appointments to prisoners working outside during the day. In our survey, 75% of young people knew whom to contact within the prison to get help with external drug courses, compared to a benchmark of 43%.

8.45 The drug and alcohol awareness course, consisting of 12-weekly group sessions, ran separately for women, young people and vulnerable prisoners, with very positive feedback from participants. Topics included harm reduction advice and overdose prevention, first aid, safer sex, understanding dependencies, relapse prevention, and anger management.

8.46 On throughcare, the community drug and alcohol service saw remand prisoners for pre-sentence reports. Three months before release, prisoners could discuss ongoing support needs with a worker who provided a bridge to community agencies. Part of his role consisted of ensuring the continuity of naltrexone prescribing begun at the prison.

8.47 While drug testing was 'voluntary', it was linked to the incentives and earned privileges scheme and was organised by the security department. One positive test or a refusal resulted in a prisoner losing their enhanced status and, if based on H wing, having to leave the enhanced wing.

8.48 All young people were required to sign up to testing. A positive test for cannabis could result in three days' loss of recreation time and one month of closed visits. Staff said that these sanctions were under review and not fully enforced. In our survey, 25% of young people felt they had been victimised by staff because of drugs, compared to a benchmark of 2%. Those testing positive were not routinely referred to the counsellor.

8.49 The prison operated a system of oral swab testing. In 2004, 4.3% of prisoners had tested positive for cannabis, opiates and benzodiazepines, but this figure did not provide a reliable indicator of prevalence.

8.50 In the absence of reliable data it was not possible to establish the prevalence of illegal drugs, although staff and prisoners said that cannabis and heroin were available in the prison. In our survey, 30% of respondents said it was easy to get illegal drugs at La Moye. Lack of resources in the security department (see paragraph 6.2) resulted in very limited searching. The quality of security information reports was described as 'low', and only seven reports had related to drugs in the previous six months. No PIN (personal identification number) telephone system was in operation.

8.51 Drug dogs were supplied by Customs and not consistently available. The visits room had CCTV, linked to an understaffed security office.

8.52 A part-time police liaison officer aimed to increase the flow of information between the organisations, but lack of security personnel made this difficult.

## Recommendations

8.53 **A comprehensive drug and alcohol strategy should be developed which integrates supply and demand reduction initiatives, contains detailed action plans and**

**performance measures, and reflects the needs of the different populations. Available data should be analysed to inform the strategy.**

8.54 **Specialist advice should be sought before there are changes to the clinical management of opiate users, as current healthcare resources are insufficient to introduce the prescribing of controlled drugs safely.**

8.55 **Drug and alcohol counselling should be extended to meet the needs of all prisoners.**

8.56 **Drug testing should be reviewed and its role clarified.**

8.57 **There should be security measures to limit the availability of illegal drugs within the prison.**

# 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.**

8.58 There was limited reintegration planning. There were one or two examples of excellent preparation for release, but too often this work was based on informal contacts or involved well-motivated individuals. Staff and prisoners were unhappy about proposed changes to the way temporary release was due to be organised. In general, there were not enough opportunities for the majority of prisoners to address their resettlement needs.

8.59 The most impressive aspect of reintegration planning was the work on the temporary release scheme. This was one of the only areas where a policy had been produced. Decisions about who would be released under this scheme were taken at properly convened assessment boards chaired by the governor or deputy governor. It was clear from the records that there was careful attention to ensure that decisions were fair, and that there was a balance between the risk of release and fair opportunities for prisoners.

8.60 At the time of the inspection, 16 prisoners were working outside the prison. Many were in good quality placements that had been identified and maintained as a result of the local knowledge of officers. One of these was a woman due to be released after completing a long sentence for a drug-related offence. She had been working out on the scheme for over a year and described how, with support from staff, she had been able to secure work as a hairdresser and go on to gain a vocational qualification. She had also been able to save a significant sum of money, which she intended using for accommodation when she returned to the UK. She was extremely positive about the continued support that she received from staff. However, her observation that most of her peers would not have been able to sustain such a long placement, because of the various pressures and temptations, was significant. We concluded that it would take an individual with a very strong character to make best use of the current opportunity, as there were no regular support systems of review and monitoring.

8.61 Most of those working out were adult men from the enhanced wing. Several of these prisoners, as well as some staff working on that wing, were unhappy about rumours of new proposals

which they felt would limit the scope for prisoners to gain temporary release. They not yet been formally advised about what was going to happen, and they felt confused and suspicious.

8.62 The governor told us that he wanted a new process that was more balanced and progressive than the previous informal arrangements. He intended to bring in a scheme where a prisoner in the last 12 months of custody would be eligible to be considered initially for a three-month unpaid community work scheme, then for three months paid work. For the final six months they would be eligible for release on electronic tag. We felt this proposal was a thoughtful attempt to bring equity and due process to a system that previously appeared to be too random and discretionary. But because some prisoners and staff might feel that opportunities for temporary release could diminish as a result, it was important that they were given clear information about the proposal to allow an informed debate.

8.63 We had additional concerns that the overall framework for temporary release might have been unduly restrictive. Changes to limit the qualifying period to the last 12 months of the sentence had been introduced during the administration of the previous governor – apparently because of a number of absconding incidents that had received adverse media attention. Temporary release arrangements were restrictive and too inflexible, limited to prisoners serving their final 12 months. Risk assessment procedures had previously been weak and greater flexibility should be accompanied by more rigorous, documented procedures.

8.64 The range of services to provide support on release was limited. Apart from a regular weekly surgery with local employment advisers, there were no regular visiting specialists. Our survey results highlighted that prisoners felt particularly poorly advised about where to seek help about housing and finance. Almost 80% said they did not know where to go to get help about accommodation, and 86% did not know where to get advice about financial matters. These identified needs were particularly difficult to meet as accommodation on Jersey was in short supply and extremely expensive, and there was no guaranteed safety net of state benefit.

8.65 Deficits in reintegration planning were directly linked to the overall weaknesses in the resettlement strategy. The absence of a needs analysis made it difficult to establish accurately what prisoners needed. The lack of a committee and designated manager also limited the ability to target services appropriately. Given the complexity and interplay of these factors, it was essential that they were dealt with coherently and in a planned way. The recommended resettlement policy committee (see recommendation 8.6) should use these issues as the basis for its agenda.

## Recommendation

8.66 **The resettlement policy committee should identify a strategy for successful reintegration planning, which should include:**

- **extending the range of direct services currently available to help with pre-release**
- **introducing a method for reviewing and monitoring work placements**
- **reviewing the provision and practice of temporary release**
- **taking account of the lack of financial support available for prisoners on release.**

# 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.**

8.67 Public protection arrangements were underdeveloped and there was an over-reliance on informal checks. Practice in the prison needed to be formalised, and internal measures needed to be compatible with work in the community. The absence of post-custody supervision was a serious deficit in the overall arrangements for protecting the public.

8.68 Staff and managers had a high level of awareness about the relatively few 'notorious' cases held in the prison. However, there was no reliable means of accurately determining, on the basis of risk, who these individuals were. This was a particular problem in cases that had been dealt with by courts in the UK, where full records were not always available to the prison.

8.69 There was no public protection policy or committee and, as a result, no means of identifying, monitoring or reviewing high risk cases. An example of this lack of clarity was the response when we asked for information about the number of sex offenders currently held, and were told, 'about 10'. This lack of precision about the type of prisoners held left managers exposed and needed to be addressed quickly.

8.70 There was some useful work by the prison-based probation officer under RAMAS (risk assessment management and audit system). Around six meetings had been convened under the auspices of RAMAS in the prison in the six months before the inspection. These were chaired by the prison's probation officer and usually also involved a governor, a representative from the wing, the police liaison officer and the prison psychologist. Unfortunately, RAMAS was not integrated into the prison's own records, and depended entirely on the probation officer to identify and bring forward relevant cases.

8.71 RAMAS was the model adopted by Jersey's Probation Department and was a well-established local procedure. There were mixed views about its efficacy. Some people felt that it did not sufficiently address all aspects of risk and placed too much emphasis on medical issues. Some believed that the introduction of the more broad-based, interdisciplinary multi-agency public protection arrangements (MAPPA) approach or some modified version, would better suit local needs. This issue required the partner agencies to reach a quick agreement to ensure that systems were compatible and effective.

8.72 The prison-based probation officer was clearly the key person coordinating public protection work within the prison. However, she was unable to devote all of her time to working in the prison and she retained a small caseload in the community. Because of the serious deficits we have referred to, it was crucial that a probation officer with the requisite skills and experience in public protection work was based full-time in the prison.

8.73 The most alarming aspect of public protection work was the absence of any form of post-custody supervision. This meant that even when prisoners had been identified as presenting a significant risk to the public on release, they could be dealt with only on a voluntary basis once

they left custody. This was unacceptable and we were informed that the authorities were actively working to address this gap.

## Recommendations

8.74 **There should be some form of compulsory post-custody supervision for prisoners identified as presenting a risk to the public.**

8.75 **A public protection committee should be convened and a public protection policy published.**

8.76 **All of the partner agencies should agree on the best means of identifying, assessing, reviewing and supervising high-risk cases.**

8.77 **A full-time probation officer should be based in the prison.**

# Section 9: Recommendations, housekeeping points and good practice

**The following is a listing of recommendations, housekeeping points 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 home affairs committee

9.1 Children and juveniles should be held in a separate secure unit. (HP51)

9.2 The prison should have a prisoner database and IT system so that it can effectively analyse and manage its prisoner population. (HP52)

9.3 The States of Jersey should consider transferring responsibility for prison health and education to the island's health and education departments. (HP53)

## Main recommendations — to the governor

9.4 The prison should draw up a Performance Improvement Plan, using the detailed recommendations in this report, and setting priorities and timed targets for action. It should include :

- Effective first night and induction processes
- A violence reduction strategy, and systems, procedures and staff training to deal with bullying
- Procedures for identifying and supporting vulnerable prisoners in appropriate locations
- Refurbishment of the accommodation for women, and specific policies and practices to meet their needs
- Effective child protection measures, while children remain at La Moye
- Systems to record prisoners' ethnicity, monitor access to regime facilities by race and ethnicity, identify and meet the needs of black and minority ethnic and foreign national prisoners
- Facilities for religious observance that meet statutory requirements
- A review of security, and the implementation of effective procedures and management systems
- The introduction of more education and skills training
- A resettlement needs analysis, followed by the implementation of effective resettlement strategy, supported by a committee and led by a manager. (HP54)

9.5 New night unlocking arrangements should be introduced immediately to ensure that an officer unlocking a cell does not carry other keys. The remaining keys should be held in a place where no prisoner has immediate access. (HP55)

## Recommendation — to the home affairs committee

9.6 There should be some form of compulsory post-custody supervision for prisoners identified as presenting a risk to the public. (8.74)

## Recommendation — to the health and social services and home affairs committees

9.7 The recommendations of the review group to transfer prison healthcare funding should be endorsed to implement the healthcare improvement proposals. (4.50)

## Recommendation — to the governor and health and social services committee

9.8 There should be formal mechanisms to promote continued joint working. (4.51)

## Recommendations — to the governor

### Courts and transfers

9.9 Adult men, women and children should be transported separately to and from La Moye and the courts. (1.6)

9.10 A prisoner escort record should be introduced. (1.7)

### First days in custody

9.11 No prisoner should be strip-searched with only a single member of staff present. (1.23)

9.12 All newly arrived prisoners should be received into the reception area on H wing. (1.24)

9.13 There should be a proper first night strategy including, as a minimum, procedures for assessing individual risk factors and suitability to share a cell. (1.25)

9.14 There should be formal vulnerability assessments of all newly arrived children. (1.26)

9.15 An induction programme should be designed and implemented. (1.27)

9.16 Prisoner Insiders should be trained to operate as peer supporters on all wings. (1.28)

9.17 The content of the induction leaflet should be reviewed and updated in consultation with prisoners. (1.29)

## Residential units

9.18 There should be a full health and safety risk assessment of the arrangements for in-cell electricity. (2.19)

9.19 The converted accommodation in the old reception unit is unfit for purpose and should be refurbished or closed. An emergency cell call system should be installed there as a matter of urgency. (2.20)

9.20 There should be a programme of refurbishment for A, B, C, E, F and G wings. (2.21)

9.21 All cells should be fitted with integral sanitation. (2.22)

## Personal officers

9.22 A policy document should be published setting out the operation of the personal officer scheme and managerial responsibilities, and there should be guidance for personal officers on their role. (2.33)

9.23 There should be routine management checks of personal officers' contact time and the quality of entries in prisoners' personal files. (2.34)

9.24 Personal officers should have scheduled times to carry out their duties. (2.35)

## Bullying

9.25 An anti-bullying coordinator should be appointed. (3.13)

9.26 An anti-bullying committee should be set up to monitor and measure the quality of the anti-bullying strategy. (3.14)

9.27 Staff should be trained in anti-bullying procedures. (3.15)

9.28 There should be systems to ensure that all information concerning bullying is correlated, communicated and used to inform intervention. (3.16)

9.29 Prisoners should not be located in the vulnerable prisoner unit without an examination of the reasons for application and an assessment of risk. (3.17)

9.30 A senior manager should give authority for segregation at the request of the prisoner. (3.18)

9.31 A senior manager should monitor the population profile of E wing each month. (3.19)

9.32 Managers should ensure that staff can supervise prisoners adequately. (3.20)

## Self-harm and suicide

9.33 Residential managers should be responsible for managing prisoners considered to be at risk of suicide and self-harm. (3.28)

9.34 Residential staff should attend all F2052SH (self-harm monitoring) case reviews. (3.29)

9.35 Residential managers should regularly attend suicide prevention committee meetings. (3.30)

9.36 The suicide prevention committee should examine the correlation of bullying and self-harm each month. (3.31)

9.37 An anti-bullying coordinator should attend all suicide prevention committee meetings. (3.32)

9.38 Prisoners considered at risk of self-harm should not be managed in strip-conditions. (3.33)

## Child protection

9.39 Children should never be strip-searched by a solitary member of staff and should never be strip-searched without a documented risk assessment beforehand. (3.42)

9.40 A senior member of staff should represent the prison at the Jersey child protection committee. (3.43)

9.41 The child protection coordinator should be allocated protected time to carry out this function. (3.44)

9.42 An internal child protection committee should be set up. (3.45)

9.43 Child protection training should be delivered to all staff who have contact with children. (3.46)

9.44 There should be enhanced police checks on all staff who have contact with children. (3.47)

9.45 There should be risk and vulnerability assessments to ensure that children are not exposed to individuals who might be an unacceptable risk to them, and that their individual needs are met. (3.48)

9.46 Prison staff should be represented in the planning for the youth action team. (3.49)

## Race relations

9.47 The prison should set up a race relations/diversity committee to champion work on race relations and diversity. (3.60)

9.48 A race relations liaison/diversity officer should be appointed to carry forward the work started by the previous race relations liaison officer. (3.61)

9.49 A programme of training on race relations and diversity should be organised for all prison staff. (3.62)

## Foreign national prisoners

9.50 The ethnicity and racial origins of all prisoners should be recorded in reception when they arrive. (3.70)

9.51 The prison should produce a policy for dealing with foreign nationals and appoint a coordinator to ensure their needs are met appropriately. (3.71)

9.52 The process of giving foreign national prisoners a free five-minute telephone call or letters in lieu of visits should be formalised, and telephone calls for foreign nationals isolated from family and friends should be subsidised. (3.72)

9.53 Management should examine the reasons why foreign national prisoners, particularly Madeirans, are placed on the vulnerable prisoner unit and should find appropriate solutions. (3.73)

## Family and friends

9.54 There should be a prisoners' telephone in the old reception unit. (3.88)

9.55 A visitors' centre should be established and should provide information on what visitors can expect from their visit and how to receive help when needed. (3.89)

9.56 The physical conditions for visits should be improved to bring them up to an acceptable condition, and there should be better facilities, particularly for those with children. (3.90)

9.57 There should be formal, scheduled, monthly reviews of prisoners on closed visits. (3.91)

9.58 Protocols on the use of the prison drug dog should be written and published. (3.92)

## Applications and complaints

9.59 A formal, auditable prisoner complaints system should be introduced. (3.99)

## Legal rights

9.60 Legal reference material should be available to prisoners in the prison library. (3.104)

## Healthcare

9.61 Algorithm-based nurse triage should be introduced. (4.52)

9.62 Nurse-led clinics should be introduced. (4.53)

9.63 Administrative staff should be employed to release nurses from non-clinical duties. (4.54)

9.64 Staff shift patterns should be reviewed to maximise resources. (4.55)

9.65 Nurses should not undertake discipline duties, such as control and restraint and locking of wings. (4.56)

9.66 There should be clinical supervision for all staff, and clinical governance should be introduced. (4.57)

9.67 A primary care-compatible IT system should be installed. (4.58)

9.68 The garden space next to the healthcare centre should be developed to provide extra clinical accommodation. (4.59)

9.69 A defibrillator should be provided and all staff (including the dentist and dental nurse) should have training in its use, as well as cardiopulmonary resuscitation. (4.60)

9.70 There should be a medicines and therapeutics committee, including the chief pharmacist and doctors, to review all pharmacy policies and procedures and introduce medicines management, review the use of drug administration charts and the use of patient group direction. (4.61)

9.71 Medication for administration should not be pre-prepared and left out in unlabelled 'tots'. (4.62)

9.72 All prescriptions, including those for stock medicines, should be faxed through to the pharmacy. (4.63)

9.73 All pre-packs and medicines issued to prisoners should be labelled in accordance with the Medicines Act requirements, and all dispensed medication should include a patient information leaflet. (4.64)

9.74 There should be a formal procedure to enable healthcare staff to administer prescription-only medicines from stock in an emergency. (4.65)

9.75 All prescriptions and instructions to administer drugs should be signed by the doctor involved. (4.66)

9.76 Agreed pharmacy stock levels should be implemented. (4.67)

9.77 Discontinued medicines awaiting destruction should be clearly quarantined, and an appropriate, licensed waste remover should be contracted to provide this service. (4.68)

9.78 The dental unit should be replaced. (4.69)

9.79 All healthcare policies should be reviewed and updated regularly. (4.70)

9.80 There should be an increase in mental healthcare provision, including that for patients with counselling needs. (4.71)

## Education and library provision

9.81 The quantity and quality of education offered to prisoners should be increased substantially to meet the needs of the population. (5.9)

9.82 Staffing levels should be increased and administrative support should be provided. (5.10)

9.83 Library resources should be improved. (5.11)

## Work

9.84 A post of head of learning and skills should be created to oversee the strategic development of work and education at La Moye. (5.20)

9.85 The quality of work available to prisoners should be improved and should enable them to learn useful skills. The emphasis should be on skills acquisition for prisoners. (5.21)

9.86 There should be an improved work allocation system which takes account of individual prisoners identified needs. (5.22)

9.87 There should be monitoring arrangements to ensure prisoners attend work and classes as programmed, and that they attend punctually. (5.23)

9.88 Workplace supervisors should ensure that prisoners use protective clothing and equipment at all times. (5.24)

## Physical education and health promotion

9.89 There should be more physical education equipment on the wings with restricted access to the main gym. (5.31)

9.90 Vocational training should be offered alongside the recreational physical education programme. (5.32)

## Faith and religious activity

9.91 The prison should employ appropriately qualified chaplain(s) to undertake the statutory duties outlined in Prison (Jersey) Rules, 1957. (5.46)

9.92 Religious services should take place in a chapel or in a room dedicated for spiritual worship, and should be accessible to all prisoners weekly. Services should be available to prisoners from non-Christian faiths. (5.47)

9.93 Enhanced-level women prisoners should have equal access to Communicare family visits. (5.48)

## Time out of cell

9.94 Exercise should only be cancelled with the authority of the duty governor, and there should be a log of the occasions when it is cancelled, who took the decision and for what reason. (5.54)

## Security and rules

9.95 There should be a security committee that holds monthly, minuted meetings. (6.10)

9.96 There should be a full review of all work related to security, as a priority, to ensure that it is adequately resourced. (6.11)

9.97 All information submitted on security information reports (SIRs) should be analysed, and a senior manager should record the follow-up action required. Any intelligence identified should be used proactively, and staff submitting SIRs should receive acknowledgement. (6.12)

9.98 Scheduled quarterly searches and target searches of cells should always be carried out. (6.13)

9.99 Tools should be held on shadow boards in secure cabinets and only issued by staff through a tally system. Tools should be returned and accounted for before prisoners leave the area. (6.14)

9.100 All potential weapons and escape equipment should be removed from the prison or stored securely, as a matter of priority. (6.15)

9.101 Contingency plans should be tested regularly through the 'desk top' method. (6.16)

9.102 A comprehensive list of the prison rules should be drawn up and publicised in all residential wings. (6.17)

## Discipline

9.103 All senior managers who conduct adjudication hearings should attend a recognised training course. (6.40)

9.104 Punishment tariffs for specific offences should be devised and published to staff and prisoners, and there should be regular, minuted standardisation meetings. (6.41)

9.105 All locations used for adjudication hearings should be risk assessed and cleared of potential weapons before the hearing. (6.42)

9.106 Prisoners placed on governor's report should be able to request witnesses and legal representation, and should be invited to do so as part of the formal process. (6.43)

9.107 Prisoners should be given written information before an adjudication that explains the process fully. (6.44)

9.108 Use of force documentation should be completed on every occasion force is used on a prisoner. (6.45)

9.109 The special cell should not be used solely to prevent acts of self-harm. The prison should develop more appropriate arrangements to support prisoners in times of crisis. (6.46)

9.110 Planned control and restraint interventions should be recorded by video camera. (6.47)

9.111 The time that a prisoner is removed from a special cell should always be recorded. Senior managers should ensure that prisoners in a special cell are closely monitored and returned to normal location at the earliest opportunity. (6.48)

9.112 There should be published selection criteria for staff working in segregation units to ensure maximum continuity. The governor should authorise all staff who work in the segregation units. (6.49)

9.113 All prisoners held in segregated conditions should receive daily access to showers. (6.50)

9.114 A governor should formally authorise in writing the status of prisoners held in segregated conditions, and their ongoing status should be reviewed formally and regularly. Prisoners should be held in segregation no longer than absolutely necessary. (6.51)

9.115 Prisoners who are located in the segregation units should not be strip-searched routinely but only if necessary following risk assessment. (6.52)

9.116 Statutory visitors should visit all prisoners in segregated conditions each day, and these visits should be recorded. A member of the board of visitors should visit at least once a week. (6.53)

9.117 All charges should be fully investigated by adjudicators. (6.54)

9.118 The punishment cells on E wing should have appropriate cell furniture. (6.55)

9.119 Entries in wing history files should be made daily, and consistently demonstrate that those held in segregated conditions are being effectively monitored. (6.56)

9.120 A record should be maintained of all women prisoners held in segregated conditions. (6.57)

## Incentives and earned privileges

9.121 There should be an incentives and earned privileges (IEP) scheme for vulnerable prisoners on E wing. (6.69)

9.122 Incentive levels for adult males should not be restricted by location. (6.70)

9.123 Enhanced status should be available to all prisoners after a reasonable period of settling in and assessment. (6.71)

9.124 Prisoners should not be downgraded in the IEP scheme for a single, minor incident or for providing a positive voluntary drug test. (6.72)

9.125 The IEP scheme on the women's wing should be more effective. (6.73)

## Catering

9.126 Kitchen workers should have parity of pay and conditions with prisoners employed in the workshops. (7.15)

9.127 All prisoners who handle food should be trained in food hygiene, and food serving should conform to food safety and hygiene requirements. (7.16)

9.128 The catering department should offer industry recognised vocational training. (7.17)

9.129 Lunch should not be served before noon, and the 16-hour gap between the evening meal and breakfast should be reduced. (7.18)

9.130 Meals should be provided to suit the cultural tastes of prisoners, particularly those from Madeiran backgrounds who are the largest minority group. (7.19)

9.131 Prisoners, including those on A, B and C wings, should receive an appropriate level of supervision at meal times. (7.20)

9.132 The catering manager should carry out a food survey at least once a year, and ensure that dishes catering for black and minority ethnic prisoners and young people are available on the menu. (7.21)

## Prison shop

9.133 All shop orders should be delivered to prisoners' cells to minimise the potential for bullying. (7.34)

9.134 Staff should not buy goods for prisoners outside the prison. All purchases, including orders from catalogues, should be made through the prison shop. (7.35)

9.135 The range of goods in the prison shop should be significantly expanded. Prisoners should be surveyed as to their requirements. (7.36)

## Resettlement strategy

9.136 A senior manager should be appointed with responsibility for resettlement. (8.5)

9.137 A resettlement policy should be produced and a resettlement policy committee convened. (8.6)

## Sentence and custody planning

9.138 A manager should be allocated lead responsibility for introducing a standard system of sentence planning for all prisoners, and should prepare plans to ensure that the new sentence planning staff can carry out their duties effectively. The system should be compatible with that used by the probation service. (8.15)

## Life-sentenced prisoners

9.139 Records for life-sentenced prisoners due for transfer should be up to date and comprehensive, and in a format compatible with those at receiving prisons. (8.21)

## Offending behaviour programmes

9.140 The prisoner needs analysis should be used to determine offending behaviour programme work, and the prison-based psychologist should establish formal links with the Prison Service offending behaviour programme unit for advice on how to develop this work. (8.28)

## Substance use

9.141 A comprehensive drug and alcohol strategy should be developed which integrates supply and demand reduction initiatives, contains detailed action plans and performance measures, and reflects the needs of the different populations. Available data should be analysed to inform the strategy. (8.53)

9.142 Specialist advice should be sought before there are changes to the clinical management of opiate users, as current healthcare resources are insufficient to introduce the prescribing of controlled drugs safely. (8.54)

9.143 Drug and alcohol counselling should be extended to meet the needs of all prisoners. (8.55)

9.144 Drug testing should be reviewed and its role clarified. (8.56)

9.145 There should be security measures to limit the availability of illegal drugs within the prison. (8.57)

### Reintegration planning

9.146 The resettlement policy committee should identify a strategy for successful reintegration planning, which should include:
- extending the range of direct services currently available to help with pre-release
- introducing a method for reviewing and monitoring work placements
- reviewing the provision and practice of temporary release
- taking account of the lack of financial support available for prisoners on release. (8.66)

### Public protection

9.147 A public protection committee should be convened and a public protection policy published. (8.75)

9.148 All of the partner agencies should agree on the best means of identifying, assessing, reviewing and supervising high-risk cases. (8.76)

9.149 A full-time probation officer should be based in the prison. (8.77)

## Housekeeping points

### First days in custody

9.150 Anti-ligature strip-clothing should not be used for strip-searches in reception. (1.30)

### Healthcare

9.151 There should be an application system for requests to see healthcare staff. (4.72)

9.152 Appropriate, lockable metal cabinets to store medicines should be provided. (4.73)

9.153 There should be more health promotion material relevant to women. (4.74)

9.154 Keys to the healthcare centre should not be taken out of the prison. (4.75)

### Time out of cell

9.155 Exercise yards should be cleaned daily. (5.55)

### Security and rules

9.156 Security key rings should be sealed to prevent keys being removed. (6.18)

### Discipline

9.157 Strip-clothing should not be laid out routinely in the special cell. (6.58)

9.158 Cells in the segregation unit should be repainted to remove graffiti, and there should be arrangements to prevent further graffiti. (6.59)

### Incentives and earned privileges

9.159 The incentives and earned privileges scheme should be well publicised in all residential units. (6.74)

### Catering

9.160 Separate utensils should be used for halal food. (7.22)

9.161 Food temperatures should be checked and logged at the point of service. Hot food should not be served below 63ºC. (7.23)

9.162 Each wing should have a food comments book for prisoners to comment on meals. (7.24)

## Good practice

9.163 Adult prisoners on enhanced status with family difficulties could attend family visits in the community. (3.93)

# Appendix I: Inspection team

| | | |
|---|---|---|
| Anne Owers | - | HM Chief Inspector of Prisons |
| Roger Haley | - | Team leader |
| Jonathan French | - | Inspector |
| Ian MacFadyen | - | Inspector |
| Steve Moffatt | - | Inspector |
| Hubisi Nwemely | - | Inspector |
| Gordon Riach | - | Inspector |

## Specialist inspectors

| | | |
|---|---|---|
| Sigrid Engelen | - | Substance use |
| Tish Laing Morton | - | Healthcare |
| John Reynolds | - | Dental |
| Tim Snewin | - | Pharmacy |
| Bob Cowdrey | - | Adult Learning Inspector (lead) |
| Bill Massam | - | Ofsted (lead) |

## Researchers

Mark Challen
Lucy Richardson

# Appendix II: Prison population profile – young men

| (i) Status | Number | % |
|---|---|---|
| Sentenced | 7 | *39* |
| Remand | 11 | *61* |
| **Total** | **18** | ***100*** |

| (ii) Sentence | Number of sentenced prisoners | % |
|---|---|---|
| Less than 6 months | 1 | *14* |
| 6 months-less than 12 months | 1 | *14* |
| 12 months-less than 2 years | 1 | *14* |
| 2 years-less than 4 years | 2 | *20* |
| 4 years-less than 10 years | 2 | *29* |
| **Total** | **7** | ***100*** |

| (iii) Length of stay | Sentenced prisoners | | Unsentenced prisoners | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | | | 3 | *27* |
| 1 month to 3 months | | | 8 | *73* |
| 1 year to 2 years | 2 | *28.5* | | |
| 2 years to 4 years | 3 | *43* | | |
| 4 years or more | 2 | *28.5* | | |
| **Total** | **7** | ***100*** | **11** | ***100*** |

| (iv) Main offence | Number | % |
|---|---|---|
| Violence against the person | 6 | *33* |
| Sexual offences | 1 | *6* |
| Burglary | 2 | *10* |
| Robbery | 1 | *6* |
| Theft and handling | 1 | *6* |
| Drugs offences | 6 | *33* |
| Other offences | 1 | *6* |
| **Total** | **18** | ***100*** |

| (v) Age | Number | % |
|---|---|---|
| 18 | 5 | *28* |
| 19 | 5 | *28* |
| 20 | 5 | *28* |
| 21 | 3 | *3* |
| **Total** | **100** | ***100*** |

| (vi) Home address | Number | % |
|---|---|---|
| Within 50 miles of the prison | 17 | *95* |
| No fixed address | 1 | *5* |
| **Total** | **18** | |

| (vii) Nationality - *Information not supplied* |
|---|

| (viii) Ethnicity | Number | % |
|---|---|---|
| *White:* | | |
| British | 14 | *78* |
| Irish | 1 | *5* |
| Other White | 1 | *5* |
| *Black or Black British:* | | |
| Other Black | 2 | *12* |
| **Total** | **18** | ***100*** |

| (ix) Religion | Number | % |
|---|---|---|
| Church of England | 1 | |
| Roman Catholic | 6 | |
| Other Christian denominations | 3 | |
| Other | 1 | |
| No religion | 7 | |
| **Total** | **18** | **100** |

# Appendix III: Prison population profile – adult men

| (i) Status | Number | % |
|---|---|---|
| Sentenced | 110 | *76* |
| Remand | 34 | *24* |
| **Total** | **144** | ***100*** |

| (ii) Sentence | Number of sentenced prisoners | % |
|---|---|---|
| Less than 6 months | 6 | *6* |
| 6 months-less than 12 months | 3 | *3* |
| 12 months-less than 2 years | 6 | *5* |
| 2 years-less than 4 years | 19 | *17* |
| 4 years-less than 10 years | 67 | *61* |
| 10 years and over (not life) | 9 | *8* |
| Total | **110** | ***100*** |

| (iii) Length of stay | Sentenced prisoners | | Unsentenced prisoners | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | 1 | | 8 | |
| 3 months to 6 months | 1 | | 26 | |
| 1 year to 2 years | 12 | | | |
| 2 years to 4 years | 28 | | | |
| 4 years or more | 68 | | | |
| **Total** | **110** | | **34** | |

| (iv) Main offence | Number | % |
|---|---|---|
| Violence against the person | 13 | *9* |
| Sexual offences | 2 | *1.39* |
| Burglary | 3 | *2.08* |
| Theft & handling | 6 | *4.17* |
| Drugs offences | 108 | *75* |
| Other offences | 12 | *8.33* |
| **Total** | **144** | ***100*** |

| (v) Age | Number | % |
| --- | --- | --- |
| 21 years to 29 years | 53 | *37* |
| 30 years to 39 years | 47 | *33* |
| 40 years to 49 years | 31 | *22* |
| 50 years to 59 years | 9 | *6* |
| 60 years to 69 years | 3 | *2* |
| 70 plus years - *maximum age: 71* | 1 | *1* |
| Total | **144** | ***100*** |

| **(vi) Home address** | **Number** | **%** |
| --- | --- | --- |
| Within 50 miles of the prison | 98 | *68* |
| Overseas | 46 | *32* |
| **Total** | **144** | ***100*** |

| **(vii) Nationality** | **Number** | **%** |
| --- | --- | --- |
| British | 126 | *88* |
| Foreign nationals | 18 | *12* |
| **Total** | **144** | ***100*** |

| **(viii) Ethnicity** | **Number** | **%** |
| --- | --- | --- |
| *White:* | | |
| British | 121 | *84* |
| Irish | 2 | *1* |
| *Asian or Asian British:* | | |
| Bangladeshi | 12 | *9* |
| *Black or Black British:* | | |
| Other Black | 8 | *6* |
| **Total** | **144** | ***100*** |

| (ix) Religion | Number | % |
|---|---|---|
| Church of England | 42 | *29* |
| Roman Catholic | 51 | *36* |
| Other Christian denominations | 6 | *4* |
| Muslim | 6 | *4* |
| Buddhist | 1 | |
| Other | 9 | *6* |
| No religion | 29 | *20* |
| **Total** | **144** | ***100*** |

# Appendix IV: Prison population profile – women

| (i) Status | Number | % |
|---|---|---|
| Sentenced | 10 | *72* |
| Remand | 4 | *28* |
| **Total** | **14** | ***100*** |

| (ii) Sentence | Number of sentenced prisoners | % |
|---|---|---|
| 6 months-less than 12 months | 1 | |
| 2 years-less than 4 years | 3 | |
| 4 years-less than 10 years | 6 | |
| **Total** | **10** | |

| (iii) Length of stay | Sentenced prisoners | | Unsentenced prisoners | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | | | 3 | |
| 6 months to 1 year | 1 | *10* | 1 | |
| 2 years to 4 years | 3 | *30* | | |
| 4 years or more | 6 | *60* | | |
| **Total** | **10** | | **4** | |

| (iv) Main offence | Number | % |
|---|---|---|
| Fraud and forgery | 1 | *7* |
| Drugs offences | 13 | *93* |
| **Total** | **14** | ***100*** |

| (v) Age | Number | % |
|---|---|---|
| 21-29 | 5 | *36* |
| 30-39 | 3 | *22* |
| 40-49 | 4 | *28* |
| 50-59 | 2 | *14* |
| **Total** | **14** | ***100*** |

| (vi) Home address | Number | % |
|---|---|---|
| Within 50 miles of the prison | 6 | *43* |
| Overseas | 8 | *57* |
| **Total** | **14** | ***100*** |

| (vii) Nationality | Number | % |
|---|---|---|
| British | 14 | *100* |
| Foreign nationals | 0 | *0* |
| **Total** | **14** | ***100*** |

| (viii) Ethnicity | Number | % |
|---|---|---|
| *White:* | | |
| British | 14 | *100* |
| **Total** | **14** | ***100*** |

| (ix) Religion | Number | % |
|---|---|---|
| Church of England | 9 | *65* |
| Roman Catholic | 4 | *28* |
| No religion | 1 | *7* |
| Total | **14** | ***100*** |

# Appendix V: Summary of prisoner 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 2 June 2005 the prisoner population at La Moye was 174. The baseline sample size was 102. Overall, this represented 59% of the prisoner population.

### Selecting the sample

Respondents were randomly selected from a local inmate database system (LIDS) prisoner population printout using a stratified systematic sampling method. This basically means every second person is selected from a LIDS list, which is printed in location order, if 50% of the population is to be sampled.

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, two 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, 86 respondents completed and returned their questionnaires. This represented 49% of the prison population. The response rate was 84%. (In addition to the three respondents who refused to complete a questionnaire, 11 questionnaires were not returned and two prisoners were released before they had completed their questionnaire.)

## 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 results from the Guernsey prisoner survey 2005. In addition, attached, is a document comparing the adult male population at Jersey with the local prison benchmark for England and Wales. This benchmark is based on respondents from all local prisons surveyed since April 2003.

Separate analysis was not carried out for the black and minority ethnic or the foreign national population because of the small numbers.

In all the above documents, 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 grey shading, results that are significantly worse are indicated by a black background and where there is no significant difference, there is no shading.

## Prisoner Survey Responses Jersey and Guernsey 2005

**Prisoner Survey Responses (Missing data has been excluded for each question) Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.**

**Key to tables**

| Key | | Guernsey | Jersey |
|---|---|---|---|
| (green) | Any numbers highlighted in green are significantly better than Guernsey 2005 | | |
| (black) | Any numbers highlighted in black are significantly worse than Guernsey 2005 | | |
| (white) | Numbers which are not highlighted show there is no significant difference between the Jersey 2005 and Guernsey 2005 | | |
| **SECTION 1: General Information (not tested for significance)** | | | |
| **1** | Number of completed questionnaires returned | 94 | 86 |
| **2** | Are you under 21 years of age? | **22** | **16** |
| **3** | Are you sentenced? | **81** | **70** |
| **4** | Is your sentence more than four years? | **20** | **42** |
| **5** | Do you have less than six months to serve? | **51** | **16** |
| **6** | Have you been in this prison less than a month? | **14** | **6** |
| **7** | Are you a foreign national? | **19** | **16** |
| **8** | Is English your first language? | **86** | **89** |
| **9** | Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White other categories) | **6** | **12** |
| **10** | Have you been in prison more than five times? | **17** | **23** |
| **11** | Do you have any children? | **37** | **38** |
| **SECTION 2: Transfers and Escorts** | | | |
| **12a** | We want to know about the most recent journey you have made either to or from court or between establishments. How was the cleanliness of the van? (very good/good) | **68** | **28** |
| **12b** | We want to know about the most recent journey you have made either to or from court or between establishments. How was your personal safety during the journey? (very good/good) | **72** | **53** |
| **12c** | We want to know about the most recent journey you have made either to or from court or between establishments. How was the comfort of the van? (very good/good) | **44** | **6** |
| **12d** | We want to know about the most recent journey you have made either to or from court or between establishments. How was the attention paid to your health needs? | **50** | **24** |
| **12e** | We want to know about the most recent journey you have made either to or from court or between establishments. How was the frequency of comfort breaks? (very good/good) | **30** | **7** |
| **13** | Did you spend more than four hours in the van? | **0** | **0** |
| **14** | Were you treated well/very well by the escort staff? | **75** | **66** |
| **15a** | Did you know where you were going when you left court or when transferred from another establishment? | **90** | **88** |
| **15b** | Before you arrived here did you receive any written information about what would happen to you? | **12** | **11** |
| **15c** | When you first arrived here did your property arrive at the same time as you? | **75** | **50** |

| SECTION 3: Reception, first night and induction | | | |
|---|---|---|---|
| 17 | Did you have any problems when you first arrived? | 59 | 75 |
| 18 | Did you receive any help/support from any member of staff in dealing with these problems within the first 24 hours? | 36 | 44 |
| 19a | Please answer the following question about reception: were you seen by a member of healthcare staff? | 88 | 94 |
| 19b | Please answer the following question about reception: when you were searched, was this carried out in a sensitive and understanding way? | 77 | 85 |
| 20 | Were you treated well/very well in reception? | 76 | 86 |
| 21a | Did you receive a reception pack on your day of arrival? | 69 | 51 |
| 21b | Did you receive information about what was going to happen here on your day of arrival? | 41 | 24 |
| 21c | Did you receive information about support for feeling depressed or suicidal on your day of arrival? | 26 | 18 |
| 21d | Did you have the opportunity to have a shower on your day of arrival? | 40 | 81 |
| 21e | Did you get the opportunity to have a free telephone call on your day of arrival? | 49 | 50 |
| 21f | Did you get information about routine requests on your day of arrival? | 40 | 22 |
| 21g | Did you get something to eat on your day of arrival? | 75 | 82 |
| 21h | Did you get information about visits on your day of arrival? | 41 | 39 |
| 22a | Did you have access to the chaplain/priest within the first 24 hours of you arriving at this prison? | 16 | 6 |
| 22b | Did you have access to someone from healthcare within the first 24 hours? | 84 | 79 |
| 22c | Did you have access to a Listener/Samaritans within the first 24 hours of you arriving at this prison? | 14 | 6 |
| 22d | Did you have access to the prison shop/canteen within the first 24 hours? | 45 | 46 |
| 23 | Did you feel safe on your first night here? | 79 | 69 |
| 24 | Did you go on an induction course within the first week? | 11 | 3 |
| 25 | Did the induction course cover everything you needed to know about the prison? | 14 | 3 |
| SECTION 4: Legal Rights and Respectful Custody | | | |
| 27a | Can you get access to legal reference books? | 27 | 19 |
| 27b | Can you get access to communication with your solicitor or legal representative? | 77 | 81 |
| 27c | Can you get access to information about leave to appeal? | 48 | 58 |
| 27d | Can you get access to legal visits? | 73 | 78 |
| 27e | Can you get access to help with legal costs? | 64 | 62 |
| 27f | Can you get access to bail information? | 40 | 38 |
| 28a | Please answer the following question about the wing/unit you are currently on: are you normally offered enough clean, suitable clothes for the week? | 90 | 99 |
| 28b | Please answer the following question about the wing/unit you are currently on: are you normally able to have a shower every day? | 94 | 100 |
| 28c | Please answer the following question about the wing/unit you are currently on: do you normally receive clean sheets every week? | 91 | 57 |
| 28d | Please answer the following question about the wing/unit you are currently on: do you normally get cell cleaning materials every week? | 90 | 78 |
| 28e | Please answer the following question about the wing/unit you are currently on: is your cell call bell normally answered within five minutes? | 22 | 21 |
| 28f | Please answer the following question about the wing/unit you are currently on: is it normally quiet enough for you to be able to relax or sleep in your cell at night time? | 64 | 77 |
| 28g | Please answer the following question about the wing/unit you are currently on: can you normally get your stored property, if you need to? | 63 | 59 |
| 29 | Have staff ever opened letters from your solicitor or legal representative when you were not with them? | 51 | 48 |
| 30 | Is the food in this prison good/very good? | 77 | 30 |
| 31 | Does the shop/canteen sell a wide enough range of goods to meet your needs? | 48 | 52 |
| 32a | Is it easy/very easy to get a complaints form? | 55 | 77 |
| 32b | Is it easy/very easy to get an application form? | 95 | 77 |
| 33a | Do you feel applications are sorted out fairly? | 61 | 21 |
| 33b | Do you feel complaints are sorted out fairly? | 19 | 9 |

| 33c | Do you feel applications are sorted out promptly? | 69 | 39 |
|---|---|---|---|
| 33d | Do you feel complaints are sorted out promptly? | 20 | 18 |
| 33e | Are you given information about how to make an appeal? | 36 | 29 |
| 34 | Have you ever been made to or encouraged to withdraw a complaint since you have been in this prison? | 14 | 10 |
| 36 | Is it easy/very easy to contact the Independent Monitoring Board (BOV)? | 35 | 46 |
| 37 | Are you on the enhanced (top) level of the IEP scheme? | 57 | 21 |
| 38 | Do you feel you have been treated fairly in your experience of the IEP scheme? | 60 | 22 |
| 39a | In the last six months have any members of staff physically restrained you (C & R)? | 5 | 9 |
| 39b | In the last six months have you spent a night in the segregation unit? | 29 | 18 |
| 40a | Do you feel your religious beliefs are respected? | 39 | 43 |
| 40b | Are you able to speak to a religious leader of your faith in private if you want to? | 51 | 41 |
| 41 | Are you able to speak to a Listener at any time, if you want to? | 37 | 22 |
| 42a | Do you have a member of staff, in this prison, that you can turn to for help if you have a problem? | 79 | 76 |
| 42b | Do most staff, in this prison, treat you with respect? | 86 | 80 |
| **SECTION 5: Safety** | | | |
| 44 | Have you ever felt unsafe in this prison? | 23 | 31 |
| 46 | Have you been victimised (insulted or assaulted) by another prisoner? | 19 | 30 |
| 47a | Have you had insulting remarks made about you, your family or friends since you have been here? (By prisoners) | 11 | 16 |
| 47b | Have you been hit, kicked or assaulted since you have been here? (By prisoners) | 8 | 16 |
| 47c | Have you been sexually abused since you have been here? (By prisoners) | 1 | 3 |
| 47d | Have you been victimised because of your race or ethnic origin since you have been here? (By prisoners) | 2 | 5 |
| 47e | Have you been victimised because of drugs since you have been here? (By prisoners) | 1 | 4 |
| 47f | Have you ever had your canteen/property taken since you have been here? (By prisoners) | 7 | 6 |
| 47g | Have you ever been victimised because you were new here? (By prisoners) | 4 | 8 |
| 47h | Have you ever been victimised because you were from a different part of the country than others since you have been here? (by prisoners | 4 | 3 |
| 48 | Have you been victimised (insulted or assaulted) by a member of staff? | 29 | 31 |
| 49a | Have you had insulting remarks made about you, your family or friends since you have been here? (By staff) | 19 | 20 |
| 49b | Have you been hit, kicked or assaulted since you have been here? (By staff) | 6 | 6 |
| 49c | Have you been sexually abused since you have been here? (By staff) | 3 | 2 |
| 49d | Have you been victimised because of your race or ethnic origin since you have been here? (By staff) | 1 | 0 |
| 49e | Have you been victimised because of drugs since you have been here? (By staff) | 5 | 12 |
| 49f | Have you ever been victimised because you were new here? (By staff) | 13 | 2 |
| 49g | Have you ever been victimised because you were from a different part of the country than others since you have been here? (By staff) | 6 | 0 |
| 50 | Did you report any victimisation that you have experienced? | 25 | 14 |
| **SECTION 6: Healthcare** | | | |
| 52 | Do you think the overall quality of the healthcare is good/very good? | 66 | 57 |
| 53a | Do you think the quality of healthcare from the doctor is good/very good? | 65 | 59 |
| 53b | Do you think the quality of healthcare from the nurse is good/very good? | 66 | 57 |
| 53c | Do you think the quality of healthcare from the dentist is good/very good? | 44 | 26 |
| 53d | Do you think the quality of healthcare from the optician is good/very good? | 32 | 18 |
| 53e | Do you think the quality of healthcare from the dispensing staff/pharmacist is good/very good? | 59 | 59 |

| | | | |
|---|---|---|---|
| 54 | Is it easy/very easy to get illegal drugs in this prison? | 26 | 30 |
| 55a | Do you think you will have a problem with drugs when you leave this prison? | 12 | 20 |
| 55b | Do you think you will have a problem with alcohol when you leave this prison? | 11 | 11 |
| **SECTION 7: Purposeful Activity** | | | |
| 57a | Do you feel your job will help you on release? | 32 | 29 |
| 57b | Do you feel your vocational or skills training will help you on release? | 17 | 27 |
| 57c | Do you feel your education (including basic skills) will help you on release? | 40 | 40 |
| 57d | Do you feel your offending behaviour programmes will help you on release? | 22 | 16 |
| 57e | Do you feel your drug or alcohol programmes will help you on release? | 24 | 30 |
| 58 | Do you go to the library at least once a week? | 48 | 23 |
| 59 | Can you get access to a newspaper every day? | 91 | 64 |
| 60 | On average, do you go to the gym at least twice a week? | 64 | 57 |
| 61 | On average, do you go outside for exercise three or more times a week? | 43 | 53 |
| 62 | On average, do you spend ten or more hours out of your cell on a weekday? (This includes hours at education, at work etc) | 23 | 35 |
| 63 | On average, do you spend ten or more hours out of your cell on a weekend day?(This includes hours at education, at work etc) | 14 | 10 |
| 64 | On average, do you go on association more than five times each week? | 55 | 54 |
| 65 | Do staff normally speak to you at least most of the time during association time? (most/all c | 30 | 40 |
| **SECTION 8: Resettlement** | | | |
| 67 | Did you first meet your personal officer in the first week? | 24 | 30 |
| 68 | Do you think your personal officer is helpful/very helpful? | 53 | 48 |
| 69 | Do you have a custody/sentence plan? | 37 | 32 |
| 70 | Were you involved/very involved in the development of your sentence plan? | 22 | 22 |
| 71 | Have you had any problems with sending or receiving mail? | 33 | 23 |
| 72 | Have you had any problems getting access to the telephones? | 9 | 32 |
| 73 | Did you have a visit in the first week that you were here? | 76 | 71 |
| 74 | Does this prison give you the opportunity to have the visits you are entitled to? (e.g. numbe and length of visit) | 86 | 80 |
| 75a | Do you know who to contact, within this prison, to get help with finding a job on release? | 54 | 27 |
| 75b | Do you know who to contact, within this prison, to get help with finding accommodation on release? | 53 | 21 |
| 75c | Do you know who to contact, within this prison, to get help with your finances in preparatior for release? | 38 | 14 |
| 75d | Do you know who to contact, within this prison, to get help with claiming benefits on release? | 45 | 11 |
| 75e | Do you know who to contact, within this prison, to get help with arranging a place at college/continuing education on release? | 44 | 18 |
| 75f | Do you know who to contact within this prison to get help with external drugs courses etc | 43 | 40 |
| 75g | Do you know who to contact, within this prison, to get help with continuity of healthcare on release? | 41 | 34 |
| 76 | Have you done anything, or has anything happened to you here that you think will make you less likely to offend in the future? | 50 | 36 |